Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive

National Service Plan 2012

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Introduction from the Chief Executive Officer

The budget provision for 2012 represents a major challenge to the HSE and comes at a time of significant reform of the public health system. The total quantifiable cost reduction target of €750m for 2012 follows two unprecedented years in the history of the health service in which the HSE had total budget reductions of €1.75bn. Staff levels have reduced by over 8,700 since the peak employment levels in 2007.

In the last two years, the reductions in health expenditure have been achieved largely through a combination of price reductions such as public service pension levy and pay cuts, procurement efficiencies, successive drug price reductions and cuts in fees for GPs and community pharmacists as well as changes in demand-led schemes, increases in charges and reductions in numbers employed. In 2012, the bulk of the savings measures relate to reductions in numbers employed but there are also other reductions in pay costs and service efficiencies. As a result of the scale of the cost reductions required and the accumulated reductions in frontline staff, the bulk of the reductions that the HSE is required to deliver in 2012 will impact increasingly directly on frontline services. This is mainly because of the anticipated reduction in the numbers of staff who will have exited the services by the end of February 2012 at the end of the "grace period". A review of this plan will be needed once the full impact of staff leaving is known.

There is a fundamental challenge in terms of our ability to maximise services through fast tracking new, innovative and more efficient ways of using a reducing resource. While it will be impossible to avoid an impact on frontline service delivery in 2012, the imperative for accelerated health reform is equally clear. There is a clear and pressing need, as outlined in the HSE National Clinical Programmes, to move to models of care across all services / care groups which treat patients at the lowest level of complexity and provide services at the least possible unit cost. This means, for example, that patients need to be treated, as far as possible, in primary care rather than hospital settings and that older people need, where appropriate, to receive community supports such as home help, home care packages and intermediate care rather than long-term residential care. If the cost base within the health service is to be adjusted in line with the requirements of the *Comprehensive Expenditure Report 2012-14*, the focus must be on reconfiguration, reform, greater productivity and challenging traditional cost structures and models of service delivery. We also need to address staffing levels, skill mix and staff attendance patterns / rosters within the context of the *Public Service Agreement 2010-2014.* However all of these efficiencies will not compensate for the loss of frontline healthcare delivery staff in such large numbers. This plan will be implemented while the structural reform of the HSE and health services are being progressed as outlined in the *Programme for Government* and as recently announced by the Minister for Health.

Our priorities for 2012 are to:

- Deliver the maximum level of safe services possible for the reduced funding and employment levels, including addressing insofar as possible the unstructured nature of the downsizing. This involves prioritising some services over others to meet the most urgent needs resulting from demographic growth and Government and service priorities.
- Deliver the cost reductions needed to deliver a balanced Vote in 2012.
- Support the continued implementation of our reform programme including the HSE National Clinical Care Programmes.
- Implement key elements of the *Programme for Government* particularly in children and families, mental health, primary care and acute hospitals, and the recommendations of the *Comprehensive Expenditure Report 2012-14.*

The Funding Position

The gross current Estimate for the HSE is **€13,317m** as set out in the published *Estimates of Receipts and Expenditure 2012*. This amounts to a reduction of **€84m** in the allocation set out in the 2011 Revised Estimates Volume[1]. The reduction in the net current Estimate is €164m, because of the extra €80m private health insurance income to be collected by HSE hospitals.[2] The 2012 HSE finances are summarised in Table 1.

[1] After subtracting the €15m ICT capital vired into Fair Deal on a one-off basis

[2] As indicated in Table 2, a further €63m has to be collected by voluntary hospitals

Table 1:

Summary of HSE Finances 2012

	€m	
Vote at 31.12.2011	**13,565**	
Less once off funding Fair Deal withdrawn	-15	
Less 2011 supplementary funding	-148	
Revised opening position	13,402	
Less savings specified in the estimate 2012	-494	Table 2
Plus additional funds set out in estimate 2012	410	Table 3
Vote at 01.01.2012	**13,317**	
Savings specified in the estimate 2012	**-494**	
Potential additional costs	**-256**	Table 4
Required total cost reductions	**750**	

The reduction of €84m is made up of a gross reduction of **€494m** less provision for new spending of **€410m (**Tables 2 and 3). Although the €494m represents an average reduction of 3.6%, the impact on the budgets of the different services is greater because the bulk of the spending in Table 3 is for demand led schemes, Nursing Homes Support Scheme – A Fair Deal (NHSS) and superannuation. The impact on the various services is shown in Tables 10 to 12.

In addition, the HSE must meet quantifiable further cost increases of **€256m** as outlined in Table 4. No specific provision for these cost pressures has been made in the budget allocations but budget holders will be required to meet the extra costs within their allocations. A substantial element of this is the annualised closing run rate (deficit). The exact amount remains to be determined but is currently estimated to be about €130m, comprising €145m for hospitals and €60m for children and family services, and offset in part by a run rate surplus of €75m in other areas. At the request of the Minister, the HSE has reallocated €40m to Children and Family services from the budgets of other community services. However, acute hospitals will have to deliver sufficient additional cost reductions to address their underlying deficits within their reduced budgets.

The total known and quantifiable cost reduction requirement is therefore **€750m**, made up of the gross reduction of **€494m** (set out in Table 2, the substantial element of which is €183m gross pay savings) and the **€256m** detailed above made up of the annualised closing run rate (deficit) of €130m and the further cost increases of €126m set out in Table 4). In addition, it will be necessary to increase our income collection by €143m (Table 9).

Finally and importantly, the HSE must deal, as best it can, with the increase in service need associated with demographic, disease incidence and other drivers of health and personal social care needs. It has received no additional funding for this purpose other than that shown in Table 3.

Table 2:

2012 Reductions in Expenditure based on the published Estimate

	€m
Measures to reduce cost	
Pay and cost reduction measures	183
Procurement	50
Care group reductions	50
Community based drug schemes reductions	124
Income – voluntary bodies	63
Pay reductions: Student nurses	12
Long stay repayment scheme	11
Other	1
Subtotal	**494**

Table 3:

Additional Expenditure to be incurred in 2012 based on the published Estimate

	€m
Nursing Home Support Scheme – A Fair Deal	55
Superannuation	147
Community based drug schemes	158
GP cards	15
Mental health investment	35
Total	**410**

Table 4:

Estimate of the Additional Financial issues facing the HSE in 2012 for which no provision is made in the published Estimate

	€m
Estimated annualised closing run rate (deficit)	130
EU Directive on agency staff	15
Increments	46
Renal Services	5
VAT – estimate	50
Removal of relief for pensions	10
Subtotal	**256**

Growth in the overdrafts in the voluntary sector have not been included in the table above on the basis that any increase in the overdraft level in 2011 will remain in place at the end of 2012 and not require additional vote funding at year end.

Pay and pay related expenditure

Delivery of this service plan is subject to the pay bill of the HSE falling by a further **€183m** in 2012 (Table 5).

Table 5:

Adjustments to the HSE Pay Bill for 2012

	€m
Recruitment moratorium	160
Overtime and premium pay	23
Sub total	**183**

The opening employment ceiling for 2012 is estimated as 105,300 whole time equivalents (WTE) reducing by 3,200 to 102,100 by the end of 2012. The projected outturn for 2011 is 104,500, some 800 below the opening 2012 ceiling. At this juncture, about 2,816 people, in WTE terms, will have availed of the end of the grace period by the end of February 2012. The plan assumes about 3,000 exits who will be paid lump sums in 2012. The plan also assumes the recruitment of approximately 400 extra staff for mental health services, the filling of as many vacancies as possible in Primary Care and continued recruitment to support the HSE National Clinical Programmes in acute hospitals.

Table 6

Profile of the staff who are availing of the end of grace period

	General Support	Health and Social Care professionals	Management / Admin	Medical / Dental	Nursing	Patient and Client Care	Other	Total
Retirement analysis by no. of staff	353	314	281	128	1,612	613	12	3,313
Retirement analysis by WTE	300	267	239	109	1,370	521	10	2,816

Table 7 sets out the reductions in pay required to fund 3,000 WTE reductions in 2012 and meet the additional pay savings.

Table 7

Reductions in the Pay Bill required to fund 3,000 WTE reductions in 2012 and breakdown of how it will be funded

	€m
Additional cost of pensions	68
Provision for lost pension related income	19
Prioritised recruitment	16
Estimated cost of additional lump sums	44
Other pay reductions	80
	227
Funded by	
Pay savings required based upon 3,000 WTE savings	160
Additional lump sum provision	44
Further pay savings required as set out in Estimate 2012	23
	227

The plan has been developed on the basis that the provision for pensions and lump sums can be incorporated into the overall pay budgetary envelope to ensure maximum flexibility. This agreement to vire funds from the subhead for lump sums to other subheads in the 2012 vote is a key and welcome component of the 2012 budgetary structure. It means any shortfall in the numbers exiting / pay savings can be offset against any unspent pension and lump sum funding and this approach will assist in maintaining the maximum possible service level in 2012. However, there is still a risk that if total retirements exceed 3,000 or there is some fundamental shift in the pay and service pattern of retirees there would be a need to provide for this from within the overall HSE resources. We will need to review some of our projections when the position becomes clearer.

The pay modelling assumption assumes a replacement factor of €16m for critical posts. The availability of this €16m is contingent on what actually happens at the end of February 2012. Given the high number of service posts which will be vacated, this represents a very limited capacity to address what undoubtedly will be critical gaps in services.

Government policy is incentivising retirements before the end of February 2012 and it is already clear there is and will be further significant loss of front line service delivery people. We need to start planning immediately to pro-actively manage, as far as possible, the impact on different services of the unstructured nature of the exits.

We also need to reduce agency usage, overtime and premium payments. We have built up an unaffordable reliance on agency staff in recent years in an attempt to maintain service, often at levels beyond that for which we had staff or budget. This cannot continue and a critical part of 2012 will be to substantially reduce agency expenditure and seek to use our own staff to keep priority services open. Agency spend in 2011 exceeded €200m. This will have to reduce by up to 50%. This reduction will impact primarily on hospitals, childcare services and community nursing units. Hospitals and childcare services must achieve these reductions in order to address their underlying deficits and community nursing units must do so in order to reduce their unit costs of care which are becoming increasingly unviable.

Community (Demand-Led) Schemes

A net additional €49m is being provided which, together with savings measures of €124m, is designed to fund the estimated cost of community schemes next year, including the cost of additional medical cards and GP visit cards and the extension of GP visit cards to claimants under the long term illness (LTI) scheme as provided for in the *Programme for Government* (Table 8). A further €5m cost reduction target will be implemented in the Revised Estimate Volume (REV) to support the recruitment of critical primary care staff.

The required reductions are building on the €414m reductions applied in 2011. In 2010, PCRS spent €1.9bn on pharmaceuticals. During the period 2000 – 2010, this was one of the fastest growing components of public expenditure. It increased by 158% in real terms and accounted for 12.9% of total public health expenditure. In recent years, a number

of changes to the pricing and reimbursement regimes have been successfully introduced and a reversal of the upward trend was seen from 2009. The number of eligible people and the number of items claimed continue to increase but the total prescription costs and the ingredient cost per item have come down. In 2012, efficiencies supported by legislative changes will provide scope for driving out further reductions in drug pricing. A target of €112m is required and will contribute to the overall HSE savings target. This will not be available to be redistributed to support service delivery or development. The HSE will face potential incremental drug costs of €30m which have not been provided for but will have to be considered in the context of total PCRS expenditure in 2012. This will require an even stronger focus on achieving more clinically and cost-effective usage of existing approved drugs.

Table 8

Community (Demand-Led) Schemes allocation as per the published Estimate

	Gross €m	A-in-A €m	Total €m
Estimate 2011	**2,419.50**	**-25.00**	**2,394.50**
Adjustments for 2012			
Full year costs of schemes	158		158
Extension of GP visit cards to LTI claimants	15		15
Savings*	-112		-112
Increase DPS threshold	-12		-12
Other	-5		-5
Estimate 2012 per published Estimate	**2,463.50**	**-25.00**	**2,438.50**

*some elements of savings will require legislative changes

Income

Significantly increased income targets have been set for 2012 and are a key component of our budgetary plan in 2012. Failure to achieve the targets would mean either a deficit in our Vote or a reduction in services. Legislative changes are needed to allow for the charging of all private patients, and the HSE will work closely with the Department of Health (DoH) to maximise income collection. The HSE has an underlying shortfall in appropriations-in-aid of €37m for 2011, which the Estimate assumes is collectable in 2012. This is a very challenging target.

Table 9

Increase in Income Target for 2012 (Statutory and Voluntary Sectors)

	€m
Legislative change to charging regime, accelerated collections and increases in charges.	143.0

Nursing Homes Support Scheme (NHSS)

The current estimate provision for the NHSS is €1,049m. As a result of further analysis, a figure of €1,046.1m has been used for this service plan. An additional €55m is being provided for the *Nursing Homes Support Scheme: A Fair Deal* in 2012. However, the once off provision in 2011 of €15m will no longer be available and the overall provision is required to be reduced as a result of the targeted savings in procurement and loss of staff costs associated with the public community nursing units. Adjustments to the NHSS subhead (B12) will be made as part of the revised estimates process to extract about €42m in non-Fair Deal ancillary costs. There may also be a further amendment to incorporate about €10m extra in Fair Deal costs which are currently outside the subhead but this is subject to further discussions. Any changes to the designation of beds in terms of use in the provision of long term or day, respite or rehabilitation care will also need to be reflected in the subhead in the REV or at year end as part of any necessary viring in completion of the 2012 vote position. In summary, the HSE anticipates that €1,004.1m will be available for the NHSS following appropriate adjustments in the REV, the detailed build up of which is outlined in Appendix 1b.

Our initial assessment is that the 2012 level of provision will support 23,611 clients by the end of 2012, 1,270 additional when compared with the projected 2011 outturn. We recognise that there is an issue relating to the growth in the weekly cost of care in public facilities based upon the decline in bed numbers. This will be subject to discussion and decision with the Department of Health.

Non pay expenditure

The plan is based on savings in non-pay of €50m. The HSE will be seeking to reduce prices and control volumes of stock of supplies and services used by the HSE and the voluntary sector and this measure should not of itself impact on services. This amount has been deducted from budgets and the Regional Directors of Operations (RDOs) will work with procurement services to deliver the required savings. Monitoring of the achievement of this non pay expenditure will be by way of monthly assessment of regional financial variances.

Children and Families

The provision in the estimate for Children and Families is €568m. For the first time there is a dedicated subhead in the Vote of the HSE showing this amount (B15). As this subhead is being established for the first time, it is to be expected that the actual provision will change in the revised estimate volume. The service plan is prepared on the basis that the actual provision for childcare will not require any extraction from other care groups other than the €40m reduction previously referenced. The HSE, the Department of Health and the Department of Children and Youth Affairs (DCYA) will determine the final childcare budget prior to the conclusion of the REV.

Service Delivery Impact in 2012

As described, the HSE faces a large reduction in budgets in 2012 following several years of delivering more with less money. The issue most directly impacting on the levels of services to which the HSE can commit is the number of staff who will be available next year to deliver our frontline services. Healthcare is a people business and ultimately we require sufficient people available to deliver the hands-on service. The year on year impact of reducing staff numbers in line with the Government's Employment Control Framework (ECF) alongside reductions in our pay budget means that much efficiency has already been delivered and it is not possible to protect services from reductions in 2012. Based on the ECF and the financial allocation, this plan is based on approximately 3,000 WTEs leaving in 2012. In addition, use of agency staff is targeted to reduce by 50%. Both of these factors directly impact on service delivery. However, the HSE is working to move to new models of care which will allow us to get more from our reduced budget. Notwithstanding this, it is clear that it will not be possible to deliver all services at the same levels as previous years.

Acute Hospitals and National Clinical Programmes

Year on year, the HSE faces an increased demand for acute hospital services arising from a range of factors including population ageing and rising levels of chronic disease. Acute hospitals have thus been under considerable budgetary pressure in recent years and capacity will have to be tailored in line with the available funding to ensure financial sustainability. In 2012, hospital budgets will drop on average by 4.4% of last year's allocation and this will require an expenditure reduction of 7.8% when account is taken of incoming closing run rate (deficits).

As a direct result of the budgetary and staff reductions, activity levels would be expected to fall in 2012 by about 6%. Bed capacity in terms of bed days must reduce in proportion to the reduction in resources but increased efficiency of clinical service delivery arising from the impact of the HSE National Clinical Programmes will ensure that as many patients as possible will be seen and managed as inpatients or day cases. Therefore, we expect to be able to limit the reduction in activity, as measured by the number of people treated, to an average of 3% against 2011 outturn.

Activity reductions will vary from hospital to hospital depending on local circumstances. Hospitals with the greatest carry forward financial challenge will find it most difficult to maintain activity levels and some will require a high intensity management process which in addition to managing significant clinical change will also focus on targeted cost reductions and maximising income billing and collection. The western hospitals are particularly challenged, given the level of the historic deficits.

The priority in 2012 will be to stabilise the level of services that can be provided for the available resource and to continue the work of our change programme. The cornerstones of the change programme are the HSE National Clinical Programmes and the rationalisation of services to ensure that best use is made of each hospital site. The HSE National Clinical Programmes provide a national, strategic and co-ordinated approach to a wide range of clinical services. The primary aim of these is to modernise the manner in which hospital services are provided across a wide range of clinical

areas through the standardisation of access to, and delivery of, high quality, safe and efficient hospital services, maximising linkages to primary care and other community services. Funding of €23.4m will be provided in 2012 to hospital budgets to recruit staff to progress the implementation of the Acute Medicine, Emergency Medicine, Stroke, Surgery and other clinical programmes, building on the work started in 2011.

The ongoing policies of moving from inpatient to day case treatment where possible ('stay to day'), increasing the rate of elective inpatients who have their principal procedure performed on day of admission and reducing the average length of stay will further serve to maximise the number of patients being treated while still reducing the number of bed days required. The HSE has targeted a reduction of 5% in average length of stay in 2012.

Decreased hospital activity will impact particularly on elective care, and in this context hospitals will work closely with the Special Delivery Unit (SDU) to ensure that, notwithstanding this reduction, nobody waits longer than 9 months for an elective procedure, thus ensuring equitable access for all. Emergency admissions will be reduced as a result of the impact of the HSE National Clinical Programmes as well as emergency department (ED) wait times, which is a critical priority.

Reorganisation of ambulance services will continue in 2012, leading to a more efficient use of resources. However, as no additional funding is available in 2012, our ability to address the newly agreed national targets will be challenging.

National Cancer Control Programme

The Cancer Control Programme has made great progress to date in improving access and services for the population at large (prevention and screening) and those in need of cancer diagnosis and treatment (surgery, radiation and medical oncology). No additional funding has been allocated in 2012 allocation and the anticipated 3% per annum growth in incidence of cancer will be met from within existing resources as a result of efficiencies. The preparatory phase of the colorectal screening programme will be advanced with the appointment and training of advanced nurse practitioners in 2012. It is planned to commence the roll out of the colorectal screening programme in quarter 4. The NCCP will continue to focus on maximising timely access to services where possible and on the development and implementation of evidence based national diagnostic and treatment guidelines.

Older People

Our priorities for 2012 will be to improve the pathway of care for older people as they access a range of services including home help, home care packages, day respite and residential services. This will require a considerable focus and will be supported by the work of the HSE National Clinical Programmes. Outside of the NHSS, the cost reduction required is on average 2.3% in 2012. The challenge will be to use the existing resource to best meet these needs.

Home Support: We will focus on the maintenance of home care packages at 2011 levels and on re-focusing home help services to prioritise personal care. Home care packages which support the most dependent to remain in their own homes will not be reduced in 2012 and the number of people in receipt of them will be the same as in 2011. There will be reductions of 4.5% nationally in the level of home help hours provided but this reduction will be compensated by a more rigorous approach to the allocation of these supports to ensure that the people most in need receive them by de-prioritising non-personal care. Service efficiencies will mean that despite this level of reduction, the reduction in the number of people in receipt of home help services will be kept to 1.2%.

Intermediate Care: Intermediate care is underdeveloped and has been identified as a critical element of the older persons care pathway. The HSE is committed to working with the DoH in allocating funding from long-term residential care and potential other sources, such as acute hospitals, to increase intermediate care capacity, i.e. step-up / step-down beds, and to provide additional community services such as home care packages. This should reduce demand on acute hospital services and prevent inappropriate admissions to long-term residential care.

Community Nursing Units: It is expected that if the anticipated reduction in staff numbers materialises, a minimum of 555 public beds will close in the course of the year. Most of these will be as a result of bed closures rather than whole unit closures but it is anticipated that a small number of units will be considered for total closure in 2012 as units are consolidated. These closures will be due to staff losses which are anticipated by the end of February and the resulting loss of funds due to the moratorium impact as well as the need to reduce agency spend. Additionally, some beds will close arising from the need to meet the National Standards in relation to the physical infrastructure of HSE homes.

It is clear therefore, that on a business as usual basis the HSE would have to close further beds across a range of public community nursing units in 2012 to deal with the situation it faces regarding staffing, funding and the age and structure of the units. This would increase the unit cost of caring for older people within the public system, undermine the viability of public community nursing units and reduce the overall number of older persons that can be supported within the

budget available for NHSS. This is not a sustainable way forward for the health services and would not meet the needs of older persons, local communities or those working in the health system.

Instead, we need an approach which seeks to protect the viability of as many public units as possible within the funding and staffing resources available. This is likely to require a combination of actions such as consolidation of services; changes in staffing, skill mix and work practices; consideration of the public and private capacity available within an area and alternative options for providing a viable community nursing service including a possible role for local communities or other voluntary providers. The HSE is examining these issues and will be working closely with the Department of Health to jointly develop an overall set of proposals for the Minister as a priority in 2012.

Nursing Homes Support Scheme: It is estimated that 23,611 clients will be supported by this scheme by the end of 2012, an increase of 1,270 on the projected closing position for 2011. Full details of the assumptions underlying this estimate are outlined in Appendix 1b.

Disability

A major change programme for disability services in Ireland has commenced in recent years with a move towards a community-based and inclusive model rather than being institutional and segregated. This process is now gathering momentum. The emerging Department of Health policy direction (Value for Money and Policy Review) will provide the framework within which the constituent parts of the overall change programme will be developed and driven. In 2012, realising this vision will be driven by the increasing need to maximise the value of the reduced funding. The allocation for disability services will reduce in 2012 by 3.7% as a consequence of the impact of the efficiency, procurement and targeted pay reduction savings. In addition, disability services will be required to cater for demographic pressures, such as new services for school leavers and emergency residential placements, from within their existing budgets.

While the allocation will reduce by 3.7% nationally, there is scope for achieving efficiencies of 2% or more through measures such as consolidation and rationalisation of back office costs. Some providers have made significant progress in this regard in recent years but considerable scope for savings remains in the case of others. All providers will be expected to achieve some efficiency savings but the level of savings will vary depending on the profile of the service provider, efficiency savings achieved to date and the scope for further savings. HSE managers will have the scope, within the national figure of 3.7%, to vary the level of reduction which will apply to individual service providers. The HSE will work closely with the Department in finalising the allocations.

Some reductions in services will be unavoidable even with such efficiencies. These will arise in day services, residential and respite services. The aim will be to tailor such reductions in a way which minimises the impact on service users and their families as much as possible. There is evidence that an accelerated move towards a new model of individualised, person centred service provision in the community can help to achieve efficiencies, particularly in relation to services for those with mild or moderate intellectual disability.

Provision has been made for investment of €1m for autism services. This will be used to address waiting times for specialist therapy services for children who have been diagnosed with autism and on developing Early Intervention Teams.

Mental Health

An additional €35m will be invested in mental health services to support the further implementation of *A Vision for Change* which is the basis for the reform of our mental health services. This will be targeted at enhancement of our child, adolescent and adult community teams as well as suicide prevention and counselling services. Approximately 400 extra staff will be recruited to support this. In addition, a number of inpatient child and adolescent units will open in 2012 which have for a long time been a critical missing service in the spectrum of mental health services. The final allocation of the €35m will be the subject of further discussion with the Department of Health.

However, like all care areas, other budget reductions as a consequence of the impact of the efficiency, procurement and moratorium savings will be applied, resulting in cost reductions on average of just less than 1% once the additional investment is taken into account. The cumulative impact of staff loss from the mental health services since 2009 and the attrition expected in early 2012, continues to challenge us to provide continuity of services. This will lead to reductions in inpatient beds in line with the strategic direction of the reform programme. There will also be reductions in payments to external agencies who will be challenged to maximise efficiencies.

Primary Care Services and Community (Demand-Led) Schemes

On average, 2.3% of cost efficiencies are required in primary care. The moratorium has had a significant effect on staffing levels in primary care and, as a result, on the capacity of primary care to deliver an appropriate range and quantum of services. In line with the commitment in the *Programme for Government* to a significant strengthening of primary care services, additional funding of €20m is being allocated to fill as many vacancies as possible and to expand existing arrangements where sessional services are provided by allied health professionals. This will be increased to €25m if it can be established that there is scope for further savings of €5m in demand-led schemes. The allocation of the extra posts will be subject to approval by the joint HSE/DoH project team overseeing the implementation of Universal Primary Care.

Funds have also been prioritised for the HPV campaign and the catch up measles campaign which is of significant public health value given recent measles outbreaks in some parts of the country.

In addition and following enactment of the appropriate legislation, GP visit cards will be issued to Long Term Illness (LTI) claimants in line with the *Programme for Government*. It is also our intention to commence a national roll out of chronic disease management for diabetes during 2012. There will be engagement with general practitioners and other stakeholders. We will also progress preparations for the roll out of similar initiatives in relation to other chronic diseases, including stroke, asthma and heart failure. A number of other initiatives in this plan (such as the enhancement of counselling services and the implementation of the clinical programmes) will further strengthen the role of primary care.

Based on the projected 2012 outturn, a growth of 105,000 medical cards has been anticipated. While the number of cards is a cost driver in schemes, as previously discussed, the primary drivers relate to prescribing practices and the number of items contained within each prescription. In light of the successes in reducing overall drugs costs in recent years, a challenging cost saving target of €124m must be achieved, which is dependent on the implementation of legislative changes in relation to reference pricing, as well as new agreements with pharmaceutical manufacturers.

Children and Families

The 2012 budget allocation shows an increase of 4% compared to the 2011 budget. However, this increase is against a backdrop of budgetary over runs in 2011. Some success was experienced in the latter half of the year in containing these over runs but there will be a requirement for further careful management of costs in 2012. An average reduction in expenditure of 7% will be required to bring spending back from 2011 anticipated outturn levels to the budget provision in 2012. As a result of the necessary budgetary discipline, it is anticipated there will be a requirement to prioritise core service needs and to ensure all activities are delivered in the most cost effective way possible. Consequently there may be some level of reduction in less targeted activities. By the end of 2012 Children and Family Services will be disaggregated from the HSE into a new agency, the Children and Family Support Agency.

Potential Risks to Delivery NSP2012

The single biggest risk we face in 2012 is lack of capacity to meet real health and personal social services needs in the face of reduced funding and availability of staff. This section identifies, where possible, the impact of other pre-existing or future risks to the delivery of planned service levels outlined in this plan. Potential risks to delivery include:

Service Risks

- The HSE has provided for expected levels of demand for community drug schemes on agreed assumptions for 2012. There is a risk of under estimation of unanticipated additional demands.
- *A Fair Deal* is a cash limited scheme. There is a risk that the resource available may not be adequate to meet demand. This would have an impact upon hospital and community services.
- The implications of the awaited *National Standards for Safer, Better Healthcare* have been taken into account, in as far as possible, whilst developing NSP2012, but a full impact assessment is not yet known.
- Some of the actions within NSP2012 may be subject to legal challenge.
- That voluntary agencies will co-operate with and deliver upon the targets set for services and finances.

HR Risks

- The availability of adequate staff numbers and types available to deliver services based on the ongoing impact of the moratorium, of retirement levels associated with the 'end of grace' period of 29 February 2012, together with loss of staff generally impacting on front line service delivery.

- Significant challenges in maintaining staffing in certain specialties and locations and maximising potential staff flexibility through the *Public Service Agreement*.

Finance Risks

- NSP2012 includes large cost reduction targets, the achievement of which is critical to delivering a balanced vote. There is a risk that the services will struggle to meet the targets set. The timing of legislation is critical to the successful delivery of community drug schemes and income targets.
- HSE ability to control the costs of health technology and medicines.
- The absence of a single national financial system and the HSE's dependence on multiple disparate / standalone or legacy systems renders data less reliable. This is problematic in an environment where the vote is being broken into care groups and systems struggle to support this.
- There may be another additional adverse financial impact if the numbers leaving exceed 3,000 WTEs. We would then have to provide for additional lump payments from service budgets.

Change Risk

- Impact of Government reform plans for the HSE.

We will actively monitor and assess all of these and other risks that emerge as 2012 proceeds and, depending on their impact, may need to adjust planned service levels during the year to ensure the HSE can operate within its Estimate.

Patient Safety and Quality

Designing and delivering services, to ensure high quality safe services for all our patients and clients, is our primary concern. A culture of continuous quality improvement through effective governance structures, clinical effectiveness, outcome measurements, and evaluation will be at the centre of our approach to improving services. We have well advanced systems for managing incidents, we have a comprehensive approach to managing complaints, and we have commenced a rolling programme of healthcare audit. All of these processes give rise to important learning which we must ensure will lead to changes in healthcare practice in order to avoid repeating mistakes and better guarantee the safety and quality of care for patients. Our patient charter, *You and Your Health Service,* is an indication of our commitment to inform and empower service users to actively look after their own health, and to influence the quality of healthcare in Ireland.

Data Protection

Data Protection ensures that an individual's rights to privacy are protected. This is particularly important in the context of patients' clinical and personal information. However, it also protects personal information relating to our many staff in the health services.

Following a number of high profile serious breaches of data protection legislation across the HSE, a comprehensive review of our guidance documents, protocols, practices and procedures will be undertaken in 2012.

During the year, a concurrent series of work streams will consider and revise the existing documentation in order to devise a series of binding standards and rules that govern the management and protection of all forms of HSE information. This will include the development of an easily accessible booklet that is comprehensible to all staff members. A key focus in this regard is to develop a process whereby the individual staff member becomes responsible and accountable for breaches that they cause.

Additionally, an important stream of work involves dealing with archived documents that are, in some situations, inappropriately stored in locations throughout HSE facilities. A system will also be developed in order to appropriately classify current documents, with a view to managing documents with varying levels of sensitivity.

Improving Our Infrastructure

Our Capital Plan prioritises the development of the National Children's Hospital, the replacement of the Central Mental Hospital and the National Project for Radiation Oncology. It also focuses on primary health care as a key component of Government strategy to deliver care locally and take pressure off the acute hospital sector.

Resource Framework

Introduction

Under the legislative framework of the *Health Act, 2004, Section 31*, the primary purpose of the annual *HSE National Service Plan (NSP)* is to set out how the Estimate (budget) allocated to the HSE will be spent in the given year on the type and volume of health and personal social services delivered to the people of Ireland, within the approved employment levels set out by Government. It is guided by the vision, mission, values and objectives of the organisation.

Finance

The finance plan will address the two month period to the 29th February and adapt to reflect the actual number of retirees which will be known at that stage. Plans may then require adjustment. The HSE will commission in 2012 a review of budgets to align them with the future organisational arrangements for health provision. This work can commence once the future structures of the health environment are announced.

Allocation bases

The HSE has allocated resources to budget holders both at regional levels and within regions, i.e. operational areas. Each operational area is composed of a number of hospitals and local health offices. The allocations reflect the vote and the subhead provision as passed by the Oireachtas. We recognise that some adjustments will be required in the REV to reflect the impact of the voted reduction in total HSE expenditure. These items are referenced elsewhere in NSP 2012.

The HSE has specifically reallocated €40m from other community services to childcare services as part of the allocation process. This is in accordance with the direction received from the Minister for Health. The impact of this allocation is to permanently write off certain developments or surpluses and also to transfer resource between regions in an effort to deal with part of the childcare deficit. Additionally, the HSE has transferred €42m of budget from other services to the *Nursing Homes Support Scheme: A Fair Deal* on its internal budgeting system to ensure that the subhead total for 2012 remains intact. In addition €5m has been transferred from NHSS to primary care to support the recruitment of primary care staff to maintain people at home.

Profiling

The profiling of the vote to the HSE on a monthly basis in 2012 which will be finalised in early January is based upon the expected timing of implementation of a number of key initiatives. The main factors to consider are as follows:

- The impact of any accelerated retirements by 29th February 2012.
- The timing of legislation to deliver upon the increase in charging and collection of private income in public hospitals.
- The timing of delivery of savings in the area of drug costs including price reductions in the cost of drugs.

The HSE will need to review the profile in early March 2012 to consider the number of retirees and whether this allows for the attainment of the pay savings of €160m included in the vote to the HSE. The profile may also be impacted by the timing and outcome of the other factors referenced above.

Care group subheads

The vote to the HSE now contains two care based subheads namely, long stay residential care and childcare. This provides a level of clarity and transparency relating to HSE expenditures that serves the public interest and is a move in the direction of programme level funding.

The HSE seeks to meet the reporting requirements for these subheads using the seven systems available to it. It should be noted that HSE is organised on a geographic basis and has not until this year had a national lead with budgetary accountability for a single service reflected in a subhead at a national level. The reporting systems of the HSE can and do facilitate area based reporting in accordance with our management structures but are not designed to report through a single financial ledger on a common chart of accounts and codes. All care group reporting data within the HSE should be considered with some caution until there is a single standardised reporting system designed to specifically meet this purpose. Additionally significant work requires to be undertaken to determine the actual service and cost components of each care group. The care group figures included in NSP 2012 are HSE corporate finance estimates and will be subject to refinement based upon the actual distribution of reductions at a regional level.

Anticipated Subhead Changes in the Revised Estimates Volume (REV)

The HSE is undertaking a project to centralise major oncology drugs. The financial effect of this project will be to remove funding from area subheads and to locate the funding in a central subhead. Currently funding for the Maternity and Infant scheme and some immunisations resides in the area subheads and should be within the PCRS subhead. It is anticipated that both of these issues will be adjusted in the REV.

Table 10

2012 Financial Allocation

Income and Expenditure 2012 Allocation	Pay €m	Non Pay €m	Income €m	Total €m
Statutory				
Hospitals	1,731	671	0	2,402
Community Services	2,185	5,069	0	7,254
Total Statutory	**3,916**	**5,740**	**0**	**9,655**
Voluntary				
Hospitals	1,535	608	-523	1,620
Community Services	488	103	-101	490
Total Voluntary	**2,023**	**711**	**(624)**	**2,110**
Hospitals	3,266	1,279	-523	4,022
Community Services	2,673	5,172	-101	7,744
Corporate	162	213	0	375
Statutory Pensions	737	0	0	737
National Services incl. Ambulance	102	161	0	264
Quality and Clinical Care	8	17	0	25
Population Health	70	80	0	150
Repayment Scheme	0	1	0	1
Grand Total	**7,018**	**6,923**	**-624**	**13,317**

Table 11

2011 / 2012 Vote Adjustments

	2011	2012										
	2011 Final	Once-Off	PCRS	Fair Deal	Pay and Pensions	Procurement	Other	Private Charges	Efficiencies	Developments	Income Acceleration	Total 2012 Allocation
	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m
Hospitals	4,207				-87	-23	-10	-42			-22	4,022
Community Services	7,867	-100	44	35	-84	-23	20		-53	38		7,744
National Services	266				-2	-1						264
Central Services	430	-48			-4	-2						375
Clinical and Quality Care	25											25
Population Health	152				-2	-1						150
Statutory Pensions	606				131							737
Repayment Scheme	12						-11					1
Gross Total	**13,565**	**-148**	**44**	**35**	**-48**	**-51**	**-1**	**-42**	**-53**	**38**	**-22**	**13,317**
Other income	-401											-401
HSE generated income made up of:												
Hospitals	-521							-51			-28	-600
Community Services	-270											-270
Other	-275											-275
Total HSE generated Income	-1,066							-51			-28	-1,145
Total Income	**-1,467**	**0**	**0**	**0**	**0**	**0**	**0**	**-51**	**0**	**0**	**-28**	**-1,546**
Nett Total	**12,098**	**-148**	**44**	**35**	**-48**	**-51**	**-1**	**-93**	**-53**	**38**	**-50**	**11,771**

Table 12

2012 Financial Allocation

Non-Acute Care Group by Programme	2011 Budget €m	2012 Budget €m
Primary Care and PCRS	2,835	2,787
Children and Families	547	568
Mental Health	712	707
Disability	1,576	1,541
NHSS – A Fair Deal	1,026	1,046
Older People	407	390
Palliative Care	81	78
Social Inclusion	119	115
Multi Care Group	486	451
Other	79	60
Total Care Group	**7,868**	**7,743**

Some 2011 budgets are re-stated since the 2011 service plan to reflect improved coding

The care group analysis above is indicative and will require adjustment when detailed budgets are uploaded from the HSE regions, as the HSE does not have a national integrated budgetary system as a component of a single national financial system. The pay reduction target has been extracted from each care group based upon employed numbers and previous retirement trends. The care group figures above are based upon the assumption that staff leave on an even basis across care groups at the end of February. Should this vary significantly the matter may be reviewed at the end of February. The HSE regions are allocating certain budgetary adjustments against embedded surpluses in the first instance. The impact of these allocations will be determined in January. To this extent the figures above should be treated as provisional care group allocations. The accountability and budget holder structure in the HSE is still primarily regionally based and the HSE allocates budgets primarily to regions not Care Groups. There has been some movement within 2011 in the care group budgets. This enables more appropriate reporting of costs. The Children and Families budget for 2012 reflected the subhead in the Vote. It is understood that this figure will change based upon a finally agreed position between the Departments of Health, Children and Youth Affairs and HSE.

Nursing Homes Support Scheme (NHSS)

Following receipt of the Abridged Estimate for Health in 2012, the HSE has to cut budgets significantly including that supporting the *Nursing Homes Support Scheme: A Fair Deal*. These cuts reflect the loss of staff under the public service 'grace period' retirements, targeted reductions in overtime, premium pay and sick leave and further targeted reductions in basic pay beyond the 'grace period' retirements. An amount of €19m has been estimated as the reduction for subhead B12, Long Term Residential Care. This amount must be regarded as an interim position for the subhead subject to amendment in the Revised Estimate in February 2012 when staff losses will be confirmed. Full details of the financial build up are contained in Appendix 1b.

Capital Programme - Improving Our Infrastructure

Government published its *Infrastructure and Capital Investment 2012-2016: Medium Term Exchequer Framework* in November 2011. Of the total investment of €17bn announced, €1.87bn has been allocated to the HSE. The HSE has been allocated €334m capital each year for investment in infrastructure and a further €40m each year for ICT projects.

The plan prioritises the development of the National Children's Hospital, the replacement of the Central Mental Hospital and the National Project for Radiation Oncology. It also focuses on primary health care as a key component of Government strategy to deliver care locally and take pressure off the acute hospital sector.

Human Resource and Workforce Management

The *Public Service Reform* plan, November 2011, will have an overarching impact on human resource and workforce management right across the public health sector for the next four years, with the main foundations laid in 2012. The key message from the plan is that we cannot sustain the current system of public service delivery, including health services, and we must change. NSP 2012 will play a key role in delivering on the Government's plan and in particular will support the change agenda and reforms set out in it.

Against the backdrop of reduced budgets and reduced staffing resources, the critical impediment to the safe delivery of services in 2012 is the availability of adequate numbers of appropriate staff. A robust workforce plan is critical to maximise and mobilise staff to deliver the objectives of this plan.

Public Service Agreement (2010 – 2014)

The *Public Service Agreement* (PSA) will be the framework for delivering significant change across the public sector. Its potential must be maximised within the HSE to deliver on a credible workforce plan for 2012. It provides the framework to transform, modernise and minimise reductions in the health services by facilitating a reduction in staff numbers, increasing efficiency and productivity, reducing cost and improving quality and assisting Government's change agenda and reforms. These opportunities must continue to be maximised in 2012. A new Health Sector Action Plan will be developed in early 2012, for implementation of the *Public Service Agreement*.

In 2012 the following will be advanced:

- **Radiography Services** – The alignment of diagnostic services with service and access requirements, while focusing on the ability to increase output with no additional costs by extending the working day and increasing efficiency within the existing working day. Discussions have been ongoing throughout 2011 on the transformation of radiology services in line with the health sector action plan. Recommendations from the Labour Court Hearing in December 2011 will commence implementation in quarter one, 2012.
- **Revised Rostering Arrangements** -The development of new rostering arrangements to include reviewing staffing levels and skill-mix. A Non Consultant Hospital Doctor (NCHD) Workforce Plan will be developed to address areas such as overtime, agency, *European Working Time Directive* (EWTD), rostering, skill mix and training.
- **Clinical Programmes** - The implementation of clinical programmes will continue across a wide spectrum of services in hospital and community settings. The Service Delivery Unit (SDU) will assist these models, particularly the Acute Medicine and Emergency Medicine Programmes.
- **Radical Cost Reductions** – The significant reduction of the volumes of both overtime and agency across all staff functions to ensure the HSE meets its budget targets.
- **Agency Policy** - A particular focus in 2012 will be on the reduction of further overall expenditure on agency staff. The *European Temporary Agency Directive* (legal effect from December 2011) will add €30m costs if the same level of usage is required in 2012.
- **Standardisation of Annual Leave Arrangements in accordance with Department of Public Expenditure and Reform** - The new annual leave agreement will be implemented throughout the Health Sector in line with the new annual leave year.

Employment Control Framework and Estimated Ceiling 2012

The HSE operated within the approved reducing employment ceiling throughout 2011, with a projected outturn of 104,500 WTEs, 800 WTEs within ceiling. The employment control environment in 2012 will demand even more for less in terms of employment numbers and costs.

- **The 2012 employment target reduction is 3,200 WTEs.**

Robust and responsive employment control, with accountability at regional and service manager level, continues to be a key driver for 2012. Reconfiguration and integration of services, reorganisation of existing work and redeployment of current staff will need to underpin the employment control framework, to deliver government policy on public service numbers within budgetary allocations. The 2012 employment control framework is being broadened to address workforce issues such as overtime and agency usage and costs, and cost of allowances. A more integrated approach will be applied in 2012.

Table 13

Care Group / Programmes Projected Sub-allocation 2011 / 2012 Pre-Approved 2012 Ceiling

Care Group / Programme	Projected WTE December 2011	Projected Start 2012 ceiling
Acute Hospitals	48,100	48,469
Cancer Services	1,200	1,209
Ambulance Services	1,503	1,515
Primary Care	10,891	10,974
Older People	10,100	10,177
Disabilities	15,304	15,421
Mental Health	9,207	9,277
Children and Families	3,118	3,142
Social Inclusion	616	621
Palliative Care	645	650
Corporate and National Functions	2,769	2,790
Quality and Patient Safety / Pop. Health	1,047	1,055
TOTAL	**104,500**	**105,300**

Note: Information in this dataset continues to be refined and therefore should be considered indicative only. Patients may be serviced by more than one programme e.g. older people and primary care.

The projected ceiling for the start of 2012 has been assessed at 105,300 and the end-of-year employment ceiling is 102,100 WTEs. Further reductions are to be expected in each of the three subsequent years to the end of 2015. These figures require further discussion and may be amended to provide specific focus on reducing overtime and agency cost and usage, as well as the impact of the transfer of HSE staff to the DCYA in 2012 / 2013. Additional information on pre-approved 2012 WTE allocations and ceilings by region / grade can be found in Appendix 3.

A profile of the staff who are availing of the end of grace period is detailed below.

	General Support	Health and Social Care professionals	Management / Admin	Medical / Dental	Nursing	Patient and Client Care	Other	Total
Retirement analysis by no. of staff	353	314	281	128	1,612	613	12	3,313
Retirement analysis by WTE	300	267	239	109	1,370	521	10	2,816

Recruitment Policy

- Staff numbers will continue to reduce in line with Government policy. The additional reduction in staff numbers will be challenging and will need careful planning to minimise impact on service delivery. However, given the level of required reductions and their accumulative impact, some services will not be able to be delivered in 2012. Some of these are represented in this plan, while others will emerge during the year.
- The affordability element of employing staff is a major barrier in addition to the restrictions of the employment control framework.
- Implementation of the 2011 non-recruitment policy, other than prioritised exceptions, will continue into 2012. This will be reviewed at the end of quarter one, 2012.
- Exceptions to the non-recruitment policy will be those posts agreed to be carried over from the NSP2011which are cancer, clinical programmes and *Ryan Report* posts for children services as well as prioritised 2012 investment and replacement areas such as Mental Health and Primary Care.
- Recruitment will only occur in approved designated areas. In the short term, this will be a centralised process, with the intention of regionalising recruitment in the future.
- Intelligent flexibility will be required to manage recruitment using the explicit management process that is in place.
- A monitoring role will be maintained by senior management, who will receive regular reports (including exceptions) from the regions.
- All voluntary bodies funded by the HSE will be required to adopt HSE workforce management processes for staff recruitment.

Overtime and Agency Usage Policy

The transposition of the *EU Temporary Agency Directive* into Irish law will have a significant potential cost implication on the usage of agency staff across the health services. Aside from ensuring compliance with the Directive, there will be a particular focus in 2012 to reduce further the overall expenditure on agency staff. This will require further controls and may involve, if the employment ceiling allows, some substitution through recruitment and employment of staff at lower costs. In 2012, a greater focus will be required to lower significantly the volumes of both overtime and agency usage across all staff functions. Where the budget allows, agency staff can continue to be used where there is a short term service need or where flexibility is required. Overtime and agency staff are not to be used to support service levels beyond those agreed in this plan or to substitute for staff losses as a result of the need to reduce health sector employment. A national policy in relation to overtime and agency use will be finalised for use in early 2012.

Non Consultant Hospital Doctors (NCHD) Recruitment Policy

- HSE and HSE-funded agencies continue to experience significant challenges maintaining NCHD staffing in certain specialties and locations.
- We will continue to recruit all service posts on the basis of a two year contract which includes placement in a large regional centre or major hospital, participation in a professional development scheme and access to a range of supports to meet registration, visa and other costs.
- We will continue to work closely with the Medical Council to ensure doctors are registered appropriately and efficiently and a centralised database of all NCHD posts will be rolled out nationally in 2012 to assist this.
- Centralised recruitment of NCHDs to non-training posts will be fully implemented.
- A NCHD Workforce Plan will be developed to address areas such as overtime / agency issues, EWTD, sensible rostering and skill mix and training. The work of the clinical programmes will support this plan.

Consultant Employment

Since 2009, there has been a significant increase in employment levels for medical consultants (up 163 on 2009 baseline and 68 on end of 2010 as at end of October 2011) and these increases will further accelerate in 2011 / 2012 as a result of the number of consultant approved posts under the clinical programmes. There will be a need to offset this growth in both employment terms and pay costs in 2012 by re-balancing NCHD numbers and through reductions on medical overtime and agency / locum.

Performance Management

The *Programme for Government* states that the current emphasis on performance reporting will change to performance management. It gives a commitment to totally overhaul the way politics and Government work, introducing corporate governance legislation, whistle blowing legislation to protect public servants who expose maladministration, incentive systems, etc. The implementation of the health sector wide performance management system in 2012, with its focus on individual and team performance management cycle, is a critical component of performance management, and is being rolled out under the umbrella of the PSA (2010-2014). Phase 1 (quarter 4 2011, and 2012) is focused on senior management grades across all disciplines and the system will cascade downwards thereafter for all grades in 2013 and 2014.

Stable Industrial Relations Climate

The challenges posed by the budgetary situation and the change agenda under the PSA have the potential to undermine the industrial relations climate across the health services in 2012. Through the correct use of existing industrial relations mechanisms, procedures and processes, coupled with adherence to the consultative approach outlined in the PSA, any threats to the industrial relations climate should be minimised. The operation of the Health Service Implementation Body (HSIB) and the National Joint Council (NJC) will continue to play a positive role in maintaining industrial relations peace in 2012.

Monitoring and Measuring NSP2012

Performance evaluation and management is a cornerstone to the improvement and more efficient delivery of health services. The HSE is committed to the evaluation and the management of performance at all levels. Progress has been made in this plan to incorporate links between funding, staffing, and service priorities and an improved set of activity measures, performance indicators and deliverables in key service areas have been included. The NSP sets out information at national, regional and programme / care group level on performance expectations. More detailed information per region in regard to service activity, finance and staffing can be found in the Regional Service Plans for HSE South, HSE West, HSE Dublin Mid Leinster and HSE Dublin North East being prepared for publication following approval by the Minister of the national plan.

Performance indicators (PIs) and agreed targets for activity during 2012 are set out in each of the care group / programme sections, with the full suite summarised at the end of this plan. A sub set of key performance indicators is represented by the performance scorecard on page 17. Progress will be published at specified intervals. Other data sets may be retained and used at regional or care group / programme level for performance management purposes and will be available as required.

During 2012 a number of improved or new measures will be developed to support us in measuring:

- The priorities as set out under the **SDU** in the areas of quality and access to emergency and scheduled care. Measures in relation to outpatients and diagnostics will also be developed with the SDU during 2012.
- The implementation of the **clinical programmes**.
- **Enhancement of services** such as immunisations, primary care and cancer services.
- **Outcomes** for people with disabilities and for people who may be socially excluded.

Stringent processes are in place at national and regional level to monitor compliance with the national and regional plans. HealthStat, an operational performance information and improvement system for regional and local managers, reports a joint view on the performance of hospitals and community areas at regional level.

All our performance reports are published monthly on www.hse.ie.

NSP 2012 Performance Scorecard

	Acute Care Programme Areas		Non-Acute Care Programme Areas	
	Performance Indicator	**Target 2012**	**Performance Indicator**	**Target 2012**
Quality	**HCAI** Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	< 0.067	**Health Protection** % of children 24 months of age who have received three doses of 6 in 1 vaccine	95%
	Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 3.0	% of children 24 months of age who have received the MMR vaccine	95%
	Re-Admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%	% of first year girls who have received the third dose of HPV vaccine by August 2012	80%
	Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%	**Child Health** % of new born babies visited by a PHN within 48 hours of hospital discharge	95%
	Stroke Care % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	At least 7.5%	% of children reaching 10 months in the reporting period who have had their child development health screening on time before reaching 10 months of age	95%
	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	50%	**Child Protection and Welfare Services** % of children in care who have an allocated social worker at the end of the reporting period	100%
	ACS % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	50%	% of children in care who currently have a written care plan, as defined by *Child Care Regulations 1995*, at the end of the reporting period	100%
			Primary Care No. of Health and Social Care Networks in development	79
Access and Activity	**Unscheduled Care** % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	**Child and Adolescent Mental Health** % on waiting list for first appointment waiting > 12 months	0%
	% of patients admitted through the ED within 9 hours from registration	100%	**Disability Services** No. of PA / home support hours used by persons with physical and / or sensory disability	1.64m
	Elective Waiting Time % of adults waiting more than 9 months for an elective procedure	0%	**Older People Services** % of complete NHSS (*Fair Deal*) applications processed within four weeks	100%
	% of children waiting more than 20 weeks for an elective procedure	0%		
	Colonoscopy / Gastrointestinal Service No. of people waiting more than 4 weeks for an urgent colonoscopy	0	No. of people being funded under NHSS in long term residential care at end of reporting month	23, 611
	% of people waiting over 3 months following a referral for all gastrointestinal (GI) scopes	≤ 5%	No. of persons in receipt of a Home Care Package	10,870
	ALOS Medical patient average length of stay (ALOS)	5.8	% of elder abuse referrals receiving first response from senior case workers within 4 weeks	100%
	Delayed Discharges Reduction in bed days lost through delayed discharges	Reduce by 10%	**Palliative Care** % of specialist inpatient beds provided within 7 days	91%
	Cancer Services % of patients attending lung cancer rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral	95%	% of home, non-acute hospital, long term residential care delivered by community teams within 7 days	79%
	% of patients attending prostate cancer rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral	90%	**Social Inclusion** Traveller Health – No. of clients to receive health awareness raising / screening programmes (breast check, cervical smear screening, men's health screening, blood pressure testing) through the Traveller Health Units / Primary Health Care Projects	1,650
	% of patients undergoing radiotherapy treatment for breast, prostate, lung or rectal cancer who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist	90%		
Resources	**Finance**		**Human Resources**	
	Variance against Budget: Income and Expenditure	≤ 0%		
	Variance against Budget: Income Collection	≤ 0%	Variance from approved WTE ceiling	≤ 0%
	Variance against Budget: Pay	≤ 0%	Absenteeism rates	3.5%
	Variance against Budget: Non Pay	≤ 0%		
	Variance against Budget: Revenue and Capital Vote	≤ 0%		

Improving Quality and Delivering Safe Services

Introduction

Designing and delivering services, to ensure high quality safe services for all our patients and clients, is our primary concern. We are focusing on the development and implementation of safe quality healthcare, where all service users attending our services receive high quality treatment at all times, are treated as individuals with respect and dignity, are involved in their own care, have their individual needs taken into account, are kept fully informed, have their concerns addressed, and are treated / cared for in a safe environment based on best international practice. We are also focusing on achieving the above standards in an environment that is safe for our staff.

The *National Standards for Safer Better Healthcare*, when launched, will outline to the public what can be expected from their healthcare services, while also outlining to service providers what is expected of them. The standards will help to drive improvements for patients by creating a common understanding of what makes a good, safe, health service. We will embrace the National Standards and will seek to support frontline services to drive quality improvement in response to these standards. We will also seek to support service providers by ensuring the overall burden of regulation and standards is managed in a coherent fashion. This is particularly important as we prepare for the roll out of licensing of healthcare provision.

Improving quality and delivering safe services is implicit and embedded in the delivery of all our services. Relevant quality metrics are contained within the performance indicators of the appropriate service sections in this plan.

Our priorities for 2012:

- Progress the development of the **Patient Safety Authority** through engagement with the DoH and Health Information and Quality Authority (HIQA).
- Develop a strong system of **corporate and clinical governance** throughout the HSE.
- Ensure there is a system-wide co-ordinated approach to the **quality agenda** that spans the spectrum of service provision and covers regulatory standards, recommended practices, and quality and safety issues.
- Implement national and international **standards** and recommended **policies / guidelines** developed by HSE, the National Clinical Effectiveness Committee, Government and other regulatory bodies.
- Strengthen **patient and service user** input through developing and implementing best practice models of customer care and service user involvement.
- Further embed integrated **risk management** across all services. Utilise the risk register mechanism as part of the HSE control framework. Learning from the HSE incident experience must inform the work, and the priorities, for the risk register and controls assurance.
- Provide transparency and accountability to the public about **quality and safety of care** by:
  - Responding to, reporting on, and learning from incidents and adverse events.
  - Implementing learning from report and review recommendations, risk analysis, serious incidents, audits, complaints, and surveys, and ensure that best practice is shared and distilled. This will prevent and minimise avoidable repeat incidents.
  - Enhancing quality, clinical and social care audit and assurance.
- Improve prevention, control, and management of **healthcare-associated infections** and improve antimicrobial stewardship.
- Continue to provide assurance to the organisation on the **implementation, monitoring, and evaluation** of the above priorities.
- Capture and provide robust intelligence information and evidence to support decision making.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Patient Safety Authority	Support the development of the Patient Safety Authority through engagement with DoH and HIQA	Ongoing
National Clinical Effectiveness Committee	Support the ongoing work of the National Clinical Effectiveness Committee	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Clinical Governance	Support the continuous development and implementation of Corporate Governance and Accountability Frameworks for Clinical Governance and Patient Safety	Ongoing
Implementing National Standards	Continue to progress the programme of change required to deliver compliance with these standards	Ongoing
Standards, Recommended Practice and Guidance	Continue to support the development and implementation of standards, recommended practice and guidance in key areas including: ▪ Healthcare records management ▪ Post Mortem Examination Services ▪ Medical Devices and Equipment ▪ Integrated Care ▪ Medication Safety ▪ Decontamination of Reusable Invasive Medical Devices ▪ Consent ▪ National document development and approval process	Ongoing
Patient Radiation Protection Regulatory Requirements	Ensure patients are adequately protected from unnecessary harmful effects of ionising radiation through issuing of national guidelines, external clinical audit, monitoring of incidents, and liaising with other regulatory bodies	Ongoing
Stakeholder Engagement	Improve communications, engagement and working arrangements with all stakeholders	Ongoing
Advocacy and Service User Involvement	Develop and implement best practice models of customer care, and service user involvement throughout the HSE in line with *National Strategy for Service User Involvement* and *Patient Charter of Rights and Responsibilities, You and Your Health Service*	Ongoing
Clinical Audit	Implement Irish Audit of Surgical Mortality (IASM)	Q4
	Implement Irish National Orthopaedic Register (INOR)	Q4
Quality and Patient Safety Audit	Continue to develop a structured programme of healthcare audits	Ongoing
	Develop and support implementation of guidance for local clinical audit	Q3
Integrated Risk Management	Continue to implement the HSE Integrated Risk Management Policy with particular focus on risk management, incident and complaints management	Ongoing
Monitoring and Learning	Progress the development of a comprehensive data collection, processes support, analysis, and information system to enable the extraction of key learning from complaints, incidents, reports, and other sources for dissemination to services	Ongoing
	Develop and implement systematic processes for the ongoing learning across the system of the lessons learned from all reports, reviews, international experience and investigations into services	Q3
National Organ Donation and Transplantation Office	Ensure implementation of EU directive and oversee the quality and safety of donation and transplantation services in Ireland	Ongoing
Healthcare Associated Infections	Improve hand hygiene by healthcare staff	Ongoing
	Ensure antimicrobials used appropriately (antimicrobial stewardship)	Ongoing
	Prevent medical device related infections (such as IV lines and urinary catheters)	Ongoing
Robust Intelligence Information and Evidence	Capture and provide robust intelligence information and evidence to support decision making through continued development of Health Atlas and other knowledge resources	Ongoing
	Continue to work with the DoH and the Health Technology Assessment (HTA) function of HIQA to support robust HTA relevant to the clinical requirements of the HSE	Ongoing

Promoting and Protecting Health

Introduction

Promoting, protecting, and improving health and reducing health inequalities are key priorities for our organisation. To do this, it is essential to re-orientate our health services from a curative focus towards one of preventing ill health and promoting positive health. Evidence shows that the most effective practices are achieved through approaches that influence the determinants of health and health inequalities. These include ethnicity, race, gender, life style factors, education, socio-economic status, environment, and living conditions. Many diseases and premature deaths are preventable. Increased morbidity and mortality are strongly related to lifestyle health determinants such as smoking, alcohol consumption and drug consumption, physical inactivity, and obesity.

There is, however, a clear relationship between socio-economic status and health behaviour: the higher an individual's education, the healthier they are. In order to address this a key principle of improving health is working collaboratively, not just internally within the organisation, but externally with all our stakeholders including statutory and non-statutory bodies and the voluntary sector.

Childhood vaccinations continue to be one of the most cost-effective public health interventions and, while we are showing significant improvements in uptake over the decade, we need to address particular areas, both geographically and socially, where uptake rates are not improving at the same level.

Promoting and protecting the population's health requires many interventions, which often occur when people are not ill or even aware of the intervention, or when we are supporting people to make healthy decisions. It also involves creating a healthier environment (green spaces for physical activity, safe food, hygienic facilities and a safe environment) where communities are supported to live healthy lives. Environmental health services play a key role in protecting the population through enforcement of legislation and the promotion of activities to assess, correct, control, and prevent those factors in the environment which can potentially adversely affect the health of the population. These include controls on food safety, tobacco, cosmetic products, pest control, poisons, etc.

A lot of these activities along with the child health services are very dependent on the availability of community and public health staff, especially public health nurses, which is now severely depleted as a consequence of the restrictions on staff replacement.

Our priorities for 2012:

Health Promotion

- Implement the Health Promotion Strategic Framework within the three priority areas of education, community and health promoting health service. There will be specific targeting of tobacco, obesity, alcohol, breastfeeding and positive mental health.
- Implement the recommendations of *Your Health is Your Wealth: A Policy Framework for a Healthier Ireland 2012-2020*, when finalised.
- Establish evidence based interventions, which will ensure the priorities of promoting and protecting health are applied across and within clinical programmes.
- Implement *HSE Health Inequalities Framework 2010-2012*.
- Sustain the impact of the work of the Crisis Pregnancy Programme and work in partnership to co-ordinate sexual health promotion across the health service.

Child Health Screening and Surveillance

- Implement revised immunisation programmes such as Human Papilloma Virus (HPV).
- Progress the National Immunisation Register.
- Ensure a national approach to child health screening and surveillance.

Health Protection

- Focus on the control of measles, tuberculosis (TB) and sexually transmitted diseases.

Emergency Management

- Plan and prepare for major emergencies.

Environmental Health

- Reconfigure environmental health services nationally to ensure equity of service delivery.
- Implement national protocols and Environmental Health Information System to ensure consistency of service delivery.
- Continue to monitor and enforce existing and new environmental health functions including food, tobacco, international health, cosmetic product and pest control, poisons licensing, environmental impact assessment and waste licensing assessment, fluoridation and safety of drinking water supplies on behalf of HSE and external agencies.

Tobacco Control

- Implement the recommendations of the *HSE Tobacco Control Framework* and the Government's strategy *Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group.*

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Policy Framework for Public Health	Implement recommendations of *Your Health is Your Wealth: A Policy Framework for a Healthier Ireland 2012-2020* in conjunction with other sectors, when finalised, and develop campaigns to support implementation	Ongoing
Health Promotion Strategic Framework	**Health Promotion Cross Setting Strategy and Policy Development** Expand community breastfeeding support	Ongoing
	Prevent Overweight and Obesity Implement a Physical Activity Action Plan	Ongoing
	Review and standardise health promotion programmes in relation to obesity	
	Promote and advocate healthy weight management throughout the lifecycle	
	Develop a national system for surveillance and screening of children, according to *Best Health for Children*	
	Develop Adult Hospital Weight Management Treatment Services (1 per HSE area) and National Paediatric Hospital Service with the full multidisciplinary team in each centre to ensure the maximum throughput of patients with severe obesity	
	Alcohol Develop and implement action plan based on relevant recommendations of the *National Substance Misuse Strategy*, when published	Ongoing
	Tobacco Implement Tobacco Free Campus	Ongoing
	Positive Mental Health Support mental health promotion priorities in partnership with mental health structures in line with *A Vision for Change*	Ongoing
	Health Promoting Community Setting Develop and implement a model for health promoting communities	Ongoing
	Develop community participation, community health needs assessment, and health equity audit within all services	
	Support participating cities to establish new Irish Healthy Cities network	
	Health Promoting Health Service Setting Develop and deliver to health care staff a national model for brief intervention training (smoking, alcohol, diet, mental health) in partnership with other stakeholders	Ongoing
	Health Promoting Education Setting Implement nationally agreed model for health promoting schools	Ongoing
	Development of health promoting tools and resources to support the development of the health promoting education setting	
	Sexual Health Co-ordinate and standardise sexual health promotion activities and agree regional sexual health promotion plans	Ongoing
Crisis Pregnancy	Fulfil all statutory requirements relating to crisis pregnancy prevention and crisis pregnancy support, and implement a strategic plan in line with legislative requirements	Ongoing
	Ensure strategic plan is fully aligned across related HSE programmes and agree regional implementation plans	

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Develop a plan to ensure that prevention activity led by the Crisis Pregnancy Programme is co-ordinated with other sexual health education and promotion activity in order to add value to work in this area	
Health Inequalities	Develop health inequalities related tools and resources	Q3
	Develop key performance indicators and measures to inform planning	Q2
National Immunisation, Infectious Diseases and Child Health	**National Immunisation** Develop a national immunisation registry for all immunisations	Ongoing
	Deliver a National Immunisation Programme, with vaccine uptake rates in accordance with international targets	
	Implement a measles elimination plan, with MMR catch-up programme	
	Implement a national standardised school based immunisation programme	Q3
	Increase influenza vaccination uptake rates in General Medical Services (GMS) and doctor only card holders aged 65 years and older	Ongoing
	Improve uptake of influenza vaccine among healthcare workers	
	Improve prevention, control, and management of infectious diseases: Implement tuberculosis (TB) guidance 2010	Ongoing
	Develop (Q3) and implement TB Action Plan which reflects the World Health Organisation (WHO) consolidated Action Plan to combat TB	
	Develop (Q3) and implement a plan to reduce sexually transmitted illnesses and improve sexual health	
	Reduce the impact of vaccine preventable diseases	
	Implement requirements of the *International Health Regulations*	
	Child Health Reach agreement on revised child health model programme and develop change plan	Q2
	Review *Best Health for Children* guidelines and develop implementation plan including review of training needs	Ongoing
	Progressively implement governance structure for all non-cancer childhood national screening programmes	Q1
	Develop a Child Injury Prevention plan	Q2
	Review and update Child Health Information Service Project (CHISP) documents and Child Health website for parents / practitioners	Q1
Emergency Management	Maintain and develop policies, standards and guidance in emergency management, ensuring an effective response to all major emergencies	Ongoing
	Further develop national and regional interagency plans and procedures in emergency management with other response agencies and governmental departments	
Environmental Health	Reconfigure environmental health services nationally to ensure equity of service delivery	Ongoing
	Implement national protocols for environmental health service activities to ensure consistency	Q1
	Implement National Environmental Health Information system for all service users throughout the country, providing evidence base for health protection decisions	Ongoing
	Target activities of tobacco control enforcement on areas of least compliance (complaints, under age sales to minors, and smoke free exempted areas)	
	Implement annual work plan under the service contract with the Food Safety Authority of Ireland	
	Participate in the European pilot study (Democophes) on human bio-monitoring	Q2
	Set up a high level advisory group to provide technical and academic oversight of any future proposed bio-monitoring studies (including fluoride intake) in Ireland	Q3
	Complete compliance building and training for the introduction of sunbed legislation nationally to reduce risk of exposure to children	Q2
	Implement the obligatory requirements of the *International Health Regulations* (IHR) including standardising the inspection of designated airports and seaports for compliance with IHR core capacities and continued involvement in the ship sanitation (SHIPSAN) project	Q2
	Implement *National Standards for Pre-School Services*, in conjunction with Children and Family Services	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Agree Memorandums of Understanding / Service Level Agreement with Environmental Protection Agency, Irish Medicines Board, and Children and Families Services	
Tobacco Control	**Tobacco Control Framework** Review smoking cessation services, develop and roll out standardised national model to include national database	Q3
	Deliver standardised training in brief intervention for smoking cessation to 3,521 frontline healthcare workers, prioritising settings going tobacco free in 2012: ▪ DNE 1,083 ▪ DML 542 ▪ South 813 ▪ West 1,083	Ongoing
	Continue national roll out of tobacco free campus policy: ▪ DNE – five hospitals, all newly opened primary care sites, all administration sites ▪ DML – two hospitals, all newly opened primary care sites, all administration sites ▪ South – two hospitals, all newly opened primary care sites, all administration sites ▪ West – four hospitals, all newly opened primary care sites, all administration sites	
	Develop and implement a national policy to protect staff from second-hand smoke exposure while working in domestic settings	Q2
	Develop and implement a national policy to protect children in care from tobacco exposure	Ongoing
	Maintain social marketing QUIT campaign	Ongoing
	Continue to monitor and evaluate the effectiveness of tobacco control measures	
	Maintain tobacco legislation enforcement	
	HSE National Tobacco Control Office Implement recommendations of *Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group* and the *Tobacco Control Framework*	Ongoing
	Support the implementation of the DoH's Tobacco Policy Review Group recommendations (when finalised)	
	Fulfil statutory obligations under Tobacco legislation	

Performance Activity and Performance Indicators

	Expected Activity / Target 2011	Projected Outturn 2011					Expected Activity / Target 2012				
	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Immunisations and Vaccines											
% children (aged 12 months) who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine Haemophilus influenzae type b (Hib_3) Polio ($Polio_3$) hepatitis B ($HepB_3$) (6 in 1)	95%	90%	88%	89%	92%	90%					95%
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV_2)	95%	90%	87%	87%	92%	89%					95%
% children at 12 months of age who have received two doses of the Meningococcal group C vaccine ($MenC_2$)	95%	90%	87%	87%	92%	89%					95%
% children (aged 24 months) who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine, Haemophilus influenzae type b (Hib_3), Polio ($Polio_3$), hepatitis B ($HepB_3$) (6 in 1)	95%	95%	94%	95%	95%	95%					95%
% children (aged 24 months) who have received 3 dose Meningococcal C ($MenC_3$) vaccine	95%					95%					95%
% children (aged 24 months) who have received 1 dose Haemophilus influenzae type B (Hib) vaccine	New PI 2012					New PI 2012					95%
% children (aged 24 months) who have received 3 doses Pneumococcal Conjugate (PCV_3) vaccine	New PI 2012					New PI 2012					95%

	Expected Activity / Target 2011	Projected Outturn 2011					Expected Activity / Target 2012				
	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
% children (aged 24 months) who have received the Measles, Mumps, Rubella (MMR) vaccine	95%					91%					95%
% children (aged 4-5 years) who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)	New PI 2012					New PI 2012					95%
% children (aged 4-5 years) who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	New PI 2012					New PI 2012					95%
% children (aged 11-14 years) who have received 1 dose Tetanus, low dose Diphtheria, Accelular Pertussis (Tdap) vaccine	New PI 2012					New PI 2012					95%
No. and % of first year girls who have received third dose of HPV vaccine by August 2012	New PI 2012					New PI 2012					New PI 2012 80%
No. and % of sixth year girls who have received third dose of HPV vaccine by August 2012	New PI 2012					New PI 2012					New PI 2012 80%
Child Health / Developmental Screening											
% of newborns who have had newborn bloodspot screening (NBS)	New PI 2012					New PI 2012					100%
% newborn babies visited by a PHN within 48 hours of hospital discharge	95%	83%	70%	87%	93%	83%					95%
% of children reaching 10 months within the reporting period who have had their child development health screening on time before reaching 10 months of age	90%	81%	90%	88%	66%	82%					95%
Tobacco Control											
No. of sales to minors test purchases carried out	80					292					216
No. of offices, per region, carrying out sales to minors test purchase activities	2 per region					13					2 per region (different offices)
No. and % HSE hospital campuses with tobacco-free policy	New PI 2012					New PI 2012	3	7	3	4	17 34%
No. of frontline staff trained in brief intervention smoking cessation across primary care and acute campuses	New PI 2012					New PI 2012	542	1,083	813	1,083	3,521
Food Safety											
% of Category 1, 2 food businesses receiving inspection target as per FSAI Guidance Note Number 1	100%					92%					100%
Cosmetic Product Safety											
No. of cosmetic product inspections	New PI 2012					New PI 2012					750
International Health Regulations											
All designated ports and airports to receive an inspection to audit compliance with the IHR 2005	8					8					8
Health Inequalities											
No. of hospitals implementing a structured programme to address health inequalities (as outlined in the HSE *Health Inequalities Framework* and specified in this metric)	New PI 2012					New PI 2012					5
No. of PCTs implementing a structured programme to address health inequalities (as outlined in the HSE *Health Inequalities Framework* and specified in this metric)	New PI 2012					New PI 2012					10

Primary Care, Community (Demand-Led) Schemes and other Community Services

Introduction

Resources- Primary Care and PCRS

		2011 Budget €m	2012 Budget €m
Finance	Total	2,835	2,787
WTE		Projected start January 2012	
	Total	10,891	

Our vision for primary care is that the health of the population will be managed, as far as possible, within a primary care setting, with the population very rarely requiring admission to a hospital. Those with additional or complex needs will have plans of care developed with the local Primary Care Team (PCT) who will co-ordinate all care required with specialist services in the community and, for hospital attendance, through integrated care pathways. The PCT will act as the central point and will actively engage on the medical and social needs of its defined population with a wider Health and Social Care Network (HSCN). The HSCN covers a number of PCTs and provides specialist and care group services such as dietetics, ophthalmology, audiology, podiatry, etc.

Implementation of a programmatic approach to improving care will ensure that primary care and acute services are provided in a systematic way, improving outcomes for patients in terms of patient care, health status, and reduced waiting lists, while saving money.

In line with the commitment in the Programme for Government to a significant strengthening of primary care services, additional funding of €20m is being allocated to fill as many vacancies as possible and to expand existing arrangements where sessional services are provided by allied health professionals. This will be increased to €25m if it can be established that there is scope for further savings of €5m in demand-led schemes. The allocation of the extra posts will be subject to approval by the joint DoH / HSE project team overseeing the implementation of Universal Primary Care. The challenging and restricting reducing financial environment impacts on all aspects of primary care services, PCT delivery, PCT and HSCN development and should not be underestimated. This new investment will help to mitigate some of impact of the loss of staff and service delivery through PCTs and HSCNs.

The Primary Care Reimbursement Service (PCRS) provides a wide range of primary care services across 12 community health schemes to the general public, through 6,500 primary care contractors. These contractors include General Practitioners, Pharmacists, Dentists and Optometrists / Ophthalmologists. This service provision forms the infrastructure through which the Irish health system delivers a significant proportion of primary care to the public. The infrastructure, both from a human resource and e-business technology perspective, supports the provision of a flexible and client focused service. The standard operating model and business processes enable us to deliver value for money for health resources.

Our budget requires the achievement of cost reductions totalling €124m in 2012. These required reductions are building on the €414m reductions applied in 2011. Delivery of this challenging cost saving target is dependent upon the implementation of legislative changes in relation to reference pricing and new agreements with pharmaceutical manufacturers. Efficiencies in prescribing will be targeted along with delisting in order to facilitate the introduction of new drugs. Priorities for 2012 will be progressed in the context of a challenging macroeconomic environment coupled with dynamic socio-economic and demographic trends.

Our priorities for 2012 for Primary Care within available resources are to ensure that the delivery of health services, for the most part, will occur in a primary care setting, with patients very rarely requiring admission to hospital services:

PCTs and HSCNs

- Respond to the episodic care needs of the population through PCTs and HSCNs and develop primary care services by improving access to services through PCTs and further developing HSCNs.

Chronic Disease

- Commence plans for the management of chronic disease in primary care in a number of areas including stroke, heart failure, asthma, diabetes, chronic obstructive pulmonary disease, dermatology / rheumatology and care of the elderly.
- Develop an overall chronic disease watch model of care with initial focus in 2012 on the diabetes programme.

GP and Community Initiatives

- Maximise opportunities to develop Community Intervention Teams (CITs).
- Implement national programmes through PCTs.

- Participate with the DoH in the development of a new general practitioner (GP) contract to meet emerging service requirements.
- Implement recommendations of the *National Review of GP Out of Hours Services.*

ICT Infrastructure

- Develop ICT electronic referrals systems within and from primary care to the acute sector.

Service User Involvement

- Implement agreed national framework for service user involvement in PCTs.

Oral and Audiology

- Implement strategic reviews on both dental and oral health services.
- Implement recommendations from the review of audiology services.

Universal Health Insurance and Eligibility

- Work with the DoH, who has the lead role in this priority, towards phased introduction of Universal Health Insurance (UHI) as required.

Our priorities for 2012 for Community (Demand-Led) Schemes:

- Continue to provide a wide range of primary care services to the general public across 12 community health schemes through our 6,500 primary care contractors.
- Advance the process of transforming primary care services provided by GPs by working with them to ensure their service arrangements support health service provision reconfiguration.
- Harness community pharmacy expertise to build capacity in primary care, optimise medicines usage in the community, encourage self care as appropriate and to provide lifestyle advice to enable people to keep active and well for as long as possible.
- Support the DoH to progress the development of new contracts with GPs and community pharmacists, which clearly define and articulate the core professional services to be provided by them within a standards based framework.
- Progress a number of key strategic projects with the objective of continuously enhancing primary care services during 2012.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Primary Care Teams and Health and Social Care Networks	Commence phased roll out of chronic disease management for diabetes	Q4
	Increase access to primary care services through 489 PCTs	Q3
	Enhance service integration through development of HSCNs, this being enabled through reconfiguration of existing resources	Q4
	Develop clinical leadership and implement clinical governance and service management for PCTs	Q3
	Continue to develop ICT electronic referrals systems within and from primary care to the acute sector (pilots in HSE South and Tallaght)	Q4
Multidisciplinary Complex Care	Improve direct access to childcare and disability services, and community mental health services through PCTs	Q3
	Develop protocols signposting referral pathways between specialist addiction / homeless / traveller services and primary care services	Q3
Enhance Primary Care Services	**Maximise opportunities to develop Community Intervention Teams (CIT)** Expand services in existing six CITs within primary care settings	Ongoing
	Implement National Programmes through PCTs Deliver Community Cancer Control Programmes through PCTs including: ▪ Promulgation of training for practice nurses and public health nurses ▪ Development of e-learning programmes in prevention, early detection and cancer care for GPs and for community nurses ▪ Delivery of GP information and training sessions in association with the ICGP and GP Continuing Medical Education (CME) networks ▪ Further implementation of electronic referral processes via GP software systems to have 20% of cancer referrals made electronically (i.e. for those specialties where electronic referral processes have been developed – breast, prostate and lung)	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	▪ Development of a standardised approach to brief intervention training in smoking cessation for all health care professionals	
	Falls Prevention Deliver falls prevention programmes through PCTs	Ongoing
Accommodation	**Sufficient and appropriate accommodation available to enable successful functioning of PCTs** Open 19 additional primary care centres accommodating 27 PCTs	Ongoing
GP Training	Conclude the transfer of the GP Training Scheme to the ICGP as contracted service providers	Q3
New GP Contract	Participate in the development of new GP contract to meet emerging service requirements (led by DoH)	Ongoing
Audiology Services	**Improve Audiology Services** **Progress Implementation of Recommendations from *National Review of Audiology Services* to include:** Restructure services into integrated audiology service, and recruit national clinical lead and other key clinical support posts	Ongoing
	Further roll out Newborn Hearing Screening Programme to include clinical education, infrastructure and equipping requirements	
	Progress consultation and negotiation of workforce planning recommendations including MSc Sponsorship Programme requirements	
	Progress Audiology IT / Patient Management System	
	Roll out of Bone Anchored Hearing Aid Programme (BAHA)	
Oral Health	Implement *Independent Strategic Review of the Delivery and Management of HSE Dental Services*	Ongoing
	Establish standards for eligible and most vulnerable patients under the Dental Treatment Services Scheme	
	Reduce urgent dental general anaesthesia waiting lists for adults with intellectual disabilities	
	Commence implementation of Phase 1 HIQA Infection Control Standards for Dental Services	
	Reconfigure primary care dental services	Q1
Enhancing Primary Care Reimbursement Services	Provide a wide range of primary care services to the general public across 12 community health schemes through our 6,500 primary care contractors.	Q4
	Oncology Centralise the reimbursement of oncology drugs by utilising the existing business expertise and IT infrastructure of PCRS	Q1
	Hi Tech Drugs Scheme Centralise the reimbursement of the High Technology Drugs Scheme (HTDS) commencing initially with rheumatology by utilising the existing business expertise and IT infrastructure of the PCRS	Q4
	National Client Index Implement a National Client Index to support delivery of a wide range of potential benefits across the health system (such as the National Integrated Patient Management System (IPMS) and the National Integrated Medical Imaging System (NIMIS)	Q4
	Strategic Review of Pharmaceutical Value Chain Complete a strategic review of the pharmaceutical value chain from manufacturer to client to ensure the optimum business model is applied to deliver value for money	Q1
	Prescribing Feedback Initiative Develop and implement proposals to influence prescriber behaviour with GPs having access to online analysis of their individual prescribing	Q4
	GP Out of Hours Review Implement recommendations from *National Review of GP Out of Hours Services*	Q4
	Validate payments to GPs who are members of out of hour co-ops by reference to claims recorded on the co-op system, with submission to PCRS via agreed processes using specified electronic files	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Dental Review Implement recommendations of Dental Treatment Services Scheme (DTSS) review	Q4
	Centralisation of Primary Care Schemes Continue to ensure centralisation of primary care schemes in collaboration with the regions and continue to work through current charging processes to facilitate implementation of new national and local billing arrangements	Q4
	Probity Programme Continue to deliver upon the probity programme for schemes to ensure that expenditure under the schemes is appropriate in accordance with the terms and conditions under which funding is approved and the facts upon which payments to claimants are verified	Q4
	Continue to improve e-commerce infrastructure, driving further efficiencies in day to day business operations	Q4
	Continue to leverage opportunities to deliver more efficient and effective medical card processing following centralisation	Q4
	Apply a clinical focus to all licensed drugs / medicines reimbursed for appropriateness	Q4
	Rationalise all licensed drugs / medicines reimbursed based on need	Q4
	Govern reimbursement decisions of all New Chemical Entities (NCE) where there is a budget impact.	Q4
	Continue to review all non-drug items reimbursed under schemes for appropriateness	Q4
Long Term Illness Scheme	Extend free GP care to LTI claimants (provision of additional €15m for 2012)	Ongoing

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Primary Care No. of PCTs implementing structured GP Chronic Disease Management for Diabetes to incorporate the structured management of chronic diseases within this cohort of patients				New PI for 2012					New PI for 2012		Dependent upon timing of commencement of programme				
No. of Health and Social Care Networks in operation				New PI for 2012					New PI for 2012		13	10	14	13	50
No. of Health and Social Care Networks in development				New PI for 2012					New PI for 2012		22	16	22	19	79
% of Operational Areas with community representation for PCT and Network Development				New PI for 2012					New PI for 2012						17 100%
GP Out of Hours No. of contacts with GP out of hours	121,967	159,720	437,537	248,776	968,000	127,795	178,651	412,265	238,415	957,126	127,795	178,651	412,265	238,415	957,126
Physiotherapy Referral No. of patients for whom a primary care physiotherapy referral was received in the reporting month				New PI for 2012					New PI for 2012		41,995	30,972	48,648	47,391	169,006
Health Care Associated Infection: Antibiotic Consumption Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)				New PI for 2012					21.7 (Q2 data)						21

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Orthodontics															
No. of patients receiving active treatment during reporting period					18,000	4,964	2,044	3,024	3,745	13,777	4,964	2,044	3,024	3,745	13,777
No. of patients in retention during reporting period			To be disaggregated in 2011			1,723	785	958	n/a	3,466	1,723	785	958	---	3,466
No. of patients who have been discharged with completed orthodontic treatment during reporting period					2,000	377	274	365	407	1,423	377	274	365	407	1,423

Community (Demand-Led) Schemes

Performance Activity	Expected Activity 2011	Projected Outturn 2011	Expected Activity 2012
Medical and GP Visit Cards			
No. persons covered by Medical Cards	1,779,585	1,733,126	1,838,126
(Incl. no. persons covered by discretionary Medical Cards)	80,502	76,644	85,000
No. persons covered by GP Visit Cards	138,816	132,097	204,482
(Incl. no. persons covered by discretionary GP Visit Cards)	17,423	16,904	20,000
Long Term Illness			
No. of claims	978,111	825,255	844,241
No. of items	3,178,861	2,731,595	2,794,437
Drug Payment Scheme			
No. of claims	3,836,264	3,187,303	2,726,939
No. of items	11,355,342	9,880,639	8,453,510
GMS			
No. prescriptions	20,364,442	20,336,688	22,154,661
No. of items	63,076,913	57,146,092	61,589,957
No. of claims – Special items of Service	740,274	863,736	859,123
No. of claims – Special Type Consultations	1,098,668	1,108,649	1,074,340
HiTech			
No. of claims	435,345	428,994	452,267
DTSS			
No. of treatments (above the line)	968,784	961,500	1,164,805
No. of treatments (below the line)	53,916	41,989	50,867
No. of patients who have received treatment (above the line)	New PI 2011	---	To be reported during 2012
No. of patients who have received treatment (below the line)	New PI 2011	---	To be reported during 2012
Community Ophthalmic Scheme			
No. of treatments	715,455	708,862	739,579
i). Adult	652,186	648,889	677,007
ii). Children	63,269	59,973	62,572

Performance Indicators	Expected Target 2011	Projected Outturn 2011	Expected Target 2012
Medical Cards	---	---	
% of Medical Cards processed which are issued within 15 working days of complete application			90%
Median time between date of complete application and issuing of Medical Card	---	---	Baseline to be set in 2012 (for reporting from Q2)

Performance Indicators	Expected Target 2011	Projected Outturn 2011	Expected Target 2012
GP Visit Cards			
% of GP Visit cards processed which are issued within 15 working days of complete application	---	---	90%
Median time between date of complete application and issuing of GP Visit Card	---	---	Baseline to be set in 2012 (for reporting from Q2)

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2012. (See also Appendix 4):

Dublin Mid Leinster

- Kilbeggan, Co. Westmeath – primary care centre, by lease agreement
- Terenure, Dublin – primary care centre, by lease agreement
- Donnybrook, Dublin – primary care centre, by lease agreement
- Longford, Co. Longford – primary care centre, by lease agreement
- Newbridge, Co. Kildare – primary care centre, by lease agreement
- Churchtown, Dublin – primary care centre, by lease agreement

Dublin North East

- Mulhuddart, Co. Dublin – primary care centre, by lease agreement
- Ashbourne, Co. Meath – primary care centre, by lease agreement
- Drogheda North, Co. Louth – primary care centre, by lease agreement
- Kingscourt, Co. Cavan – primary care centre, by lease agreement
- Navan, Co. Meath – primary care centre, by lease agreement
- Blanchardstown, Dublin – primary care centre refurbishment

South

- Schull, Co. Cork – primary care centre, by lease agreement
- Kenmare, Co. Kerry – primary care centre, by lease agreement

West

- Abbey, Co. Limerick – primary care centre, by lease agreement
- Glenties, Co. Donegal – primary care centre
- Monksland, Co. Roscommon – primary care centre, by lease agreement
- Athenry, Co. Galway – primary care centre, by lease agreement
- Castlerea, Co. Roscommon – primary care centre, by lease agreement

Hospital Services

Introduction

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total Hospital	4,207	4,022
	Total Ambulance	140	138
		Projected start January 2012	
WTE	Hospital	48,100	
	Ambulance	1,503	

Acute hospitals deliver, on a regional, supra-regional or national basis, a wide range of services for acute, complex and non-urgent conditions. Over the last number of years, we have been restructuring the way in which we provide these services both in terms of how, and where, they are delivered. Hospital budgets are under considerable pressure as demand for services continues to grow year on year and, based on traditional ways of service provision, is outstripping service capacity within our current system. The priority in 2012 will be to stabilise the level of services that can be provided for the available resource and to continue the work of our change programme. The cornerstone of the change programme are the national clinical programmes of care and the rationalisation of services to ensure that best use is made of each hospital site. In 2012 we are committed to continuing to reorganise our hospital resources to ensure patients receive the best possible outcomes.

The national clinical programmes of care provide a national, strategic and co-ordinated approach to a wide range of clinical services. The primary aim of these is to modernise the manner in which hospital services are provided across a wide range of clinical areas through the standardisation of access to, and delivery of, high quality, safe and efficient hospital services, maximising linkages to primary care and other community services.

We will also continue to focus on improving timely and equitable access to services and will work with the DoH's Special Delivery Unit (SDU) to improve waiting times for emergency services and scheduled / planned care.

Our priorities for 2012:

- **Reform** acute services to ensure we achieve best patient outcomes, including continuing to change the roles of many of our hospitals.
- Implement standardised national **clinical programmes** which will ensure generic models of care and efficient service delivery solutions. These will deliver improvements in the delivery, quality and patient safety of services.
- Improve **access** to hospital services by linking the work of the clinical programme with that of the SDU. We will work with the SDU to minimise patient waiting times in emergency care and inpatient facilities as follows:
  - Ensure that 95% of all attendees at EDs are discharged or admitted within 6 hours of registration, and that those who need to be admitted through ED wait no more than 9 hours from registration.
  - Ensure that nobody is waiting more than 9 months for planned surgery.
  - Set and implement targets for improved access to outpatient and diagnostic services in the first quarter of 2012.
- Commence implementation of a national model for **paediatric care**.
- Change the way we **resource hospitals** in order to maintain service levels and drive improvement efficiencies such as funding certain elective orthopaedic procedures in selected hospitals on a cost per procedure (DRG) basis.
- Strengthen hospital management to **improve accountability** for hospital service and budgetary performance.
- Reconfigure **pre-hospital emergency care services** to respond to changing models of service within available resources.

We will further develop and implement clinical programmes in the following areas:

- Stroke
- Heart Failure
- Acute Coronary Syndrome
- COPD
- Asthma
- Diabetes
- Renal
- Radiology
- OPAT / Home IV Community Intervention Teams
- Care of the Elderly
- Rehabilitation
- Obstetrics and Gynaecology
- Palliative Care
- Neurology / Epilepsy
- Emergency Medicine
- Critical Care
- Day surgery, day of surgery and average length of stay national targets
- Productive theatre
- Surgical audit
- Surgical pathway and guidelines
- Orthopaedics
- Dermatology
- Rheumatology

Funding of €23.4m will be allocated to the base budgets of Regional Directors of Operations to allow them complete the roll out of key clinical programmes. Progress will be monitored during the course of 2012 to ensure achievement of objectives and where sufficient progress has not been made, funding will be redirected.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Clinical Programmes *We will further develop and implement clinical programmes with a particular focus on delivering guidelines, protocols, pathways, clinical decision making tools and associated metrics. This will provide implementation support by way of education and clinical leadership engagement.*	**Acute Medicine**	
	Acute Medicine model fully operational in 18 initial sites	Ongoing
	National Early Warning operational in a targeted number of sites	
	Emergency Medicine Programme	
	Implement improved patient access to Consultant delivered care	Q2
	Improve ED throughput by implementation of process, system and measurement improvements	Q4
	Establish Emergency Care networks	Q1
	Stroke	
	Stroke units operational to KPI standard	Q3
	Explore development of stroke rehabilitation units in a targeted number of sites	Q2
	Provision of 24/7 Thrombolysis in all hospitals admitting acute stroke patients	Q2
	All patients to have rapid access to specialist TIA (transient ischemic attack) services	Q4
	Implement the stroke register in 80% of all hospitals admitted acute stroke patients	Q3
	Critical Care	
	Implement critical care audit nationally on a phased basis	Ongoing
	Heart Failure	
	Roll out of heart failure guidelines and protocols	Q1
	Structured heart failure programmes operational in 12 acute hospitals	Q1
	Acute Coronary Syndrome	
	Pre-hospital protocols for all ACS (STEMI and Non-STEMI ACS) in place	Q2
	Minimum of four Primary PCI centres in operation	Q2
	Chronic Obstructive Pulmonary Disease (COPD)	
	Implement COPD register / data set	Q3
	Structured COPD outreach programme operational in 12 acute hospitals	Q1
	Asthma	
	Develop national model of care for asthma together with implementation plan	Q3
	Asthma Education Programme operational	Q2
	Diabetes	
	Commence phased roll out of chronic disease management for diabetes	Q4
	Roll out of subcutaneous CSII for treatment (for under fives) (insulin pumps)	Q3
	Continue to implement the national diabetic retinopathy screening programme	Ongoing
	Implement the national footcare programme	Q2
	Develop national guidelines for diabetes in pregnancy	Q4
	Renal	
	Maintain / increase number of renal transplants performed by National Renal Transplant Programme with a target of 200 procedures 2012	Q4
	Expand the no. of patients accessing home (peritoneal dialysis and home haemodialysis) therapies from 245 in 2011 to 280 procedures 2012	Q4
	National Peritoneal Dialysis Tender in 2012	Q2
	Commission six contracted satellite haemodialysis units to ensure adequate capacity and geographic spread of access for the growth in haemodialysis demand in 2012	Q4
	Enhance procurement of equipment and consumables processes to ensure access to the most modern equipment in the remaining two of the eleven networks of renal units in 2012	Q4
	Roll out of Kidney Disease Clinical Patient Management System to the remaining six of the eleven networks of Renal Units in 2012 and 2013	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Radiology	
	Optimise service to meet turnaround times for unscheduled care in line with AMP / EMP programmes	Q4
	Outpatient Antimicrobial Therapy OPAT	
	Award tender for national compounder	Q2
	Establish five regional OPAT centres	Q4
	Roll out national registry	Q3
	Palliative Care	
	Develop palliative care competency framework	Q3
	Care of the Elderly	
	Roll out comprehensive geriatric service model in those sites where configuration of geriatric trained resources is possible	Q2
	Surgical Care	
	Implement Average Length of Stay (AvLOS) Programme and associated reporting tool in six sites	Q4
	Support the attainment of National Elective Surgery wait list targets	Ongoing
	Establish Acute Surgery Programme	Q2
	Productive theatre programme operational in nine sites	Q4
	Outpatient programmes: dermatology, neurology, orthopaedics, epilepsy, rheumatology	
	30% increase in new patient attendances and wait list targets achieved	Q4
	Implement national clinical guidelines and pathways	Q4
	Six Regional Epilepsy Centres operational	Q3
	12 musculo-skeletal physiotherapy led clinics for rheumatology and orthopaedics operational	Q2
	Paediatric Care	
	National Model of Care and associated guidelines designed	Q4
	Neonatal Retrieval	
	Design and implement Phase 1 (Dublin Maternity Hospitals) of a National 24/7 Neonatal Retrieval Transfer Service	Q4
	Obstetrics and Gynaecology Services	
	Develop strategic five year workforce plan for Obstetrics and Gynaecology	Q3
	Establish local process improvement / implementation teams in the 19 maternity sites	Q2
	Develop, disseminate and implement national guidelines	Q4
	Audiology Services	
	These actions are specific to the clinical programmes. Please also see Primary Care	
	Appoint National and Regional Leads	Ongoing
	Develop patient management system	
	Implement workforce planning recommendations of *National Review of Audiology Services*	
	Integration of community and acute audiology services into a single managerial and clinical structure	
	Rehabilitation	
	Develop regional networks, local rehabilitation teams and associated protocols, pathways and bundles	Q1
	In association with other programmes (e.g. Stroke, Care of the Elderly) define an enhanced model for community based rehabilitation services	Q2
	Medication Management	
	Develop strategic plan for medicines management for older people	Q2
	Undertake analysis of biologic infusion therapies	Q1
	Haemochromatosis	
	Implement national model of care and guidelines for Haemochromatosis treatment	Q2
	To establish three regional walk-in venesection clinics, each providing care for 1,250 patients per location in an integrated care model with GPs	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Blood Transfusion Establish National Transfusion Committee and Task Force in line with the recommendations of the *National Blood Strategy Implementation Group (NBSIG) Report 2004*	Q1
	Reduction in platelet usage across the hospitals by 3% of 2011 usage – i.e. 2012 usage target of 21,500 units	Ongoing
	Establish framework to deliver reduction in red cell usage of 10% over 2011 baseline over three years 2012 - 2014	
	Percentage of red cells ordered by hospitals returned unused < 2%; rerouted to hub hospital < 5%	
	Establish methodology to deliver implementation of recommendation 5 of *NBSIG Report 2004*: reduction of excess O negative blood use, by 2014	
	Identify and execute savings in procurement of consumables, disposables and equipment through regional level action	
Resource Allocation Pilot *Complete an initiative which commenced in 2011 to pilot a change to procedure-based funding of hospital services instead of block grants*	Extend prospective funding model to remaining elective orthopaedic sites	Q2
	Develop a plan to roll out the prospective funding model to other elective surgery services	Q2
Cystic Fibrosis	National Model of Care and associated guidelines designed	Q4
	CF Unit to open in St. Vincent's Hospital (due to be operational Q3, 2012) and planning will continue for the extension of Mayo General Hospital, Beaumont Hospital and Galway University Hospital in line with recommendations of *The Treatment of Cystic Fibrosis in Ireland: Problems and Solutions 2005 (Pollock Report)*	Q4
Hospital Laboratories	Continue the consolidation of cold laboratory work in 2012	Q4
Endoscopy Services *Provision of high quality, timely and accurate services with associated quality patient experience*	Complete phase 2 of the procurement project for the Endoscopy Reporting System (ERS)	Q2
	Develop plans for the installation of ERS in remaining 10 public hospitals	Q3
	Complete specification for the national database	Q1
Smaller Hospitals *Re-organisation of Smaller Hospitals*	Publish in conjunction with the Department of Health, the Framework for Smaller Hospitals and the re-organisation plans for 9 smaller hospital sites (to be agreed with Government)	Q1
	Undertake a public communication and consultation process nationally on the framework and locally on the re-organisation process that will be implemented in the 9 sites	Q1
	Undertake a communication and consultation process with HIQA on the plans for smaller hospitals and provide monitoring reports as required	Ongoing
National Paediatric Hospital	Continue development of joint initiatives between the three hospitals that will make up the National Paediatric Hospital (Our Lady's Children's Hospital Crumlin, Children's University Hospital Temple Street and National Children's Hospital within Adelaide and Meath Hospital Tallaght) to: ▪ Implement the relevant national clinical programmes and prepare to operate under this umbrella in the new hospital	Ongoing
	▪ Move towards and put in place effective agreed unitary management for the new hospital in line with agreed governance structures for the new hospital to be developed in conjunction with the DoH	
	▪ Continue to progress the ongoing capital development process working with the National Paediatric Hospital Development Board and Estates	
National Integrated Management Information System *Enabling radiological services to be 'filmless', with secure and rapid movement of patient image data through the health services*	Implementation of system completed in designated areas: St. Luke's Rathgar, Our Lady's Hospital for Sick Children, Naas, Connolly, South Infirmary, South East Region, Mid-West Region, Mayo, Kerry, National Rehabilitation Hospital, St. Columcille's, Mallow, Bantry	Q4
	Integration of existing PACs sites into NIMIS: St. James', Cork University Hospital, University College Hospital Galway, Tullamore, Mullingar, South Infirmary Victoria, Mercy, Letterkenny, Roscommon, Adelaide and Meath incorporating the National Children's Hospital, Temple St.	Q4
European Working Time	Establish a National Working Group on EWTD	Q1

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Directive *for NCHDs*	Implement EWTD in respect of interns	Q2
	Implement revised rosters for Senior House Officers (SHOs), Registrars and Specialist Registrars that maximise EWTD compliance	Q2-Q3
	Report on consequent reduction in hours	Q4
	Report progress bi-annually	Q2 and Q4
Pre-Hospital Emergency Care Services *Re-configure Ambulance Services to respond to changing models of service*	**Implementation of National Ambulance Service Control Centre Reconfiguration Project and associated ICT enabling Projects:** Operationalise Control of National Ambulance Service assets	Q4
	Implement a Patient Equipment Replacement Programme to match Product Lifecycles	Q2
	Prepare the National Ambulance Service to support changes to Acute Hospital Services: Roll out of Education and Competency Assurance Plan to support ACS Clinical Care Programme and revised Clinical Practice Guidelines	Q3
	Develop and implement Pre Hospital National Appropriate Hospital Access Protocols for Paediatrics, Obstetrics, Stroke, ACS and Trauma in conjunction with Clinical Care Programmes	Q4
	Continue to develop suite of key performance indicators with HIQA on pre-hospital emergency care	Q2

Clinical Programme Performance Indicators

A number of key performance indicators have been developed which will support implementation of the clinical programmes and these are set out below. Some targets have been set and can be seen in the full Performance Indicator and Activity Suite. Some programmes will establish indicator baselines during the year, and only then will reporting commence. These will then inform the setting of targets in 2013. In addition, we will develop new performance indicators for other clinical programmes during 2012 (such as neurosurgery, etc.)

Acute Medicine

- % of all new medical patients attending the acute medical unit (AMU) who spend less than 6 hours from ED registration to AMU departure
- Medical patient average length of stay

Emergency Medicine Programme

- % of all patients arriving by ambulance wait < 20 mins for handover to doctor / nurse
- % of new ED patients who leave before completion of treatment
- % of patients spending less than 24 hours in Clinical Decision Unit

Stroke

- % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit
- % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis
- % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit

Heart Failure

- Rate (%) re-admission for heart failure within 3 months following discharge from hospital
- Median LOS and bed days for patients admitted with principal diagnosis of acute decompensated heart failure
- % patients with acute decompensated heart failure who are seen by HF programme during their hospital stay

Acute Coronary Syndrome

- % STEMI patients (without contraindication to reperfusion therapy) who get PPCI
- % reperfused STEMI patients (or LBBB) who get timely PPCI or thrombolysis
- Median LOS and bed days for a) STEMI and b) Non-STEMI pts

COPD

- Mean and median LOS (and bed days) for patients with COPD
- % re-admission to same acute hospitals of patients with COPD within 90 days
- No. of acute hospitals with COPD outreach programme
- % of acute hospitals and Operational Areas with access to Pulmonary Rehabilitation Programme

Asthma

- % nurses in primary and secondary care who are trained by national asthma programme

- No. of asthma bed days prevented annually
- No. of deaths caused by asthma annually

Diabetes

- % reduction in lower limb amputation from Diabetes
- % reduction in hospital discharges for lower limb amputation and foot ulcers in diabetics
- % of registered Diabetics invited for retinopathy screening

Epilepsy

- % reduction in Median LOS for epilepsy inpatient discharges
- % reduction in no. of bed days for epilepsy inpatient discharges

Dermatology OPD

- No. of new patients waiting > 3 months for dermatology OPD appointment
- Referral: New Attendance ratio

Rheumatology OPD

- No. of new rheumatology outpatients seen per hospital per year
- Referral: New Attendance ratio

Neurology OPD

- Length of time patients are waiting for neurology outpatient appointment
- Referral: New Attendance ratio

Acute Hospitals and National Clinical Programmes

Year on year, the HSE faces an increased demand for acute hospital services arising from a range of factors including population ageing and rising levels of chronic disease. Acute hospitals have thus been under considerable budgetary pressure in recent years and capacity will have to be tailored in line with the available funding to ensure financial sustainability. In 2012, hospital budgets will drop on average by 4.4% of last year's allocation and this will require an expenditure reduction of 7.8% when account is taken of incoming closing run rates (deficits).

As a direct result of the budgetary and staff reductions, activity levels would be expected to fall in 2012 by about 6%. Bed capacity in terms of bed days must reduce in proportion to the reduction in resources but increased efficiency of clinical service delivery arising from the impact of the Clinical Programmes will ensure that as many patients as possible will be seen and managed as inpatients or day cases. Therefore, we expect to be able to limit the reduction in activity, as measured by the number of people treated, to an average of 3% against 2011 outturn.

Activity reductions will vary from hospital to hospital depending on local circumstances. Hospitals with the greatest carry forward financial challenge will find it most difficult to maintain activity levels and some will require a high intensity management process which in addition to managing significant clinical change will also focus on targeted cost reductions and maximising income billing and collection. The western hospitals are particularly challenged, given the level of the historic deficits.

The priority in 2012 will be to stabilise the level of services that can be provided for the available resource and to continue the work of our change programme. The cornerstones of the change programme are the national clinical programmes of care and the rationalisation of services to ensure that best use is made of each hospital site. The national clinical programmes of care provide a national, strategic and co-ordinated approach to a wide range of clinical services. The primary aim of these is to modernise the manner in which hospital services are provided across a wide range of clinical areas through the standardisation of access to, and delivery of, high quality, safe and efficient hospital services, maximising linkages to primary care and other community services. Funding of €23.4m will be provided in 2012 to hospital budgets to recruit staff to progress the implementation of the Acute Medicine, Emergency Medicine, Stroke, Surgery and other clinical programmes, building on the work started in 2011.

The ongoing policies of moving from inpatient to day case treatment where possible ('stay to day'), increasing the rate of elective inpatients who have their principal procedure performed on day of admission and reducing the average length of stay will further serve to maximise the number of patients being treated while still reducing the number of bed days required. The HSE has targeted a reduction of 5% in average length of stay in 2012.

Decreased hospital activity will impact particularly on elective care, and in this context hospitals will work closely with the Special Delivery Unit (SDU) to ensure that, notwithstanding this reduction, nobody waits longer than 9 months for an elective procedure, thus ensuring equitable access for all. Emergency admissions will be reduced as a result of the impact of the Clinical Programmes as well as ED wait times, which is a critical priority.

Reorganisation of ambulance services will continue in 2012, leading to a more efficient use of resources. However, as no additional funding is available in 2012, our ability to address the newly agreed national targets will be challenging.

Activity, Performance Measures and Indicators

Performance Activity	Expected Activity 2011					Projected Outturn 2011					Expected Activity 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Discharges Activity*															
Inpatient	176,400	107,700	144,000	146,300	574,400	181,134	106,904	149,362	148,461	585,861	175,700	103,697	144,881	144,007	568,285
Day Case	**276,700	143,100	163,000	172,300	**755,100	**278,037	141,079	160,884	175,474	**755,474	269,696	136,847	156,057	170,210	732,810
% Discharges which are Public															
Inpatient					80%					78%					80%
Day Case					80%					85%					80%
Unscheduled Activity															
No. of emergency presentations	331,700	240,200	307,500	320,500	1,199,900	323,199	237,017	310,413	301,539	1,172,168	331,700	236,000	307,500	320,500	1,195,700
No. of emergency admissions	94,500	71,800	87,900	107,200	361,400	98,809	69,010	94,537	109,143	371,499	94,500	68,000	87,900	107,200	357,600
Outpatients Activity															
No. of outpatient attendances	1,377,500	810,800	714,700	688,700	3,591,700	No data available due to reclassification of metrics					To be confirmed by Quarter 1 2012				
Births Activity															
Total no. of births					74,200					73,490					73,216
Dialysis Modality															
Haemodialysis					1,650 – 1,740					1,670					1,760 – 1,870
Home Therapies					245 – 270					245					280 – 290
Total					1,895 – 2,010					1,915					2,040 – 2,160

*The actual breakdown of reductions between inpatient and day cases may vary once detailed hospital business plans are finalised
** Dublin Mid Leinster figures do not include St. Luke's day case activity

Performance Indicators	Target 2011	Projected Outturn 2011	Target 2012
ALOS			
Overall ALOS for all inpatient discharges and deaths	5.6	6	5.6
Overall ALOS for all inpatient discharges and deaths excluding LOS over 30 days	5	4.7	4.5
Inpatients			
% of elective inpatients who had principal procedure conducted on day of admission	75%	49%	75%
% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	New PI 2012	New PI 2012	9.6%
No. of people re-admitted to ICU within 48 hours	New PI 2012	New PI 2012	New PI 2012 Baseline to be established
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	New PI 2012	80%	95%
No. of first presentations to hospital with a primary diagnosis of development dysplasia of hip (DDH) at 1 year of age or older	New PI 2012	New PI 2012	New PI 2012
Delayed Discharges			
No. of hospital delayed discharges	---	817	Reduce by 10%
Reduction in bed days lost through delayed discharges	New PI 2012	New PI 2012	Reduce by 10%
Day case			
% of day case surgeries as % of day case plus inpatients, for a specified basket of procedures	75%	72%	75%

Performance Indicators	Target 2011	Projected Outturn 2011	Target 2012
Outpatients (OPD)			
An agreed set of OPD metrics will be in place and reported by Quarter 2 2012	---	---	To be confirmed by Q1 2012
Births			
% delivered by Caesarean Section	20%	27%	20%
Colonoscopy / Gastrointestinal Service			
No. of people waiting more than 4 weeks for an urgent colonoscopy	0	0	0
No. and % of people waiting over 3 months following a referral for all gastrointestinal scopes	New PI 2012	New PI 2012	New PI 2012 ≤ 5%
Unscheduled Care:			
% of all attendees at ED who are discharged or admitted within 6 hours of registration	100%	Data in 2011 was not inclusive of all hospitals. New reporting being introduced in 2012 will capture this data	95% by Sept. 2012
No. and % of patients who were admitted through ED within 9 hours from registration	New reporting time band 2012	New reporting time band 2012	100%
Scheduled Care			
No. and % of adults waiting > 9 months (inpatient)	New reporting time band 2012	New reporting time band 2012	0 0%
No. and % of adults waiting > 9 months (day case)			0 0%
No. and % of children waiting > 20 weeks (inpatient)	0	1,294 60%	0 0%
No. and % of children waiting > 20 weeks (day case)	0	1,312 53%	0 0%
Consultant Public: Private Mix			
Casemix adjusted public private mix by hospital for inpatients	80:20	Under review, baseline to be established	80:20
Casemix adjusted public private mix by hospital for daycase	80:20		80:20
Consultant Contract Compliance			
% of consultants compliant with contract levels by hospital type (Type B / B* / C)	100%		100%
Blood Policy			
No. of units of platelets ordered in the reporting period	22,000	22,210	21,500 (3% reduction)
% of units of platelets outdated in the reporting period	< 10%	< 4.5%	< 10%
% usage of O Rhesus negative red blood cells	< 11%	< 12.9%	< 11%
% of red blood cell units rerouted to hub hospital	< 5%	< 4.4%	< 5%
% of red blood cell units returned out of total red blood cell units ordered	< 2%	< 1.1%	< 2%
Health Care Associated Infection (HCAI)			
Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	0.085	0.071 (Q2 data)	< 0.067
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	New PI for 2012	3.2 (Q2 data)	< 3.0
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	76	86 (combined Q1 and Q2 data)	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	23	22.7 (combined Q1 and Q2 data)	23
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	New PI for 2012	75%	85%

Ambulance	Expected Activity 2011	Projected Outturn 2011					Expected Activity 2012
	Total	DML	DNE	South	West	Total	Total
First Responder response times to potential or actual 112 (999) life threatening emergency calls							
% of Clinical Status 1 ECHO incidents responded to by first responder in 7 minutes and 59 seconds or less	75%	60.4%	38.8%	56.9%	39.1%	49%	75%
% of Clinical Status 1 DELTA incidents responded to by first responder in 7 minutes and 59 seconds or less	75%	25.6%	28.9%	28.2%	23.9%	26%	75%
% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	Baseline to be established					69%	80% by June 2012 85% by Dec 2012
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	Baseline to be established					67%	80% by June 2012 85% by Dec 2012

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2012. (See also Appendix 4):

Dublin Mid Leinster

- St. Vincent's University Hospital, Dublin– new clinical building including wards, CF unit and dermatology unit

Dublin North East

- Mater Misericordiae University Hospital, Dublin– redevelopment of Mater Adult Hospital, including new ED, OPD, ICU / HDU (36 beds), 12 theatres, radiology, CSSD, 12 observation beds (A&E extension) and 120 replacement beds
- Connolly Hospital, Blanchardstown, Dublin – MRI installation

South

- Kerry General Hospital, Tralee – new ED
- St. Mary's Orthopaedic Hospital, Cork– upgrade of existing ward to facilitate relocation of Mercy University Hospital OPD
- Cork University Hospital – upgrade and refurbishment of existing cardiac theatres to create new trauma and one emergency theatre
- Cork University Hospital – refurbishment of an existing ward area to provide a surgical assessment unit
- Cork University Hospital – provision of an MRI above existing PET scanner
- Cork University Hospital – acute medical assessment unit
- Cork University Maternity Hospital – upgrade of existing recovery area to create an emergency obstetric theatre
- Waterford Regional Hospital – ED extension including neonatal unit
- Mallow General Hospital, Co. Cork – day procedures unit: endoscopy suite

West

- Letterkenny General Hospital, Co. Donegal – medical block including ED (19 bays), acute assessment unit (11 bays), three 24 bed wards
- University College Hospital Galway – neonatal department upgrade
- Mayo General Hospital, Castlebar – upgrade / replacement of fire detection system
- Mayo General Hospital, Castlebar – replacement of radiology equipment in ED
- Sligo General Hospital – replacement of radiology equipment
- Mid-Western Regional Hospital, Limerick – new critical care block providing 12 ICU, 14 HDU and 16 CCU beds

Ambulance

- Thurles, Co. Tipperary – new ambulance station
- Nenagh, Co. Tipperary – new ambulance station
- Tuam, Co. Galway – new ambulance station
- National – national ambulance control and call centre; national ambulance service college

Cancer Services

Introduction

The goals of the programmatic approach to cancer services, commenced in 2007 by the National Cancer Control Programme (NCCP), are to improve cancer prevention, detection and increase survival rates. This is being achieved through the development of a comprehensive national service, based on evidence and best practice.

NCCP is working to ensure that designated cancer centres for individual tumour types have adequate case volumes, expertise and a concentration of multi-disciplinary specialist skills. Symptomatic breast diagnosis and treatment and rapid access lung and prostate clinics established in the eight cancer centres since 2009 will continue to be monitored through the collection of monthly key performance indicators. Lung surgery has been centralised into four regional centres. Final centralisation of prostate cancer surgery and rectal surgery can only be achieved in tandem with the reconfiguration project. The new radiation oncology units (Phase 1) in Beaumont Hospital and St. James' Hospital opened in 2011. Formal approval for Phase 2 is still awaited.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total	105.1	100.7
		Projected start January 2012	
WTE	Total	1,200	

*In addition to the NCCP funding above, €38.2m has been allocated to hospitals in 2011, with a similar amount being allocated in 2012

In 2011, five site specific expert tumour groups were established with the objective of developing evidence based diagnostic and treatment guidelines for breast, prostate, lung, gastrointestinal and gynaecological cancers. This work will be further developed late in 2012, with additional tumour groups to be established for other cancers.

In 2012, NCCP will initiate measures to support optimal management of cancer drugs and will pursue the appointment of new consultant medical oncologists. The national cancer screening work programme includes planning to extend BreastCheck to an upper age group, continued provision of cervical screening and preparation for the colorectal screening programme. The 2012 community oncology work programme includes building on its existing partnership with Irish College of General Practitioners, increasing the proportion of electronic referrals and delivering a community nurse training programme for medical oncology patients.

Our priorities for 2012:

- Plan for the extension upwards of the age range for **BreastCheck** screening, continue **CervicalCheck** programme and prepare for the launch of the **colorectal** screening programme in quarter four.
- Deliver **cancer surgical services**, within multidisciplinary diagnostic and therapeutic environments, inclusive of medical and radiation oncology services.
- Progress the **national medical oncology programme,** developing national protocols for drug usage and national practices.
- Progress the **radiation oncology programme** to create a national network of radiotherapy facilities.
- Assist and support national **expert groups for common cancers** established by NCCP for the development of national clinical practice guidelines.
- Scope the development of a **national cancer information system** and support regional IT connectivity to support areas such as electronic prescribing and electronic referral.
- Develop **professional staff knowledge**, through collaboration with relevant colleges and educational bodies. Develop primary care skills in prevention, diagnosis, care, and follow up to facilitate safe, high quality care in the community.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
National Cancer Screening Services	**BreastCheck**	
	Continue to provide breast screening to women aged 50-64	Ongoing
	Plan for the extension of screening to 65-69 year old age range	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	CervicalCheck Continue to provide cervical screening and colposcopy services to women aged 25-60 years on a 3 or 5 year basis, dependent on age	Ongoing
	Introduce HPV testing post treatment	Q1
	Colorectal Screening Continue to plan for roll out of national colorectal screening programme: ▪ Appoint 20 candidate Advance Nurse Practitioners to the approved gastroenterology training programme	Q1
	▪ Procure FIT testing and lab service providers to support the roll out	Q4
	▪ Commence roll out of screening programme	Q4
	Continue to develop initiatives to promote participation in **all** screening programmes by marginalised groups	Ongoing
Development of Eight Cancer Centres (and Letterkenny)	**Rapid Access Lung and Prostate Clinics** Monitor activity and KPIs across rapid access clinics	Ongoing
	Prostate Cancer Surgery Complete transfer of prostate cancer surgery into six centres: ▪ South: Transfer prostate surgery from the Mercy University Hospital into Cork University Hospital (CUH)	Q1
	▪ DML: Transfer prostate cancer surgery from Adelaide and Meath, incorporating National Children's Hospital, Tallaght (AMNCH) into St. Vincent's and St. James' Hospitals	Q4
	Rectal Cancer Surgery Complete transfer of rectal cancer surgery into eight cancer centres and continue to monitor implementation and impacts on other surgical services in the centres: ▪ South: Transfer rectal cancer surgery into CUH	Q1
	▪ West: Transfer rectal surgery from Sligo General Hospital and Mayo General Hospital into Galway University Hospital	Q3
	▪ DML: Transfer rectal surgery from AMNCH into St. James' and St. Vincent's Hospitals	Q3
	Pancreatic Surgery Complete establishment of pancreatic satellite unit in CUH linking into St. Vincent's National Centre	Q1
	Upper GI Evaluate and select upper gastrointestinal (GI) cancer surgical centres	Q3
	Skin Cancers Monitor recruitment of dermatology posts in Waterford Regional Hospital and Mid-Western Regional Hospital, Limerick	Q1
	Monitor recruitment of the third skin post	Q3
	Develop services for treatment of skin cancers	Q4
	Gynaecological Cancer Plan regional centres for gynaecological cancers	Q2
	Haematological malignancies Evaluate services for haematological malignancies	Q2
	Other Cancers Analyse scope of cancer head and neck services	Q4
	Continue to consolidate regional and national clinical governance models in collaboration with regional partners	Ongoing
National Medical Oncology Programme	Review medical oncology services from a quality assurance (QA) and safety perspective	Q4
	Continue to assess new drugs and related predictive laboratory tests through the Health Technology Review Committee and present to HSE Management Team for approval	Ongoing
	Recruit pharmacist to advise on drug utilisation costs and pharmacy ICT	Q1
	Assist in the development of mechanisms for the management of the cancer budget within the Community (Demand-Led) Schemes section	Q1
	Develop national protocols for drug usage, and standardise practice nationally	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Radiation Oncology Services	Continue to increase capacity at Centres at St. James' Hospital and Beaumont Hospital as required until fully functional (Phase 1)	Q1
	Develop 5 year operational plan for St. Luke's Hospital pending delivery of Phase 2 facilities	Q2
	Progress the radiation oncology programme with the development of facilities as set out in the National Plan for Radiation Oncology (NPRO) within a single clinical framework.	Ongoing
	Continue the development of the National Radiation Oncology Network by: ▪ Implementation of national clinical guidelines and standards ▪ Implement the national performance management and monitoring system established to drive quality and service improvement. ▪ Implement national programmes for prostate brachytherapy.	Q2
	Continue to establish performance management and monitoring systems to drive service quality and service improvement	Q1
Quality and Safety: National Expert Tumour Groups	Direct and facilitate the cohesive national specialist clinical networks established for the purpose of clinical audit, sharing of good practice and problem solving for breast, lung, prostate and rectal cancers	Ongoing
	Drive and guide the five national expert tumour groups established for breast, lung, prostate, gastrointestinal and gynaecological cancers in the development of national evidence based clinical practice guidelines	
	Continue to define appropriate parameters to devise and monitor quality domains across cancer services	
	Continue to assist in the development of a National Radiology Quality Assurance Programme, led by the Faculty of Radiologists, including development of diagnostic radiology guidelines	
	Continue to assist in the development of a National Histopathology Quality Assurance Programme, led by the Faculty of Pathology, including the development of QA benchmarks and implementation of a framework for national histopathological reporting	
	Define strategies for QA for prognostic and predictive cancer tests including molecular testing	
National Cancer Information System (NCIS)	Scope the development of an integrated national cancer information system which will enable audit, evaluation, programme monitoring and programme planning for the purposes of cancer control and will satisfy the requirements for cancer registration	Ongoing
	Subject to enabling legislation, integrate the National Cancer Registry of Ireland (NCRI) into the NCCP	Q3
	Develop National / Regional IT connectivity across all medical oncology units to support electronic prescribing	Q4
	Disseminate information on standards of care, treatment protocols, cancer management guidelines, and cancer outcomes to health professionals, patients, and the public via website	Q4
	Develop a mechanism to enable the electronic transfer of pathology reports to the NCRI and National Cancer Screening Service (NCSS) databases	Q4
Quality Care in the Community	Promulgate use of standardised electronic referral processes developed for common tumours	Ongoing
	Partnership with ICGP to implement integrated cancer care	Ongoing
	Enhance smoking cessation training for all health care professionals including e-learning in partnership with primary care specialists	Ongoing
	Expand delivery of community nurse training programme for cancer care in association with specialist services	Q4
	Deliver training courses for Primary Care Nurses and develop e-learning format	Q3
	Interface with specialist services and GPs to deliver appropriate follow up cancer care of common cancers in the Primary Care setting	Q4
	Review GP referral guidelines for breast, lung and prostate cancers	Q4
	Develop Strategic Nurse Cancer framework with Office of Director of Nursing and Midwifery Services	Q2
	Support the public health framework to reduce chronic disease incidence and mortality	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Education and Research	Engage with professional training / educational bodies regarding training, educational needs, and workforce planning for cancer staff	Q4
	Promote the goals and objectives of the NCCP through educational sessions in primary care and also through collaboration with consultant staff nationally including conference presentations	Ongoing

Performance Activity and Performance Indicators

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
Symptomatic Breast Cancer Services			
No. of urgent attendances	13,000	13,690	13,000
No. of non urgent attendances	26,000	24,666	25,000
No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(No. and % offered an appointment that falls within 2 weeks)*	12,350 95%	13,590 99.3%	12,350 95%
No. and % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals *(No. and % offered an appointment that falls within 12 weeks)*	25,000 95%	23,441 95%	23,750 95%
Breast Cancer Screening			
No. of women who attend for breast screening	New PI for 2012	New PI for 2012	140,000
Lung Cancers			
No. of attendances at rapid access lung clinic	New PI for 2011	1,924	To be determined
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre	95%	1,713 89%	95%
Prostate Cancers			
No. of centres providing surgical services for prostate cancers	5	7	6
No. of new / return attendances and DNAs at rapid access prostate clinics	New PI for 2012	New PI for 2012	To be determined
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	New PI for 2012	New PI for 2012	90%
Rectal Cancers			
No. of centres providing services for rectal cancers	8	13	8
Radiotherapy			
No. of patients who completed radiotherapy treatment for breast, lung, rectal or prostate cancer in preceding quarter	New PI for 2012	New PI for 2012	To be determined
No. and % of patients undergoing radiotherapy treatment for breast, prostate, lung or rectal cancer who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist	New PI for 2012	New PI for 2012	90%

Older People Services

Introduction

The services we provide aim to support older people to remain independent, in their own home or within their community environment, for as long as possible. This is achieved through the provision of home and community-based support services (including home help services, home care packages, respite care, day care, meals on wheels, health promotion initiatives / programmes, etc). Where this is no longer possible, we support older people in residential care under the Nursing Homes Support Scheme (NHSS). An additional €55m has been allocated for this scheme in 2012.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Older People	407	390
	NHSS	1,026	1,046
	Total	**1,433**	**1,436**
		Projected start January 2012	
WTE	**Total**	**10,100**	

The particular challenge for older people services in 2012 will be to respond to the increasing demand for health and social services which is resulting from the growth in the number of older people, particularly in the upper age group (over 75yrs), while reducing the overall expenditure on this programme.

Our priorities for 2012 will be to improve the pathway of care for older people as they access a range of services. This will be supported by the work of the clinical care programmes. Funding will be focused on the maintenance of the delivery of home care services, particularly home care packages and on re-focusing home help services to prioritise personal care. We will also work on optimising the provision and quality of residential care.

Intermediate care is underdeveloped and has been identified as a critical element of the older persons care pathway. The HSE is committed to working with the DoH in allocating funding from long-term residential care and potential other sources, such as acute hospitals, to increase intermediate care capacity, i.e. step-up / step-down beds, and to provide additional community services such as Home Care Packages. This should reduce demand on acute hospital services and prevent inappropriate admissions to long-term residential care.

2012 is European Year for Active Ageing and Solidarity between Generations and we will work closely with the DoH to promote this agenda and to progress the recommendations of the *National Positive Ageing Strategy* when published.

Our priorities for 2012:

- Centralise the administration of the **Nursing Homes Support Scheme**.
- Provide quality **long term residential care** services for older persons who can no longer be maintained at home, in line with available funding under the *Nursing Homes Support Scheme*. This budget capped scheme will support 23,611 clients in 2012, an increase of 1,270 on 2011.
- The challenges associated with the continued provision of **residential care in public facilities** as a result of staff reductions and the *National Standards for Residential Care Settings for Older People in Ireland* will lead to a continued reduction in the numbers of public beds in 2011. In the absence of reform, this would increase the cost of caring for older people within the public system, undermine the viability of public community nursing units, and reduce the overall number of older persons that can be supported within the budget available for NHSS. It is anticipated that a minimum of 555 residential beds will close in the course of year. The majority of the beds identified are based on consolidation and reduction of public bed capacity in Public Long Stay Units. The number of actual units proposed to be closed will be kept to a minimum but will be as a result of the need to maximise value and sustainability through the consolidation of units. A decision to close a unit will only be taken following an extensive consultation process with the clients and staff of the identified long stay units.
- Work closely with the Clinical Strategy and Programmes Directorate in the development of the **programme for older persons.**
- Continue to improve the **quality of home care services** being delivered by implementing the *National Quality Guidelines for Home Care Support Services*. Following the completion of the national tender for Enhanced Home Care Packages, ensure standard implementation and monitoring of the approved providers.
- Provide the supports required for older persons to live independently, in their own homes, for as long as possible through the use of **high quality home support services** targeted at those in need of support for personal care.
- Respond to referrals of allegations of **elder abuse** in a timely and appropriate manner, in line with *Protecting Our Future*.
- Progress the **Single Assessment Tool** to determine patient / client need, and ensure equitable access to services based on this need.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Nursing Homes Support Scheme – A Fair Deal	**Nursing Homes Support Scheme (NHSS) – A Fair Deal** Full utilisation of *NHSS – A Fair Deal* within the funding allocated under Subhead B12	Ongoing
	▪ Support 23,611 clients under NHSS in 2012 (based on an average of public bed closures)	Q4
	Centralise administration and financial management of the scheme in a central national office (CNO), including the National Placement List	Q2
	▪ Business Case for NHSS Centralisation completed. From January 1st 2012, block funding for public long stay residential beds will cease	Q1
	▪ A system will be developed to fund public long stay residential care on a named patient / occupied bed basis	Q1
	▪ Implementation of this new funding system	Q2
	Participate in the substantive DoH review of the scheme	Q4
Public Care Settings for Older People	Provide an agreed level of public long term residential beds	Ongoing
	Reconfiguration / rationalisation / closure of a minimum of 555 beds to occur in 4 regions as follows: ▪ DML = 111 ▪ DNE = 105 ▪ South = 180 ▪ West = 159 Please note the figures referred to above are proposed bed closures only, and include a small number of units for closure. However, any decision to close a unit will only be taken following an extensive consultation process with the clients and staff of the identified long stay units.	Ongoing
	Efficiency Examine skill mix to ensure appropriate staffing is provided to meet needs of residents by reviewing current Skill Mix Configuration and Human Resource Deployment in HSE Care Units in line with Regional reconfiguration objectives, and make recommendations inclusive of best practice and cost effectiveness	Q1
	Examine elements of cost of long term residential care in HSE Care Units e.g. rostering arrangements	Q2
Older People Clinical Programme	**Reconfiguration of Public Residential Facilities** Review and determine short term bed requirements for rehabilitation (< 12months) / respite, short stay, step up / step down and assessment	Q2
	Identify, within public bed stock, number of beds that can be converted to meet short term bed requirements	Q1
	Service Model Work with the clinical programmes and consultant geriatricians to develop a geriatric service model	Q2
Community and Home Supports	**Intermediate and Home Care** Identify and implement innovative models of care for people requiring intermediate and home care with a view to preventing inappropriate admissions to acute hospitals / long term residential care and addressing delayed discharges, etc. in a more timely way	Ongoing
	Home Care Complete the *National Quality Guidelines for Home Care Support Services*	Q1
	Implement on a phased basis	Ongoing
	Home Help Service Complete the *National Home Help Guidelines* and implement on a phased basis	Ongoing
	Implement regular reviews of home help clients to ensure optimal use of available resource	Q2-Q4
	Examine home help delivery model with a view to value for money (VFM) and service improvement	Ongoing
	Home Care Packages Undertake reviews of home care package clients to ensure optimal use of available resource	Ongoing
	Finalise and implement the procurement process for home care packages	Q1

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Ensure regional governance of implementation of Approved Provider Panel	Ongoing
	Legislative Framework – Community Services Continue to work with DoH on legislative proposals for community services	Q4
	Provision of equitable ancillary care / aids and appliance services to all older persons Complete work of National Ancillary Group to put in place standardised processes around the delivery of these services to both the community sector and the residential sector within available resources	Q3
	Develop protocol for access to ancillary services for older people in designated centres	Q1
Keep Older People Healthy and Out of Hospital	Work with DoH in developing *National Positive Ageing Strategy* and, when published, in implementing the recommendations	Q4
	Work with DoH towards promotion of European Year for Active Ageing and Solidarity between Generations	Ongoing
	Work with DoH on development and roll out of *Dementia Strategy*	Q4
	Select four demonstration sites and complete the planning phase of the HSE / Genio Dementia Project to outline community based supports and commence implementation	Q2-Q3
	Work with the Ageing Well Network in the national development of Age Friendly counties	Ongoing
	Liaise with the primary care service to ensure the identified needs of older people are met through the PCTs, Primary Care Networks and Community Intervention Teams	Q4
	Implement (on a phased basis) recommendations from the *Strategy to Prevent Falls and Fractures in Ireland's Ageing Population*, with the primary care service and the Clinical Strategy and Programmes Directorate	Ongoing
	Complete procurement process for the Telecare project to support for older people at home and implement	Q1-Q2
Elder Abuse	**Protection of Older People – *Protecting Our Future*** ▪ Provide a timely / appropriate response to allegations of elder abuse in line with agreed performance measures ▪ Review all referrals of abuse at least six monthly	Ongoing
Standardised Assessment in Community and Acute Settings	**Single Assessment Tool (SAT)** Conclude pilot SAT and analyse findings	Q1
	Prepare business case for consideration	Q2

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Home Care Packages* Total no. of persons in receipt of a HCP	2,355	3,385	2,345	2,145	10,230	2,662	3,545	2,425	2,238	10,870	2,662	3,545	2,425	2,238	10,870
No. of HCPs provided	1,460	1,253	1,304	1,283	5,300	1,460	1,253	1,304	1,283	5,300	1,460	1,253	1,304	1,283	5,300
No. of new HCP clients	1,000	1,150	1,000	1,250	4,400	1,497	1,771	1,184	1,177	5,629	1,250	1,100	1,100	1,350	4,800
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	2.16m	2.41m	3.9m	3.5m	11.98m	2.00m	2.15m	3.79m	3.26m	11.20m	1.91m	2.06m	3.62m	3.11m	10.70m
No. of people in receipt of home help hours (excluding provision of hours from HCPs)	12,000	12,900	14,700	14,400	54,000	12,003	9,486	15,681	13,453	50,623	12,003	9,486	15,053	13,460	50,002
Day Care No. of day care places for older people	Baseline to be set					National survey undertaken Q4 to inform 2012 targets					Targets to be determined				
NHSS No. of people being funded	Baseline to be set					6,223	4,246	6,157	5,715	22,341	Centralised scheme in 2012				23,611

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
under NHSS in long term residential care at end of reporting month															
No. and proportion of those who qualify for ancillary state support who chose to avail of it	Baseline to be set					1,032	731.2	1,004.8	976	3,744	Demand-led				
% of complete applications processed within four weeks					100%	100%	100%	100%	100%	100%					100%
Subvention and Contract Beds															
No. in receipt of subvention	Dependent on uptake of NHSS					270	250	320	460	1,300	135	250	275	100	760
No. in receipt of enhanced subvention	Dependent on uptake of NHSS					10	255	240	95	720	100	150	220	70	540
No. of people in long-term residential care who are in contract beds	New PI for 2012					New PI for 2012					To be reported in 2012				
No. of long stay residents in public and voluntary nursing homes admitted before 27 Oct 2009 (saver cases)	New PI for 2012					New PI for 2012					To be reported in 2012				
Public Beds															
No. of beds in public residential care setting for older people	2,300	1,300	2,300	2,300	8,200	1,963	1,349	2,420	2,255	7,987	1,731-1,852	1,169-1,244	2,170-2,240	2,019-2,096	7,089-7,432
											Minimum and maximum range				
Elder Abuse															
No. of new referrals by region	Demand-led					290	466	574	330	2,213	400	390	770	440	2,000
No. and % of new referrals broken down by abuse type:															
i). Physical	Baseline to be set					61	64	75	52	335 11%					---
ii). Psychological	Baseline to be set					126	188	188	170	897 30%					---
iii). Financial	Baseline to be set					101	113	130	96	587 19%					---
iv). Neglect	Baseline to be set					56	113	111	81	482 16%					---
No. of active cases	New PI for 2011					290	310	803	395	1,798					---
% of referrals receiving first response from senior case workers within four weeks					100%	100%	100%	100%	100%	100%					100%

*The outturn for the number of new HCP clients for 2011 includes additional clients funded under the €8m new development funding and clients approved following implementation of the new standard definition for HCPs in 2011. Therefore the number of new clients for 2012 is expected to be 4,800 overall and is based on turnover within existing funding.

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2012. (See also Appendix 4):

Dublin Mid Leinster

- Inchicore, Dublin – 50 bed community nursing unit (CNU)
- St. Mary's Unit, Mullingar (Older People / Mental Health) – 100 bed community hospital to accommodate replacement beds from the existing unit

Dublin North East

- Cuan Ros, Community Unit, Dublin - refurbishment
- Seanchara Community Unit, Dublin - refurbishment
- Lusk Community Unit, Co. Dublin – refurbishment
- St. Oliver Plunkett Hospital, Dundalk - refurbishment

South

- Tralee, Co. Kerry – 50 bed CNU
- Farranlea Road, Cork – 100 bed CNU

Mental Health Services

Introduction

The mental health of the population plays a vital role in the vibrancy and economic life of the country. Therefore, investing in promoting positive mental health and in early intervention is not only an investment in the individual's quality of life but also in the global health status of the nation.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total	712	707
WTE		Projected start January 2012	
	Total	9,207	

The HSE is required to deliver its mental health services within a decreasing budget and headcount. Our mental health services include a broad range of primary and community services as well as specialised secondary care services for children and adolescents, adults, and older persons. In recent years there has been increased specialisation, including rehabilitation and recovery, liaison, forensic, mental health services for people with an intellectual disability, and suicide prevention initiatives. Services are provided by the HSE and voluntary sector partners in a number of different settings including the service users' own home, acute inpatient facilities, community mental health centres, day hospitals, day centres, and supported community residences.

Guiding the development of our services is *A Vision for Change* – a progressive, evidence-based and pragmatic policy document, which proposes a new model of service delivery designed around the service user, one that is recovery-orientated and community-based. *A Vision for Change* is strong on values and sets out a comprehensive change programme for our mental health services. When published, it included a number of very significant commitments on infrastructure, new revenue funding and new multidisciplinary staff (+ 1,800). Since *A Vision for Change*, the HSE has spent €190m on mental health capital and has further contracted commitments of €57m. The multi annual capital plan also shows non-contracted but planned spend of a further €170m. That means that a total of €417m of investment will be made. This does not include the community facilities that have been acquired under the primary care centre lease programme (estimated equivalent value to date €20m). In that period there has been a total of €37m from sale of lands. *A Vision for Change* states "the value of these assets significantly counterbalances the cost of the new mental health service infrastructure requirement". This has very clearly not been the case, however the full capital investment required in *A Vision for Change* has been met.

In 2012, prioritised under the Programme for Government, an additional €35m has been made available to enhance General Adult and Child and Adolescent Community Mental Health Teams, improve access to psychological therapies in primary care and implement suicide prevention strategies in line with *Reach Out – National Strategy for Action on Suicide Prevention*. Approximately 400 extra staff will be recruited to support this. In addition, a number of inpatient child and adolescent units will open in 2012 which have for a long time been a critical gap in the spectrum of mental health services. Within the additional €35m, €2m will be allocated to Genio projects.

However, like all care areas, other budget reductions as a consequence of the impact of the efficiency, procurement and moratorium savings will be applied, resulting in cost reductions of just less than 1% once the additional investment is taken into account. The cumulative impact of staff loss from the mental health services since 2009 and the attrition expected in early 2012, continues to challenge us to provide continuity of services to our patients and clients. It will however support us in expediting our strategic reform programme with the closure of old psychiatric institutions and associated inpatient beds. There will also be reductions in payments to external agencies who will be challenged to maximise efficiencies.

We will continue to minimise the impact of the above on our obligations under mental health legislative and regulatory directives, wherever possible, with *A Vision for Change* remaining the strategic direction for the future delivery of mental health services in Ireland.

Our priorities for 2012:

- Promote **positive mental health and prioritise suicide prevention**; in particular, implement outstanding actions in *Reach Out – National Strategy for Action on Suicide Prevention.*
- Strengthen **General Adult Community Mental Health Team (CMHT) capacity** by ensuring, at a minimum, that at least one of each mental health professional discipline is on each general adult community mental health team.
- Strengthen **Child and Adolescent Community Mental Health Team (CAMHT) capacity** by ensuring, at a minimum, that at least one of each mental health professional discipline is on each team.
- Maintain and increase **child and adolescent acute inpatient capacity.**

- Continue to review the number and location of **acute and continuing care beds** so as to rationalise inpatient provision.
- Continue to work with all stakeholders to plan for the closure to admissions to the **traditional psychiatric hospitals**.
- Develop the capacity to effectively manage mental health needs appropriate to a **primary care setting**.
- Ensure access to quality **psychotherapy and counselling services** for patients eligible under the general medical services within primary care.
- Progress the project plan to relocate Central Mental Hospital to St. Ita's, Portrane and progress associated national forensic infrastructure to include Forensic CAMHS Unit, Forensic Mental Health Intellectually Disability (MHID) Unit and provision of four Intensive Care Rehabilitation Units (ICRUs).
- Implement agreed **clinical care programmes in mental health**.
- Develop effective partnerships with **voluntary and statutory agencies** to deliver integrated care for service users.
- Develop the **service user and carer partnership** by ensuring service user representation on Area Mental Health Management Teams.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Positive Mental Health and Suicide Prevention	Implementation of *Reach Out – National Strategy for Action on Suicide Prevention* and the Management of Self-Harm Presentations to ED Clinical Programme	Q4
	Mental Health Promotion Continue the roll out of ASIST and Safetalk programmes by training an additional 4,000 and 2,000 people, respectively, per annum	Ongoing
	Maintain the public mental health awareness campaigns to encourage positive mental health and reduce stigma associated with suicide and mental health	
General Adult Community Mental Health Teams	Expand and rationalise the membership of general adult CMHTs to ensure improved multidisciplinary representation. (The allocation of additional resources to professionally complete General Adult CMHTs is contingent on those teams implementing the mental health clinical programmes when agreed)	Ongoing
	DNE - merge CMHTs to achieve economies of scale coterminous with Health and Social Care Networks	Ongoing
Child and Adolescent Community Mental Health Teams	Complete the multidisciplinary profile of the existing Child and Adolescent CMHTs to include at least one of each profession (medical, nursing, clinical psychology, social work, occupational therapist, speech and language therapist, child care worker)	Ongoing
Child and Adolescent Acute Inpatient Capacity	Implement measures to increase acute inpatient capacity: ▪ South: Child and adolescent acute inpatient unit open to full capacity in Bessboro, Cork	Q1
	▪ West: Child and adolescent acute inpatient unit open to full capacity in Merlin Park, Galway	Q4
	▪ DNE: Additional 6 beds in Phase 2, St. Vincent's Fairview capital project completed	Q2
	▪ DML: Development of 8 bed interim Child and Adolescent Acute Inpatient Unit for St. Loman's, Palmerstown	Q1
	▪ DML: Commissioning of Day Hospital in Cherry Orchard	Q1
Enhance Young People's Mental Health	In partnership with Headstrong, progress the six new Jigsaw sites in development through the allocation of €1m Innovation Funding	Ongoing
Rationalise Acute Inpatient Provision in line with A Vision for Change	Reduction of a minimum of 153 adult acute inpatient beds nationally **South (**301 acute beds currently) ▪ Reduce by 61 beds to 240	Ongoing
	West (331 acute beds currently) ▪ Donegal / Sligo / Leitrim – reduce by 15 acute beds ▪ Galway / Mayo / Roscommon – reduce by 37 acute beds ▪ Limerick / Clare / North Tipperary – reduce by 30 acute beds	
	DNE (205 acute beds currently) ▪ Closure plans for St Brigid's Ardee will be progressed in line with the new unit in Drogheda	

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	▪ Closure of acute inpatient beds in St Vincent's Hospital, Fairview will be progressed in line with the refurbishment of the acute beds at Mater Hospital	
	DML (270 acute beds currently) ▪ Reduction by 10 beds to 260	
	Discontinue direct medium and low support housing provision managed by the mental health services (This does not impact on the provision of clinical support)	
Closure of old psychiatric hospitals to acute inpatient admissions	Continue to work with all stakeholders to plan for the closure to admissions of old psychiatric hospitals **West** – Progress closure of St Joseph's Hospital in Limerick	Ongoing
	DNE – Closure of St Brigid's Ardee will be progressed in line with the new unit in Drogheda	
	South – St Luke's Clonmel will close as an approved centre in 2012 and in St Finans, direct admissions will cease by Q1	
	DML – Complete the closure of the old psychiatric hospital at St Loman's Mullingar	
Inappropriate Placements	Establish a Working Group with Disability Services to address people with intellectual disability inappropriately placed in psychiatric settings	Q1
Mental Health in Primary Care and Access to Psychotherapy Services	**Mental Health in Primary Care** Continue participation by PCTs in the team based approaches to mental health in the Primary Care Accredited Programme, as funding permits	Q1
	Provide access to psychotherapy and counselling for patients eligible under the general medical services	Ongoing
National Forensic Mental Health Services	**Replacement of Central Mental Hospital (CMH)** Progress the project plan to relocate CMH to St. Ita's Portrane and progress associated national forensic infrastructure to include Forensic CAMHS Unit, Forensic Mental Health Intellectual Disability (MHID) Unit and provision of 4 ICRUs	Ongoing
	DML Complete high support hostel and outreach service for people granted conditional discharge under Criminal Law Insanity Acts	Q1
Clinical Care Programmes in Mental Health	Prepare a detailed plan for the implementation of the agreed mental health clinical programme	Q2-Q4
Voluntary and Statutory Agencies	Continue to work with statutory and voluntary agencies to improve social inclusion for service users – housing authorities, gardai, educational and training agencies	Ongoing
	Continue to work with voluntary partners in mental health to ensure co-ordinated delivery of services across agencies in line with objectives of *A Vision for Change*	
Service User and Carer Partnership	Ensure service user representation on Area Mental Health Management Teams	Ongoing
Embed Recovery Ethos	Implement the guidelines for the delivery of recovery-focused mental health services	Q2-Q4
Mental Health Services Management	Complete the multidisciplinary Mental Health Services Management Teams in all operational areas through reconfiguration of existing management roles	Q2
	Establish the business requirements for a national Mental Health Information System	Q2
Fostering Innovation	Allocation of €2m to Genio to accelerate innovative practice and service modernisation in mental health in line with *A Vision for Change*	Ongoing

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Adult Inpatient Services															
No. of admissions to adult acute inpatient units	3,532	2,686	4,712	3,978	14,908	3,426	2,699	4,338	3,700	14,163	3,426	2,699	4,338	3,700	14,163
Median length of stay	11.0	10.0	11.0	10.0	10.5	10	9	12	12	11	10	9	12	12	11
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	73.2	72.6	108.9	98.1	88.1	69.6	73	101.3	91.3	83.5	64.7	66.4	93.5	85.5	77.3

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	22.4	24.8	33.5	26.2	26.7	22.1	28	31.9	25.3	26.7	20.5	25.5	29.4	23.7	24.6
Acute re-admissions as % of admissions	70%	63%	69%	73%	69%	68%	62%	68%	72%	68%	68%	62%	68%	72%	68%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	50.8	47.6	75.4	71.9	61.4	47.5	45	69.3	65.9	56.9	44.2	40.9	64.0	61.8	52.7
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	20.6	21.4	26.4	28.3	24.2	20.6	21.4	26.4	28.3	24.2	19.7	20.1	20.7	30.6	22.6
No. of adult involuntary admissions	320	248	384	380	1,332	320	250	415	403	1,388	320	250	415	403	1,388
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	6.58	6.68	8.85	9.38	7.86	6.6	6.8	9.7	10	8.2	6.0	6.2	8.9	9.3	7.6
Child and Adolescent															
No. of child and adolescent Community Mental Health Teams	18	10	13	13	54	19	10	13	14	56	19	11	13	14	57
No. of child and adolescent Day Hospital Teams	2	1	---	---	3	1	1	-	-	2	1	1	-	-	2
No. of Paediatric Liaison Teams	2	1	---	---	3	2	1	-	-	3	2	1	-	-	3
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	---	---	---	---	220	38	42	29	31	140	38	42	29	31	140
No. of children / adolescents admitted to adult HSE mental health inpatient units*					< 100					130					80
i). < 16 years										4					0
ii). < 17 years										33					16
iii). < 18 years										93					64
No. and % of involuntary admissions of children and adolescents					16 5%					16 5%					16 5%
No. of child / adolescent referrals (including re-referred) **received** by mental health services	3,644	2,218	2,795	2,662	11,319	4,033	2,520	2,957	2,983	12,493	4,033	2,520	2,957	2,983	12,493
No. of child / adolescent referrals (including re-referred) **accepted** by mental health services	2,639	1,465	1,734	2,087	7,925	2,895	1,651	1,674	2,241	8,461	2,895	1,651	1,674	2,241	8,461
Total no. of new (including re-referred) child / adolescent referrals **offered** first appointment and seen	2,272	1,426	1,729	2,076	7,503	2,468	1,371	1,857	2,128	7,824	2,468	1,371	1,857	2,128	7,824
No. and % of new / re-referred cases offered first appointment and seen															
i). < 3 months	1,608	823	1,134	1,523	5,088 68%	1,633 57%	858 54%	1,307 61%	1,569 71%	5,367 61%					70%

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
ii). > 12 months	67	116	283	253	720 9%	148 5%	56 3%	210 10%	209 9%	623 7%					0%
No. and % of cases closed / discharged by CAMHS service	New PI 80% of accepted referrals					2,773 104%	1,845 89%	1,734 97%	1,388 161%	7,740 109%	2,773 80%	1,845 80%	1,734 80%	1,388 80%	7,740 80%
Total no. on waiting list for first appointment at end of each quarter	628	317	666	610	2,221 (reduce no. waiting by > 5%)	536	275	447	598	1,856	505	259	465	570	1,799 (reduce no. waiting by > 5%)
No. and % on waiting list for first appointment at end of each quarter by wait time															
i). < 3 months	260	167	208	167	802	284 53%	105 38%	137 31%	120 20%	646 35%	270 53%	100 39%	139 30%	114 20%	624 35%
ii). 3-6 months	217	75	136	143	570	137 26%	84 31%	102 23%	137 23%	460 25%	130 26%	80 31%	111 24%	130 23%	452 25%
iii). 6-9 months	151	75	172	174	570	110 21%	83 30%	104 23%	165 28%	462 25%	52 10%	40 15%	115 25%	157 28%	365 20%
iv). 9-12 months					---					New PI	52 10%	39 15%	99 21%	168 29%	358 20%
v). > 12 months	0	0	150	127	277	5 1%	3 1%	104 23%	176 29%	288 16%					0
No. of suicides in arrears per CSO Year of Occurrence	New PI					506 (2008 validated)									---
No. of repeat deliberate self harm presentations in ED	1,342 1% reduction on 2010									1,348					1,348

*The Mental Health Commission Regulations recognise that there will be occasions where it is clinically necessary to admit a child to an adult unit

Improving our Infrastructure

Capital projects that are to be completed and / or become operational in 2011. (See also Appendix 4):

Dublin Mid Leinster

- Ballyfermot Hostel, Cherry Orchard Hospital, Dublin – 17 bed low support hostel
- St. Loman's, Clondalkin Road, Dublin – 17 bed hostel
- St. Loman's Hospital, Mullingar – replacement of St. Edna's ward, to provide a 20 bed special behavioural unit and up to 24 replacement beds
- Grosvenor Road, Dublin – upgrade of hostel
- Cherry Orchard, Ballyfermot, Dublin – new day centre comprising outpatients, adolescents' day hospital and administration
- Ballyfermot, Dublin – new primary care and mental health centre
- St. Mary's Unit, Mullingar (Mental Health / Older People) – 100 bed community hospital to accommodate replacement beds from St Loman's Psychiatric Hospital for patients with continuing care needs

Dublin North East

- St. Vincent's Hospital, Fairview, Dublin – 6 additional beds in adolescent unit
- Grangegorman, Dublin – replacement accommodation on existing site for all services, including accommodation for residents and a day hospital
- Beaumont Hospital, Dublin – 44 bed psychiatric unit

South

- Clonmel, Co. Tipperary – 40 bed residential unit to accommodate current residents of St. Luke's
- Clonmel, Co. Tipperary – high support hostel
- St. John's, Enniscorthy, Co. Wexford – Havenview, 14 place residence to provide accommodation to re-house residents from St. Senan's Hospital
- St. John's, Enniscorthy, Co. Wexford – 13 place high support house (Mill View) to re-house residents from St. Senan's Hospital
- Clonmel, Co. Tipperary – day hospital and accommodation for sector team
- Waterford Regional Hospital – upgrade acute mental health unit
- Wexford – 50 bed CNU to accommodate current residents of St. Senan's Hospital
- Kerry General Hospital, Tralee – high observation unit

West

- Ennis, Co. Clare – Gort Glas day centre

Disability Services

Introduction

A major change programme for disability services in Ireland has commenced in recent years. Service provision has been moving towards a community-based and inclusive model rather than being institutional and segregated. This process is now gathering momentum towards achieving the vision of a society where people with disabilities are supported to participate fully in economic and social life, and have access to a range of quality supports and services to enhance their quality of life and well-being.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total	1,576	1,541
WTE		Projected start January 2012	
	Total	15,304	

The emerging DoH policy direction (*Value for Money and Policy Review*), coupled with recommendations from HSE national working groups on key service areas such as congregated settings and day services, has emphasised the need for a new model of service provision that, if agreed by Government, will further the independence of people with disabilities in a manner which is efficient and cost-effective. This will include a robust implementation plan which will be developed through the National Consultative Forum and will include a monitoring and evaluation framework. The findings and recommendations of the *Value for Money and Policy Review* will provide the framework within which the constituent parts of the overall change programme will be developed and driven. This radical change is not the sole responsibility of the HSE but, rather, a collaborative responsibility shared between the person, their families and carers, a multiplicity of agencies, Government, and society as a whole.

The allocation for disability services will reduce in 2012 by 3.7% as a consequence of the impact of the efficiency, procurement and targeted pay reduction savings. In addition, disability services will be required to cater for demographic pressures, such as new services for school leavers and emergency residential placements, from within their existing budgets. While the allocation will reduce by 3.7% nationally, there is scope for achieving efficiencies of 2% or more through measures such as consolidation and rationalisation of back office costs. Some providers have made significant progress in this regard in recent years but considerable scope for savings remains in the case of others. All providers will be expected to achieve some efficiency savings but the level of savings will vary depending on the profile of the service provider, efficiency savings achieved to date and the scope for further savings. HSE managers will have the scope, within the national figure of 3.7%, to vary the level of reduction which will apply to individual service providers. The HSE will work closely with the Department in finalising the allocations.

Some reductions in services will be unavoidable even with such efficiencies. These will arise in day services, residential and respite services. The aim will be to tailor such reductions in a way which minimises the impact on service users and their families as much as possible. There is evidence that an accelerated move towards a new model of individualised, person centred service provision in the community can help to achieve efficiencies, particularly in relation to services for those with mild or moderate intellectual disability. .

Provision has been made for investment of €1m for autism services. This will be used to address waiting times for specialist therapy services for children who have been diagnosed with autism and on developing Early Intervention Teams.

Our priorities for 2012:

- **Maximise the provision of services** within available resources.
- Develop and continue a **total system reconfiguration** of service provision though the implementation of:
  - The programme for *Progressing Disability Services for Children and Young People*
  - The *Review of Autism Services*
  - Reconfiguring adult day services as outlined in *New Directions: Report of the National Working Group for the Review of HSE Funded Adult Day Services*
  - Reconfiguring residential services as recommended in *Time to Move on From Congregated Settings*, and
  - *The National Neuro-Rehabilitation Strategy*.
- Develop systems and processes to **mainstream all services in the community** such as speech and language therapy, occupational therapy and physiotherapy in collaboration with primary care and network teams.

- Support organisations in the delivery of high quality and safe services, in preparation for the commencement of a **system of registration and inspection of residential services** for adults and children with disabilities.
- Implement measures to ensure that **children assessed under the Disability Act, 2005** receive those assessments in accordance with the standards laid down, and that processes are improved and services reconfigured in order to make progress towards compliance with the timeframes set out in legislation
- Review the current **information systems and information needs** for disability services and make recommendations for future planning.
- Develop an action plan including short, medium and long-term goals, for the implementation of the recommendations of the ***VFM and Policy Review*.**

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Service Provision and Total System Reconfiguration	Develop systems and processes to ensure that, where appropriate, people with disabilities access services in the mainstream of primary care services	Ongoing
	In conjunction with the National Disability Authority (NDA), develop a resource allocation model reflective of the service arrangements and the recommendations of the *VFM and Policy Review*	Q3
	Test a system of resource allocation through demonstration projects	Q4
	Develop an action plan to implement the recommendations of the *VFM and Policy Review*	Q2
	Develop new models of service provision, such as Host Family Support, to improve the choice available to people with disabilities	Ongoing
	Conduct a pilot of alternative models of respite care provision in Mid-West service area	Q3
	Progressing Disability Services for Children and Young People Continue development of regional and area level implementation plans	Q2-Q4
	Establish clear pathways and links to school services	Q3
	In those areas where plans are completed, commence the reconfiguration of available resources with key stakeholders	Q3
	Review of Autism Services Link with children's disability services programme and engage with service providers and education sector	Q1
	Develop regional and area level implementation plans and commence implementation based on the review's recommendations, taking cognisance of relevant aspects of other policies such as the *Congregated Settings* and *New Directions* reports	Q3-Q4
	Disability Act 2005 Continue to refine the processes under the Act and integrate them into the services for children and young people as they are reconfigured, in order to develop more efficient provision of children's therapy services	Ongoing
	Implement the recommendations of the NDA's study of the determinants of an efficient and effective assessment of need	
	Child Protection and Welfare Agency Maintain close co-operation with services for children and families during the development of the Child Welfare and Protection Agency to ensure that services for children with disabilities are delivered appropriately and develop clear protocols in this regard	Q1-Q2
	Adult Day Services Continue to liaise with the DoH and the relevant Government Departments, through the mechanism of the Cross Sectoral Working Group on an Employment Strategy for People with Disabilities, on arrangements for the future provision of sheltered and supported employment by the appropriate department / agency	Q1-Q2
	Develop a high-level, national implementation plan taking a phased approach and working with those providers already progressing the agenda for change, or in readiness for same (In conjunction with key government departments)	Q1
	Develop regional and area level implementation plans, based on the national implementation plan	Q3

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Congregated Settings – Reconfiguration of Residential Services Monitor current projects to ensure they deliver on expectations and disseminate the learning from the projects	Ongoing
	In conjunction with Genio, identify and implement a number of demonstration sites to test feasibility and identify best practice	Q2-Q4
	Agree a date for the cessation of admissions to congregated settings	Q3
	In conjunction with the Department of Environment, Community and Local Government develop a high-level, national framework to ensure co-ordination between the implementation of the recommendations of the report on congregated settings and the *National Housing Strategy for People with a Disability*	Q1
	Develop a national implementation plan taking a phased approach and working with those providers already progressing the agenda for change, or in readiness for same	Q2
	Develop regional and area level implementation plans in consultation with key stakeholders and based on the national implementation plan	Q3
	Reconfiguration / rationalisation of residential places (Genio projects): ▪ DML - 50 people to be moved from congregated settings ▪ South - 10 people to be moved from congregated settings	Ongoing
	Review of Performance Measures / Indicator Set In conjunction with the DoH, carry out a comprehensive review of the full performance indicator set to bring it into line with the new policy direction and make it fit for purpose	Q4
	Relocation of Persons with ID inappropriately placed in psychiatric settings Continue to transfer people to more appropriate settings, progressed through an agreed implementation plan	Q4
	Establish a working group with Mental Health Services to progress	Q1
	Neuro-Rehabilitation Strategy Work with the Rehabilitation Medicine Programme to support the development of an implementation plan based on the recommendations of the *National Neuro-Rehabilitation Strategy*	Ongoing
	Establish Regional Rehabilitation Networks	Q2
	Commence development of regional inpatient rehabilitation facilities	Q3-Q4
Registration and Inspection of Residential Services for Adults and Children with Disabilities	Update and maintain database for adults and for children in residential and respite services	Q1
	Share the learning from the self audit of a percentage of adult residential services with all providers via the umbrella organisations to develop the next phase of preparation	Q1
	Develop an action plan and self-audit tool for children's residential services to support quality improvement, assurance and compliance with the draft standards	Q2
	Child Protection Audit Using information gathered from phase 1 of the audit, identify findings in relation to policy, process and training in order to inform national policy	Q2
Information Systems	Carry out a review of the existing information systems in disability services in both the statutory and non-statutory sectors	Q2
	Carry out a review of information needs in both sectors	Q2
	Make recommendations for future planning in this regard	Q3
Thalidomide in Ireland	Continue to work with Beaumont Hospital to support the development of an agreed multidisciplinary team (MDT) assessment process	Q1

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Day Services No. of work / work-like activity WTE places provided for persons with intellectual disability (ID) and / or autism	378	196	460	359	1,393	411	187	583	432	1,613	Regional breakdown to be determined				1,578
No. of persons with ID and / or autism benefiting from work / work-like activity services	644	399	951	737	2,731	673	383	1,174	854	3,084	Regional breakdown to be determined				3,084
No. of work / work-like activity WTE places provided for persons with physical and / or sensory disability	13	4	12	29	58	12	5	21	35	73	Regional breakdown to be determined				71
No. of persons with physical and / or sensory disability benefiting from work / work-like activity services	37	6	23	46	112	42	7	34	55	138	Regional breakdown to be determined				138
No. of Rehabilitative Training places provided (all disabilities)	715	451	653	805	2,624 New PI	723	446	653	805	2,627	723	446	653	805	2,627
No. of persons (all disabilities) benefiting from Rehabilitative Training (RT)	724	519	762	910	2,915	721	526	780	964	2,991	721	526	780	964	2,991
No. of persons with ID and / or autism benefiting from Other Day Services (excl. RT and work / work-like activities)					14,077	4,513	2,515	2,791	2,611	12,430	Regional breakdown to be determined				12,430
No. of persons with physical and / or sensory disability benefiting from Other Day Services (excl. RT and work / work-like activities)					3,924	476	827	570	708	2,581	Regional breakdown to be determined				2,581
Residential Services No. of persons with ID and / or autism benefiting from residential services	2,222	1,696	2,198	2,234	8,350	2,231	1,672	2,015	2,498	8,416	Regional breakdown to be determined				8,416
No. of persons with physical and / or sensory disability benefiting from residential services	290	151	226	227	894	220	196	137	155	708	Regional breakdown to be determined				708
Respite Services No. of bed nights in residential centre based respite services used by persons with ID and / or autism	40,491	26,740	26,706	45,519	139,456	31,482	22,571	40,200	48,451	142,704	Regional breakdown to be determined				139,565
No. of persons with ID and / or autism benefiting from residential centre based respite services	1,336	967	1,121	1,257	4,681	1,683	729	1,327	1,376	5,115	Regional breakdown to be determined				5,115
No. of bed nights in residential centre based respite services used by persons with physical and / or sensory disability	345	393	1,676	4,047	6,461	3,231	8,253	1,257	1,351	14,092	Regional breakdown to be determined				13,782
No. of persons with physical and / or sensory disability benefiting from residential centre based respite services	980	482	819	698	2,979	602	207	232	179	1,220	Regional breakdown to be determined				1,220

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Personal Assistant (PA) / Home Support Hours No. of PA / home support hours used by persons with physical and / or sensory disability	Original Target NSP11 required reclassification due to definitional issues					302,623	423,608	361,203	589,889	1.68m	Regional breakdown to be determined				1.64m
No. of persons with physical and / or sensory disability benefiting from PA / home support hours	Original Target NSP11 required reclassification due to definitional issues					818	646	5,931	4,176	11,571	Regional breakdown to be determined				11,571
Disability Act Compliance No. of requests for assessments received	896	483	1,091	536	3,006	1,093	476	1,180	556	3,305	1,202	524	1,298	612	3,636
No. of assessments commenced as provided for in the regulations	841	415	848	541	2,645	977	476	1,039	528	3,020	1,100	479	1,188	560	3,327
No. of assessments commenced within the timelines as provided for in the regulations	841	415	848	541	2,645	655	420	612	512	2,199	1,100	479	1,188	560	3,327
No. of assessments completed as provided for in the regulations	489	555	733	569	2,346	1,145	479	1,052	533	3,209	1,100	479	1,188	560	3,327
No. of assessments completed within the timelines as provided for in the regulations	489	555	733	569	2,346	103	209	161	252	725	1,100	479	1,188	560	3,327
No. of service statements completed	489	555	733	569	2,346	753	345	765	389	2,252	935	407	1,010	476	2,828
No. of service statements completed within the timelines as provided for in the regulations	489	555	733	569	2,346	270	191	479	266	1,205	935	407	1,010	476	2,828
Services for Children and Young People % progress towards completion of local implementation plans for progressing disability services for children and young people					New PI					New PI					100%

Note: Due to regional variations in service developments and budget allocations, data collected under the current performance indicators has become increasingly unreliable. For this reason, and in order to bring the PI set into line with the new policy direction, there will be a comprehensive review in 2012.

Improving our Infrastructure

Capital projects that are to be completed and / or become operational in 2012. (See also Appendix 4):

Dublin North East

- Oakridge Day Unit, Daughters of Charity, Blanchardstown, Dublin – early intervention and assessment unit

Child Protection and Welfare Services

Introduction

Resources

Finance		2011 Budget €m	2012 Budget €m
	Total	**547**	**568**
WTE		Projected start January 2012	
	Total	**3,118**	

Under existing legislation (*Child Care Act, 1991)*, the HSE has a statutory duty for the care and protection of children and their families. In meeting this statutory responsibility, we deliver a range of preventative and support services in co-operation and in partnership with children and their families. We are committed to the principle of supporting families as the basis for ensuring child health and welfare. It is a fundamental belief that loving families, who set clear boundaries for their children, provide the most effective environment for children to grow into full members of society, equipped to play their part as citizens of a modern democratic society with the skills and aptitude to work and learn flexibly, and to embrace change throughout their lives. However, some children do not receive adequate care and protection therefore legislative powers such as emergency, interim and full care orders, as well as supervision orders where a child is deemed to be at risk, are utilised when required to ensure that child protection plans are implemented in full.

Under the *Programme for Government,* fundamental changes as to how child and family services are delivered in Ireland are proposed by Government in order to develop a service that is fit for purpose. These changes will be achieved firstly through the delivery of a major reform programme for family support, child protection and alternative care, accompanied by the associated changes in management structures. The financial challenge in the short to medium term will be examined and the method of allocating resources reviewed. Systems will be strengthened to ensure priorities are determined according to need.

Secondly the programme is aligned to the emerging dimension within the development of the new children's agency under the aegis of the newly established Department of Children and Youth Affairs. The change will be informed by the need for:

- A commitment to putting the well being and interests of children first
- Transparent accountability and clearly articulated levels of responsibility, and
- Increased community engagement and a commitment to deliver inclusive, accessible services.

The primary focus of this plan for children and families in 2012 is the implementation of the comprehensive change programme which has consolidated all the reform initiatives arsing from recent reviews into a co-ordinated change programme.

During 2012 we will work with Department of Children and Youth Affairs to ensure that the priorities as identified in the *Programme for Government* are implemented where they relate to children and family services. This is particularly relevant in relation to establishing the new agency which will assume responsibility for the services presently delivered by the HSE.

Our priorities for 2012:

- Promote the **major culture change** required in planning and delivering services to children and their families.
- Implement consistent child protection procedures in line with the revised national guidelines - ***Children First, 2011 – National Guidance for the Protection and Welfare of Children.***
- Continue the reforms necessary to provide a comprehensive range of high quality services for **children in care**.
- Improve effective **multidisciplinary shared practice** and efficient **community engagement.**

Key Result Areas

Key Result Area	Deliverable Output	Target Completion Quarter
Delivery of statutory services	**Maintain progress to ensure that all children in need of care and protection are assessed in a timely fashion, have an allocated social worker and defined care plans, which are reviewed as per the regulations:**	
	▪ Participate in the process to review the standards for children in care	Q1
	▪ Review the use of supervision orders and establish a national protocol	Q1

Key Result Area	Deliverable Output	Target Completion Quarter
	▪ Increase use of supervision and other protective strategies to maintain children at home safely	Q3
	▪ Monitor the application of the national practice guidance on compliance with Section 3 of the *Child Care Act*	Q3
Cultural Change	**Implement procedures whereby all children are consulted about decisions that affect them, and children's collective views influence policy development:**	
	▪ Develop a set of national standards and training on consultation with children and young people	Q4
	▪ Disseminate the *Quick Guide* for staff on working with children and young people	Q1
	▪ Determine an appropriate participation framework for the new Children and Family Agency	Q4
	Develop and implement a Quality Assurance and Audit Framework across child protection, welfare, and alternative care services:	
	▪ Develop a Quality Assurance and audit framework	Q3
	▪ Introduce an audit tool to assess workload management in each Health Area	Q3
	▪ Prepare for the implementation of the HIQA child protection standards	Q2
	▪ Continue the audit of catholic church congregations and orders	Q1
	▪ Establish a national system to monitor local serious incidents at national level	Q1
	▪ Complete phase 1 of the set of Practice / Policy Manuals for Child Protection, Foster Care, Residential Care, Aftercare, Children First and Pre-Schools	Q4
	Consolidate arrangements to learn more from practice including serious case reviews:	
	▪ Review formal processes for serious case and child death reviews and the analysis and learning from such reviews	Q1
Revise and implement consistent child protection procedures in line with revised national guidelines - Children First	**Devise , in conjunction with interdepartmental group a project plan to support the consistent implementation of the Children First National Guidance across all relevant government sectors**	
	▪ Review and implement joint Agency / Garda protocols	Q4
	▪ Standardise and deliver HSE and An Garda Siochana Joint Children First training provided to child protection social work staff and relevant gardai	Q3
	▪ Commence joint HSE / Gardai scenario training (HYDRA) to key senior management at multiagency level	Q4
	▪ Complete Children First briefings for HSE funded agencies	Q3
	▪ Enforce adherence to Children First guidance through Service level agreements	Q3
	▪ Implement a plan to support government departments and non funded services in relation a consistent standardised implementation of Children First	Q1
	▪ Joint HSE / Garda Specialist interview training	Q4
	Ensure that child protection services can be readily accessed by local communities	
	▪ Develop a new National Service Delivery Model for children and family services in line with Children First, the Standardised Business Processes, and learning from pilot development sites	Q4
	Policy framework to revise and develop a consistent Child Protection system	
	▪ Standardise the implementation and structure of case conferences	Q1
	▪ Standardise thresholds for care and protection	Q1
	▪ Develop and implement a risk assessment and measurement tool	Q1
	▪ Develop a system for monitoring workloads	Q2
	▪ Develop a system of how cases are prioritised and allocated	Q2
	▪ Establish a Child Protection Register	Q2
	▪ Develop a framework for further assessment	Q2

Key Result Area	Deliverable Output	Target Completion Quarter
	Re-enforce consistent, objective, evidence-based initial and core assessments which clearly assess the level of risk:	
	▪ Review the implementation of Phase 1 of the standard business process which include implementation of a standardised initial assessment	Q2
	▪ Implementation of Phase 2 of the standard business process	Q3
	▪ * Complete the implementation of the recommendations of 2007 *Report on Treatment Services for Persons who have Exhibited Sexually Harmful Behaviour*	Q4
	▪ * Review and evaluate the **out of hours** pilot sites	Q1
	▪ * Analysis and identification of best practice of addiction services for children nationwide	Q3
Complete a series of reforms necessary to provide a comprehensive range of high quality services for children in care	**Provide time in care which is commensurate with the child's needs through the development and implementation of an integrated children services programme:**	
	▪ Design an implementation plan based on the recommendations from the review of capacity within the alternative care services	Q1
	▪ Develop a Corporate Parenting Strategy for children and family services	Q4
	▪ Establish, in partnership with advocacy agencies, four regional forums for children and young people in care	Q3
	Ensure that there is up to date, timely, and accurate data on the number and circumstances of all children in the care system:	
	▪ Continue project on Management Information Frame work including the development of appropriate performance indicators	Q4
	▪ Select and procure a national case management information system (the national childcare information system)	Q3
	▪ Prepare the service for the introduction of the national childcare information system	Q3
	*** Complete the reform and modernisation of the special care service and associated therapeutic interventions:**	
	▪ Establish a national therapeutic team for children in care and detention	Q2
	▪ Establish a national forensic mental health team for children at risk	Q2
	Ensure efficient and effective liaison with the new adoption authority by establishing a **strategic planning forum** with the Adoption Authority	Q2
	Introduce and implement procurement process for high tariff alternative care placements	Q3
	* Monitor implementation of the HSE **aftercare policy**	Q3
	Ensure that homeless children are given full access to children and family services under the *Child Care Act 1991*:	
	▪ Revise policy on Section v of the *Child Care Act 1991* implemented	Q1
	▪ Implement a policy on the use of accommodation options and on the use of and assessment criteria on supported lodgings providers	Q3
	▪ * Project plan for archiving records of all children in care	Q3
	▪ * Exit interview conducted with children leaving or changing care placements	Q3
	▪ * Data collection regarding children form ethnic minority backgrounds commenced	Q3
Promote effective multidisciplinary shared practice and efficient community engagement	**Take forward consistent family support arrangements as per the Family Support Action plan:**	
	▪ Develop a national and local commissioning strategy for community / voluntary sector	Q4
	▪ Develop a community-based prevention and early intervention strategy	Q2
	▪ * Commission additional counselling services for survivors of abuse	Q3
	▪ Commence the establishment of partnership with advocacy agencies, four regional care forums for children and young people	Q4
	Continue to support the children's services committees and contribute to the departmental review of future initiatives in this area	Q4

Key Result Area	Deliverable Output	Target Completion Quarter
	Implement the *National Standards for Pre-School Services* in a cross-departmental and cross-agency manner: ▪ Develop an Early Years framework inspection model for inspection of Early Childhood Care and Education (ECCE) settings in collaboration with DES Inspectorate (Field Study)	Q3
	▪ Develop and implement national agreed standard operating policies / procedures with related business processes for the Early Years Inspectorate	Q4
	▪ Continue phased implementation of the Pre-School Standards	Q4
Work Force Development	▪ Develop a Children and Family Services Workforce Development Strategy incorporating a national structure and work programme that reflects national priorities and addresses continuous professional development needs for relevant staff	Q4
	▪ Develop court practice and procedure skills training	Q4
	▪ Review of the National Child and Family Services Staff Supervision Policy (2009). Develop an implementation framework of standardised supervision	Q4
	▪ Implement rotation of social workers across childcare, child protection and welfare teams where appropriate	Q3
	▪ Deliver training for supervisors and supervisees	Q4
	▪ Deliver leadership development training to 17 Children and Family Managers and senior staff	Q4
	▪ Establish a probationary year of limited caseload, supervision and support for newly qualified social workers	Q1
	▪ Enhance practice placement supports for social work students	Q1
Work to ensure that the priorities as identified in the Programme for Government are implemented relating to children and family services	**Prepare for the establishment of the New Children Agency** ▪ Progress transition arrangements with DCYA	Q1
	▪ Develop a services delivery model	Q1
	▪ Carry out a census of staff and resources	Q1
	▪ Develop an organisational design at regional and local level	Q1
	▪ Review the change programme in line with the framework of the new agency	Q1
	▪ Participate in the development of management structure and corporate governance	Q1

** Denotes implementation of actions arising from the Report of the Commission to Inquire into Child Abuse (Ryan Report), 2009 and the Commission to Inquire into Child Abuse.*

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
After Care No. of young adults aged 18 to 21 in receipt of an aftercare service on the last day of the reporting period					New PI					---					Baseline to be established in 2012
No. of young adults aged 18 to 21 in receipt of an aftercare service who are in full time education on the last day of the reporting period					New PI					---					Baseline to be established in 2012
Child Protection – Child Abuse i). No. of referrals of child abuse and welfare concerns					To be reported in 2011					---					Demand-led
ii). % of referrals of child abuse where a preliminary enquiry took place within 24 hours	---	---	---	---	78%					---					Baseline to be established in 2012

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
iii). % of referrals which lead to an initial assessment					New PI					---					Demand-led
iv). % of these initial assessments which took place within 21 days of the referral	---	---	---	---	100%					---					Baseline to be established in 2012
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)					New PI					---					Demand-led
Family Support Services															
No. of children referred during the reporting period					New PI					New PI					Baseline to be established in 2012
No. of children in receipt of a family support service at the end of the reporting period					New PI					New PI					Baseline to be established in 2012
Residential and Foster Care															
No. and % of children in care by care type	1,580	1,448	1,748	1,209	5,985	1,596	1,504	1,837	1,278	6,215	1,676	1,579	1,929	1,342	6,526
i). Special Care					< 0.2%	0.6%	0.2%	0.2%	0.4%	0.3%					0.3%
ii). High Support					< 0.5%	0.3%	0.1%	0.8%	0.8%	0.5%					0.5%
iii). Residential General Care (Note: Include special arrangements)					< 6.3%	10%	8.5%	4.7%	2.3%	6.5%					< 7%
iv). Foster care (not including day fostering)					60%	58.1%	55.9%	64.1%	67.3%	61.2%					59%
v). Foster care with relatives					30%	29%	32.1%	27.6%	27.1%	28.9%					30%
vi). Other care placements					3%	2.1%	3.1%	2.6%	2.1%	2.5%					3%
No. and % of children in private residential care (Note: Include special arrangements)					New PI					New PI					0%
No. and % of children in foster care private					New PI					New PI					1%
No. of children in single care residential placements					0	5	1	5	1	12					0
No. of children in residential care age 12 or under					0	22	16	7	1	46					0
No. of children in care in third placement within 12 months (all care types)					0	45	40	33	32	150					0
Children in Care in Education															
i). No. of children in care aged 6 to 16 inclusive					New PI	1,149	1,098	1,119	792	4,158	1,206	1,153	1,175	831	4,365
ii). No. and % of children in care between 6 and 16 years, in full time education					100%	1,125 97.9%	1,082 98.5%	1,095 97.9%	770 97.2%	4,072 97.9%					100%
Allocated Social Workers															
No. and % of children in care who have an allocated social worker at the end of the reporting period					100%	1,465 91.8%	1,304 86.7%	1,826 99.4%	1,194 93.4%	5,789 93.1%					100%
i). No. and % of children in special care					100%	9 100%	3 100%	3 100%	5 100%	20 100%					100%

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
ii). No. and % of children in high support					100%	4 100%	2 100%	15 100%	8 80.0%	29 93.5%					100%
iii). No. and % of children in residential general care					100%	160 100%	127 99.2%	87 100%	30 100%	404 99.8%					100%
iv). No. and % of children in foster care					100%	840 90.6%	737 87.6%	1,170 99.3%	803 93.4%	3,550 93.3%					100%
v). No. and % of children in foster care with relatives					100%	422 91.1%	394 81.6%	504 99.4%	321 92.8%	1,641 91.2%					100%
vi). No. and % of children in other care placements					100%	30 90.9%	41 87.2%	47 100%	27 100%	145 94.2%					100%
Care Planning No. and % of children in care who currently have a written care plan as defined by *Child Care Regulations 1995*, at the end of the reporting period					100%	1,476 92.5%	1,231 81.8%	1,736 94.5%	1,270 99.4%	5,713 91.9%					100%
i). No. and % of children in special care					100%	9 100%	3 100%	3 100%	5 100%	20 100%					100%
ii). No. and % of children in high support					100%	4 100%	2 100%	15 100%	8 80%	29 93.5%					100%
iii). No. and % of children in residential general care					100%	158 98.8%	116 90.6%	87 100%	30 100%	391 96.5%					100%
iv). No. and % of children in foster care					100%	849 91.6%	705 83.8%	1,117 94.8%	853 99.2%	3,524 92.6%					100%
v). No. and % of children in foster care with relatives					100%	426 92.0%	370 76.6%	473 93.3%	345 99.7%	1,614 89.7%					100%
vi). No. and % of children in other care placements					100%	30 90.9%	35 74.5%	41 87.2%	27 100%	133 86.4%					100%
Foster Carer Total no. of foster carers					New Pl	935	917	1,272	936	4,060	982	963	1,336	983	4,263
No. and % of foster carers approved by the foster care panel					New Pl	763 81.6%	617 67.3%	1,147 90.2%	864 92.3%	3,391 83.5%	884 90%	867 90%	1,202 90%	885 90%	3,837 90%
No. and % of relative foster carers where children have been placed for longer than 12 weeks whilst the foster carers are awaiting approval by the foster care panel, Part III of Regulations					0%					New Pl	Baseline to be established in 2012				
No. and % of approved foster carers with an allocated worker					100%	664 87.0%	520 84.3%	1,043 90.9%	819 94.8%	3,046 89.8%					100%
Children and Homelessness No. of children placed in youth homeless centres / units for more than four consecutive nights (or more than 10 separate nights over a year)					New Pl					New Pl	Baseline to be established in 2012				
No. and % of children in care placed in a specified youth homeless centre / unit					New Pl					New Pl	Baseline to be established in 2012				
Out of Hours No. of referrals made to the Emergency Out of Hours Place of Safety Service					New Pl	69	68	121	119	377	72	71	127	125	395

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
No. of children placed with the Emergency Out of Hours Placement Service					New PI	45	51	83	79	257	47	54	87	83	270
No. of nights accommodation supplied by the Emergency Out of Hours Placement Service					New PI	80	79	185	179	523	120	83	194	188	549
Early Years Services															
No. of notified early years services in operational areas					4,461	1,315	1,073	1,098	1,355	4,841	1,315	1,073	1,098	1,355	4,841
% of early years services which received an inspection					100%	55.8%	49.1%	66.4%	63.9%	59.0%	100%	100%	100%	100%	100%
No. and % of early years services that are fully compliant					New PI					---					Baseline to be established in 2012
No. of notified full day early years services					New PI	489	400	347	333 7 areas	1,569	489	400	347	333 7 areas	1,569
% of full day services which received an annual inspection					100%					---	100%	100%	100%	100%	100%
No. of early years services in the operational area that have closed during the quarter					New PI					---					Demand-led
No. of early years service complaints received					New PI					---					Demand-led
% of complaints investigated					100%					---					100%
No. of prosecutions taken on foot of inspections in the quarter					New PI					---					Demand-led

Palliative Care

Introduction

Palliative care is an approach that improves the quality of life of patients and their families, facing the challenges associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment, and treatment of pain and other physical, psychosocial, and spiritual problems. In recent years, the scope of palliative care has broadened and includes supporting people through non-malignant and chronic illness, in addition to cancer related diseases.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total	81	78
WTE		Projected start January 2012	
	Total	645	

Palliative care services are organised according to a collaborative, inclusive model that incorporates care provided by generalist and specialist providers to meet population needs. The term 'generalist palliative care provider' refers to all those health and social care professionals who have a 'first contact' relationship with the person with life-limiting illness. These professionals should be able to effectively meet many of the palliative care needs of patients, their families and carers. However, a significant number of patients experience unstable symptoms or complex problems as a consequence of their illness, and, therefore, may require input from specialist palliative care services.

Based on the recommendations in the *Report of the National Advisory Committee on Palliative Care 2001* and the *Palliative Care Services – Five Year / Medium Term Development Framework (2009 – 2013),* our goal for palliative care is to ensure that patients with life-limiting conditions, and their families, can easily access a level of palliative care service that is appropriate to their needs, regardless of age, care setting, or diagnosis. We will also ensure that a uniformly high standard of palliative care is available in all healthcare settings. In 2012 we will progress actions to meet these goals.

Our priorities for 2012:

- Expand the provision of **specialist palliative care services for adults** within existing resources.
- Progress the development of **paediatric palliative care** services.
- Work with the clinical programmes to develop **national standardised admission, discharge and referral criteria** to increase efficiency and uniformity of care.
- Support the delivery of generalist and specialist palliative **care in the community** through the development and implementation of **evidence-based guidelines**, and tailor standardised and optimised **clinical pathways** for generalist and specialist palliative care practitioners.
- Improve collaboration with primary care teams, specifically for out-of-hours services.
- Improve the quality of palliative care provision in the **hospital setting** and improve the environment of care for those who are dying, bereaved, or deceased.
- Strengthen **service user and family involvement** through a national advance care planning programme to empower patients and their families to express their wishes about treatment choices and care provision towards the end of life.
- Educate staff, and support **research programmes** in palliative care that promote evaluation and development of services, and improve approaches to care provision.
- Strengthen the quality, efficiency, and effectiveness of existing service provision through the development and collection of **evidence-based performance measures** that support the quality improvement cycle.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Specialist Palliative Care Services – Inpatient Unit	Plan for the development of the Specialist Inpatient Units in Kerry and Waterford	Q4 into 2013
	Develop specialist palliative care outpatient community nursing at St. Francis' Hospice, Blanchardstown, including the provision of services to patients with non-malignant disease	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Paediatric Palliative Care	Progress the implementation of recommendations in the national policy document *Palliative Care for Children with Life-Limiting Conditions in Ireland (2009)*: ▪ Implement the national Education and Governance Framework for outreach nurses for children with life-limiting conditions	Q1
	▪ Complete the national needs assessment for respite facilities for children with life-limiting conditions, and their families, in each HSE region	Q2
	▪ Complete a feasibility study on the establishment of a national database for the identification of children with life-limiting conditions under the oversight of the National Development Committee on Children's Palliative Care	Q4
	▪ Develop a national dataset for children with life-limiting conditions	Q3
	▪ Develop a strategic plan for a children's 'Hospice at Home' service model	Q4
Access, Assessment of Need and Referral to Specialist Palliative Care Services	Develop national standardised admission, discharge and referral criteria to increase efficiency and uniformity of care	Q1
	Establish and implement a benchmark for time from referral of patient to specialist palliative care services first point of contact	Q3
	Develop a national referral form for specialist palliative care services	Q2
	Develop a systematic process of assessment of need, resulting in the development of care plans for people with life-limiting conditions	Q4
Integration and Governance	Develop a Role Delineation Framework that defines levels of palliative care services and outlines appropriate access to services. This will facilitate strategic planning and evaluation and clearly define HSE service provision for patients with palliative care needs	Q3
	Develop a Palliative Care Competence Framework to support organisations across the sector in recruitment, workforce planning and development, role redesign, career progression and skill mix	Q4
	Complete business plan and develop implementation strategy for optimal redeployment of existing resources to meet the palliative care needs of patients	Q4
Generalist and Specialist Palliative Care in the Community	Develop and implement evidence-based guidelines and clinical pathways for generalist and specialist palliative care practitioners	Ongoing
	Develop and implement guidelines and pathways to improve out of hours services	Q4
Palliative Care in the Hospital Setting	Undertake a national review of the criteria and function of palliative care support beds in order to determine optimal local configuration and development of these beds	Q3
Design and Dignity Grant Scheme	Work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme in order to assist projects that are designed to enhance the dignity of people who die in hospitals	Ongoing
Education and Research	Collaborate with the All-Ireland Institute of Hospice and Palliative Care, Education Centres in Specialist Palliative Care Units, professional bodies, and universities, to provide programmes that ensure health and social care staff have the necessary training to better identify and respond to people with palliative care needs, to help staff initiate discussions about their preferences for care, and to enable them provide quality end of life care	Ongoing
Involving Patients and their Families	Support services to develop good practice in advance care planning through the development of national guidelines, an e-learning programme and a national recording system	Q4
	Promote the importance of involving families and carers in decisions about care through advance care planning and needs assessment processes	Ongoing
	Provide organisations with readily available information on local palliative care services	Q1
	Provide organisations with information on how to access bereavement support services	Q3
Develop Evidence-based Performance Measures	Develop additional datasets within the National Palliative Care Minimum Dataset to collect data on specialist palliative care activity in: ▪ Acute hospitals	Q3
	▪ Outpatient services	Q4 into 2013
	▪ Bereavement services	Q1
	Strengthen the mechanisms for the collection and analysis of data to support the development and evaluation of palliative care services	Ongoing

Performance Activity and Performance Indicators.

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Waiting Times Inpatient															
i) Specialist palliative care inpatient bed within 7 days					92%	83%	94%	100%	92%	91%	83%	94%	100%	92%	91%
ii) Specialist palliative care inpatient bed within 1 month	95%	98.1%	100%	99.5%	98.2%	96%	100%	100%	97%	98%	96%	100%	100%	97%	98%
Waiting Times Community															
Specialist palliative care services in the community (home care) provided to patients in their place of residence within 7 days (Home, Nursing Home, Non Acute hospital)					78%	82%	62%	79%	89%	79%	82%	62%	79%	89%	79%
Specialist palliative care services in the community (home care) provided to patients in their place of residence within 1 month (Home, Nursing Home, Non Acute hospital)	99%	94%	99%	99%	98%	99%	92%	97%	98%	97%	99%	92%	97%	98%	97%
Inpatient Units															
No. of patients in receipt of treatment in specialist palliative care inpatient units	96	38	62	130	326	108	42	60	139	349	108	42	60	139	349
No. of admissions to specialist palliative care inpatient units	727	297	480	1,113	2,617	833	350	465	1,217	2,865	833	350	465	1,217	2,865
No. of discharges, transfers from the specialist palliative care inpatient unit															
i). Discharges	84	6	71	116	277	61	0	28	59	148	61	0	28	59	148
ii). Transfers	420	237	305	524	1,486	228	52	112	578	970	228	52	112	578	970
iii). Deaths*					---	427	243	270	449	1,389					---
Community Home Care															
No. of patients in receipt of specialist palliative care in the community	618	543	816	874	2,851	653	604	866	903	3,026	653	604	866	903	3,026
Day Care															
No. of patients in receipt of specialist palliative day care services	74	48	73	82	277	87	61	83	89	320	87	61	83	89	320
Community Hospitals															
No. of patients in receipt of care in designated palliative care support beds	53	6	27	39	125	56	8	59	31	154	56	8	59	31	154
New Patients															
No. of new patients seen or admitted to the specialist palliative care service (reported by age profile)															
i). Specialist palliative care inpatient units	45	22	30	23	120	54	26	31	63	174	54	26	31	63	174
ii). Specialist palliative care services in the community (home care)	154	120	171	160	605	170	125	179	171	645	170	125	179	171	645

NB: it is planned to develop additional indicators during the year as the palliative care clinical programme is implemented.

* Outturn 2011 is actual number as reported in October 2011 Performance Report

Social Inclusion

Introduction

Social Inclusion focuses on addressing health inequalities through the provision of specific targeted services, supporting enhanced responsiveness of mainstream services and facilitating partnership and inter-sectoral working. In parallel, mechanisms for empowerment and greater participation in designing, planning, monitoring and decision making for marginalised groups and communities are put in place alongside provision of appropriate support for staff.

Resources

		2011 Budget €m	2012 Budget €m
Finance	Total	119	115
		Projected start January 2012	
WTE	Total	616	

Poverty and social exclusion have a direct impact on the health and well being of the population. Vulnerable and / or people at risk may be unable to access and utilise health services in a fair manner. In response to the needs of this diverse population, services are provided either directly or through funding to non-governmental organisations, community and voluntary sector.

In 2012 we will progress initiatives to ensure that people in low socio-economic groupings or those affected by a range of social exclusion issues can access and use health and personal social services when they need them.

Our priorities for 2012:

- Implement / co-ordinate a range of **national social inclusion strategies and policies**. These include actions in areas such as addiction services, homelessness, intercultural health, Travellers' Health, Lesbian, Gay, Bisexual, and Transgender health (LGBT).
- Continue to implement **quality standards** in both the statutory and voluntary-managed **addiction services** by enabling services to become QuADS (Quality in Addiction and Drug Services), or equivalent, compliant.
- Continue to implement the ***National Drugs Strategy 2009-2016*** actions in relation to treatment, rehabilitation and prevention.
- Prioritise and implement recommendations of anticipated ***National Substance Misuse Strategy***.
- Prioritise and implement recommendations of anticipated ***HSE National Hepatitis C Strategy***.
- Implement ***The Way Home – A Strategy to Address Adult Homelessness in Ireland*** in conjunction with other key partners.
- Continue to progress recommendations of the ***HSE National Intercultural Health Strategy 2007-2012***.
- Continue to progress priority actions informed by the ***All Ireland Traveller Health Study 2011***.
- Develop Health Strategy and associated Action Plan for **Lesbian, Gay, Bisexual, and Transgender** people (LGBT) across all appropriate care groupings.
- Continue to progress priority actions agreed by the **National AIDS Strategy's** Education and Prevention Sub-committee.

Key Result Areas

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Addiction Services	**Implementation of the *National Drugs Strategy (NDS) 2009-2013*** **Implement recommendations from HSE *Opioid Treatment Protocol*:** ▪ Establish a national data collection, collation and analysis group to maximise the use of current data, identify new data, and develop a brief outcome monitoring process for individuals	Q1
	▪ Develop joint clinical guidelines on the treatment of opioid addiction across the full range of drug services by the ICGP, ICP, PSI and the HSE. The guidelines will include an implementation plan for the move to less urine testing and a greater clinical focus on the use of the results of drug testing samples	Ongoing
	▪ Produce a quarterly analysis report on Methadone Waiting list	Ongoing
	▪ Produce a quarterly analysis report on exits from the Methadone Treatment list	Q2-Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Implement *Report of the Working Group on Residential Treatment and Rehabilitation (Substance Users) 2007* and *HSE National Drugs Rehabilitation Framework 2010:* ▪ Conduct an analysis of HSE's *National Drugs Rehabilitation Framework* for usefulness for the following groups: service users, case managers, key workers within other disciplines and service managers	Q4
	▪ Measure client care plan progression over the course of 2012	Q4
	▪ Identify the barriers that hinder care planning / case management at the systemic and individual client level	Q4
	Prioritise and implement HSE actions in the *National Substance Misuse Strategy,* following its publication: ▪ Develop an annual training plan which targets emerging trends in addiction and reflects best practice via the HSE National Addiction Training Programme	Q1
	▪ Implement Quality Standards (Quality in Addiction and Drug Services, QuADS) in both the statutory and voluntary-managed addiction services	Ongoing
	▪ Conduct an effectiveness review exercise on all current forms of needle exchange provision currently funded by the HSE	Q4
	▪ Launch an Alcohol Public Education / Awareness Campaign	Q1
	▪ Further develop web based information and awareness systems for addiction	Q4
	▪ Develop a national drug and alcohol service directory to include in-depth information on treatment and rehabilitation and geo-mapping for staff and service (linked with HSE Health Intelligence Unit and Health Atlas)	Q3
Homelessness	**Implement *The Way Home – A Strategy to Address Adult Homelessness in Ireland* in conjunction with other key partners:** ▪ Agree interagency referral and care pathways between in-reach and targeted health services for homeless people, travellers and other social inclusion targeted groups, and mainstream health services in community and hospital settings	Ongoing
	▪ Ensure that the existing care plan / key worker system is operating effectively to support the introduction of the proposed care and case management approach across the homeless services sector	Ongoing
	▪ Review existing discharge protocols for homeless persons leaving acute care in each operational area to ensure that the recommended practices of the HSE *Code of Practice for Integrated Discharge Planning* are fully implemented	Q2
Intercultural Health	**Implement recommendations from the HSE *National Intercultural Health Strategy:*** ▪ Enhance accessibility, improve data and support staff in ensuring culturally competent service delivery	Ongoing
	▪ Extend the roll out of the ethnic identifier to capture key health information of minority ethnic groups in each HSE region	Q2
	▪ Develop a national database to support staff in accessing and developing appropriate translated health related material	Q4
Traveller Health	Progress delivery of recommendations in the *All-Ireland Traveller Health Study,* with particular reference to those priority areas identified such as mental health, suicide, men's health, addiction / alcohol, domestic violence, diabetes and cardiovascular health	Ongoing
LGBT Health	Finalise and launch *Health Strategy and Action Plan* for LGBT people	Q1
	Develop LGBT health specific actions in respect of identified priority areas such as transgender health, mental health and lesbian health	Q4
National Hepatitis C Strategy	Implement prioritised, resource neutral recommendations of HSE *National Hepatitis C Strategy* once published	Q2-Q4
HIV / AIDS	Deliver a social marketing campaign on HIV prevention and decrease in the rate of HIV infections	Q4

Performance Activity and Performance Indicators

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Methadone Treatment															
No. of clients in methadone treatment (outside prisons)	4,900	3,050	275	275	8,500	4,948	3,062	323	289	8,622	4,950	3,050	350	290	8,640
No. of clients in methadone treatment (prisons)					500					564					520
Substance Misuse															
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment					--- 100%	228 92.9%	61 91%	604 99%	132 89.8%	1,025 95.8%					1,260 100%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within two weeks following assessment					--- 100%	24 100%	6 100%	46 94%	14 100%	86 100%					105 100%
Homeless Services															
No. of individual service users admitted to statutory and voluntary managed residential homeless services who have medical cards					New PI for 2011 75%	483 73.9%	272 88%	386 89.6%	205 76%	1,346 81%	483 ---	272 ---	386 ---	205 ---	1,346 75%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities whose needs have been formally assessed within one week					---				New PI for 2012						80%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities who have a written care plan in place within two weeks					---				New PI for 2012						80%
Needle Exchange															
No. of pharmacists recruited to provide Needle Exchange Programme					---				New PI for 2012						45 in Q1 65 in Q3
Traveller Health Screening															
No. of clients to receive national health awareness raising / screening programmes (breast check, cervical smear screening, men's health screening, blood pressure testing) delivered through the Traveller Health Units / Primary Health Care Projects					---				New PI for 2012				10% proportion of targeted population in each region		1,650

National Performance Indicator and Activity Suite

Promoting and Protecting Health				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Immunisations and Vaccines % children (aged 12 months) who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine Haemophilus influenzae type b (Hib_3) Polio ($Polio_3$) hepatitis B ($HepB_3$) (6 in 1)	AND HP Quarterly	95%	90%	95%
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV_2)		95%	89%	95%
% children at 12 months of age who have received two doses of the Meningococcal group C vaccine ($MenC_2$)		95%	89%	95%
% children (aged 24 months) who have received 3 doses Diphtheria (D_3), Pertussis (P_3), Tetanus (T_3) vaccine, Haemophilus influenzae type b (Hib_3), Polio ($Polio_3$), hepatitis B ($HepB_3$) (6 in 1)		95%	95%	95%
% children (aged 24 months) who have received 3 dose Meningococcal C ($MenC_3$) vaccine		95%	95%	95%
% children (aged 24 months) who have received 1 dose Haemophilus influenzae type B (Hib) vaccine		New PI 2012	New PI 2012	95%
% children (aged 24 months) who have received 3 doses Pneumococcal Conjugate (PCV_3) vaccine		New PI 2012	New PI 2012	95%
% children (aged 24 months) who have received the Measles, Mumps, Rubella (MMR) vaccine		95%	91%	95%
% children (aged 4-5 years) who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)		New PI 2012	New PI 2012	95%
% children (aged 4-5 years) who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine		New PI 2012	New PI 2012	95%
% children (aged 11-14 years) who have received 1 dose Tetanus, low dose Diphtheria, Accelular Pertussis (Tdap) vaccine		New PI 2012	New PI 2012	95%
No. and % of first year girls who have received third dose of HPV vaccine by August 2012	AND HP Annually	New PI 2012	New PI 2012	New PI 2012 80%
No. and % of sixth year girls who have received third dose of HPV vaccine by August 2012		New PI 2012	New PI 2012	New PI 2012 80%
Child Health / Developmental Screening % of newborns who have had newborn bloodspot screening (NBS)	AND HP Quarterly	New PI 2012	New PI 2012	100%
% newborn babies visited by a PHN within 48 hours of hospital discharge		95%	83%	95%
% of children reaching 10 months within the reporting period who have had their child development health screening on time before reaching 10 months of age	AND HP Monthly	90%	82%	95%
Tobacco Control No. of sales to minors test purchases carried out	AND EH Quarterly	80	292	216
No. of offices, per region, carrying out sales to minors test purchase activities	AND EH Bi-annually	2 per region	13	2 per region (different offices)
No. and % HSE hospital campuses with tobacco-free policy	ND Quality and Patient Safety Quarterly	New PI 2012	New PI 2012	17 34%
No. of frontline staff trained in brief intervention smoking cessation across primary care and acute campuses		New PI 2012	New PI 2012	3,521
Food Safety % of Category 1, 2 food businesses receiving inspection target as per FSAI Guidance Note Number 1	AND EH Quarterly	100%	92%	100%
Cosmetic Product Safety No. of cosmetic product inspections	AND EH Quarterly	New PI 2012	New PI 2012	750
International Health Regulations All designated ports and airports to receive an inspection to audit compliance with the IHR 2005	AND EH Bi-annually	8	8	8

Promoting and Protecting Health				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Health Inequalities	AND EH			
No. of hospitals implementing a structured programme to address health inequalities (as outlined in the HSE *Health Inequalities Framework* and specified in this metric)	Bi-annually	New PI for 2012	New PI for 2012	5
No. of PCTs implementing a structured programme to address health inequalities (as outlined in the HSE *Health Inequalities Framework* and specified in this metric)		New PI for 2012	New PI for 2012	10

Primary Care, Community (Demand-Led) Schemes and other Community Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Primary Care	AND PC			
No. of PCTs implementing structured GP Chronic Disease Management for Diabetes to incorporate the structured management of chronic diseases within this cohort of patients	Quarterly	New PI for 2012	New PI for 2012	Dependent upon timing of commencement of programme
No. of Health and Social Care Networks in operation	AND PC	New PI for 2012	New PI for 2012	50
No. of Health and Social Care Networks in development	Monthly	New PI for 2012	New PI for 2012	79
% of Operational Areas with community representation for PCT and Network Development	ND Quality and Patient Safety Quarterly	New PI for 2012	New PI for 2012	17 100%
GP Out of Hours	AND PCRS			
No. of contacts with GP out of hours	Monthly	968,000	957,126	957,126
Physiotherapy Referral	AND PC			
No. of patients for whom a primary care physiotherapy referral was received in the reporting month	Monthly	New PI for 2012	New PI for 2012	169,006
Health Care Associated Infection: Antibiotic Consumption	ND Quality and Patient Safety			
Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	Bi-annually	New PI for 2012	21.7 (Q2 data)	21
Orthodontics	National Lead Oral Health			
No. of patients receiving active treatment during reporting period	Quarterly	18,000	13,777	13,777
No. of patients in retention during reporting period		Disaggregated in 2011	3,466	3,466
No. of patients who have been discharged with completed orthodontic treatment during reporting period		2,000	1,423	1,423
Community (Demand-Led) Schemes: Performance Activity				
Medical and GP Visit Cards	AND PCRS			
No. persons covered by Medical Cards	Monthly	1,779,585	1,733,126	1,838,126
(Incl. no. persons covered by discretionary Medical Cards)		80,502	76,644	85,000
No. persons covered by GP Visit Cards		138,816	132,097	204,482
(Incl. no. persons covered by discretionary GP Visit Cards)		17,423	16,904	20,000
Long Term Illness	AND PCRS			
No. of claims	Monthly	978,111	825,255	844,241
No. of items		3,178,861	2,731,595	2,794,437
Drug Payment Scheme	AND PCRS			
No. of claims	Monthly	3,836,264	3,187,303	2,726,939
No. of items		11,355,342	9,880,639	8,453,510
GMS	AND PCRS			
No. prescriptions	Monthly	20,364,442	20,336,688	22,154,661
No. of items		63,076,913	57,146,092	61,589,957
No. of claims – Special items of Service		740,274	863,736	859,123
No. of claims – Special Type Consultations		1,098,668	1,108,649	1,074,340

Primary Care, Community (Demand-Led) Schemes and other Community Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
HiTech No. of claims	AND PCRS Monthly	435,345	428,994	452,267
DTSS No. of treatments (above the line)	AND PCRS Monthly	968,784	961,500	1,164,805
No. of treatments (below the line)		53,916	41,989	50,867
No. of patients who have received treatment (above the line)		New PI 2011	---	To be reported during 2012
No. of patients who have received treatment (below the line)		New PI 2011	---	To be reported during 2012
Community Ophthalmic Scheme No. of treatments	AND PCRS Monthly	715,455	708,862	739,579
i). Adult		652,186	648,889	677,007
ii). Children		63,269	59,973	62,572
Community (Demand-Led) Schemes: Performance Indicators				
Medical Cards % of Medical Cards processed which are issued within 15 working days of complete application	AND PCRS Quarterly, reporting commencing Q2	---	---	90%
Median time between date of complete application and issuing of Medical Card		---	---	Baseline to be set in 2012 (for reporting from Q2)
GP Visit Cards % of GP Visit cards processed which are issued within 15 working days of complete application	AND PCRS Quarterly, reporting commencing Q2	---	---	90%
Median time between date of complete application and issuing of GP Visit Card		---	---	Baseline to be set in 2012 (for reporting from Q2)

Hospital Services: Clinical Programmes New Performance Indicators 2012		
Performance Indicators	**Reported By and Frequency**	**Target 2012**
Acute Medicine % of all new medical patients attending the acute medical unit (AMU) who spend less than 6 hours from ED registration to AMU departure	Clinical Lead Monthly	95%
Medical patient average length of stay		5.8
ED % of all patients arriving by ambulance wait < 20 mins for handover to doctor / nurse	Clinical Lead Monthly	95%
% of new ED patients who leave before completion of treatment		< 5% of new patient attendances
% of patients spending less than 24 hours in Clinical Decision Unit		95%
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Clinical Lead Bi-annually, commencing Q4	50%
% of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis		At least 7.5%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		50%
Heart Failure Rate (%) re-admission for heart failure within 3 months following discharge from hospital	Clinical Lead Quarterly Commencing Q3	27%
Median LOS and bed days for patients admitted with principal diagnosis of acute decompensated heart failure	Clinical Lead Quarterly Commencing Q1	7 days
% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay	Clinical Lead Quarterly Commencing Q3	65%

Hospital Services: Clinical Programmes New Performance Indicators 2012		
Performance Indicators	**Reported By and Frequency**	**Target 2012**
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Clinical Lead Quarterly Commencing Q3	50%
% reperfused STEMI patients (or LBBB) who get timely a) PPCI or b) thrombolysis		70% 70%
Median LOS and bed days for a) STEMI b) Non-STEMI pts	Clinical Lead Quarterly Commencing Q1	4 6.5
COPD Mean and median LOS (and bed days) for patients with COPD	Clinical Lead Quarterly	1 day reduction in AVLOS in sites with COPD outreach by end 2012
% re-admission to same acute hospitals of patients with COPD within 90 days		Reduce rate by 15% in hospitals with COPD outreach progs; all other acute hospitals with AMU / AMAU by 5%
No. of acute hospitals with COPD outreach programme	Clinical Lead Bi-annually	15 programmes
% of acute hospitals and Operational Areas with access to Pulmonary Rehabilitation Programme		25%
Asthma % nurses in primary and secondary care who are trained by national asthma programme	Clinical Lead Annually	90%
No. of asthma bed days prevented annually		1,258
No. of deaths caused by asthma annually		55
Diabetes % reduction in lower limb amputation from Diabetes	Clinical Lead Annually	40%
% reduction in hospital discharges for lower limb amputation and foot ulcers in diabetics		40%
% of registered Diabetics invited for retinopathy screening	Clinical Lead Quarterly Commencing Q3	90%
Epilepsy % reduction in median LOS for epilepsy inpatient discharges	Clinical Lead Quarterly	10%
% reduction in no. of bed days for epilepsy inpatient discharges		10%
Dermatology OPD No. of new patients waiting > 3 months for dermatology OPD appointment	Clinical Lead Quarterly, commencing Q2	0
Referral: New Attendance ratio		Baseline to be set in 2012
Rheumatology OPD No. of new rheumatology outpatients seen per hospital per year	Clinical Lead Quarterly, commencing Q2	Baseline to be set in 2012
Referral: New Attendance ratio		
Neurology OPD Length of time patients are waiting for neurology outpatient appointment	Clinical Lead Quarterly, commencing Q2	Baseline to be set in 2012
Referral: New Attendance ratio		

Hospital Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity 2011**	**Projected Outturn 2011**	**Expected Activity 2012**
Performance Activity				
Discharges Activity* Inpatient	AND Acute Services	574,400	585,861	568,285
Day Case		**755,100	**755,474	732,810
% Discharges which are Public Inpatient	AND Acute Services Monthly	80%	78%	80%

Hospital Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity 2011**	**Projected Outturn 2011**	**Expected Activity 2012**
Day Case		80%	85%	80%
Unscheduled Activity No. of emergency presentations	AND Acute Services	1,199,900	1,172,168	1,195,700
No. of emergency admissions		361,400	371,499	357,600
Outpatients Activity No. of outpatient attendances	AND Acute Services	3,591,700	No data available due to reclassification of metrics	To be confirmed by Q1 2012
Births Activity Total no. of births	AND Acute Services	74,200	73,490	73,216
Dialysis Modality Haemodialysis	National Renal Office Bi-annually	1,650 – 1,740	1,670	1,760 – 1,870
Home Therapies		245 – 270	245	280 – 290
Total		1,895 – 2,010	1,915	2,040 – 2,160
Performance Indicators				
ALOS Overall ALOS for all inpatient discharges and deaths	AND Acute Services Monthly	5.6	6	5.6
Overall ALOS for all inpatient discharges and deaths excluding LOS over 30 days		5	4.7	4.5
Inpatient % of elective inpatients who had principal procedure conducted on day of admission		75%	49%	75%
% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	AND Acute Services Monthly	New PI 2012	New PI 2012	9.6%
No. of people re-admitted to ICU within 48 hours	AND Acute Services Monthly	New PI 2012	New PI 2012	New PI 2012 Baseline to be established
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	AND Acute Services Monthly	New PI 2012	80%	95%
No. of first presentations to hospital with a primary diagnosis of development dysplasia of hip (DDH) at 1 year of age or older	AND Acute Services Quarterly	New PI 2012	New PI 2012	New PI 2012
Delayed Discharges No. of hospital delayed discharges	AND Acute Services / AND Older People Monthly	---	817	Reduce by 10%
Reduction in bed days lost through delayed discharges		New PI 2012	New PI 2012	Reduce by 10%
Day case % of day case surgeries as % of day case plus inpatients, for a specified basket of procedures	AND Acute Services Monthly	75%	72%	75%
Outpatients (OPD) An agreed set of OPD metrics will be in place and reported by Quarter 2 2012	AND Acute Services Monthly	---	Data unavailable due to reclassification of metrics in 2011	To be confirmed by Q1 2012
Births % delivered by Caesarean Section		20%	27%	20%
Colonoscopy / Gastrointestinal Service No. of people waiting more than 4 weeks for an urgent colonoscopy		0	0	0
No. and % of people waiting over 3 months following a referral for all gastrointestinal scopes		New PI 2012	New PI 2012	New PI 2012 ≤ 5%
Unscheduled Care % of all attendees at ED who are discharged or admitted within 6 hours of registration		100%	Data in 2011 was not inclusive of all hospitals. New reporting being introduced in 2012 will	95% by Sept. 2012

Hospital Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity 2011**	**Projected Outturn 2011**	**Expected Activity 2012**
			capture this data	
No. and % of patients who were admitted through ED within 9 hours from registration		New reporting time band 2012	New reporting time band 2012	100%
Scheduled Care % of adults waiting > 9 months (inpatient)	AND Acute Services Monthly	New reporting time band 2012	New reporting time band 2012	0 0%
% of adults waiting > 9 months (day case)				0 0%
No. and % of children waiting > 20 weeks (inpatient)		0	1,294 60%	0 0%
No. and % of children waiting > 20 weeks (day case)		0	1,312 53%	0 0%
Consultant Public: Private Mix Casemix adjusted public private mix by hospital for inpatients	AND Acute Services Quarterly	80:20	Under review, baseline to be established	80:20
Casemix adjusted public private mix by hospital for day case		80:20		80:20
Consultant Contract Compliance % of consultants compliant with contract levels by hospital type (Type B / B* / C)		100%		100%
Blood Policy No. of units of platelets ordered in the reporting period	ND Quality and Patient Safety Monthly	22,000	22,210	21,500 (3% reduction)
% of units of platelets outdated in the reporting period		< 10%	< 4.5%	< 10%
% usage of O Rhesus negative red blood cells		< 11%	< 12.9%	< 11%
% of red blood cell units rerouted to hub hospital		< 5%	< 4.4%	< 5%
% of red blood cell units returned out of total red blood cell units ordered		< 2%	< 1.1%	< 2%
Health Care Associated Infection (HCAI) Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	ND Quality and Patient Safety Quarterly	0.085	0.071 (Q2 data)	< 0.067
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used		New PI for 2012	3.2 (Q2 data)	< 3.0
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	ND Quality and Patient Safety Bi-annually	76	86 (combined Q1 and Q2 data)	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used)		23	22.7 (combined Q1 and Q2 data)	23
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	ND Quality and Patient Safety Bi-annually	New PI for 2012	75%	85%
Ambulance				
First Responder response times to potential or actual 112 (999) life threatening emergency calls % of Clinical Status 1 ECHO incidents responded to by first responder in 7 minutes and 59 seconds or less	AND Ambulance Monthly	75%	49%	75%
% of Clinical Status 1 DELTA incidents responded to by first responder in 7 minutes and 59 seconds or less		75%	26%	75%
% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less		Baseline to be established	69%	80% by June 2012 85% by Dec 2012
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less		Baseline to be established	67%	80% by June 2012 85% by Dec 2012

*The actual breakdown of reductions between inpatient and day cases may vary once detailed hospital business plans are finalised
** Dublin Mid Leinster figures do not include St. Luke's day case activity

Cancer Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Symptomatic Breast Cancer Services	NCCP			
No. of urgent attendances	Monthly	13,000	13,690	13,000
No. of non urgent attendances		26,000	24,666	25,000
No. and % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals *(No. and % offered an appointment that falls within 2 weeks)*		12,350 95%	13,590 99.3%	12,350 95%
No. and % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals *(No. and % offered an appointment that falls within 12 weeks)*		25,000 95%	23,441 95%	23,750 95%
Breast Cancer Screening	NCCP			
No. of women who attend for breast screening	Monthly	New PI for 2012	New PI for 2012	140,000
Lung Cancers	NCCP			
No. of attendances at rapid access lung clinic	Quarterly	New PI for 2011	1,924	To be determined
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre		95%	1,713 89%	95%
Prostate Cancers	NCCP			
No. of centres providing surgical services for prostate cancers	Quarterly	5	7	6
No. of new / return attendances and DNAs at rapid access prostate clinics		New PI for 2012	New PI for 2012	To be determined
No. and % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre		New PI for 2012	New PI for 2012	90%
Rectal Cancers	NCCP			
No. of centres providing services for rectal cancers	Quarterly	8	13	8
Radiotherapy	NCCP			
No. of patients who completed radiotherapy treatment for breast, lung, rectal or prostate cancer in preceding quarter	Quarterly	New PI for 2012	New PI for 2012	To be determined
No. and % of patients undergoing radiotherapy treatment for breast, prostate, lung or rectal cancer who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist		New PI for 2012	New PI for 2012	90%

Older People Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Home Care Packages*	AND SOP			
Total no. of persons in receipt of a HCP	Monthly	10,230	10,870	10,870
No. of HCPs provided		5,300	5,300	5,300
No. of new HCP clients		4,400	5,629	4,800
Home Help Hours	AND SOP			
No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	Monthly	11.98m	11.20m	10.70m
No. of people in receipt of home help hours (excluding provision of hours from HCPs)		54,000	50,623	50,002
Day Care	To be determined			
No. of day care places for older people		Baseline to be set	National survey undertaken Q4 to inform 2012 targets	Targets to be determined
NHSS	AND SOP			
No. of people being funded under NHSS in long term residential care at end of reporting month	Monthly	Baseline to be set	22,341	23,611
No. and proportion of those who qualify for ancillary state support who chose to avail of it		Baseline to be set	3,744	Demand-led

Older People Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
% of complete applications processed within four weeks		100%	100%	100%
Subvention and Contract Beds No. in receipt of subvention	AND SOP Monthly	Dependent on uptake of NHSS	1,300	760
No. in receipt of enhanced subvention		Dependent on uptake of NHSS	720	540
No. of people in long-term residential care who are in contract beds		New PI for 2012	New PI for 2012	To be reported in 2012
No. of long stay residents in public and voluntary nursing homes admitted before 27 Oct 2009 (saver cases)		New PI for 2012	New PI for 2012	To be reported in 2012
Public Beds No. of beds in public residential care setting for older people	AND SOP Monthly	8,200	7,987	7,089-7,432 Minimum and maximum range
Elder Abuse No. of new referrals by region	AND SOP Quarterly	Demand-led	2,213	2,000
No. and % of new referrals broken down by abuse type: i). Physical		Baseline to be set	335 11%	---
ii). Psychological		Baseline to be set	897 30%	---
iii). Financial		Baseline to be set	587 19%	---
iv). Neglect		Baseline to be set	482 16%	---
No. of active cases		New PI for 2011	1,798	---
% of referrals receiving first response from senior case workers within four weeks		100%	100%	100%

*The outturn for the number of new HCP clients for 2011 includes additional clients funded under the €8m new development funding and clients approved following implementation of the new standard definition for HCPs in 2011. Therefore the number of new clients for 2012 is expected to be 4,800 overall and is based on turnover within existing funding.

Mental Health Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Adult Inpatient Services No. of admissions to adult acute inpatient units	AND MH Quarterly	14,908	14,163	14,163
Median length of stay		10.5	11	11
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area		88.1	83.5	77.3
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area		26.7	26.7	24.6
Acute re-admissions as % of admissions		69%	68%	68%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area		61.4	56.9	52.7
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area		24.2	24.2	22.6
No. of adult involuntary admissions		1,332	1,388	1,388
Rate of adult involuntary admissions per 100,000 population in mental health catchment area		7.86	8.2	7.6
Child and Adolescent No. of child and adolescent Community Mental Health Teams	AND MH Quarterly	54	56	57
No. of child and adolescent Day Hospital Teams		3	2	2

Mental Health Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
No. of Paediatric Liaison Teams		3	3	3
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	AND MH Monthly	220	140	140
No. of children / adolescents admitted to adult HSE mental health inpatient units* i). < 16 years ii). < 17 years iii). < 18 years	AND MH Quarterly	< 100	130 4 33 93	80 0 16 64
No. and % of involuntary admissions of children and adolescents	AND MH Annually	16 5%	16 5%	16 5%
No. of child / adolescent referrals (including re-referred**) received** by mental health services	AND MH Monthly	11,319	12,493	12,493
No. of child / adolescent referrals (including re-referred) **accepted** by mental health services		7,925	8,461	8,461
Total no. of new (including re-referred) child / adolescent referrals **offered** first appointment and seen		7,503	7,824	7,824
No. and % of new / re-referred cases offered first appointment and seen i). < 3 months		5,088 68%	5,367 61%	 70%
ii). > 12 months		720 9%	623 7%	 0%
No. and % of cases closed / discharged by CAMHS service		New PI 80% of accepted referrals	7,740 109%	7,740 80%
Total no. on waiting list for first appointment at end of each quarter	AND MH Quarterly	2,221 (reduce no. waiting by > 5%)	1,856	1,799 (reduce no. waiting by > 5%)
No. and % on waiting list for first appointment at end of each quarter by wait time: i). < 3 months		802 ---	646 35%	624 35%
ii). 3-6 months		570 ---	460 25%	452 25%
iii). 6-9 months		570 ---	462 25%	365 20%
iv). 9-12 months		---	New PI	358 20%
v). > 12 months		277 ---	288 16%	0
No. of suicides in arrears per CSO Year of Occurrence	NOSP Annually	New PI	506 (2008 validated)	---
No. of repeat deliberate self harm presentations in ED		1,342 1% reduction on 2010	1,348	1,348

*The Mental Health Commission Regulations recognise that there will be occasions where it is clinically necessary to admit a child to an adult unit

Disability Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Day Services No. of work / work-like activity WTE places provided for persons with intellectual disability (ID) and / or autism	AND Disabilities Bi-annually	1,393	1,613	1,578
No. of persons with ID and / or autism benefiting from work / work-like activity services		2,731	3,084	3,084

Disability Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
No. of work / work-like activity WTE places provided for persons with physical and / or sensory disability		58	73	71
No. of persons with physical and / or sensory disability benefiting from work / work-like activity services		112	138	138
No. of Rehabilitative Training places provided (all disabilities)	AND Disabilities Monthly	2,624 New PI	2,627	2,627
No. of persons (all disabilities) benefiting from Rehabilitative Training (RT)		2,915	2,991	2,991
No. of persons with ID and / or autism benefiting from Other Day Services (excl. RT and work / work-like activities)	AND Disabilities Bi-annually	14,077	12,430	12,430
No. of persons with physical and / or sensory disability benefiting from Other Day Services (excl. RT and work / work-like activities)		3,924	2,581	2,581
Residential Services No. of persons with ID and / or autism benefiting from residential services	AND Disabilities Quarterly	8,350	8,416	8,416
No. of persons with physical and / or sensory disability benefiting from residential services		894	708	708
Respite Services No. of bed nights in residential centre based respite services used by persons with ID and / or autism	AND Disabilities Quarterly	139,456	142,704	139,565
No. of persons with ID and / or autism benefiting from residential centre based respite services		4,681	5,115	5,115
No. of bed nights in residential centre based respite services used by persons with physical and / or sensory disability		6,461	14,092	13,782
No. of persons with physical and / or sensory disability benefiting from residential centre based respite services		2,979	1,220	1,220
Personal Assistant (PA) / Home Support Hours No. of PA / home support hours used by persons with physical and / or sensory disability	AND Disabilities Quarterly	Original Target NSP11 required reclassification due to definitional issues	1.68m	1.64m
No. of persons with physical and / or sensory disability benefiting from PA / home support hours		Original Target NSP11 required reclassification due to definitional issues	11,571	11,571
Disability Act Compliance No. of requests for assessments received	AND Disabilities Quarterly	3,006	3,305	3,636
No. of assessments commenced as provided for in the regulations		2,645	3,020	3,327
No. of assessments commenced within the timelines as provided for in the regulations		2,645	2,199	3,327
No. of assessments completed as provided for in the regulations		2,346	3,209	3,327
No. of assessments completed within the timelines as provided for in the regulations		2,346	725	3,327
No. of service statements completed		2,346	2,252	2,828
No. of service statements completed within the timelines as provided for in the regulations		2,346	1,205	2,828
Services for Children and Young People % progress towards completion of local implementation plans for progressing disability services for children and young people	AND Disabilities Bi-annually Q2 and Q4	New PI	New PI	100%

Child Protection and Welfare Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
After Care No. of young adults aged 18 to 21 in receipt of an aftercare service on the last day of the reporting period	Office of ND Quarterly	New PI	---	Baseline to be established in 2012

Child Protection and Welfare Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
No. of young adults aged 18 to 21 in receipt of an aftercare service who are in full time education on the last day of the reporting period	Office of ND Quarterly	New PI	---	Baseline to be established in 2012
Child Protection – Child Abuse i). No. of referrals of child abuse and welfare concerns	Office of ND Quarterly	To be reported in 2011	---	Demand-led
ii). % of referrals of child abuse where a preliminary enquiry took place within 24 hours		78%	---	Baseline to be established in 2012
iii). % of referrals which lead to an initial assessment		New PI	---	Demand-led
iv). % of these initial assessments which took place within 21 days of the referral		100%	---	Baseline to be established in 2012
v). % of initial assessments which led to the child being listed on the Child Protection Notification System (CPNS)		New PI	---	Demand-led
Family Support Services No. of children referred during the reporting period	Office of ND Quarterly	New PI	New PI	Baseline to be established in 2012
No. of children in receipt of a family support service at the end of the reporting period		New PI	New PI	Baseline to be established in 2012
Residential and Foster Care No. and % of children in care by care type	Office of ND Monthly	5,985	6,215	6,526
i). Special Care		< 0.2%	0.3%	0.3%
ii). High Support		< 0.5%	0.5%	0.5%
iii). Residential General Care (Note: Include special arrangements)		< 6.3%	6.5%	< 7%
iv). Foster care (not including day fostering)		60%	61.2%	59%
v). Foster care with relatives		30%	28.9%	30%
vi). Other care placements		3%	2.5%	3%
No. and % of children in private residential care (Note: Include special arrangements)		New PI	New PI	0%
No. and % of children in foster care private		New PI	New PI	1%
No. of children in single care residential placements		0	12	0
No. of children in residential care age 12 or under	Office of ND Quarterly	0	46	0
No. of children in care in third placement within 12 months (all care types)		0	150	0
Children in Care in Education i). No. of children in care aged 6 to 16 inclusive	Office of ND Quarterly	New PI	4,158	4,365
ii). No. and % of children in care between 6 and 16 years, in full time education	Office of ND Bi-annually	100%	4,072 97.9%	100%
Allocated Social Workers No. and % of children in care who have an allocated social worker at the end of the reporting period:	Office of ND Monthly	100%	5,789 93.1%	100%
i). No. and % of children in special care		100%	20 100%	100%
ii). No. and % of children in high support		100%	29 93.5%	100%
iii). No. and % of children in residential general care		100%	404 99.8%	100%
iv). No. and % of children in foster care		100%	3,550 93.3%	100%
v). No. and % of children in foster care with relatives		100%	1,641 91.2%	100%
vi). No. and % of children in other care placements			145	

Child Protection and Welfare Services				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
		100%	94.2%	100%
Care Planning No. and % of children in care who currently have a written care plan as defined by *Child Care Regulations 1995*, at the end of the reporting period	Office of ND Monthly	100%	5,713 91.9%	100%
i). No. and % of children in special care		100%	20 100%	100%
ii). No. and % of children in high support		100%	29 93.5%	100%
iii). No. and % of children in residential general care		100%	391 96.5%	100%
iv). No. and % of children in foster care		100%	3,524 92.6%	100%
v). No. and % of children in foster care with relatives		100%	1,614 89.7%	100%
vi). No. and % of children in other care placements		100%	133 86.4%	100%
Foster Carer Total no. of foster carers	Office of ND Quarterly	New PI	4,060	4,263
No. and % of foster carers approved by the foster care panel		New PI	3,391 83.5%	3,837 90%
No. and % of relative foster carers where children have been placed for longer than 12 weeks whilst the foster carers are awaiting approval by the foster care panel, Part III of Regulations		0%	New PI	Baseline to be established in 2012
No. and % of approved foster carers with an allocated worker		100%	3,046 89.8%	100%
Children and Homelessness No. of children placed in youth homeless centres / units for more than four consecutive nights (or more than 10 separate nights over a year)	Office of ND Annually (Q4)	New PI	New PI	Baseline to be established in 2012
No. and % of children in care placed in a specified youth homeless centre / unit		New PI	New PI	Baseline to be established in 2012
Out of Hours No. of referrals made to the Emergency Out of Hours Place of Safety Service	Office of ND Quarterly	New PI	377	395
No. of children placed with the Emergency Out of Hours Placement Service		New PI	257	270
No. of nights accommodation supplied by the Emergency Out of Hours Placement Service		New PI	523	549
Early Years Services No. of notified early years service in operational areas	Office of ND Quarterly	4,461	4,841	4,841
% of early years services which received an inspection	Office of ND Monthly	100%	59.0%	100%
No. and % of early years services that are fully compliant	Office of ND Quarterly	New PI	---	Baseline to be established in 2012
No. of notified full day early years services		New PI	1,569	1,569
% of full day services which received an annual inspection		100%	---	100%
No. of early years services in the operational area that have closed during the quarter		New PI	---	Demand-led
No. of early years service complaints received		New PI	---	Demand-led
% of complaints investigated		100%	---	100%
No. of prosecutions taken on foot of inspections in the quarter		New PI	---	Demand-led

Palliative Care

Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
Waiting Times Inpatient:	AND Acute Services Monthly			
i) Specialist palliative care inpatient bed within 7 days		92%	91%	91%
ii) Specialist palliative care inpatient bed within 1 month		98.2%	98%	98%
Waiting Times Community Specialist palliative care services in the community (home care) provided to patients in their place of residence within 7 days (Home, Nursing Home, Non Acute hospital)	AND Acute Services Monthly	78%	79%	79%
Specialist palliative care services in the community (home care) provided to patients in their place of residence within 1 month (Home, Nursing Home, Non Acute hospital)		98%	97%	97%
Inpatient Units No. of patients in receipt of treatment in specialist palliative care inpatient units	AND Acute Services Monthly	326	349	349
No. of admissions to specialist palliative care inpatient units		2,617	2,865	2,865
No. of discharges, transfers from the specialist palliative care inpatient unit				
i). Discharges		277	148	148
ii). Transfers		1,486	970	970
iii). Deaths*		---	1,389	---
Community Home Care No. of patients in receipt of specialist palliative care in the community	AND Acute Services Monthly	2,851	3,026	3,026
Day Care No. of patients in receipt of specialist palliative day care services	AND Acute Services Monthly	277	320	320
Community Hospitals No. of patients in receipt of care in designated palliative care support beds	AND Acute Services Monthly	125	154	154
New Patients No. of new patients seen or admitted to the specialist palliative care service (reported by age profile)	AND Acute Services Monthly			
i). Specialist palliative care inpatient units		120	174	174
ii). Specialist palliative care services in the community (home care)		605	645	645

* Outturn 2011 is actual number as reported in October 2011 Performance Report

Social Inclusion

Performance Activity / Key Performance Indicator	Reported By and Frequency	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
Methadone Treatment	National Lead SI Monthly			
No. of clients in methadone treatment (outside prisons)		8,500	8,622	8,640
No. of clients in methadone treatment (prisons)		500	564	520
Substance Misuse	National Lead SI Quarterly			
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment		--- 100%	1,025 95.8%	1,260 100%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within two weeks following assessment		--- 100%	86 100%	105 100%
Homeless Services	National Lead SI Quarterly			
No. of individual service users admitted to statutory and voluntary managed residential homeless services who have medical cards		New PI for 2011 75%	1,346 81%	1,346 75%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities whose needs have been formally assessed within one week	National Lead SI Quarterly, commencing Q2	---	New PI for 2012	80%
No. and % of service users admitted to homeless emergency accommodation hostels / facilities who have a written care plan in place within two weeks		---	New PI for 2012	80%

Social Inclusion				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Needle Exchange No. of pharmacies recruited to provide Needle Exchange Programme	National Lead SI Bi-annually Q1 and Q4	---	New PI for 2012	45 in Q1 65 in Q3
Traveller Health Screening No. of clients to receive national health awareness raising / screening programmes (breast check, cervical smear screening, men's health screening, blood pressure testing) delivered through the Traveller Health Units / Primary Health Care Projects	National Lead SI Bi-annually	---	New PI for 2012	1,650

Governance				
Performance Activity / Key Performance Indicator	**Reported By and Frequency**	**Expected Activity / Target 2011**	**Projected Outturn 2011**	**Expected Activity / Target 2012**
Quality and Patient Safety Audit Service (QPSAS) % of QPSAS audits commenced as specified in annual QPSAS strategic plan	ND Quality and Patient Safety Quarterly	100%	100%	100%
% of QPSAS audits completed within the timelines agreed in approved QPSAS audit plans		75%	85%	90%
% of audit recommendations from final QPSAS audit reports tracked within timelines		New PI 2012	New PI 2012	100%
% of QPSAS audits incorporating structured service user involvement		New PI 2012	New PI 2012	50%
Service Level Agreements Agencies with whom the HSE has a Service Arrangement / Grant Aid Agreement in place: i). % of agencies	AND ISD Quarterly	100%	99%	100%
ii). % of funding		100%	99%	100%
Parliamentary Questions % of Parliamentary Questions dealt with within 15 days	ND Communications Quarterly	75%	75%	75%
Complaints % of complaints investigated within legislative timeframe	ND Quality and Patient Safety Quarterly	75%	76%	75%
Finance and HR Variance from budget under: i). I&E	AND Finance Monthly	To be reported in the Annual Financial Statements 2011		≤ 0%
ii). Income collection				≤ 0%
iii). Pay				≤ 0%
iv). Non pay				≤ 0%
v). Revenue and Capital Vote				≤ 0%
Absenteeism rates	AND HR Monthly	3.5%	4.75%	3.5%
Variance from approved WTE ceiling		≤ 0%	-0.76%	≤ 0%

Appendix 1a – Financial Tables

NB: All financial information in tables has been rounded

Agency Forecast Outturn 2011

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
Voluntary Providers					
Hospitals					
St John's Hospital	20	7	26	-8	18
Mater Misericordiae Hospital	181	82	263	-49	214
Beaumont Hospital	217	92	309	-69	240
The Rotunda Hospital	51	13	64	-19	45
Children's University Hospital	70	23	93	-16	76
Cappagh National Orthopaedic	21	12	33	-7	25
The Adelaide and Meath	181	69	250	-62	188
Coombe Women's Hospital	51	13	64	-17	47
Our Lady's Hospital for Sick Children, Crumlin	112	41	154	-28	125
St James' Hospital	246	141	387	-71	317
St Vincent's University Hospital	170	80	250	-39	211
St Michael's Hospital	24	9	34	-7	27
National Maternity Hospital	52	13	65	-20	44
Royal Victoria Eye and Ear	21	7	27	-7	21
Mercy University Hospital	62	22	85	-27	58
South Infirmary Hospital	47	18	65	-19	46
Hospital Total	**1,528**	**641**	**2,169**	**-465**	**1,703**
Community					
Cork Dental Hospital	2	1	2	0	2
Clontarf Orthopaedic	9	2	11	-4	7
St Vincent's Hospital	14	2	16	-2	14
Daughters of Charity	60	8	68	-9	59
St Michael's House	72	12	84	-13	71
Central Remedial Clinic	15	3	19	-4	15
National Rehabilitation Hospital	23	8	31	-7	25
Dublin Dental School	5	2	8	-1	6
Leopardstown Park Hospital	12	3	15	-3	12
Sisters Of Charity	16	3	18	-3	15
The Royal Hospital Donnybrook	17	4	21	-2	19
The Drug Treatment Centre	6	2	9	-1	8
Our Lady's Hospice	30	7	37	-9	28
St John of God	85	24	109	-23	86
Cheeverstown House	22	5	27	-3	23
Kare	15	2	17	-2	14
Sunbeam House Services	18	4	22	-1	20
Peamount Hospital	23	4	27	-4	23
Stewarts Hospital	43	8	51	-8	43
The Children's Sunshine Home	4	1	5	-1	4
Community Total	**491**	**105**	**596**	**-102**	**494**
Total Voluntary	**2,018**	**746**	**2,764**	**-567**	**2,197**
Statutory Providers					
Hospitals					
Waterford Regional Hospital	112	58	170	-25	145
St Lukes Kilkenny	55	15	70	-12	58
Wexford General Hospital	51	11	61	-11	51
St Josephs Hospital	44	11	56	-8	48
Our Ladys Hospital Cashel	0	0	0	0	0
Cork University Hospital	230	91	321	-51	269
Mallow General Hospital	16	4	19	-2	17
Kerry General Hospital	63	21	84	-13	72
Bantry General Hospital	15	3	19	-1	18
Sligo General Hospital	93	28	121	-17	104
Letterkenny General	89	27	116	-11	106
UCH Galway	200	100	300	-35	264

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
St Columcille's General Hospital	32	9	41	-1	40
Mayo General Hospital	64	22	86	-9	77
Roscommon General Hospital	20	5	25	-4	21
Portiuncula Acute Hospital	44	13	57	-11	46
Regional Hospital Dooradoyle	115	63	177	-29	149
Regional Maternity Hospital	19	5	24	-5	19
Regional Orthopaedic Hospital	10	7	17	-5	12
Ennis General Hospital	16	4	20	-1	19
Nenagh General Hospital	16	5	21	-3	18
Our Lady of Lourdes	108	32	140	-17	123
Louth County Hospital	17	6	23	-1	21
Cavan Monaghan General Hospital	58	21	78	-7	72
Monaghan General Hospital	12	4	16	0	16
Our Lady's Hospital Navan	34	12	46	-3	42
Naas General Hospital	45	15	60	-3	57
Mullingar General Hospital	51	15	67	-7	60
Tullamore General Hospital	63	28	91	-8	83
Portlaoise General Hospital	43	9	52	-5	47
Connolly Memorial Hospital	74	25	99	-8	91
Hospital Total	**1,809**	**667**	**2,477**	**-314**	**2,163**
Community					
LHO Kerry	76	43	120	-5	115
LHO West Cork	59	180	239	-9	230
LHO Nth Cork	56	38	94	-4	91
LHO Nth Lee	76	35	111	-3	108
LHO Sth Lee	81	59	140	-11	128
LHO Sth Tipperary	58	43	101	-2	99
LHO Waterford	58	69	126	-4	122
LHO Wexford	64	44	107	-3	105
LHO Carlow / Kilkenny	75	68	143	-3	140
LHO Donegal	122	47	169	-9	160
LHO Sligo / Leitrim	98	61	159	-8	151
LHO Mayo	88	73	161	-5	156
LHO Roscommon	38	33	71	-3	68
LHO Galway	122	128	250	-8	242
LHO Clare	53	50	103	-3	100
LHO Limerick	83	90	172	-6	166
LHO Nth Tipperary	40	86	125	-3	122
LHO Cavan Monaghan	73	37	110	-4	106
LHO Louth	62	38	100	-3	96
LHO Meath	49	42	92	-2	90
LHO 6 Dublin North	103	113	216	-4	212
LHO 7 Dublin North	54	117	172	-4	167
LHO 8 Dublin North	87	121	208	-5	203
LHO Area 10 Wicklow	33	55	89	-2	87
LHO Area 9 Kildare / West Wicklow	62	108	170	-13	157
LHO Area 11 Laois / Offaly	93	74	167	-7	160
LHO Area 12 Longford / Westmeath	102	42	144	-6	138
LHO Area 1 Dun Laoghaire	20	34	54	-1	53
LHO Area 2 Dublin South East	45	67	112	-5	107
LHO Area 3 Dublin South City	67	64	131	-6	125
LHO Area 4 Dublin South West	27	33	61	-1	60
LHO Area 5 Dublin West	112	60	172	-3	170
Total Community	**2,235**	**2,153**	**4,387**	**-153**	**4,234**
Total Statutory	**4,044**	**2,820**	**6,864**	**-467**	**6,397**
Total Provider Outturn	**6,063**	**3,566**	**9,628**	**-1,034**	**8,594**

*This table excludes HSE Regional and National services

EU Obligations

The amounts shown in the table reflect the position statements, as at 31 December 2010, submitted by Member States to, and recorded in the report of, the Rapporteur to the Audit Board of the EU Administrative Commission on Social Security for Migrant Work, together with additional claims received in 2011. Claims are subject to verification and, accordingly, the amounts shown need not necessarily represent actual liabilities.

Member State	Creditors End 2010 €000	Movement During Year €000	Creditors End 2011 €000
Austria	91	76	167
Belgium	0	0	0
Bulgaria	4	2	6
Cyprus	71	3	74
Czech Republic	300	84	384
Denmark	0	0	0
Estonia	13	0	13
Finland	118	21	139
France	1,555	0	1,555
Germany	354	738	1,092
Greece	65	0	65
Hungary	12	9	21
Iceland	6	1	7
Italy	1,396	131	1,527
Latvia	2	0	2
Liechtenstein	0	0	0
Lithuania	15	0	15
Luxembourg	0	0	0
Malta	60	0	60
Netherlands	770	477	1,247
Norway	0	0	0
Poland	1,329	853	2,182
Portugal	447	229	676
Romania	21	0	21
Slovakia	224	114	338
Slovenia	32	12	44
Spain	10,923	2,359	13,282
Sweden	430	543	973
Switzerland	831	55	886
United Kingdom	(a)	(a)	(a)
Total	**19,069**	**5,707**	**24,776**
Claims projected in 2012	0	0	6,000
Charges to be raised in 2012	0	0	3,000
Estimated invoice payments 2012	0	0	10,000

Note (a): Ireland operates a bilateral healthcare reimbursement agreement with the United Kingdom whereby nett liabilities are paid on a lump sum payment basis. Claims under the Treatment Abroad Scheme are not included.

Schemes

Schemes	Budget 2011 €m	Outturn 2011 €m	Budget 2012 €m
Medical Card Scheme (PCRS)	1,724	1,761	1,782
Sub-Total	**1,724**	**1,761**	**1,782**
Community Drug Schemes (PCRS)			
Drug Payment Scheme	248	136	116
Long Term Illness Scheme	122	115	116
High Tech	117	143	158
Dental Treatment Services	63	52	63
Health Amendment Act	1	2	1
Community Ophthalmic Scheme	25	27	24
Methadone Treatment	19	18	19
Childhood Immunisation	6	9	6
Doctors Fees / Allowances (Immunisations/ Heartwatch)	14	22	7
Sub-Total	**615**	**524**	**510**
Primary Care Schemes			
Drug Payment Scheme (incl. Drug Refund)	46	80	43
Long Term Illness Scheme	8	6	7
High Tech	2	4	2
Dental Treatment Services	0	0	0
Health Amendment Act	5	6	4
Hardship	69	79	65
Mobility Allowance	13	19	13
Capitation	11	12	10
Infectious Diseases	0	0	0
Blind Welfare Allowances	9	11	9
Maternity Cash Grants	0	0	0
Sub-Total	**163**	**217**	**156**
TOTAL SCHEMES	**2,502**	**2,501**	***2,448**

Note: Net of €25m appropriations in aid
* Inclusive of €10m which the HSE expects will be vired to schemes in the REV

Medical Card Scheme

2011	€m	Card Numbers
Forecast Outturn (accruals based)	1,761	1,733,126
2012	**€m**	**Card Numbers**
Total Cost in 2012	**1,782**	**1,838,126**

Service Plan 2012 Income

Income Details A-in-A	Budget 2011	Estimated Outturn 2011	Variance 2011	Budget 2012
	A-in-A	A-in-A	A-in-A	A-in-A
	€m	€m	€m	€m
D1 Levies	0	0	0	0
D1 SIF	0	0	0	0
D2 EU Levies	220	270	50	220
D3 Tobacco	168	168	0	168
D4 Ophthalmic	5	1	-4	5
D5 Dental	8	1	-7	8
D8 Revenue Dormant Accounts	1	1	0	0
D6 Maintenance	376	328	-48	455
D10 Superannuation	200	192	-8	200
D11 Miscellaneous	152	152	0	153
D12 Pension Levy	337	358	21	337
TOTAL INCOME	**1,467**	**1,471**	**4**	**1,546**

Income Details Not A-in-A	Budget 2011	Estimated Outturn 2011	Variance 2011	Budget 2012
	Not A-in-A	Not A-in-A	Not A-in-A	Not A-in-A
	€m	€m	€m	€m
Superannuation Income	191	190	-1	191
Maintenance Charges (private / semi)	235	232	-3	299
Inpatient Charges (public - statutory)	25	24	-1	25
Outpatient Charges (public - statutory)	7	5	-1	7
RTA	6	7	1	6
Long Stay	11	12	0	11
Other Income	85	98	13	85
TOTAL INCOME	**560**	**567**	**7**	**624**

Pay Analysis*

Pay Breakdown	Outturn 2010 €m	Forecast Outturn 2011 €m
Basic	4,891	4,796
Overtime	279	269
Allowances	88	80
On Call	168	167
Weekend / Public Holidays	259	254
Night Shift	101	99
PRSI Employers	480	468
Locum / Agency	199	219
Superannuation Total**	742	676
Pay Total	**7,207**	**7,027**

*Includes Voluntary Providers
**2010 figures include the effect of the VER and VRS exit schemes

Superannuation

	2011 Budget €m	2011 Forecast Outturn €m	Variance €m	2012 Estimate €m	Increase over 2011 budget €m
Statutory Pensions	485.7	432.3	53.4	572.7	87.0
Statutory Lump Sums	120.0	120.0	0.0	164.0	44.0
Gross Statutory Superannuation	**605.7**	**552.3**	**53.4**	**736.7**	**131.0**
Superannuation Income	-199.2	-197.4	-1.8	-199.2	0.0
Nett Statutory	406.5	354.9	51.6	537.5	131.0
Voluntary Pensions	112.6	104.3	8.3	112.6	0.0
Voluntary Lump Sums	16.0	16.0	0.0	16.0	0.0
Gross Voluntary Superannuation	**128.6**	**120.3**	**8.3**	**128.6**	**0.0**
Superannuation Income	-83.6	-88.9	5.3	-83.6	0.0
Nett Voluntary	45.0	31.4	13.6	45.0	0.0
Total Pensions	598.3	536.6	61.7	685.3	87.0
Total Lump Sums	136.0	136.0	0.0	180.0	44.0
Gross Total Superannuation	**734.3**	**672.6**	**61.7**	**865.3**	**131.0**
Superannuation Income	-282.6	-286.3	3.7	-282.8	0.0
Nett Total	451.7	386.3	65.4	582.5	131.0

There is a requirement to adjust appropriations-in-aid in the Revised Estimates Volume to reflect loss of staff contributions from salary. Additionally, some pensions and lump sum funding will be provided to voluntary bodies based on the uptake of the 'grace period'

2012 Financial Allocation

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
Voluntary Providers					
Hospital Total	1,535	608	2,143	-523	1,620
Community Total	488	103	591	-101	490
Total Voluntary 2012	**2,023**	**711**	**2,734**	**-624**	**2,110**
Statutory Providers					
Hospital Total	1,731	671	2,402	0	2,402
Community Total	2,185	5,069	7,254	0	7,254
Total Statutory 2012	**3,916**	**5,740**	**9,655**	**0**	**9,655**

Agency Budget 2011

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
Voluntary Providers					
Hospital Total	1,514	615	2,129	-460	1,669
Community Total	492	104	596	-101	495
Total Voluntary 2011	2,006	719	2,726	-561	2,164
Statutory Providers					
Hospital Total	1,808	639	2,448	-350	2,097
Community Total	2,235	2,056	4,291	-159	4,132
Total Statutory 2011	**4,043**	**2,696**	**6,739**	**-509**	**6,229**
Total Agency Outturn 2011	**6,049**	**3,415**	**9,464**	**-1,071**	**8,394**

Agency Forecast Outturn 2011

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
Voluntary Providers					
Hospital Total	1,528	641	2,169	-465	1,703
Community Total	491	105	596	-102	494
Total Voluntary 2011	**2,018**	**746**	**2,764**	**-567**	**2,197**
Statutory Providers					
Hospital Total	1,809	667	2,477	-314	2,163
Community Total	2,235	2,153	4,387	-153	4,234
Total Statutory 2011	**4,044**	**2,820**	**6,864**	**-467**	**6,397**
Total Agency Outturn 2011	**6,063**	**3,566**	**9,628**	**-1,034**	**8,594**

Variance

	Pay €m	Non Pay €m	Gross €m	Income €m	Nett €m
Voluntary Providers					
Hospital Total	14	25	39	-6	34
Community Total	-2	1	-1	0	-1
Total Voluntary 2011	**12**	**27**	**39**	**-6**	**33**
Statutory Providers					
Hospital Total	1	28	29	36	65
Community Total	0	96	96	6	103
Total Statutory 2011	**2**	**124**	**126**	**42**	**168**

This table does not include National Services and only relates to Agency outturn and budget. The figures in this table are forecast year end positions completed before the end of the financial year. Expenditure is on an accruals basis.

Appendix 1b – Nursing Homes Support Scheme: A Fair Deal

Following receipt of the Abridged Estimate for health in 2012, the HSE has to cut budgets significantly. These cuts reflect the loss of staff under the public service 'grace period' retirements as well as targeted reductions in overtime, premium pay and sick leave.

An amount of €19m has been estimated as the reduction for subhead B12 – Long Term Residential Care. This amount must be regarded as an interim position for the subhead subject to amendment in the Revised Estimate in February 2012 when staff losses will have been crystallised and the national budgeting process will have been completed at local area level. The subhead published in the Abridged Estimates Volume is €1,049.7m. This figure was estimated before a number of factors were known as part of the HSE service planning process which led to an estimate of €1,046.1m being used in the HSE Service Plan. This includes viring €0.9m out of the subhead to fund the central administration of the scheme.

The HSE has no basis by which to determine how many staff will leave public homes in 2012 and therefore it is not possible to accurately predict the number of clients who can be supported in public homes using the interim subhead. The number used in the table below is subject to alteration based on the final impact of the retirement scheme.

Client numbers are calculated on a proposed adjusted subhead total of €1,004.1m. This figure is the subhead after adjustment for €42m of 'ancillary services' such as physiotherapy which will be taken out of the Long Term Residential Care subhead in the Revised Estimate. The following factors underpin the projected client numbers for 2012:

- Reductions of €25.3m are being borne in the public homes. New funding of €46.3m is being applied to the private system.
- No reductions are being applied to the private homes as the HSE does not have legal capacity to reduce the amounts it is paying to private homes. If the NTPF agrees price increases with private homes in 2012 it will have the effect of reducing available NHSS places.
- Significant numbers of public beds have been lost in the system in 2011 because of HIQA requirements, fire and safety standards and the non-replacement of staff through the public sector recruitment moratorium. While the running costs of units have come down significantly in the last 2 years, the losses of beds have had an impact on the cost per bed in the affected homes. This service plan is prepared using the estimated bed costs as determined at the end of 2011 – adjusted for 2012 reductions.
- Client contributions move in a number of ways under the Fair Deal legislation and the following factors are relevant in this plan:
    - As 'pre-NHSS' clients in public homes are replaced with NHSS clients the related client contributions increase. The average weekly contribution from a public 'pre-NHSS' client is €170. The average weekly contribution from an NHSS client is €300.
    - Client contributions in private homes in January 2011 were €277.28 per week on average. In October 2011 those contributions remain at €276.61 per week on average. As a result €277 per week has been used in the plan.
    - Contributions from both private and public clients may fall in 2012 due to the recession as clients seek reviews of their assessed means. The value of property assets has typically declined in recent years and client cash assets may have been depleted.

  In addition, as clients reach the end of the 3-year maximum contribution related to the family home contributions reduce.
    - Client contributions will be a key aspect of the monitoring framework for Fair Deal in 2012.
- It is assumed that the number of clients in private subvented and private contracted beds will decline at the rate seen between August and October 2011. The HSE has no control over the rate of decline in these beds however as the beds are vacated, funding is made available for purchase of beds at NTPF rates in the private system based on the agreed 'approval criteria' and available resources for the scheme.

- At the time of writing, it is forecast that private clients assigned under Fair Deal will be 13,306 by the end of December 2011. This represents an increase of 3,077 since December 2010. There is a full year cost for these clients. There are also full-year savings arising from the reduced level of subvention and contract beds. These were 4,869 at December 2010 and are projected to fall to 3,180 by December 2011 – a reduction of 1,689.
- Overall the 2012 service plan takes account of the following factors and determines the capacity of the central unit to purchase additional capacity in the year:
    - Private subvention and private contract beds falling further by 853 clients and their funding being transferred to the central unit for NHSS clients.
    - S39 clients falling by a further 44 and their funding being transferred to the central unit for NHSS clients.
- The NHSS legislation allows any 'pre-NHSS' client to seek an assessment under Fair Deal and to be paid arrears back to the commencement of the scheme on 27 October 2009. There is no available data by which to estimate the number of clients who will exercise this legislative option. The plan provides €17m for these legal arrears.
- In relation to the Section 38 providers, a service review of their beds is required to determine if some of them are in fact palliative care or other services – otherwise the costs being attributed to NHSS beds would be considerable. This review may have the effect of moving some funding out of the subhead.
- The forecast excess on the Fair Deal subhead at the end of 2011 is €24.6m. This excess has to be financed from the 2012 allocation as it represents approximately 755 clients in beds for which there is no funding in place in 2012.
- The 2,842 additional places being planned in the private system are phased over the 12 months of 2012 to arrive at projected cost of €486.9m.
- In summary, the funding of Fair Deal in 2012 has three components:
    - New funding is going to the private system.
    - Reductions in funding are being applied to the public system.
    - The estimated incoming deficit of €24m is being financed by savings in contracted and subvented beds.

	Forecast Closing Clients 2011	Planned Closing Clients 2012	Change	Forecast €m
Public homes – gross cost before income	5,661	4,986	-675	399.1
Private subvented and contracted beds	3,179	2,326	-853	90.3
Private homes - net cost after income	13,306	16,148	2,842	486.9
Section 39 private homes	195	151	-44	10.4
Arrears for clients in homes at 27-10-09				17.4
Sub total	**22,341**	**23,611**	**1,270**	**1,004.1**
Ancillary costs				**42.0**
Grand total				**1,046.1**

Subhead B12 in the Abridged Estimate is €1,049.7bn. This figure will be adjusted in the Revised Estimate to reflect the table above.

Appendix 2 – Additional Expenditure

Key Result Area	Deliverable 2012	Funding €m	WTE	Target Completion
Primary Care				
Schemes	Full year 2011 funding and additional medical cards in 2012	€158m	0	Q4
Long Term Illness	Extension of free GP care to all claimants of medicines under the Long Term Illness Scheme	€15m	0	Q4
	Sub Total	**€173m**	**0**	-
Older People Services				
Nursing Homes Support Scheme (Fair Deal)	To support Nursing Homes Support Schemes	€55m	0	Q4
	Sub Total	**€55m**	**0**	-
Mental Health Services				
Suicide Prevention	Implement various measures in relation to mental health promotion, *Reach Out,* the National Suicide Prevention Strategy and the Management of Self-Harm Presentations to Emergency Departments Clinical Programme	€5m	34	Ongoing
General Adult Community Mental Health Teams	Expand and rationalise the membership of general adult CMHTs to ensure improved multidisciplinary representation	€16m	220	Ongoing
Child and Adolescent Community Mental Health Teams	Complete the multidisciplinary profile of the existing 53 Child and Adolescent CMHTs to include at least one of each profession (Medical, nursing, clinical psychology, social work, Occupational Therapist, Speech and Language Therapist, Child Care Worker)	€7m	150	Ongoing
Mental Health in Primary Care and Access to Psychotherapy Services	Provide access to psychotherapy and counselling	€5m	10	Ongoing
	Sub Total	**€33m**	**414**	-
Mental Health and Disability Services				
Genio	To accelerate innovative practice and service modernisation in mental health and disability services in line with strategic direction (Note €2m from MHS and also €3m from Disabilities services)	€5m	0	Ongoing
	Sub Total	**€5m**	**0**	-
Palliative Care				
St. Francis Blanchardstown	Develop specialist palliative care outpatient community nursing at St. Francis' Hospice, Blanchardstown, including the provision of services to patients with non-malignant disease	€.019m	0	Q4
	Sub Total	**€.019m**	**0**	

Appendix 3 – HR Information

Service and Region	WTE Dec 2010	WTE Oct 2011	Projected WTE Dec 2011	Indicative Ceiling 1 Jan 2012	Indicative End Ceiling 2012
Acute Hospital Services	16,819	16,409	16,650	16,296	Significant work will be undertaken in 2012 to allocate the ceilings
Primary and Community Services	14,902	14,374	14,650	14,645	
Dublin Mid-Leinster	**31,721**	**30,783**	**31,300**	**30,941**	
Acute Hospital Services	10,673	10,537	10,750	10,398	
Primary and Community Services	11,230	10,327	10,400	10,427	
Portion of Ceiling to be allocated	0	0	0	122	
Dublin North-East	**21,903**	**20,864**	**21,150**	**20,947**	
Acute Hospital Services	10,872	10,629	10,550	10,461	
Primary and Community Services	12,185	11,504	11,400	11,698	
Portion of Ceiling to be allocated	0	0	0	165	
South	**23,058**	**22,133**	**21,950**	**22,324**	
Acute Hospital Services	10,954	10,795	10,700	10,718	
Primary and Community Services	13,840	13,172	13,090	13,391	
West	**24,794**	**23,967**	**23,790**	**24,109**	
Acute Hospital Services	0	0	0	20	
National Cancer Control Programme	764	739	750	762	
Primary and Community Services	191	282	280	300	
Portion of Ceiling to be allocated	0	0	0	0	
National	**955**	**1,021**	**1,030**	**1,082**	
Unallocated	0	0	0	586	
Total ISD	**102,430**	**98,767**	**99,220**	**99,990**	
North Leinster	647	625	640	612	
Southern	398	409	415	404	
Western	449	463	475	452	
Ambulance Services	**1,494**	**1,497**	**1,530**	**1,468**	
Corporate	**2,989**	**2,758**	**2,750**	**2,796**	
Q&PS \ Population Health	**1,060**	**1,043**	**1,000**	**1,045**	
Total Health Services	**107,972**	**104,065**	**104,500**	**105,300**	**102,100**

Note 1: Includes DATHs Nurse Banks and former Health Board Companies
Note 2: The table is based on the end of year approved employment ceiling of 105,300 and projected data based on October census returns
Note 3: Any recruitment in 2012 is subject to the ECF and based on the reducing ceiling of target of 102,000 by end of 2012
Note 4: This table is a statement of the gap between the ECF and current employment levels
Note 5: All information in table has been rounded

Staffing by Category	Dec 2010	WTE Oct 2011	Projected WTE Dec 2011	Indicative Ceiling 1 Jan 2012
Medical / Dental	8,096	8,281	8,300	Not allocated
Nursing	36,503	35,769	35,800	
Health and Social Care Professionals	16,355	16,178	16,230	
Management / Admin	17,301	16,062	16,270	
General Support Staff	11,421	10,546	10,600	
Other Patient and Client Care	18,295	17,228	17,300	
Total Health Service	**107,972**	**104,065**	**104,500**	**105,300**

Appendix 4 – Capital Projects by Care Group / Programme 2012

This appendix outlines capital projects that were completed in 2010 / 2011 but not operational, due to be completed and operational in 2012 and also projects due to be completed in 2012 but not operational until 2013. The full HSE Capital Plan for 2011 is available on www.hse.ie

Care Group	Facility's Location	Project Details	Project Completion Q	Q Fully operational	Additional Beds	Replacement Beds	Capital Cost €m		2012 Implications	
							2012	Total	WTEs	Revenue Costs €m
Dublin Mid-Leinster										
Primary Care	Kilbeggan, Co. Westmeath	Primary Care Centre, by lease agreement.	Q4	Q1 2013	0	0	0.25	0	0	0
Primary Care	Terenure, Dublin	Primary Care Centre, by lease agreement.	Q4	Q1 2013	0	0	0	0	0	0
Primary Care	Donnybrook, Dublin	Primary Care Centre, by lease agreement.	Q4	Q4	0	0	0	0	0	0
Primary Care	Longford, Co. Longford	Primary Care Centre, by lease agreement.	Q1	Q1	0	0	0	0	0	0
Primary Care	Newbridge, Co. Kildare	Primary Care Centre, by lease agreement.	Q4	Q4	0	0	0	0	0	0
Primary Care	Churchtown, Dublin	Primary Care Centre, by lease agreement.	Q4	Q4	0	0	0	0	0	0
Dublin North East										
Primary Care	Mulhuddart, Co. Dublin	Primary Care Centre, by lease agreement.	Q1	Q2	0	0	0	0	0	0
Primary Care	Ashbourne, Co. Meath	Primary Care Centre, by lease agreement.	Q1	Q2	0	0	0	0	0	0
Primary Care	Drogheda North, Co. Louth	Primary Care Centre, by lease agreement.	Q2	Q3	0	0	0	0	0	0
Primary Care	Kingscourt, Co. Cavan	Primary Care Centre, by lease agreement.	Q1	Q2	0	0	0	0	0	0
Primary Care	Navan, Co. Meath	Primary Care Centre, by lease agreement.	Q2	Q3	0	0	0	0	0	0
Primary Care	Blanchardstown, Dublin	Primary Care Centre refurbishment.	Q3	Q4	0	0	0	0	0	0
South										
Primary Care	Schull, Co. Cork	Primary Care Centre, by lease agreement.	Q4	Q4	0	0	0	0	0	0
Primary Care	Kenmare, Co. Kerry	Primary Care Centre, by lease agreement.	Q1	Q2	0	0	0	0	0	0
West										
Primary Care	Abbey, Co. Limerick	Primary Care Centre, by lease agreement.	Q3	Q4	0	0	0	0	0	0
Primary Care	Glenties, Donegal	Primary Care Centre.	Q4 2011	Q1	0	0	0.43	1.72	0	0
Primary Care	Monksland, Co. Roscommon	Primary Care Centre, by lease agreement.	Q3	Q4	0	0	0	0	0	0
Primary Care	Athenry, Co. Galway	Primary Care Centre, by lease agreement.	Q3	Q4	0	0	0	0	0	0

Care Group	Facility's Location	Project Details	Project Completion Q	Q Fully operational	Additional Beds	Replacement Beds	Capital Cost €m		2012 Implications	
							2012	Total	WTEs	Revenue Costs €m
Primary Care	Castlerea, Co. Roscommon	Primary Care Centre, by lease agreement.	Q3	Q3	0	0	0	0	0	0
				Total	**0**	**0**	**€0.68m**	**€1.72m**	**0 WTEs**	**€0m**
Dublin Mid Leinster										
Acute	St. Vincent's University Hospital, Dublin	Phase 2 - New clinical building including wards, CF unit and dermatology unit.	Q2	Q2/Q3	0	100	25.00	30.00	0	0
Dublin North East										
Acute	Mater Misericordiae University Hospital, Dublin	Redevelopment of Mater Adult Hospital on existing site. Includes new ED, OPD, ICU/HDU (36 beds), 12 new theatres, radiology, CSSD; 12 Observation beds (A&E extension) and 120 replacement beds.	Q2	Q2/Q3	48 (36 ICU/HDU, 12 observation)	120	50.00	205.00	Opening to be considered in light of 2012 funding	
Acute	Connolly Hospital, Blanchardstown, Dublin	MRI installation.	Q3	Q3	0	0	1.5	1.5	0	0
South										
Acute	Kerry General Hospital, Tralee	New ED.	Q2	Q3	0	0	2.00	5.90	0	0
Acute	St. Mary's Orthopaedic Hospital, Cork	Upgrade existing ward to facilitate relocation of the Mercy University Hospital OPD to St. Mary's Orthopaedic Hospital.	Q4	Q4	0	0	0.30	0.30	0	0
Acute	Cork University Hospital	Upgrade and refurbishment of existing cardiac theatres to create new trauma and one emergency theatre.	Q4	Q4	0	0	0.90	1.20	0	0
Acute	Cork University Hospital	Refurbishment of an existing ward area to provide a surgical assessment unit.	Q3	Q3	0	30	0.02	0.70	0	0
Acute	Cork University Hospital	Provision of an MRI above existing PET scanner.	Q3	Q3	0	0	2.25	2.50	0	0
Acute	Cork University Hospital	Development of an acute medical assessment unit.	Q4 2011	Q1	13	0	0.75	3.50	0	0
Acute	Cork University Maternity Hospital	Upgrade of existing recovery area to create an emergency obstetric theatre.	Q2	Q2	0	0	0.55	1.00	0	0
Acute	Waterford Regional Hospital	ED extension including neonatal unit.	Q4	Q4	19 (5 Neonatal, 14 ED)	30 (20 Neonatal, 10 ED)	5.00	13.00	0	0
Acute	Mallow General Hospital, Co. Cork	Day procedures unit - endoscopy suite.	Q3	Q3/Q4	0	0	1.00	1.50	0	0
West										
Medical Block	Letterkenny General Hospital, Co. Donegal	New medical block including ED (19 bays), acute assessment unit (11 bays) and three 24 bed wards.	Q1	Q1	0	72	2.00	22.00	Opening to be considered in light of 2012 funding	
Paediatric Care	University College Hospital Galway	Upgrade of neonatal department..	Q1	Q1	3	14	0.15	2.68	0	0
Acute	Mayo General Hospital, Castlebar	Upgrade / replacement of fire detection system.	Q1	Q1	0	0	0.12	0.29	0	0
Acute	Mayo General Hospital, Castlebar	Replacement of radiology equipment in ED.	Q2	Q2	0	0	0.30	0.30	0	0
Acute	Sligo General Hospital	Replacement of Radiology equipment..	Q1	Q1	0	0	0.10	1.60	0	0

Care Group	Facility's Location	Project Details	Project Completion Q	Q Fully operational	Additional Beds	Replacement Beds	Capital Cost €m		2012 Implications	
							2012	Total	WTEs	Revenue Costs €m
Critical Care	Mid-Western Regional Hospital, Limerick	Provision of a new critical care block (linked directly to the main theatre block), to provide 12 ICU, 14 HDU and 16 CCU bed, (24 beds opening in 2012 - cost neutral).	Q2	Q2	0	24	17.00	35.00	0	0
Ambulance	Ambulance station, Thurles, Co. Tipperary	New ambulance station.	Q3	Q4	0	0	0.70	1.10	0	0
Ambulance	Ambulance station, Nenagh, Co. Tipperary	New ambulance station.	Q4	Q4	0	0	0.90	1.10	0	0
Ambulance	Ambulance station, Tuam, Co. Galway	New ambulance station.	Q3	Q3	0	0	0.95	1.10	0	0
National										
Ambulance Service	National ambulance control and call centre; ambulance service college	Provision of a national ambulance control and call centre and national ambulance service college.	Q3	Q4	0	0	7.00	11.00	0	0
				Total	**83**	**390**	**€118.49m**	**€342.27m**	**0 WTEs**	**€0m**
Dublin Mid-Leinster										
Older People	Community Nursing Unit (CNU), Inchicore, Dublin	50 bed CNU.	Q4 2010	Q1	0	50	0	10	0	0
Older People/Mental Health	St. Mary's Unit, Mullingar	100 bed community hospital to accommodate replacement beds from the existing unit.	Q1	Q2	0	50 TBC (see Mental Health)	*1 (see also Mental Health)	*16.50	0	0
Dublin North East										
Older People	Cuan Ros Community Unit, Dublin	Refurbishment of Cuan Ros Community Unit.	Q3	Q4	2	0	0.90	1.10	0	0
Older People	Seanchara Community Unit, Dublin	Refurbishment of Seanchara Community Unit.	Q3	Q4	5	0	0.50	0.60	0	0
Older People	Lusk Community Unit, Co. Dublin	Refurbishment of Lusk Community Unit.	Q3	Q4	0	0	1.30	1.50	0	0
Older People	St. Oliver Plunkett Hospital, Dundalk	Refurbishment of St Oliver Plunkett Hospital.	Q4	Q1 2013	0	0	1.10	1.30	0	0
South										
Older People	CNU, Tralee	50 bed CNU.	Q4 2010	Q1	0	29	0	9.40	0	0
Older People	CNU, Cork	100 Bed CNU, Farranlee Road.	Q4 2010	Q3	25 (young disabled adults)	75 (continuing care)	0	18.92	0	0
				Total	**32**	**204**	**€4.8m**	**€59.32m**	**0 WTEs**	**€0m**
Dublin Mid-Leinster										
Mental Health	Ballyfermot Hostel, Cherry Orchard Hospital, Dublin	New 17 bed low support hostel.	Q1	Q1	17	0	2.19	2.80	0	0
Mental Health	St. Loman's Hostel, Clondalkin Road, Dublin	New 17 bed hostel.	Q1	Q1	17	0	2.37	3.00	0	0
Mental Health	St. Loman's Hospital, Mullingar	Replacement of St. Edna's ward to provide a 20 bed special behavioural unit and up to 24 replacement beds.	Q4	Q4	0	44	4.50	6.00	0	0

Care Group	Facility's Location	Project Details	Project Completion Q	Q Fully operational	Additional Beds	Replacement Beds	Capital Cost €m		2012 Implications	
							2012	Total	WTEs	Revenue Costs €m
Mental Health	Grosvenor Road, Dublin	Upgrade of Hostel.	Q4	Q4	0	0	0.40	0.75	0	0
Mental Health (Child and Adolescent)	Cherry Orchard Hospital, Ballyfermot, Dublin	New day centre comprising outpatients, adolescents day hospital and administration.	Q1	Q1	0	0	6.40	9.05	0	0
Mental Health	Ballyfermot, Dublin – Primary Care and Mental Health Centre	New Primary Care and Mental Health Centre.	Q2	Q2	0	0	7.70	12.45	0	0
Mental Health/Older People	St. Mary's Unit, Mullingar	100 bed community hospital to accommodate replacement beds from St Loman's Psychiatric Hospital for patients with continuing care needs.	Q1	Q2	0	50 TBC (See Older People)	*(See Older People)		0	0
Dublin North East										
Mental Health (Child and Adolescent)	St. Vincent's Hospital, Fairview, Dublin	Phase 2 – provision of 6 additional beds in adolescent unit.	Q2	Q3	6	0	1.00	2.50	Resources provided in NSP2011	
Mental Health	Grangegorman, Dublin	Provision of replacement accommodation on the existing site for all services, including accommodation for residents and a day hospital.	Q4	Q1/Q2 2013	0	66	12.00	19.00	0	0
Mental Health	Beaumont Hospital, Dublin	44 bed psychiatric unit.	Q4	Q2 2013	0	44	8.00	13.00	0	0
South										
Mental Health	Clonmel, Co. Tipperary	Provision of a 40 bed residential unit, on the existing site, to accommodate current residents of St Luke's.	Q1	Q1	0	40	1.00	8.00	0	0
Mental Health	Clonmel, Co. Tipperary	High support hostel.	Q2	Q2	0	12	1.00	1.80	0	0
Mental Health	St. John's Hospital, Enniscorthy, Co. Wexford	Havenview, 14 place residence to provide accommodation to re-house residents from St. Senan's Hospital	Q3	Q4	0	14	2.00	2.40	0	0
Mental Health	St. John's Hospital, Enniscorthy, Co. Wexford	13 place high support house (Mill View) on the grounds of St John's Hospital, Enniscorthy, to re-house residents from St Senan's Hospital.	Q4	Q4	0	13	1.40	1.75	0	0
Mental Health	Clonmel, Co. Tipperary	Day Hospital and accommodation for sector team	Q1	Q1	0	0	2.00	3.50	0	0
Mental Health	Waterford Regional Hospital	Upgrade Acute Mental Health Unit.	Q1	Q1	0	0	0.80	1.10	0	0
Mental Health	Wexford	50 bed CNU to accommodate current residents of St. Senan's Hospital.	Q3	Q4	0	50	5.00	8.00	0	0
Mental Health	Kerry General Hospital, Tralee	High observation unit.	Q4	Q4	0	4	1.40	2.00	0	0
West										
Mental Health	Ennis, Co. Clare	Gort Glas Day Centre.	Q4 2011	Q1	0	0	0.25	0.25	0	0
				Total	**40**	**337**	**€59.41m**	**€97.35m**	**0 WTEs**	**€0m**

Care Group	Facility's Location	Project Details	Project Completion Q	Q Fully operational	Additional Beds	Replacement Beds	Capital Cost €m		2012 Implications	
							2012	Total	WTEs	Revenue Costs €m
Disability	Oakridge Day Unit, Daughters of Charity, Blanchardstown, Dublin	Early intervention and assessment unit.	Q2	Q3	0	0	0.30	1.90	0	0
				Total	**0**	**0**	**€0.30m**	**€1.90m**	**0 WTEs**	**€0m**
West										
Corporate	St. Joseph's Hospital, Stranorlar, Letterkenny.	Refurbishment as an Administrative HQ.	Q3	Q4	0	0	1.90	2.50	0	0
				Total	**0**	**0**	**€1.90m**	**€2.50m**	**0 WTEs**	**€0m**

Abbreviations

ACS	Acute Coronary Syndrome
ALOS	Average Length of Stay
AMP	Acute Medicine Programme
ASIST	Applied Suicide Intervention Skills Training
bn	billion
CAMHS	Child and Adolescent Mental Health Services
CCU	Coronary Care Unit
CF	Cystic Fibrosis
CIT	Community Intervention Team
CMHT	Community Mental Health Team
CNU	Community Nursing Unit
COPD	Chronic Obstructive Pulmonary Disease
CSII	Continuous Subcutaneous Insulin Infusion
CSO	Central Statistics Office
CSSD	Central Sterile Services Department
CTM	Clinical Team Meeting
DATH	Dublin Academic Teaching Hospital
DCYA	Department of Children and Youth Affairs
DES	Department of Education and Skills
DML	Dublin Mid Leinster
DNA	Did Not Attend
DNE	Dublin North-East
DoH	Department of Health
DPS	Drug Payments Scheme
DRG	Diagnosis Related Group
DTSS	Dental Treatment Services Scheme
ECF	Employment Control Framework
ED	Emergency Department
EMP	Emergency Medicine Programme
ERS	Endoscopy Reporting System
EWTD	European Working Time Directive
FSAI	Food Safety Authority of Ireland
GI	Gastrointestinal
GMS	General Medical Services
GP	General Practitioner
HCAI	Health Care Associated Infection
HCP	Home Care Package
HDU	High Dependency Unit
HF	Heart Failure
HIQA	Health Information Quality Authority
HPV	Human Papilloma Virus
HR	Human Resources
HSCN	Health and Social Care Network
HSE	Health Service Executive
HTA	Health Technology Assessment
ICGP	Irish College of General Practitioners
ICP	Irish Council for Psychotherapy
ICT	Information and Communication Technology
ICRU	Intensive Care Rehabilitation Unit
ICU	Intensive Care Unit
ID	Intellectual Disability
KPI	Key Performance Indicator
LBBB	Left Bundle Branch Block
LGBT	Lesbian, Gay, Bisexual and Transgender
LHO	Local Health Office
LOS	Length of Stay
LTI	Long Term Illness
m	million
MMR	Measles, Mumps, Rubella vaccine
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCCP	National Cancer Control Programme
NCHD	Non Consultant Hospital Doctor
NCRI	National Cancer Registry of Ireland
NDA	National Disability Authority
NHSS	Nursing Homes Support Scheme
NIMIS	National Integrated Management Imaging System
NSP	National Service Plan
NSTE ACS	Non-ST Segment Elevation Acute Coronary Syndrome
NVRL	National Virus Reference Laboratory
OPAT	Outpatient Antimicrobial Therapy
OPD	Outpatient Department
PA	Personal Assistant
PCRS	Primary Care Reimbursement Service
PCT	Primary Care Team
PET	Positron Emission Tomography
PHN	Public Health Nurse
PI	Performance Indicator
PPCI	Primary Percutaneous Coronary Intervention
PSA	Public Service Agreement
PSI	Psychological Society of Ireland
QA	Quality Assurance
QPSAS	Quality and Patient Safety Audit Service
RDO	Regional Director of Operations
REV	Revised Estimate Volume
SDU	Special Delivery Unit
STEMI	ST Elevation Myocardial Infarction
TB	Tuberculosis
VER	Voluntary Early Retirement
VRS	Voluntary Redundancy Scheme
WTE	Whole Time Equivalent

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