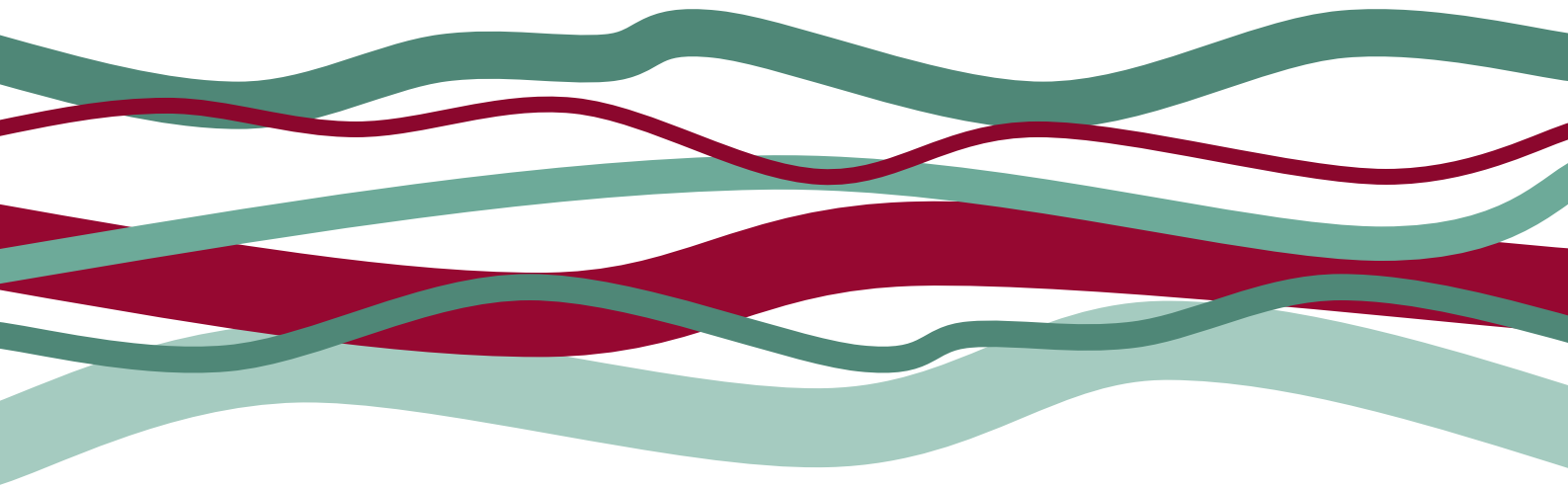
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE National Service Plan 2012

Executive Summary



Executive Summary of NSP2012

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%		