Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE SOUTH

Regional Service Plan 2012

9th February 2012

Contents

Introduction - Regional Director of Operations

The Chief Executive Officer, Mr Cathal Magee, published the HSE National Service Plan 2012 (NSP) on the 13th January, 2012, having been approved by the Minister for Health & Children. This HSE South Regional Service Plan has been prepared consistent with these national policies, frameworks, performance targets, standards & resources. The Regional Service Plan sets out the type and volume of service the HSE South will provide directly or through a range of agencies funded by us during 2012.

Resources for 2012

A summary of the funding and staff numbers available to deliver the Regional Service Plan is outlined in the Resource Framework on the next section of the plan. The detail of funding, staff numbers and the service delivery plan for the year in each care group or service is outlined under each section of the plan.

Finance

While the gross reduction in budget for the HSE South in 2012 amounts to €208m, this does not represent the service impact this year. Comparisons between gross budget figures for 2011 and 2012 are difficult this year as there has been a significant reorganisation of some funding streams, e.g. Fair Deal has been centralised nationally. These changes together with the income measures and related issues amount to €142m which can be regarded as non-service impacting in 2012. Furthermore additional funding of €14m has been provided in respect of children's services, to address some service pressures and to allow some limited and targeted recruitment in priority areas to help limit the impact of retirements on frontline services. When the budget is adjusted for these figures, the budget reduction for the South in 2012 which is service impacting amounts to €80m (3.7%). In addition the underlying deficit and service pressures from 2011, which will need to be addressed in 2012, amounts to €35m (1.8%), which presents a resource challenge of €115m (5.5%) for HSE South in 2012.

Staff Numbers

Apart from this overall budget reduction, a significant challenge for the HSE South in 2012 will be managing the reduction in levels of staff employed arising from the retirements associated with the grace period in February 2012. In addition, the government policy to reduce the size of the public sector and overall employment levels through the moratorium will continue. The cumulative impact on staff reductions from this year and previous years will present a significant challenge for the HSE South in delivering services. The reduction in staff numbers in HSE South over the past number of years can be summarised as follows:

- 2,276 staff reduction since 2007 peak
- 1,412 less staff at end 2011 than started 2010
- 1,000 staff left in 2011

The table below outlines the number of WTE staff who will be retiring on an area & care group basis from November 2011 to February 2012. It also identifies the numbers retiring as a percentage of our overall workforce. In all, this represents 736 individuals who have left since November 2011. A further 173 individuals had left the service between Sept to Nov 2011 (excluding Corporate and Home Helps) bringing the overall total to 909 individuals.

Care Group	CK/ST	Cork	Kerry	WT/WX	WTE as % of Total Care Group Resource
Acute Hospitals	35	101	17	61	214 (2.0%)
Children & Families	4	8	1	10	23 (2.3%)
Disabilities	8	45		17	70 (2.1%)
Mental Health	38	56	19	11	124 (4.9%)
Older People	43	67	34	27	171 (5.2%)
Primary Care	3	12	4	4	23 (1.8%)
Social Inclusion		1			1 (0.9%)
Grand Total	**131**	**290**	**76**	**129**	**626 (2.8%)**

- 736 individuals equating to 626 WTE have notified that they will retire (in the period Nov11 to Feb12)
  - Nursing 371 WTE (4.3%) of which
    - *Acute* *114 WTE (2.6%)*
    - *Mental Health* *97 WTE (6.3%)*
    - *SOP* *124 WTE (7.5%)*
    - *Disabilities* *30 WTE (3.7%)*
  - General Support staff 69 WTE (2.5%)

- Other patient & Client Care (HCA's) 60 WTE (1.9%)
- Health & Social Care Professionals 55 WTE (1.7%)
- Management / Admin 43 WTE (1.6%)
- Medical Dental 29 WTE (1.7%)

Responding to the Resource Challenge–Minimising impact on Frontline Services

Work has been underway since Autumn 2011 in preparing for the reduction in staff numbers with many of these staff having retired which can be seen from the figures outlined above. This Regional Service Plan has been prepared taking account of the overall reduction in resources in terms of both budget reduction and staff numbers leaving.

The HSE South is seeking to mitigate the impact of the retirements on frontline services in a number of ways:

- by using the provision of the Public Service Agreement to bring about greater flexibilities in work practices and rosters, redeployment and other changes to achieve more efficient delivery of services.
- Delivering greater productivity through the National Clinical Programmes to reduce the average length of stay, improve day of admission surgery rates, increase the numbers of patients treated as day cases, etc.
- Some limited and targeted recruitment in priority areas to help limit the impact of retirements on frontline services.

If we are to successfully implement the Regional Service Plan, the fundamental challenge for HSE South in 2012, is to:

- Fast-track implementing our change programmes
  - New, innovative and efficient ways of using a reducing resource
  - Challenging traditional cost structures & models of service delivery
  - Implementing the health reform programme
- Move to new models of care across all services & Care Groups which;
  - Deliver at the lowest level of complexity
  - Provide services at the lowest possible unit cost
  - Reorganisation of hospital services & implementing National Clinical Programmes
  - Improvement programmes across all Care Groups based on agreed national policies, e.g. Vision for Change, VFM report in Disability, Primary Care Strategy
- Our HR Strategy and workforce plan will be implemented to ensure that staff resources are allocated to the area of greatest priority with a strong focus on
  - workforce planning
  - redeployment to match staffing resources with service & activity priorities
  - Review of rostering arrangements
  - Enhancing skill mix where appropriate in care areas

Public Sector Agreement

The Public Sector Agreement provides the framework for delivering on this significant change programme across the HSE South during the course of 2011. It provides a unique opportunity to further transform and modernise the health services by facilitating a reduction in staff numbers, increasing efficiency and productivity, reducing costs and improving quality.

During 2012 there has been very positive engagement on implementing major change programmes across all four areas of HSE South with clear evidence of new ways of working and with a strong "can do" attitude. Staff are responding in a proactive manner to the change agenda with a developing awareness that each staff member has a contribution to make to the viability of our services and maximising sustainable employment. The Public Service Agreement has served us well to date in the South, and the challenge now, is to increase the pace of change as we implement new ways of working to deliver on the 2012 Regional Service Plan. I am confident that we can all respond to this challenge, which will see HSE South as a high performing area, which continues to value the contribution of all staff.

We are already working closely with staff and their staff associations through a detailed information and consultation process at local and regional level. This engagement will see a move to new models of care across all services which deliver at the lowest level of complexity and at the lowest possible unit cost. Our focus will be on maximising new and innovative service delivery options with a shared ownership of the reform agenda. We will maintain our high performance culture with the emphasis on implementation and delivery. An outline of the range of planned changes is set out in Appendix 3. This appendix is not an exhaustive list of initiatives underway but serves as an illustration of some of the key change initiatives being undertaken across

HSE South. I wish to acknowledge the active participation by staff and the staff associations in engaging in this process. Regional and local meetings have been taking place through which the initiatives are being discussed and progressed. This is a dynamic process and will continue to develop and evolve as the year progresses and as we monitor and evaluate progress in collaboration with staff and their representative bodies.

Service Delivery Impact in 2012

Acute Services

The budget reduction for Acute services in the South which is service impacting amounts to €28m. This represents a reduction of (3.76%). In addition the underlying deficits and service pressures from 2011 which will need to be addressed in 2012 amounts to €26.411m (3.54%). There are 214 staff WTE (2%) who will leave the service as a result of the grace period 2012. To address the funding issues and reduction in staff numbers a range of measures are being implemented for Acute services in 2012 as summarised below:

The strategy across acute hospitals in the service plan will be to mitigate the impact of budget and staff reductions through rigorous implementation of the clinical programmes particularly in Acute Medicine, Emergency Department and Surgery within the hospitals, in an accelerated way. The capacity in the system will be tailored to available funding and staff resources to ensure a sustainable model of service delivery. Through this approach it is hoped to reduce on average the impact on services and activity by approximately 3%. This will involve:

- Planned seasonal bed closures – comprehensive structured annual leave planning – redeployment
- Top priority AMP, Surgery, ED-Supported by Stroke ACS, COPD, OPD programme
- Increase move from inpatient to day care across all hospitals
- Increased rate of elective patients with procedures performed on day of admission.
- Reduce average length of stay
- Maximise numbers treated
- Reduce numbers of beds required

Overall additional investment of €6m is being provided to support the change initiatives including the appointment of 50 additional staff including 20 Consultant posts. Given that CUH is a regional hospital & cancer centre which also provides a significant range of national specialties, and WRH being the south east cancer centre and having a regional service component, these two hospitals are prioritised in the allocation of the development funding receiving €1.9m and €2m respectively. However, each hospital in the region is being provided with some additional resource to support their overall implementation of the national clinical programmes. The details are outlined in the individual hospital schedules in the following pages.

Additional resources are provided to support the implementation of the Clinical Programmes & the SDU initiatives as outlined in the plan. Each hospital will be required to implement the total package of initiatives including a breakeven funding position as part of their 2012 plan. Arrangements are already underway to implement the overall change programme with support from the National Clinical Leads and SDU as required throughout the year. The net effect is that the capacity is being tailored to the available funding and staff resources to ensure a sustainable model of service delivery which is safe and responsive to the needs of the public.

Primary Care

The budget reduction for Primary Care in the South amounts to €5.960m which represents a 5% reduction. There are 23.5 WTE staff who will leave the service in the context of the grace period 2012 representing 1.8%. To address the funding issues and reduction in staff numbers a range of measures necessitated for Primary Care services in 2012 are summarised below.

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.

Our overall approach is to deliver services at the lowest level of complexity which are available locally to maximise health outcomes whilst reducing the need for patients to travel outside their communities. The structured delivery of primary care will support the transfer of appropriate care from the acute hospital sector towards the primary care setting.

Efficiencies will be achieved regionally in line with national measures including national pharmacy agreements, and also through ongoing work with the Primary Care Reimbursement Scheme. Every effort will be made to minimise the impact of the budget reductions on frontline service provision.

We will also continue to enhance our primary care accommodation with the provision of 4 new Primary Care Centres in 2012. Service priorities for 2012 include the continued focus on chronic disease management programmes with initiatives in selected primary care teams across the region. In addition we will continue to expand and further develop Community Intervention Teams in selected locations throughout the South.

Mental Health

The budget reduction for mental health services in the South amounts to €11.455m which represents a 6.1% reduction. There are 124 WTE staff who will leave the service in the context of the grace period 2012 representing 4.9%. To address the funding issues and reduction in staff numbers a range of measures necessitated for mental health services in 2012 are summarised below.

We will be maximising the reorganisation of rostering, reduction in overtime and agency, and increasing skill mix and other measures to limit the impact on frontline services. Priority posts will be filled on a targetted basis within the service. The re-organisation of services in line with A Vision for Change will support the development of community services while at the same time reduce the overall cost of services, maximising the benefit to service users.

The HSE South plan for Mental Health Services includes a range of measures aimed at improving service user health, independence and experience and, at the same time, continuing to reconfigure service delivery to ensure increased efficiency. In line with the modernisation and reconfiguration of services envisaged in *A Vision For Change*, HSE South continues to accelerate the programme of closure of old long-stay institutions, reduce dependency on inpatient beds and prioritise the development of community based Mental Health Services across the four extended Catchment Areas.

The priority service focus in HSE South in 2012 will be;

- To complete the implementation of reconfiguration of services in line with Vision for Change in Waterford/Wexford and Carlow/Kilkenny & South Tipperary areas.
- To fully implement the recommendations of the Mental Health Commission in relation to the Kerry services.
- The priority in the Cork services in 2012 will be to significantly progress implementation of a Vision for Change. A Project Implementation Group representative of all stakeholders is being established to determine how the service will change to focus on a recovery and community based model of service delivery in Cork. This project implementation group will be provided with an overview of the work undertaken to date by a multidisciplinary group of clinicians and managers across all mental health services in Cork. A senior manager will be appointed to chair the group which will report by the end of the first quarter with the intention of proceeding with implementation on a phased basis over the reminder of the year.

In line with the Programme for Government, funding of €35m is being provided nationally 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. Nationally 400 staff have been made available to support this. The HSE South will receive an appropriate allocation from this resource, which will assist in progressing implementation of the overall programme and to fill priority posts or gaps in service which may arise.

Services for Older People

The budget reduction for Services for Older People excluding Fair Deal in the South amounts to €8.959m which represents 4.5%. There are 171 WTE staff who will leave the service in the context of the grace period 2012 representing 5.2%. To address the funding issues and reduction in staff numbers a range of measures necessitated for Service for Older People in 2012 are summarised below.

Significant progress has been made across HSE South in developing an integrated model of care in Services for Older People ensuring that Older People with complex care needs are supported appropriately through the developing PCTs and with appropriate access to specialist care by way of Consultant Geriatrician input. Overall there is an increase in the levels of dependency of older people living at home and receiving significant and multi disciplinary service levels.

The ongoing roll out and development of the integrated model of care is ensuring that the various options within residential care, particularly in relation to rehabilitation and convalescence will be best utilised, to ensure that they provide value for money and that those in need of such services receive them as a matter of priority.

While there will always be a need for older people to access acute hospital care it is vital that once the acute episode has been addressed that they can access the appropriate service at home or by way of rehabilitation etc to ensure that they can maintain or improve their level of independence.

Having regard to the budget reduction and the numbers retiring it will be necessary to significantly reorganise our rostering arrangements, staffing levels and work practices as well as revising the Skill-mix of our staff and maximise the opportunities for redeployment to ensure that we minimise the impact on the reduction of public residential beds and the broader range of community services.

- **Prioritising Residential Beds**
  In 2012 the HSE South will provide over 2,100 public residential care beds in 40 units (including the new Tralee CNU) providing long stay beds and short term respite, rehabilitation and convalescent care. Each of the 4 Areas across the HSE South has undertaken a comprehensive assessment of capacity and resource availability associated with this service for the coming year. The areas undertook the review based on a number of factors :
  - Demand for beds particularly choice of care by applicants for long stay beds through the Nursing Home Support Scheme (Fair Deal) process
  - Estimated number of retirements of care staff to end of February 2012 and to year end
  - Cost of care in the unit and the potential / need to economise through roster changes and skill mix adjustments
  - Audit of compliance of each unit with current and future HIQA environmental standards and in particular Fire Safety Standards and Legislation
  - Review of HIQA inspection reports by unit to identify improvements required to meet standards particularly care related issues
  - Cost of level of agency/cost containment and requirements for 2012
  - % occupancy of all public beds (long stay and community supports) and profile and trend of patient use of these beds

  Following the comprehensive assessment undertaken utilising the criteria outlined above, the position in relation to bed closures in HSE South has been revised downwards from a proposed minimum figure of 180 in the NSP to a planned reduction of 128 public residential care beds.

  The successful implementation of our change programme and implementation of the model of care for older people will be a critical factor in enabling HSE South to minimise the impact on public long stay bed provision and full cooperation will be required from all stakeholders if this is to be achieved.

  An important factor in the overall consideration of residential care bed closures was the fact that 101 of the 128 beds proposed for closure are currently vacant due to the staff retirements and reduction in agency costs as well as the demand for the Nursing Home Support Scheme, HIQA environmental standards, etc.

- **Community supports**
  The priority in HSE South for 2012 will be to maintain Home Care Packages at 2011 levels. We will minimise the impact of the 4.5% reduction in home help hours through concentrating the resource in supporting personal care and necessary domestic duties. In refocusing our Home Help service, we will maximise the no. of working hours for existing Home Helps within the system. All high dependency clients will receive a service. Clients with low dependency may not be eligible for a service as heretofore; however, those applicants will be linked into other services and advised of the various supports available.

Disability Services

The budget reduction for Disability Services in the South amounts to €11.576m which represents a reduction of 3.7% There are 70 WTE staff who will leave the service in the context of the grace period 2012 representing 2.1%. To address the funding issues and reduction in staff numbers a range of measures necessitated for Disability services in 2012 are summarised below.

- Progress implementation change programme based on DOH policy set out in VFM & policy review
- Develop a community based & inclusive model rather than institutional segregated
- Budget & staff reductions will be focused on
  - Efficiency
  - Consolidation
  - Reorganisation
  - Rationalisation of back office activity
- Some impact on services unavoidable but tailored to minimise impact to service users.
- 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.

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. 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. 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. It will be a priority for HSE South to engage positively in implementing this approach in 2012.

Child Care Services

Child Protection and Welfare Services have had an increase of €3.139m (2.7%) in budget in HSE South. However, this increase is against a backdrop of budgetary over runs in 2011 and cost management measures are required to reduce the cost base as set out below: There are 23 WTE staff who will leave the service in the context of the grace period 2012 representing 2.3%.

Under the *Programme for Government*, fundamental changes as to how child and family services are delivered in Ireland are proposed 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.

Budgetary over runs in 2011 and cost management measures are required to reduce the cost base as set out below:

- Reduce costs related to private residential care provision by maximising capacity in HSE services and reduce reliance on additional external provision.
- Establish standardisation of approach and payments across the region for After Care Services.
- Reduction in costs associated with agency staffing through management of absenteeism and re-organisation of staff rosters. An independent review of staff rostering in HSE residential units is currently taking place in order to facilitate a more flexible approach in the services provided. It is envisaged that following the review more efficient rosters will be established providing greater capacity and cost savings.
- Reduction in funding to voluntary agencies in line with national direction
- Back office services efficiencies / reduction in travel expenses, procurement etc.
- Reduction in level of enhanced Foster Care payments and limits on discretionary payments in excess of standard weekly foster care payment. No reduction in service anticipated.

Social Inclusion & other services

The budget reduction for Social Inclusion services in the South amounts to €1.2m which represents a reduction of 6.3%. There are 0.7 WTE staff who will leave the service in the context of the grace period 2012 which represents a reduction of 0.9%. To address the funding issues and reduction in staff numbers a range of measures necessitated for Social Inclusion and other services in 2012 are summarised below.

HSE South Social Inclusion services improve access to mainstream services, target services to marginalised groups, address inequalities in access to health services and enhance the participation and involvement of socially excluded groups and local communities in the planning, design, delivery, monitoring and evaluation of health services. The budget reduction for social inclusion services in the South amounts to €1.22m which represents a 6.3% reduction. Efficiencies will be achieved in non pay expenditure in core budgets and regional committee core budgets. In addition, there will be some reduction in Voluntary Agencies funding. The Social Inclusion team including the Community Workers, Drug & Alcohol Addiction teams as well as Homeless services and the Travelling Community will work with all our care groups and services to ensure that we continue to support the most vulnerable within our community, while at the same time implementing the Regional Service Plan in line with the national framework.

Potential Risks to the delivery of Regional Service Plan 2012

There are a number of potential risks which may impact on the delivery of the regional service plan, including Service, HR & Finance risks. These are set out on pages 9 & 10 of the National Service Plan and in the region we monitor and assess all of these and other risks that emerge as 2012 progresses and dependent on their impact, we may need to adjust planned service levels during the year to ensure that we can operate within the resources provided.

Quality, Risk & Clinical Care

The HSE South is committed to delivering high quality services to all our patients and clients and to creating a quality promoting workplace for staff. An important task for us all is to ensure that our services are safe; this is achieved through the implementation of a comprehensive quality and patient safety framework and by mitigating risk in the operational health system. We must also make sure that where serious incidents do arise that we manage our response effectively and implement appropriate measures in order to improve our systems. Ensuring compliance with national standards in relation to quality & patient safety will be an increasing focus for our services in 2012. Significant progress is already being made across hospitals and community services at local level and to support this work we have put in place in 2011 a more comprehensive regional Quality and Patient Safety Programme, which we are now rolling out at Area Level in 2012, the detail of which is outlined on page 13 of this plan.

Conclusion

This Regional Service Plan can only be delivered through the collective efforts of the Health and Social Care professionals from all of our care disciplines and services. Our services are now more than ever dependent on our staff to continue to make the extra effort for all our patients and clients. HSE South has a strong tradition in delivering fully on our service plan targets. This is a reflection of the high calibre and the exceptional commitment of the individual staff and teams and I wish to thank all staff for their contribution to date and look forward to the continuation of this commitment in 2012.

Resource Framework

Introduction

This HSE South Regional Service Plan has been prepared consistent with national policies, frameworks, performance targets, standards and resources and sets out the type and volume of service the HSE South will provide directly or through a range of agencies funded by us during 2012.

The decisions which the Regional Management Team has taken in the allocation of resources and the prioritisation of services and cost measures were carefully considered so that we would be in a position to continue to deliver high quality responsive services and continue to support the most vulnerable while implementing the key HSE national priorities for 2012.

Finance

It is important to acknowledge that a significant effort has been made this year to ensure that cost reduction measures are implemented in a way which minimises the impact on front line services at regional and local level.

HSE South	€m
Base Budget 2011	1,898.606
Cost reductions – service impacting	(80.307)
Cost reductions – non-service impacting	(142.631)*
Additional Funding	14.287**
Sub-total	(208.651)
Budget 2012	1,689.955
WTE Ceiling Start 2012	22,324

* The non service impacting reductions include a budget retraction amounting to €116.512m in relation to Fair Deal which will be managed as a centralised national budget in 2012.
**Additional Funding was received in respect of childcare (€10.000m), replacement of non exempt staff (€3.287m) and service pressures (€1.000m).

In addition, a range of measures to address the 2011 excess run rate including once off savings in 2011 will also have to be implemented in 2012. This equates to €35.221m, which represents an additional 1.8% reduction, which is split between hospital €26.411m and community €8.810m. The range and quantum of services to be provided in 2012 takes account of the reduction in 2012 budget, together with residual underlying deficits and cost pressures and the decrease in staffing levels.

Pay and pay related expenditure

	€m
Adjustments for 2012	
Recruitment moratorium	32.850
Overtime reductions	1.562
Premium pay	1.845
Sick leave	1.386
Sub total	**37.643**

There are critical linkages between a number of pay-related elements in this plan. These elements cannot be considered in isolation and must be offset against each other depending on the number of staff who leave under the ‘grace period’, their salary level and their length of service. To the extent that staff do not leave as provided for within this plan, pay savings will not be delivered and the resulting shortfalls must be offset by the funding provided for lump sums.

Human Resources

In the HSE South

- 2,276 staff reduction since 2007 peak
- 1,412 less staff at end 2011 than start of 2010
- 1,000 left in 2011
- Over 400 WTE indicated departure by end of February 2012

With a permanent reduction in the overall levels employed in the public sector, management will be required to prioritise services to ensure that the impact on frontline services is kept to a minimum. Such an approach will require re-deployment and re-assignment of staff right across all of our functional areas.

There is a requirement that our cost base be adjusted in line with budget requirements and our focus must be on reform of traditional cost structures and models of service delivery.

As part of our ongoing reform, we will also maximise the reorganisation of rosters, reduction in overtime and agency, and increasing skill mix and other measures to limit impact on frontline services.

This service plan has been developed on the basis that the full budget reduction has been applied across all care groups including acute services, detailed cost containment plans have been drawn up to meet the reductions required. Work is continuing on these plans and will be finalised over a number of weeks in consultation with the national system. There is continuous assessment of the service implications associated with these cost management plans.

In the resource framework outlined above the moratorium (€32.8m) is the main contributory factor to the budget reduction of €80m. The capacity of the service to deliver on this aspect of the plan is limited by the extent to which staff retire or resign during the year and we have emphasised the link between this and the nationally held pension budget. Further work remains to be done to finalise how this overall issue will be handled in 2012. This may not crystallise until February 2012 and the regional service plan may need to be revised in that context.

Contingency Measures

Specific contingency measures will be in place across all services to respond appropriately to meet local service demands:

- Optimising deployment of staff
- Revising/re-working of rosters
- Deployment of staff to high risk areas
- Closer management of sick leave
- Maximising potential of shared service functions
- Maximise use of technology to facilitate redeployment of staff
- Relocation of workload
- Review management/governance structures
- Maximise potential for skillmix
- Match between service level activity and staffing levels and appropriate use of skill mix
- Limited recruitment and conversion of agency and overtime

Implementing our Change Programmes

A major theme of the HSE South Regional Service Plan 2012 is to continue the implementation of our national clinical programmes across our hospital system. In addition to these national programmes, our own reorganisation plans for the acute hospital services will continue as core elements of the change programme in the region. Similarly, a range of innovative change programmes will be implemented across our social care services and care groups. The implementation of the change programmes highlighted above will support the reorganisation and development of service across primary, community & hospital services to focus on the complete needs of the patient or client, while also prioritising effective working relationships across services and providing a more responsive and accountable service.

Public Service Reform through full utilisation of Public Service Agreement

The regional service plan is focused on:

- Placing customer service at the core of everything we do
- Maximising new and innovative service delivery channels
- Radically reducing our cost to deliver better value for money
- Strong focus on implementation and delivery

The Public Service Agreement (PSA) continues to provide the framework for delivering on this significant change programme across the health sector. It provides a unique opportunity to further transform and modernise the health services by facilitating a reduction in staff numbers, increasing efficiency and productivity, reducing costs and improving quality.

In 2011 HSE South delivered major change programmes in both acute and community services, for example, the reorganisation of mental health services in Waterford / Wexford and Carlow/ Kilkenny/South Tipperary consistent with Vision for Change. In the Cork area a major reorganisation of acute services has delivered major change in orthopaedics, cardiology, medical rehabilitation, ED, and older peoples services. Approximately 1,000 staff were involved in these changes.

We have worked closely with staff and their staff associations to deliver on these changes and will continue to build on this in 2012.

2012 will require an increase in the pace and delivery of change. It is fundamental that there is full engagement on the reform agenda by all stakeholders within specific timeframes. There is a requirement for strong leadership and management of the reform programme with a relentless focus on service and results and through the effective engagement with all of our staff.

Monitoring and Measuring RSP 2012

Performance management in the region is led by the RDO & Regional Management Team. Performance is managed through specific workplans which set out clear outcomes, timelines and responsibilities in each area, which also identify the named individuals to which they are assigned. The 2012 Performance Scorecard is the National Scorecard by which performance is assessed against the three criteria of quality, access and resources and this will be used in conjunction with existing performance management processes to deliver on this Regional Service Plan.

National 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.

Regional Quality and Patient Safety Programme

Purpose

The purpose of the programme relates to conformance with and performance of the Quality and Patient Safety system in place in the region as follows;

1. Conformance – to provide assurance to the RDO and Regional Management Team in relation to the systems and processes that are required to manage issues relating to quality and patient safety. This includes compliance with relevant standards (Mental Health Commission (MHC)), Health Information Quality Authority (HIQA) standards, the HSE's Integrated Risk Management Policy - the systems for the reporting and management of incidents (to include serious incidents), the HSE Medical Device and Equipment Management Policy, the HSE Procedure for the Development of Policies, Procedures, Protocols and Guidelines etc.
2. Performance - to place an emphasis on incremental improvement and increasing safety for those who work in and access services in the region. This will be achieved through monitoring of trends that may indicate underperformance and the identification and exploration of best practice models to improve performance in these areas.

The programme recognises that quality and risk management is a line management responsibility and seeks to support, enable and advise line management. In order to provide organisational assurance surveillance and monitoring will be a key aspect of the programme.

Objectives

- To outline the accountability arrangements for Quality and Patient Safety management within the Region and to have in place a structure for Quality and Patient Safety that ensures clear lines of accountability for quality and risk management leading up to the Regional Director of Operations (RDO).
- To ensure that the core processes for quality and patient safety are defined, communicated and implemented in a consistent manner in all areas within the Region e.g. risk registers, incident management (including the management of serious incidents), serious incident escalation, compliance with relevant standards, quality improvement programmes etc.
- To support the development of capacity and capability of staff in the region with respect to the requirements of the quality and patient safety programme.
- To provide mechanisms to support the professional development and networking of quality and risk staff within the region.
- To support the development of mechanisms to promote best practice and share learning to improve quality and patient safety
- To collaborate with the National and other three Regional HSE Quality and Patient Safety Departments functions to ensure alignment with National Quality and Patient Safety Programme.
- To monitor the outcomes of the Quality and Patient Safety Programme by way of measuring Healthcare Quality Indicators.
- To provide the RDO and Regional Management Team with assurance in relation to the progress and performance of the regional quality and patient safety programme.

Scope

Accepting that quality and patient safety is a line management function, the scope of this programme is one of establishing and monitoring consistent frameworks and providing advice and support to enable their implementation.

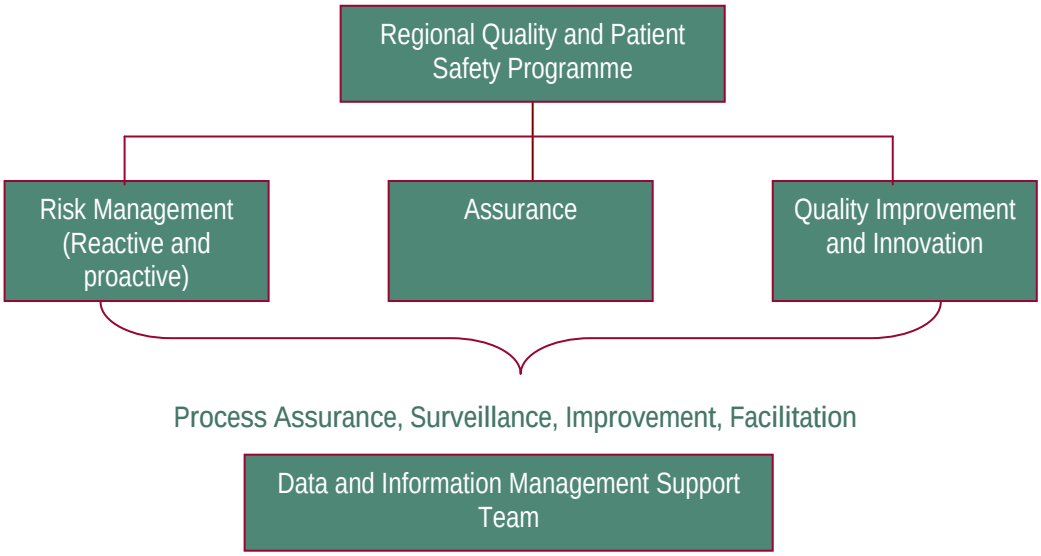
Organisational Arrangements

This programme is predicated on the basis of a Quality and Patient Safety Department which oversees the programmes of work and a related governance structure which in turn ensure embedment at all levels in the services.

The organisational arrangements for the operation of the Quality and Patient Safety department and Regional Quality and Patient Safety governance structure are outlined below.

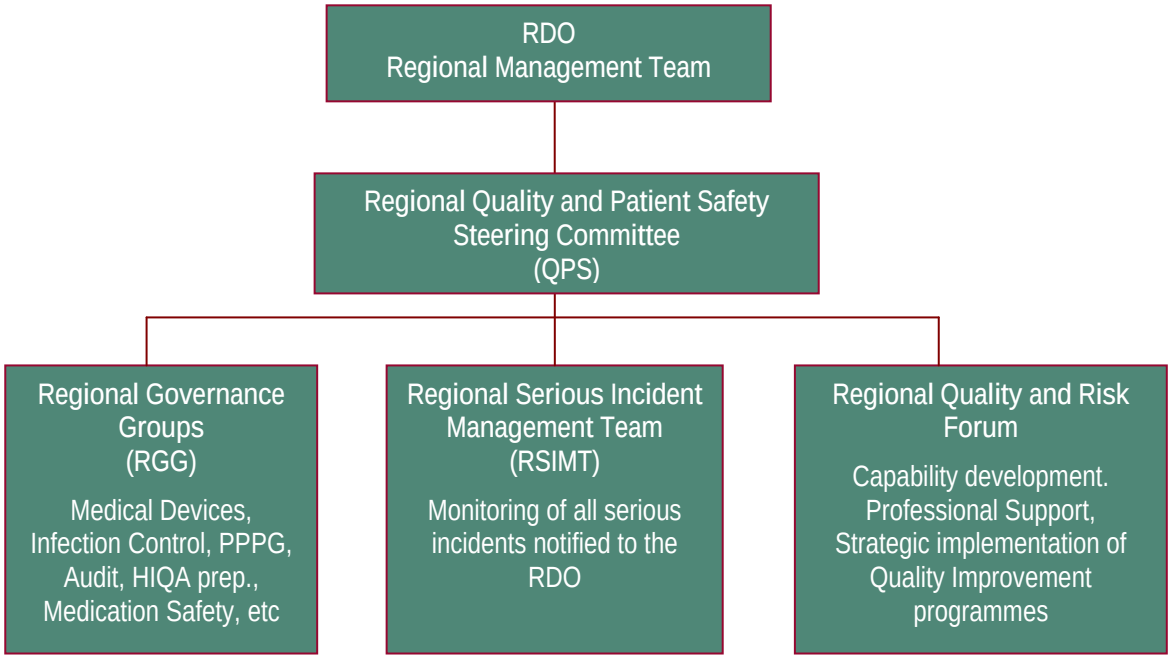
Regional Quality and Patient Safety Department Function

Figure 1



Regional Quality and Patient Safety Governance Structure

Figure 2



Quality and Patient Safety Governance Structure

Regional Quality and Patient Safety Steering Committee

The Committee is responsible for overseeing and coordinating quality and patient safety initiatives in the Region by ensuring that systems are in place to identify, evaluate and control the risks that threaten the achievement of the Region's objectives and to provide assurance to the Regional Director of Operations with regard to the management of Quality and Patient Safety in the Region. The Committee has a paramount role in the promotion of quality improvement in seeking to improve service user care and outcomes. It is chaired by the Regional General Manager for Quality and Patient Safety and its membership includes the Area Managers (4), Clinical Directors (2), and a Director of Public Health Medicine.

Regional Serious Incident Management Team (RSIMT)

This group oversees the management of all incidents escalated to the RDO. This team determines whether an issue that is escalated to the Office of the RDO can be managed by the RSIMT or whether it is of national significance and needs to be escalated to the National Incident Management Team in line with the HSE South Serious Incident Escalation Procedure and the HSE National Serious Incident Management Procedure. The Lead of this team is the Regional General Manager for Quality and Patient Safety and Chair of the Regional Quality and Patient Safety Steering Committee

Regional Governance Groups

Each Care and Clinical specialist area is required to have in place a Regional Governance Group. This also includes groups with a particular interest, for example, Medical Devices, PPPGs, and Infection Control etc. The purpose of these governance groups will be to:

- Monitor compliance regionally with standards and other regulatory requirements relevant to the clinical/care group/specialist area.
- Review and quality assure reports arising from the review of serious incidents occurring in the clinical/care group/specialist area in the region and to identify learning that can be shared from these incidents.
- To assist in the process of ensuring the best use of resources and the use of standardised processes relevant to the care/clinical group/specialist area.
- Promote the use of a consistent approach to audit and other relevant quality tools within their care/clinical group/specialist area
- To report to the Regional Quality and Patient Safety Steering Committee in an agreed manner

Regional Quality and Risk Forum

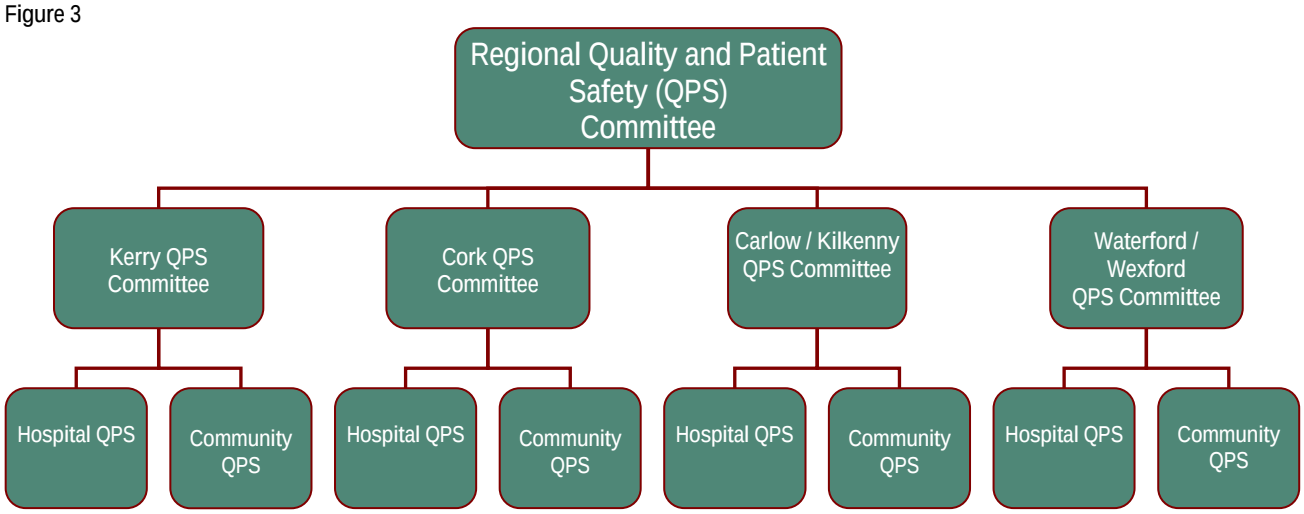
Membership of this forum is made up of Quality and Risk practitioners from all service areas within the region. Its key purpose is to improve the capability of its members and to address the quality and risk agenda in a consistent manner across the region. It is therefore a forum for learning and development and also for planning a strategic approach to implementation of key quality and risk programmes, such as the implementation of the IHI Care Bundles.

Area Quality and Patient Safety Committees

Each Area has a Quality and Patient Safety Committee, chaired by the Area Manager, and comprising of representatives from the hospital(s), Older Persons Services, Child and Family Services, Disability Services, Mental Health, Ambulance Services, Quality Manager, Risk Manager and Health and Safety Services. The Committee meets monthly and is responsible for overseeing and coordinating quality and patient safety initiatives in its own Area by ensuring that systems are in place to identify, evaluate and control the risks that threaten the achievement of the Area's objectives and to provide assurance to the Regional Director of Operations (via the Regional Quality and Patient Safety Committee) with regard to the management of Quality and Patient Safety in each Area. The Committee has a paramount role in the promotion of quality improvement in seeking to improve service user care and outcomes.

Regional / Area Quality and Patient Safety Governance Structure

Figure 3



Key Linkages for the Quality and Patient Safety Programme

To facilitate a whole systems approach to the programme it will develop linkages with regional supports i.e. Performance and Development, Organisational Development and Design, Occupational Health and Safety, Ambulance Services, Primary Care and local specialist posts e.g. quality and risk, infection control, clinical engineering.

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
Clinical Governance	Support the continuous development and implementation of Corporate Governance and Accountability Frameworks for Clinical Governance and Patient Safety HSE South Multidisciplinary QPS committees established in each Area	Ongoing
	- monthly reports from each Area to Regional QPS committee by end of each month	Q1
	- active involvement of Clinical Directors on Area QPS committees	Q2

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Implementing National Standards	Continue to progress the programme of change required to deliver compliance with these standards	Ongoing
	HSE South	
	▪ 8 working groups established to identify gap analysis in preparation for National Standards for Better Safer Care (HIQA)	
	– Identification of Structures and Processes already in place and those needed to be prioritised in region.	Q1
	– Identification of Outcomes to be measured to monitor readiness and compliance with National Standards (HIQA)	Q1
	– This will form a suite of metrics to be measured.	
	– Measurement of theses Outcomes for analysis and to inform priorities for Quality and Patient Safety in the Region	Q3
	– Monthly reports from 8 Leads to Regional HIQA Preparation Governance Group	Q1
	▪ Patient Safety Culture Survey will be conducted across the Region in acute hospitals and community hospitals	
	▪ Quality Assurance programme to ensure compliance with Ennis/Mallow General Reports	Q2
	– Regional Mallow Report Group Governance Group established 2011	Ongoing
	– Comprehensive survey sent to all acute hospitals in Q4 2011	Ongoing
	– Analysis of results of surveys	Q1
	– Site visits to all acute hospitals to verify results of survey	Q1
Standards, Recommended Practice and Guidance	Continue to support the development and implementation of standards, recommended practice and guidance in key areas including:	Ongoing
	▪ Healthcare records management	
	▪ Post Mortem Examination Services	
	▪ Medical Devices and Equipment	
	HSE South	
	▪ Regional MDEMC established	Q1
	▪ Self Assessment against the MDEMC Standards	Q1
	▪ Quarterly reports to Regional QPS committee	
	▪ Integrated Care	
	▪ Medication Safety	
	HSE South	
	▪ Development of Regional Medication Safety Governance Group	Q2
	▪ Decontamination of Reusable Invasive Medical Devices	
	HSE South	
	▪ Regional Audit Committee to be established to focus on auditing of all internal self-assessments such as HSE Code of Practice of Decontamination of RIMD	Q2
	▪ Consent	
	▪ National document development and approval process	
	HSE South	
	▪ Regional PPPG group to be established to identify, prioritise, support development of and sign off on HSE South Regional PPPGs	Q2
	▪ Training on development of PPPGs	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
	HSE South	
	▪ Collaborate with Regional General Manager, Consumer Affaires to implement *Patient Charter of Rights and Responsibilities, You and Your Health Service* as part of work undertaken for National Standards Preparation Theme 1 – Person Centred Care.	Q4
	▪ All regional committees will have a Service User representative	Q4
Clinical Audit	Implement Irish Audit of Surgical Mortality (IASM)	Q4
	Implement Irish National Orthopaedic Register (INOR)	Q4
Quality and Patient Safety	Continue to develop a structured programme of healthcare audits	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
Audit	Develop and support implementation of guidance for local clinical audit	Q3
	HSE South	
	▪ Establish Regional Audit Governance Group to monitor, analyse and support recommendations arising from all Healthcare Audits conducted in the region.	Q2
Integrated Risk Management	Continue to implement the HSE Integrated Risk Management Policy with particular focus on risk management, incident and complaints management	Ongoing
	HSE South	
	▪ Area QPS committees to send bimonthly risk register reports to Regional QPS committee for assurance, analysis, audit and shared learning	Q1
	▪ Training on Risk Register development	Ongoing
	▪ Monthly reports to Regional SIMT regarding incidents on the RDO and NIMT logs	Ongoing
	▪ Incident Management training	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
	HSE South	
	▪ Review monitoring arrangements currently available in region and link with 3 other regions to inform the development of a regional approach/system for monitoring.	Q2
	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
	HSE South	
	▪ Regional Quality and Patient Safety website established in May 2010, alert system for this website to highlight key lessons learned.	Ongoing
	▪ Communication Strategy on the website to be launched.	Q1
	▪ Provide education and training on Quality and Patient safety to staff	Ongoing
	▪ Identify list of "mandatory" training	Q2
	▪ Support small scale local Quality Improvement Programmes	Ongoing
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
	HSE South	
	▪ Regional HCAI/AMR committee established in 2010.	Q1
	– Identification of gaps in key personnel to provide regional specialist advice	
	– Quarterly reports on EARS-net Bloodstream Infection Hospital and Community; *C-difficile* surveillance, Hospital Hand Hygiene (Hand-gel consumption and reports from Lead Auditors), EARS-Net Enhanced Bacteraemia – these will be analysed and discussed at Regional HCAI/AMR meetings quarterly.	
	▪ Care Bundles to prevent Catheter Associated Infections implemented in all HSE South Hospital ICUs	Q4
	▪ Care Bundles to prevent Ventilator Associated Pneumonia in the Tertiary Hospital ICUs	Q4
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.

The National Service Plan has identified the following 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.*

The budget reduction for the promoting and protecting health services in the South amounts to €0.127m which represents a 4.2% reduction.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	Ensure strategic plan is fully aligned across related HSE programmes and agree regional implementation plans	
	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
	Agree Memorandums of Understanding / Service Level Agreement with Environmental Protection Agency, Irish Medicines Board, and Children and Families Services	

Key Result Area	Deliverable Output 2012	Target Completion Quarter
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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	Total	South	South
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% (National)	89%	95% (National)
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV_2)	95% (National)	87%	95% (National)
% children at 12 months of age who have received two doses of the Meningococcal group C vaccine ($MenC_2$)	95% (National)	87%	95% (National)
% 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% (National)	95%	95% (National)
% children (aged 24 months) who have received 3 dose Meningococcal C ($MenC_3$) vaccine	95% (National)	95% (National)	95% (National)
% children (aged 24 months) who have received 1 dose Haemophilus influenzae type B (Hib) vaccine	New PI 2012	New PI 2012	95% (National)
% children (aged 24 months) who have received 3 doses Pneumococcal Conjugate (PCV_3) vaccine	New PI 2012	New PI 2012	95% (National)
% children (aged 24 months) who have received the Measles, Mumps, Rubella (MMR) vaccine	95% (National)	91%	95% (National)
% 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% (National)
% children (aged 4-5 years) who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	New PI 2012	New PI 2012	95% (National)

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	Total	South	South
% 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% (National)
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% (National)
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% (National)
Child Health / Developmental Screening % of newborns who have had newborn bloodspot screening (NBS)	New PI 2012	New PI 2012	100% (National)
% newborn babies visited by a PHN within 48 hours of hospital discharge	95% (National)	87%	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% (National	88%	95% (National)
Tobacco Control No. of sales to minors test purchases carried out	80 (National)	292 (National)	216 (National)
No. of offices, per region, carrying out sales to minors test purchase activities	2 per region	13 (National)	2 per region (different offices)
No. and % HSE hospital campuses with tobacco-free policy	New PI 2012	New PI 2012	3
No. of frontline staff trained in brief intervention smoking cessation across primary care and acute campuses	New PI 2012	New PI 2012	813
Food Safety % of Category 1, 2 food businesses receiving inspection target as per FSAI Guidance Note Number 1	100% (National)	92% (National)	100% (National)
Cosmetic Product Safety No. of cosmetic product inspections	New PI 2012	New PI 2012	750 (National)
International Health Regulations All designated ports and airports to receive an inspection to audit compliance with the IHR 2005	8 (National)	8 (National)	8 (National)
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 (National)
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 (National)

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

Introduction

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 the impact of the loss of staff and service delivery through PCTs and HSCNs.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	61.956	58.858
Kerry	11.739	11.162
Carlow /Kilkenny/Sth Tipp	30.464	28.962
Waterford/Wexford	16.858	16.017
Total	121.017	114.999

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	893	865
Kerry	221	214
Carlow /Kilkenny/Sth Tipp	445	431
Waterford/Wexford	378	366
Total	1,937	1,876

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 (1,746 in primary care contractors in HSE South). 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.

The national budget requires the achievement of cost management totalling €124m in 2012 (€6.018m in HSE South). 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.

The National Service Plan priorities for 2012 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.

The National Service Plan has identified the following 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 (1,746 in HSE South).
- Advance the process of transforming primary care services provided by GPs by working with them to ensure their service arrangements support health service provision reorganisation.
- 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 through for instance promoting electronic referrals within and from primary care to the acute services and further roll out of the Newborn Hearing Screening Programme.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum

In 2012 we will:

- Provide 134 Primary Care Teams (PCTs) - including 23 new PCTs to be developed in 2012

LHO	Actual No. of PCTs in operation Y/E 2011	Target No. PCTs in Operation *Y/E 2012*	Target No. PCTs full rollout *Y/E 2012*
Carlow / Kilkenny	14	16	2
Kerry	9	16	7
North Cork	8	12	4
North Lee	21	21	0
South Lee	19	22	3
South Tipperary	7	10	3
Waterford	9	12	3
West Cork	8	8	0
Wexford	16	17	1
TOTAL	111	134	23

- Reorganise services within the 36 Health and Social Care Networks necessary to support the PCTs in the provision of community based services and care groups. This will include services such as mental health and child protection amongst others.

- Further develop services within the five Primary Care Centres opened in 2011 in Ayrefield, Kilkenny; Callan, Kilkenny and Tramore; Carlow Primary Care / Medical Centre; Blackrock Hall, Cork
- Opening four new Primary Care Centres in Macroom, Gorey (2), Schull and Kenmare.
- Develop the following Primary Care Centres through the PPP - these are at various stages of development and will be progressed during 2012/2013

Location	No. of PCT's	Current Status
Cork		
Cobh	1	Agreement for Lease signed Completion Q1 2014
Newmarket	1	Agreement for Lease signed Completion Q1 2014
Togher inc. Greenmount /The Lough	3	City council to offer site for sale inc PCC site
Fermoy	2	Negotiations ongoing
Mayfield	1	Discussions ongoing
Charleville	1	Agreement for Lease signed Completion Q1 2014
Schull	1	To commence construction shortly
Ballineen	1	Proposal subject to HSE approval
Carrigaline	2-3	Proposal subject to HSE approval
Kerry		
Listowel	2	Agreement for lease signed completion Q1 2013
Caherciveen	1	Progressing subject to legal and agreement on plans
Carlow/Kilkenny South Tipperary		
Tipperary Town	1	Agreement for lease signed Completion Q1 2014
Kilkenny City (2)	1	Negotiations ongoing
Thomastown	1	Agreement for lease signed.
Waterford/Wexford		
Enniscorthy	1	Negotiations ongoing
New Ross	1	Bid process ongoing

- In association with Caredoc and Southdoc, further develop Community Intervention Teams (CITs) in Carlow/Kilkenny and Cork City and establish CITs in Waterford and Kerry.
- Continue health promotion through the Primary Care Teams in schools, the workplace and the community
- Undertake a local health needs assessment to inform and influence service developments as we develop each primary care team

Cost Management & Employment Control Measures

The budget reduction for primary care services in the South amounts to €5.960m which represents a 5% reduction in 2012 budget. The range and quantum of services to be provided in 2012 (as outlined above) takes account of the reduction in 2012 budget. The cost management measures necessitated by the reduced funding available for primary care services in 2012 are summarised below. Every effort is made to ensure that the impact on services is minimised.

- Reduction in funding to the GP co-operatives – Caredoc and Southdoc in line with the relevant recommendations of the national GP Out of Hours Review. Savings to be achieved without reduction in the quantum of service provided to patients.

Service Improvements

- Development of Community Infusion Unit at Ayrfield Primary Care Centre, Kilkenny - joint initiative between St Luke's Hospital and Primary Care Team and Community Services.
- Research Project on Efficacy of Primary Care Teams to be undertaken in North Cork.
- In line with national developments and in relation to the Diabetic Chronic Disease Management Programme, work towards establishing a new specialist multidisciplinary paediatric diabetic centre in Cork.
- The existing Primary Care Diabetes Initiatives will develop in line with the National Diabetes Programme to consolidate and expand existing Primary Care Diabetes Initiatives and the discharge of Type 2 Diabetes patients from the hospital serving those Primary Care Diabetes Initiatives by Q4.

Improving our Infrastructure

Location	Development	Operational Date
Gorey (2)	Primary Care Centre - By lease agreement	Q2 2012
Schull	Primary Care Centre - By lease agreement	Q 4 2012
Kenmare	Primary Care Centre - By lease agreement	Q2 2012
Macroom	Primary Care Centre - By lease agreement	Q1 2012

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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 HSE South: ▪ 134 PCTs in HSE South (23 to be developed in 2012)	Q3 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 HSE South Expand services in Carlow/Kilkenny and Cork CITs and, in association with Caredoc and Southdoc, develop Community Intervention Teams in Waterford and Kerry.	 Ongoing Q3
	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) ▪ Development of a standardised approach to brief intervention training in smoking cessation for all health care professionals	Ongoing
	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 HSE South ▪ Open 4 additional primary care centres in Schull, Gorey (2), Macroom and Kenmare	 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 HSE South ▪ Support the restructuring of services into integrated audiology service, establish developments initially within Cork /Kerry ISA	 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	

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	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 commun 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
	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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
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	14
No. of Health and Social Care Networks in development	New PI for 2012	New PI for 2012	22
% of Operational Areas with community representation for PCT and Network Development	New PI for 2012	New PI for 2012	17 100% (National)
GP Out of Hours No. of contacts with GP out of hours	437,537	412,265	412,265
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	48,648
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) (National)	21 (National)
Orthodontics No. of patients receiving active treatment during reporting period	18,000 (National)	3,024	3,024
No. of patients in retention during reporting period	To be disaggregated in 2011	958	958
No. of patients who have been discharged with completed orthodontic treatment during reporting period	2,000 (National)	365	365

Community (Demand-Led) Schemes

Performance Activity	Expected Activity 2011	Projected Outturn 2011	Expected Activity 2012
	National	National	National
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

Performance Activity	Expected Activity 2011	Projected Outturn 2011	Expected Activity 2012
	National	National	National
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
	National	National	National
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)
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)

Hospital Services

Introduction

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.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	402.806	372.683
Kerry	71.319	65.162
Carlow /Kilkenny/Sth Tipp	101.224	94.019
Waterford/Wexford	186.589	174.211
Total	761.938	706.075

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	5,414	5,222
Kerry	939	915
Carlow /Kilkenny/Sth Tipp	1,567	1,521
Waterford/Wexford	2,517	2,454
Total	10,437	10,112

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.

Monitoring and Measuring Acute Hospital Performance 2012

The 2012 Performance Scorecard is the National Scorecard by which performance is assessed against the three criteria of quality, access and resources.

In the HSE South performance will be monitored under those 3 criteria with a specific focus on the following activity targets set by the SDU

Unscheduled care

- 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.
- An average length of stay (ALOS) of 5.8 days or less
- A reduction in bed days lost through delayed discharges

Scheduled care

- Ensure that nobody is waiting more than 9 months for planned surgery
- Ensure that nobody is waiting more than 20 weeks for paediatric elective inpatient or day case surgery
- Ensure that nobody is waiting more than 4 weeks for an urgent colonoscopy
- Ensure that nobody is waiting more than 13 weeks for routine GI endoscopy (colonoscopy/gastroscopy)

The focus of SDU is to ensure long term sustainability to the ongoing service improvements and to be satisfied that there is a sufficient degree of flexibility across unscheduled and scheduled care service delivery in the region.

In addition to the specific targets set out above, the region is committed to working with the SDU in relation to delivering on the priorities set by the Minister for Health and ensuring that integrated plans addressing the balance of capacity, demand, resources and associated risks across the region are in place during the implementation of any changes to how services are delivered. Specifically; service reorganisation, cost containment plans and ongoing financial monitoring, implementation of the "Framework for Smaller Hospitals" and the impact of staff retirements.

The acute hospital services in HSE South are delivered across a number of sites including:

South West Acute Hospital Network:

Cork Area

- Cork University Hospital Group - comprising Cork University Hospital (CUH), Cork University Maternity Hospital (CUMH), Mallow General Hospital (MGH)
- Bantry General Hospital (BGH)
- 2 Voluntary Hospitals in Cork City also provide Public Acute Hospital Services, namely:
  - Mercy University Hospital (MUH);
  - South Infirmary/Victoria University Hospital (SIVUH).

Kerry Area

- Kerry General Hospital (KGH)

South East Acute Hospital Network:

Carlow / Kilkenny & South Tipperary Area

- South Tipperary General Hospital (STGH),
- St. Luke's General Hospital including Kilcreene Orthopaedic Hospital (SLGH)

Waterford / Wexford Area

- Waterford Regional Hospital (WRH)
- Wexford General Hospital (WGH)

The National Service Plan has identified the following 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.
- Planned Care - Treatment of patients in chronological order for both inpatient and day case to achieve the PTL targets. *The exceptions being clinical urgency and cancer patients*
- For All Care
  - To deliver 7 day early morning ward rounds by a senior decision maker achieving a significant increase of weekend discharges and a balanced distribution of discharges by day of week.
  - To deliver full implementation of the estimated date of discharge (EDD) process for each patient linked to an explicit treatment plan and best practice.
  - To meet all the targets for unscheduled care.
  - To deliver on all KPI's on the Balanced Scorecard of Quality, Access and Finance.
  - To meet the deliverables and schedules of the Clinical Care Programmes as defined explicitly by the programmes.
- 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.
- Reorganise pre-hospital emergency care services to respond to changing models of service within available resources.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Cost Management & Employment Control Measures

The budget reduction for Acute services in the South which is service impacting amounts to €28m. This represents a reduction of (3.76%). In addition the underlying deficits and service pressures from 2011 which will need to be addressed in 2012 amounts €26.411m (3.54%). There are 214 staff WTE (2%) who will leave the service as a result of the grace period 2012. To address the funding issues and reduction in staff numbers a range of measures are being implemented for Acute services in 2012 are summarised below:

In 2012, the approach in the first instance to cost containment will be to reduce inpatient treatment while maintaining day case procedures in line with the targets set in the National Service Plan. We will be using the

National Clinical Programmes, in particular around acute medicine, emergency department and surgery to enable the hospital service to maximise activity while reducing overall cost and headcount. However, given the scale of the resource reduction in terms of finance and staff numbers, it will be necessary to reduce our capacity (clinics / theatre sessions / beds etc.) and overall activity levels within the hospital system while minimising the impact on patients and clients. The HR strategy deployed within the acute hospital service will seek to ensure that staff resources are allocated to the areas of greatest priority utilising the Public Service Agreement to support our change programme. We will focus on maximising the reorganisation of rostering, reduction in overtime and agency, and increasing skill mix and other measures to limit impact on frontline services and the overall patient experience.

2012 Resource Challenge - Acute Hospitals

Hospital	Budget 2011	Incoming Deficit	Budget Cut 2012	Total 2012 Resource Challenge
	€m	€m	€m	€m
CUH Group	270.995	9.139	9.793	18.932
MUH	56.379	2.035	2.365	4.400
S. Vic	46.268	1.871	1.894	3.765
BGH	16.975	0.340	0.566	0.906
WRH	135.465	8.497	5.090	13.587
WGH/ Ely	47.772	0.433	1.895	2.328
SLK/ Kilcreene	55.728	1.478	2.183	3.661
STGH	45.604	1.118	1.772	2.890
KGH	71.319	1.500	2.477	3.977
HSE South	**746.505**	**26.411**	**28.035**	**54.446**

Service Quantum

In partnership with all key stakeholders, a range of inpatient, outpatient and day case services are provided by 12 acute hospitals in HSE South to a population in excess of 1.14m and to a broader population for certain specialist services. Services are delivered in accordance with the principles of equity, people centredness, quality and accountability.

2012 Projected Activity	Inpatient	Day Case	Combined
South Region Targets	**138,958**	**161,970**	**300,928**
Cork University Hospital	26,696	55,297	**81,993**
Cork University Maternity Hospital	13,740	5,360	**19,100**
Mallow General Hospital	2,956	3,500	**6,456**
Bantry General Hospital	1,889	1,725	**3,614**
Mercy Hospital	8,684	19,324	**28,008**
South Infirmary - Victoria Hospital	7,985	18,069	**26,054**
Kerry General	13,936	9,843	**23,779**
Waterford Regional Hospital	22,237	19,564	**41,801**
South Tipperary General Hospital	11,561	7,523	**19,084**
Wexford General Hospital	14,890	9,300	**24,190**
St Luke's Hospital - Kilkenny	13,487	11,545	**25,032**
Orthopaedic Hospital - Kilcreene	897	920	**1,817**

2011 outturn indicates that we delivered more inpatient activity than planned with hospitals running 3.9% over their 2011 target level. At the same time, the 2011 outturn for daycase indicates that hospitals in the south delivered less activity than planned with 1.5% under our target. The focus for 2012 will be to reverse this trend by reducing inpatient activity but seeking to increase our daycase activity moving far closer to the national target of 75%. Each hospital will target improving their performance on procedures on day of admission as well as the daycase rate for the agreed basket of surgical procedures to the national target of 75%. The specific deliverables for each hospital are outlined in the relevant sections of this document,

National Clinical Programmes, Service Development & Reorganisation

A fundamental challenge for the two hospital networks in HSE South in 2012 is to fastrack implementation of the National Clinical Programmes and SDU initiatives to mitigate the impact of the resource challenge around reduced budgets and staff numbers this year. In implementing these programmes we will look to new and innovative ways of using a reducing resource while challenging traditional cost structures & models of service delivery.

This Regional Service Plan outlines the resource provided and key deliverables required for each hospital. Implementation of the National Clinical Programmes & SDU initiatives for each hospital are outlined in this plan.

Overall additional investment of €6m is being provided to support the change initiatives including the appointment of 50 additional staff including 20 Consultant posts. Given that CUH is a regional hospital & cancer centre which also provides a significant range of national specialties, and WRH being the south east cancer centre and having a regional service component, these two hospitals are prioritised in the allocation of the development funding receiving €1.9m and €2m respectively. However, each hospital in the region is being provided with some additional resource to support their overall implementation of the national clinical programmes. The details are outlined in the individual hospital schedules in the following pages.

A key focus for each hospital in 2012 will be to maximise delivery on the SDU targets for scheduled and unscheduled care with an absolute priority to substantially reduce the ED trolley issues.

Management Structures and Processes

Within HSE South during 2011 we commenced the next phase of implementing our organisational structures and process across the two hospital networks. This is being done to ensure a cohesive approach to the management of the hospitals in each network, and in supporting the development of clinical leadership and the roll out of the clinical directorate model. These processes are being rolled out in line with the nationally agreed framework "Principles for Establishing Clinical Directorates". They will position the region well to engage proactively with the new health reform programme being implemented by the Minister for Health.

An Acute Hospital Executive Management Group will be established in each network. The group in Cork/Kerry commenced in May 2011. The membership consists of the executive decision makers with responsibility for implementation of the Service Plan within and across the acute hospital sites including CEO/Hospital Manager, Executive Clinical Directors (currently Clinical Directors), OP's Managers in the community and is chaired by the two Area Managers. The Clinical Directors who will be appointed shortly to each of the four clinical directorates will also be members of the group. While the accountability continues to rest with the Area Management Team and individual hospitals, the Executive Management Group supports collaborative working and ensures coordinated implementation of the service plan in a strategic way across the network, including the implementation of national clinical programmes and the reorganisation of acute hospital services.
Some of the specific areas that they will focus on in 2012 include

- Establish outpatients central referrals office for acute hospitals in Cork and Kerry.
- Implement electronic GP referral processes for Acute Hospitals in Cork and Kerry.
- Prepare a comprehensive plan for rehabilitation services across acute hospitals and community settings.
- Review delivery of Laboratory services in all Acute Hospitals to meet service needs with optimal efficiency.
- Continued roll out of LEAN management project

The Regional Director and senior members of the Regional Management Team attend the Executive Management Group on a quarterly basis to support the overall performance management process and to clear any obstacles or issues that are impeding the effective implementation of our change programmes across the network, or the performance of any individual hospital.

Similarly, in the South East an Acute Hospital Executive Management Group is being established in early 2012. The membership will consist of the executive decision makers with responsibility for implementation of the Service Plan within and across the acute hospital sites including Hospital Managers, Executive Clinical Directors (currently Clinical Directors), Operations Managers in the community and be chaired by the two Area Managers. The Clinical Directors who will be appointed shortly to each of the four clinical directorates will also be members of the group. While the accountability continues to rest with the Area Management Team and individual hospitals, the Executive Management Group will support collaborative working and ensures coordinated implementation of the service plan in a strategic way across the network. This group will oversee implementation of the Regional Service Plan and the National Clinical Programmes across the Network of hospitals and provide an engagement forum between the RDO and Senior Management Team and the Executive Clinical Directors in the South East.

We will be proceeding to appoint Executive Clinical Directors and Clinical Directors across the acute hospital system in HSE South in 2012. Executive Clinical Directors will be appointed to Model 3 and Model 4 hospitals. In addition, each acute hospital network will have Clinical Directors in each of four Clinical Directorates, i.e. medicine, perioperative, diagnostics and women and children. The Clinical Director will be based in the Model 4 hospital, but will have a role in service planning and clinical governance in respect of the services provided in that directorate across all hospitals in the network.

In Cork and Kerry, the Reconfiguration Forum provided an opportunity for consultation, discussion and consensus building which contributed significantly to the process of developing the *Roadmap for Acute Hospital*

Services, published in November 2010. As we progress implementation, and taking on board the emergence of the SDU and the national clinical programmes, the overall arrangements have been reorganised.

The Reconfiguration Forum is now re-established with new membership and terms of reference under the chairmanship of Prof John Higgins, Head of the College of Medicine and Life Sciences at UCC. The Forum will be a consultative and advisory body, which will provide the mechanism for engagement, consultation and advice to senior managers, clinical leaders and project managers involved in the reorganisation of the hospital services in Cork and Kerry to ensure that the process is in line with the vision and the principles of the *Roadmap.* A full programme of work will be finalised in Q1 as the new process is bedded in.

The Non-Executive Advisory Board remains in place and connections between the Advisory Board, the new Forum and the Regional Management Team have been strengthened with joint meetings and greater communication between key office holders. By linking the Advisory Board, the new Forum and the Regional Management Team in this way, we will be able to focus all the expertise at our disposal on the many challenges that confront us in implementing the roadmap and reorganising the hospital system in line with government policy.

Cork University Hospital Group (CUHG)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days – 4 additional Acute Medicine Physicians and 1 Consultant Radiologist additional resource assigned to support the implementation of this programme and the full operationalisation of the Acute Medical Assessment Unit. Fully implement the recommendations of the Acute Medicine Programme review undertaken in December 2011
- Emergency Medicine Programme (EMP) – Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care –2 additional ED Consultants assigned to support the implementation of this programme
- Surgery – Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures. This will be complemented by the implementation of The Productive Operating Theatre (TPOT) in all theatres and the opening of a Surgical Assessment Unit and Day of Surgery Admission (DOSA) Lounge. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.
- Fully implement the reorganisation of surgical services as led by Mr. Denis Richardson - Establish emergency surgery rota for all Cork hospitals, based in CUH, with access to an emergency theatre and to surgical assessment and admission unit.
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways & establishment of acute unit - 1 CNM2, .5 Physiotherapist, .5 Speech & Language Therapist assigned to support the implementation of this programme and the opening of Stroke Unit
- Epilepsy – Commence implementation of new regional Adult & Paediatric Epilepsy Centre - 2 Neurophysological Measurement Technicians, 10.5 nurses (incl. 1 Paediatric nurse) and 1 administrative post, assigned to support the implementation of this programme
- Neurology – Focus of this programme on reducing OPD waiting lists - 2 Consultant Neurologists and 1 Consultant Paediatric Neurologist assigned to support the implementation of this programme
- Acute Coronary Syndrome – Focus of this programme on ensuring timely and appropriate care for cardiac patients - 1 Consultant Cardiologist assigned to support the implementation of this programme. Detailed programme to be signed off at hospital, area and regional level
- Heart Failure – 2 nurses and .5 administrative post assigned to support the implementation of this programme
- COPD – Implementation of programme targets to reduce admissions and average length of stay (ALOS) - 1 Senior Physiotherapist, 1 nurse and .5 administrative post assigned to support the implementation of this programme. Detailed programme to be signed off at hospital, area and regional level
- Critical Care – 1.5 Nurses resource assigned to support the implementation of this programme. This resource will be made available initially to provide clinical care and when the audit of critical care services is ready to roll out, will be assigned to support the audit
- Engage with and support all Clinical Programmes as they come on stream for implementation
- Commissioning of new publicly owned M.R.I. Scanner
- Provision of PET scanner (Q2)
- Rollout of IMRT Radiotherapy Programme
- Implementation of 4 Clinical Directorates
- Commence infrastructure for the development of paediatric services to consolidate paediatric hospital services in CUH.
- Develop detailed implementation plan to consolidate medical oncology in CUH.

National Cancer Control Programme

- Transfer of Rectal, Prostate, Upper G.I. & Pancreatic Cancer from MUH to CUH. See separate National Cancer Control Programme section of this plan
- Transfer of Gynaecological Cancer service from SIVUH

Cork University Hospital Group (CUHG) Contd.

Small Hospital Framework

- Fully implement the small hospital framework as agreed for 2012 in respect of MGH and BGH, in particular transfer of agreed volumes of daycase activity to reduce pressure on CUH and to maximise the utilisation of MGH and BGH

Cost Management & Employment Control Measures

- Impact of capacity reduction to be mitigated through implementation of national clinical programmes, specifically Surgery and other associated programmes
  - Closure of 35 surgical beds
  - Reconfigure 35 beds from 7 day to 5 day
  - Seasonal closures and comprehensive structured annual leave
- Review of rosters and staffing levels
- Reduction in sick leave
- CUMH – Closure of 8 – 10 Postnatal beds on a rotational basis in Wards 3 South, 3 East and 2 East.
- Ongoing review and reduction of Medical Overtime / Agency
- Reduce on Call payments in Theatre, Cathlabs
- Reduce Agency staffing in Clinical Support Services
- Income generation and collection
- Pathology Efficiencies -reduced internal and external tests through revised protocols for ordering lab tests.
- Radiology efficiencies through
  - Implementation of Labour Court recommendations
  - Reduction in out of hours from opening of second Cath Lab
- Reorganisation of clinical administrative staff and structures through the implementation of the Clinical Administrative Secretarial Services (CASS) Project in CUH
- Non-pay Reduction:
  - Medical & Surgical appliances through reduced activity, price reductions and ongoing tight control on approvals
  - Medicines, review of usage and price reductions.
  - Other Non-pay savings, e.g. Admin expenses, Transport & Staff Travel, Laundry and Postage;

Improving our Infrastructure

- Full implementation of the Acute Medical Assessment Unit – Q1 2012
- CUH - Upgrading and refurbishment of existing Cardiac theatres to create additional trauma and emergency theatres – Q3 2012
- CUH - Refurbish an existing ward area to provide a surgical assessment and admission unit – Q3 2012
- CUMH - Upgrade of existing recovery area to create an Emergency Obstetric Theatre – Q1 2012

2012 Planned Activity

- **Inpatient:** 26,696 (CUH) 13,740 (CUMH) **Day Case:** 55,297 (CUH) 5,360 (CUMH)

Mallow General Hospital (MGH)

National Clinical Programmes, Service Development & Reorganisation

- Implementation of Small Hospital Framework
- Increase in volume and range of day surgery
- Commence Advanced Paramedic Rollout
- Open Local Injuries Unit
- Establish Acute Medical Assessment Unit
- Expansion of Endoscopy Services
- Establish dedicated patient transport services

Cost Management & Employment Control Measures

- Impact of volume reduction is being mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Seasonal closures and comprehensive structured annual leave
- Medical Roster Revision
- Review of Nursing Rosters
- General Support Services Initiative – revised Weekend Roster
- Non-pay Cost Reduction
- Pathology Restructuring
- Income generation – Car Parking

Improving our Infrastructure

- Acute Medical Assessment Unit – Q3 2012
- Day Procedures Unit - Endoscopy Suite (reorganisation of acute services) – Q3 2012

2012 Planned Activity

- **Inpatient:** 2,956 **Day Case** 3,500

Bantry General Hospital (BGH)

National Clinical Programmes, Service Development & Reorganisation

- Implementation of Small Hospital Framework
- Increase in volume and range of day surgery
- Rollout of outreach Endoscopy Service;
- Open Local Injuries Unit
- Establish dedicated patient transport services
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways - .5 CNM2 and .5 Dietician assigned to support the implementation of this programme

Cost Management & Employment Control Measures

- Impact of volume reduction is being mitigated through the implementation of National Clinical Programmes, service developments & Reorganisation outlined above, i.e. Surgery, Acute Medicine & ED and other associated programmes
  - Seasonal closures and comprehensive structured annual leave
- Review of nursing rosters and staffing levels
- Re-organisation of Staffing rosters to cover planned leave;
- Non-pay Efficiencies;
- Rolling 2011 Cost Containment Plans which will be carried forward into 2012, e.g.:
  - Reduction in Agency Costs:
  - Cessation in Theatre On-Call.

2012 Planned Activity

- **Inpatient** 1,889 **Day Case**: 1,725

South Infirmary Victoria University Hospital (SIVUH)

National Clinical Programmes, Service Development & Reorganisation

- Full implementation of reorganised orthopaedic service consistent with prospective funding programme
- Rheumatology & Orthopaedic — 2 Physiotherapists assigned to support the implementation of this programme
- Dermatology – 1 Consultant Dermatologist assigned to support the implementation of this programme
- Transfer of ophthalmology inpatient and day surgery from CUH
- Transfer of non cancer gynaecology from CUMH
- Fully implement the reorganisation of surgical services as led by Mr. Denis Richardson
- Elective Surgery Programme – programme focussed on implementing national ALOS and daycase targets for most common elective and inpatient procedures through the implementation of TPOT in all theatres. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters while having regard to normal clinical protocols.
- Conclude reorganisation of ED Department following completion of work of city-wide clinical group led by Dr. Colm Henry. Finalisation of this plan will be cleared by the Regional Management Team in consultation with the SDU and Acute Medicine Programme
- Fully operationalise regional Pain Medicine Unit
- Recommencement of Paediatric Orthopaedic Service

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Seasonal closures and comprehensive structured annual leave
- Increased income generation from
  - Increased day case designation
  - Increased focus on elective activity
  - Full year impact of bed closures in 2011
  - Reduction in replacement of staff on maternity leave
  - Reduce nursing agency costs
  - Reduction in medical overtime

Improving our Infrastructure

- Commence ophthalmology OPD facility

2012 Planned Activity

- **Inpatient**: 7,985 **Day Case:** 18,069

Mercy University Hospital (MUH)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days. Commence development of Acute Medical Assessment Unit and review the utilisation of medical beds with the support of the National Clinical Programmes and SDU team
- Establishment of Short Stay Medical Unit
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways & establishment of acute unit - 1 CNM2 and .5 Occupational Therapist assigned to support the implementation of this programme
- Emergency Medicine Programme - Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care
- COPD – 1 Physiotherapist, 1 nurse and .5 administrative post assigned to support the implementation of this programme
- Elective Surgery Programme – Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through implementation of TPOT in all theatres. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.
- Fully implement the reorganisation of surgical services as led by Mr. Denis Richardson
- Transfer specific non cancer surgery from CUH.
- Development of regional gastroenterology service
- Acute Coronary Syndrome - Focus of this programme on ensuring timely and appropriate care for cardiac patients
- Asthma – implementation of programme targets
- Establishment of Short Stay Medical Unit
- Implementation of plans for Gastroenterology services
- Full commissioning of Urgent Care Centre in St. Mary's Health Campus

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through implementation of national clinical programmes, specifically Surgery and other associated programmes outlined above
  - Closure of 1 theatre and 12 surgical beds
  - Closure of 6 paediatric beds
  - Seasonal closures and comprehensive structured annual leave
- Income Generation through increased occupancy of private beds
- Reorganisation of admin staff
- Non-pay Initiatives
  - Procurement pharmacy costs;
  - Contract renewals for MRI Service;
  - Insurance premiums;
  - Review of Leases

Improving our Infrastructure

- Upgrade existing ward at St. Mary's Health Campus to facilitate relocation of the Mercy University Hospital OPD to SMOH – Q4 2012

2012 Planned Activity

- **Inpatient:** 8,684 **Day Case:** 19,324

Kerry General Hospital (KGH)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days
- Emergency Medicine Programme - Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care
- Stroke – commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways & establishment of acute unit – 1 CNM2 and 1 Speech & Language Therapist assigned to support the implementation of this programme
- Rheumatology – 1 Consultant Rheumatologist assigned to support the implementation of this programme
- Diabetes – Continued roll out of this programme locally – 1.25 Podiatrists assigned to support the implementation of this programme
- Surgery - Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through implementation of TPOT in all theatres. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.

Kerry General Hospital (KGH) Contd.

- Acute Coronary Syndrome - Focus of this programme on ensuring timely and appropriate care for cardiac patients
- Obs/Gynae - Continued roll out of national programme elements e.g. policies and procedures issued by national lead. 4th Consultant Obs/Gynae post to be re-advertised.
- OPD restructuring – Implement national clinical guidelines e.g. process improvements / patient pathways
- Implementation of Clinical Divisions – Rollout locally
- Mapping & shaping delivery of medical services into the future
- CNU opening
- Establish & management of processes for patient transfers
- ICT Various initiatives e.g. NIMIS Qtr 3 2012
- Development of Endoscopy service in order to comply with JAG accreditation standards
- Reorganisation of Catering services - streamlining the catering process and utilising improved technology to enable the release of MTA staff to the wards from the Catering function. This will help to address service pressures on the wards and will also lead to more appropriate staffing levels in Catering, making the service more sustainable into the future
- Reorganisation of administration services - there are a number of initiatives currently underway which will lead to more efficiencies within the administration function and enable services to be maintained with fewer staff. These include the use of scanners for tracking records, the implementation of a new process for Interim Discharge Letters, the restructuring of the administration function focussing on more local decision-making and a revised arrangement for the maintenance of records on-site
- Focus on Absenteeism - a number of targeted initiatives aimed at bringing absence levels into line with national targets

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Seasonal closures and comprehensive structured annual leave
- Reduction in Medical Overtime
- Eliminate Consultant Locums in selected specialties
- Elimination of Agency NCHDs
- Elimination of nursing agency/OT and revisit nursing rosters
- Reduction in surgical/medical consumables
- Reduce security costs
- Negotiate price reduction for MRI's
- Reduce drug costs
- Income generation and collection

Improving our Infrastructure

- Emergency Department (phased) and AMAU

2012 Planned Activity

- **Inpatient**: 13,936 **Day Case**: 9,843

Waterford Regional Hospital (WRH)

National Clinical Programmes, Service Development & Reorganisation

In line with NSP 2012, WRH as the Regional Hospital and cancer centre for the South East will be adjusting its Inpatient and Daycase activity by a 3% reduction vs 2011 outturn. This reduction is based on 3.76% budget reduction and having regard to €8.4m core deficit for 2012. Activity levels for 2012 will be sustained at this modest reduction based on the implementation of the National Clinical Programmes and targets as specified in the NSP. The Emergency Medicine, Acute Medicine Programme, Elective Surgery Programme and NCCP Key Performance Indicators (KPIs) and the associated national targets for unscheduled and scheduled care in line with DoH/SDU policy are the key performance measures underpinning same.

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days and reduced ALOS – 2 additional Acute Medicine Physician posts (including 1 Consultant Endocrinologist) assigned to support the implementation of this programme
- Emergency Medicine Programme – Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care - 2 Emergency Medicine Consultants assigned to support the implementation of this programme
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways & establishment of acute unit – 1 CNM2 and .5 Physiotherapist assigned to support the implementation of this programme
- Elective Surgery Programme - Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through implementation of TPOT in all theatres. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.

Waterford Regional Hospital (WRH) Contd.

- Pilot Protected Surgical In-Patient Beds - Commencing January 2012
- Diabetes – Continued roll out of this programme locally in conjunction with AMP programme, a consultant physician with a special interest in Endocrinology (as outlined above) and 1.75 Podiatrist assigned to support the implementation of this programme
- Acute Coronary Syndrome – Focus of this programme on ensuring timely and appropriate care for cardiac patients - 1 Consultant Cardiologist assigned to support the implementation of this programme. The full year cost is being made available to the hospital, the post will be implemented on a half year basis from July to enable the detailed plan and programme of work to be agreed and the non-pay cost to be worked through
- Heart Failure – 1 Nursing and .5 administrative post assigned to support the implementation of this programme.
- Critical Care - .75 Nurse resource assigned to support the implementation of this programme. This resource will be made available initially to provide clinical care and when the audit of critical care services is ready to roll out, will be assigned to support the audit
- Neurology – Focus of this programme on reducing OPD waiting lists - 1 Consultant Neurologist assigned to support the implementation of this programme
- Dermatology – 1 Consultant Dermatologist assigned to support the implementation of this programme
- Rheumatology & Orthopaedics – 2 Physiotherapists assigned to support the implementation of this programme
- Short stay unit – diagnostics special initiative feasibility study
- Service Delivery Model for Gynae Cancer to be finalised

National Cancer Control Programme

- Rapid Access Prostate Service - Replacement of retired Consultant Urologist 2012 and the progression of a 2nd Consultant Urologist to meet Regional Urology requirements Post is to be progressed to support the increased demand for Urology Services from the commencement of the Rapid Access prostate Service in line with NCCP Policy at the end of 2011. Joint funding from NCCP and WRH agreed in respect of 1 post – 2nd Post will progress in second half of 2012 based on successful implementation of the overall plan.
- Gynae – Oncology Service - In line with the NCCP and Maternity Clinical Programme priorities as specified in the National Service Plan 2012 the Service Delivery Model for Gynae Cancer for the South East is to be finalised – Q3 2012
- Dermatology Skin Cancer Service - The 2nd Consultant Dermatologist is being processed for appointment in 2012. A new facility is being refurbished to accommodate the service expansion and will be completed in May 2012

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Closure of 25 surgical beds
  - 1 Operating Theatre Closure
  - 1 ICU – efficiencies generated through opening 4 HDU beds
  - 4 Paediatric inpatient beds.
  - Seasonal closures and comprehensive structured annual leave
- Clinical services internally will be aligned with the CCP and staffing reductions in line with impact of Resignations 2012. In addition to the reduced inpatient (25 beds) and Theatre capacity (2), 1 Intensive care Unit Bed (ICU) and 2 Paediatric Day beds will close. The impact of the ICU bed will be mitigated by the availability of the High Dependency Unit (HDU) which opened at end of 2011. The impact of the Paediatric Day Care bed reduction will be mitigated by efficiencies in line with the Elective Surgery and TPOT Clinical Programmes.
- Efficiencies in Regional Dept of Laboratory Medicine - These efficiencies will be achieved by introduction where possible of evidence based clinical protocols to standardise demand, optimise appropriateness of specialist testing and minimise duplicate testing to manage year on year increased demand across the acute and community services.
- Efficiencies in the medical pay budget - This initiative requires the restructuring of the Regional Vitreo Retinal Ophthalmic Service and the associated consultant post. Temporary Consultant Post with Special Interest Vitreo Retinal will cease end February 2012 and an alternative service delivery model will be progressed
- Further reduction in agency expenditure - Elimination of medical agency expenditure 2nd half of 2011 will apply for the full year 2012. Nursing agency, Laboratory Scientific staff and Catering Services costs will further reduce in 2012.
- Efficiencies in the use of high drugs cost in the acute settings
- Increase car park charges
- Income generation and collection
- In line with NSP 2012 priorities re services for Older People 5 WTE nursing staff and 2.5 WTE Healthcare Attendant Staff will be transferred to Waterford Community services to open up additional intermediate care capacity and reduce demand on acute hospital services.

Improving our Infrastructure

- ED extension including Neonatal Unit – Q4 2012

2012 Planned Activity

- Inpatient: 22,237 Day Case: 19,564

Wexford General Hospital (WGH)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days – 1 Acute Medicine Physician assigned to support the implementation of this programme
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways – 1 CNM2 and .5 Physiotherapist assigned to support the implementation of this programme
- COPD – 1 Physiotherapist (Respiratory), 1 nurse and .5 admin post assigned to support the implementation of this programme
- Diabetes – 1 Podiatrist assigned to support the implementation of this programme
- Acute Coronary Syndrome - Focus of this programme on ensuring timely and appropriate care for cardiac patients
- Heart Failure – 1 nurse and .5 administrative post assigned to support this programme
- Emergency Medicine Programme - Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care
- Elective Surgery Programme– Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through implementation of TPOT in all theatres. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.
- Pilot Protected Surgical In-Patient Beds - Commencing January 2012
- Short stay unit – diagnostics special initiative feasibility study
- Business Case for Special Initiative WGH 2012 (Development of Models of Care) – A business case is being prepared to establish the feasibility of developing a 10 bed short stay unit which would target a cohort of patients for diagnostic type procedure such as endoscopy, acute abdominal investigations and a range of other targeted procedures. Business case to be developed in Q1.

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
- Seasonal closures and comprehensive structured annual leave bringing inpatient, outpatient and day case activity in line with funded levels
- Further reduction in Locum costs equivalent to 15 WTEs across all service areas.
- Reduction in staff on call
- Increase car park charges
- Income generation and collection

Improving our Infrastructure

- Continue development of A&E Department, New Delivery Suite and Obstetric Theatre

2012 Planned Activity

- **Inpatient**: 14,890 **Day Case**: 9,300

St Luke's General Hospital incl. Kilcreene Orthopaedic Hospital (SLGH)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme - Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days – 1 Consultant Radiologist and 1 Consultant Respiratory & General Physician assigned to support the implementation of this programme
- Asthma – this programme will be supported by the new Consultant Respiratory Physician (AMP) and the existing Respiratory Nurse
- Acute Coronary Syndrome - Focus of this programme on ensuring timely and appropriate care for cardiac patients
- Diabetes – 1.25 Podiatrists assigned to support the implementation of this programme
- Emergency Medicine Programme - Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways - 1 CNM2 assigned to support the implementation of this programme
- Elective Surgery Programme - focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through continued implementation of TPOT and roll out to obstetrics / orthopaedics in all theatres. TPOT rolled out to Kilcreene during 2012. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.
- Obs/Gynae – the local implementation group is in place and is implementing guidelines in accordance with the national programme.
- Commence enabling works for the approved €13m Capital Project for the Susie Long Day Services Unit A/E&AMAU Q1 2012

St Luke's General Hospital incl. Kilcreene Orthopaedic Hospital (SLGH) Contd.

- NIMIS - Installation of digital & filmless systems for Radiology
- Roll out of New Born Hearing Screening as part of national project
- Continue the Depuy ASR recall at Kilcreene Orthopaedic Hospital and Prospective Funding Initiative
- Develop an integrated care model for Paediatric Diabetes Management
- Pilot for Productive Ward Surgical 2 ward (under the auspices of the NMPDU) and in line with national clinical programmes
- Day of Surgery Admission (DOSA) will reduce the average length of stay and will maximise the number of patients that can be treated while reducing the number of bed days used.
- A discharge lounge will be used as a DOSA admission area as promoted through TPOT.

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Reduction in costs in line with nationally agreed Laboratory & Radiology agreements under the PSA along with intensified demand management. AMP and Radiological programme will drive protocols to reduce any unnecessary demand.
  - Further seasonal closure (June – October) of 10 inpatient beds
  - Comprehensive structured annual leave
- Elimination of agency locums and more efficient rostering of NCHDs in line with the European Working Time Directive.
- Further reorganisation across all services to accommodate the impact of the moratorium
- Maximise contract savings on Laboratory Equipment, Radiology and Medical/Surgical consumables
- Income generation and collection
- Non pay efficiencies across all areas in terms of procurement efficiencies and minimising waste.
- Increased hospital staff canteen charges

Improving our Infrastructure

- Commence enabling works for the redevelopment of ED / AMAU and Day Service Unit (Susie Long Unit) in Q1 with construction commencing in Q3

2012 Planned Activity

- **Inpatient**: 13,487 (SLGH) 897 (KOH) **Day Case:** 11,545 (SLGH) 920 (KOH)

South Tipperary General Hospital (STGH)

National Clinical Programmes, Service Development & Reorganisation

- Acute Medicine Programme – Implementation of programme targets / focus on same day and early discharge i.e. within 0 to 2 days. The AMAU will continue to use initiatives to promote rapid diagnosis and admission avoidance, reducing emergency admissions and reducing ALOS for patients who are managed through the acute medical pathway.
- Emergency Medicine Programme - Implementation of the EMP to improve the safety and quality of care in EDs and to reduce waiting times for patients and to improve cost effectiveness in emergency care
- Stroke – Commence implementation of programme targets / reduce ALOS by 2 days over 3 years / Development of patient pathways – 1 CNM2 and .5 Speech & Language Therapist assigned to support the implementation of this programme
- Obs/Gynae – commencement of an early pregnancy assessment unit . Local implementation group is in place and is implementing guidelines in accordance with the national programme.
- Acute Coronary Syndrome - Focus of this programme on ensuring timely and appropriate care for cardiac patients
- Elective Surgery Programme - Programme focussed on implementing national average length of stay and day case targets for most common elective and inpatient procedures, through implementation of TPOT in all theatres. The continuation of ring fenced elective beds in the hospital's 5 day elective ward opened in September 2011 will produce further improvements in Day case rates, ALOS and Day of Surgery Admission (DOSA). Development of Surgical Assessment Unit and Admission Protocols for abdominal pain will be employed to create efficiencies in the emergency surgical pathway. Particular requirement to ensure that the organisation of surgical procedures is in line with the requirements of the SDU and that patients are seen in a chronological order to address the requirements of long waiters, while having regard to normal clinical protocols.
- NIMIS - Installation of digital & filmless systems for Radiology
- JAG accreditation of STGH Endoscopy Service
- Pilot site for endoscopy IT system rollout
- Diabetes - Pilot site for Integrated Care model for Diabetes management - this will involve the management of Diabetic patients outside of the acute setting through joint working and utilising an integrated approach with Community services and GPs
- Business Case for Special Initiative for STGH for provision of additional endoscopy and surgical capacity to address national waiting lists.

South Tipperary General Hospital (STGH) Contd.

Cost Management & Employment Control Measures

- Impact of volume reduction to be mitigated through the implementation of National Clinical Programmes, Service Developments & Reorganisation outlined above, in particular Surgery, Acute Medicine & ED and other associated programmes
  - Continued focus and improvements in elective and emergency patient pathways will enable the 10 beds closed in 2011 to be carried forward to 2012. The 5 day elective ward with ring fenced beds for both Surgical and medical Elective patients continues to improve Day of Admission targets
  - Through the management of minor surgery in alternative settings there will be a reduction in Day case activity
  - Seasonal bed & theatre closures and comprehensive structured annual leave
- Changes to NCHD rosters to reduce rostered overtime hours when on call, unrostered overtime and NCHD pay costs
- Reduction in Consultant Locum through management of capacity and demand for Scheduled care over a 43 week year to reflect Consultant leave allocation
- Income generation and collection
- Contract savings on Laboratory Equipment, Radiology and Medical/Surgical consumables

2012 Planned Activity

- **Inpatient:** 11,561 **Day Case**: 7,523

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	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
	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	Q2

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	model for community based rehabilitation services	
	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
	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*	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	Q4

Key Result Area	Deliverable Output 2012	Target Completion Quarter
the health services	incorporating the National Children's Hospital, Temple St.	
European Working Time Directive *for NCHDs*	Establish a National Working Group on EWTD	Q1
	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
Develop & maintain HSE policies, standards and guidance in Emergency Management	Develop ▪ Crowd event procedures ▪ Hospital Major emergency/ major incident plan template ▪ Revise the National Influenza Pandemic Plan ▪ Procedures for the management of Biological incidents ▪ Procedures for the management of Chemical incidents ▪ A National Weather plan Implement ▪ Crowd event procedures compliant with legislative requirements & HSE procedures ▪ Commence Hospital Major emergency/ major incident plan template compliance ▪ Procedures for the management of Biological incidents ▪ Procedures for the management of Chemical incidents ▪ Two Emergency Management exercises in each region(one of which must involve a CMT) ▪ Seveso site external plans in accordance with EU Directive and HSE National policy	 Q1 Q3 Q2 Q2 Q4 Q3 Q1 Q4 Q2 Q4 Each quarter Each quarter
Work with other response and their parent Gov Departments agencies to further develop national and regional interagency plans and procedures in Emergency management.	▪ Finalise interdepartmental & interagency reviews of Severe Weather Response. ▪ Improve System of National joint appraisal to deliver on regional compliance with the interagency Framework and its associated guidance and protocols ▪ Finalise Module 1 of the Interdepartmental Chemical, Biological, Radiological and Nuclear Protocol ▪ Develop and deliver on programs of interagency training ▪ Conduct 1 interagency exercises in each Region	Q1 to Q4 Q2 Q1 Q1 – Q4 Q2 & Q4

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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

Performance Activity	Expected Activity 2011	Projected Outturn 2011	Expected Activity 2012
	South	South	South
Discharges Activity*			
Inpatient	144,000	149,362	144,881
Day Case	163,000	160,884	156,057
% Discharges which are Public			
Inpatient	80% (National)	78% (National)	80% (National)
Day Case	80% (National)	85% (National)	80% (National)
Unscheduled Activity			
No. of emergency presentations	307,500	310,413	307,500
No. of emergency admissions	87,900	94,537	87,900
Outpatients Activity			
No. of outpatient attendances	714,700	No data available due to reclassification of metrics (National)	To be confirmed by Quarter 1 2012 (National)
Births Activity			
Total no. of births	74,200 (National)	73,490 (National)	73,216 (National)
Dialysis Modality			
Haemodialysis	1,650 – 1,740 (National)	1,670 (National)	1,760 – 1,870 (National)
Home Therapies	245 – 270 (National)	245 (National)	280 – 290 (National)
Total	1,895 – 2,010 (National)	1,915 (National)	2,040 – 2,160 (National)

*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
	National	National	National
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%

Performance Indicators	Target 2011	Projected Outturn 2011	Target 2012
% 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%
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	New PI for 2012	3.2	< 3.0

Performance Indicators	Target 2011	Projected Outturn 2011	Target 2012
hospitals per 10,000 bed days used		(Q2 data)	
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
	South	South	South
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% (National	56.9%	75% (National)
% of Clinical Status 1 DELTA incidents responded to by first responder in 7 minutes and 59 seconds or less	75% (National)	28.2%	75% (National)
% 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% (National)	80% by June 2012 85% by Dec 2012 (National)
% 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% (National)	80% by June 2012 85% by Dec 2012 (National)

National Cancer Control Programme

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.

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.

The National Service Plan has identified the following 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.

HSE South East – Cancer Programme Business Plan 2012

Key Result Areas

Key Result Area	Output 2011	Deliverables 2012	High level actions	Target Q Timescale
Lung Cancer Services	▪ Rapid Access Clinic fully operational ▪ EBUS is operational ▪ Resection rate improvements continued	• Explore the provision of surgical service to patients from HSE South East with CUH	• Monitor activity and KPI's • Steering Group Meeting with WRH/CUH to be reconvened in 2012.	Q1-Q4
Prostate/ Urology Cancer Services	▪ Rapid Access Clinics for prostate cancers in WRH established. ▪ Establishment of a Prostate/ Urology MDT ▪ Pathways for patients for assessment, diagnosis and treatment options established.	• Prostate cancer surgery consolidated at CUH for all of HSE South	• Monitor activity and KPI's • Monitor and review patient pathways • Consider the possibility of having a 1 stop RAC for prostate. (same day) • Progress the recruitment of Consultant Urologist(s) for HSE.SE • Launch of Rapid Access Prostate Referral form.	Q1 –Q4
Gynae – oncology	▪ Commence the process for the centralisation of gynae-oncology surgical service at WRH.	▪ Plan regional centre for Gynae oncology services	▪ Establish joint Gynae OncologyMDT's CUH/WRH.	Q2

Key Result Area	Output 2011	Deliverables 2012	High level actions	Target Q Timescale
Breast Cancer Services	▪ Recommendations from HIQA audit Implemented. ▪ Monitoring process in place for the HIQA standards ▪ Participated in national referral and triage audit	▪ Implement national protocols for family risk. ▪ Maintain Breast standards	▪ Monitor activity and KPIs	Q1-Q4
Rectal cancer services	▪ Rectal cancer surgical services centralise at WRH	▪ Monitor implementation and impacts on other surgical services in the region	▪ Monitor activity and KPIs ▪ Consolidation of the current single handed surgical services at WRH- Regional reorganisation of surgical /Rectal Cancer services.	Q1-Q4
Skin cancer services	▪ Service configuration and model agreed ▪ Refurbishment of new ambulatory area commenced	▪ Consultant Dermatologist appointed ▪ Establish a pathway for the Implementation of the NCCP referral forms for Melanoma and BCC	▪ Commission of ambulatory care area	Q1
Theatre/ICU/ Support	▪ Additional theatre, ICU/HDU and support staff provided to enable cancer surgical throughput in designated centre	▪ Cancer patients have access to appropriate/HDU care	▪ Monitor activity	Q1- Q4
Medical Oncology	▪ 3rd permanent Medical Oncologist to be appointed. ▪ Participated in NCCP national review of Medical Oncology drugs and resources. ▪ The business case for the new build cancer centre reviewed nationally.	▪ Review medical oncology services from a quality assurance and safety perspective ▪ Assist in the development of mechanisms for the management of the cancer drug budget within the Community (demand led) schemes section ▪ Adopt national protocols for drug usage and standardised practice as they become available	▪ Monitor capacity, utilisation and KPIs across region	Q1-Q4
Radiation Oncology	▪ SLA/contact for 2011 agreed ▪ Contact monitoring arrangements agreed and implemented ▪ Monthly review process in place	▪ 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. ▪ SLA for 2012 agreed ▪ Performance management framework established with WOA	▪ Monitor activity and KPIs ▪ Participate in capital planning process for phase 2	Q1-Q4
Quality and Safety; Expert Tumour Groups	▪ Lead clinicians participated in the national specialist clinical network	▪ Lead clinicians participation in cohesive national specialist clinical networks established by NCCP for the purpose of clinical audit, sharing of good practice and problem solving for breast, lung, prostate and rectal cancers	▪ Lead clinicians nominated to prostate, lung, breast and rectal cancer groups	Q1-Q4
Quality Care in the Community	▪ Proportion of electronic GP referrals increased ▪ Brief interventions with smoking cessations with primary care teams developed.	▪ Smoke Free Campus ▪ Promulgate use of standardised electronic referral processes developed for common tumours ▪ Enhance smoking cessation training for all health care professionals in partnership with primary care specialists ▪ Participate in delivery of community nurse training programme for cancer acre in	▪ WRH – Tobacco Free Working Group established- Tobacco free Campus at WRH 22ND February 2012. ▪ Pilot of Community Nurse Program being undertaken in Kilkenny. ▪ GP meetings facilitated by the cancer team at WRH continue to be held around the region.	Q1-Q4

Key Result Area	Output 2011	Deliverables 2012	High level actions	Target Q Timescale
		association with specialist services ▪ Work with local GPs and specialist services to deliver appropriate follow up care for common cancers in the primary care setting as per nationally agreed guidelines and protocols		
Governance Arrangements	▪ Performance management arrangements with Cancer centre agreed and implemented ▪ Implementation processes established for each tumour group	▪ Continue to consolidate regional and national clinical governance models in collaboration with NCCP ▪ Performance management system in place ▪ Resources to support cancer services at WRH identified and agreed	▪ Tumour specific governance groups in place with leads appointed ▪ Quarterly review meetings with GM and Clinical Director for each group ▪ Audit governance arrangements ▪ Monthly review meetings with Gm/Clinical Director and NCCP ▪ Mechanism for the migration of resources to the cancer centre associated with cancer moves agreed and implemented	Q1-Q4 Q1

HSE South West – Cancer Programme Business Plan 2012

Key Result Areas

Key Result Area	Output 2011	Deliverable 2012	High Level Actions	Target Q Timescale
Lung Cancer Services	▪ Rapid Access Clinic for lung cancers in CUH fully operational	▪ Continue integration of existing service at MUH ▪ Improve access to surgery ▪ Resection rate improvements continued ▪ Scope potential for the development of surgical services for patients from HSE SE	▪ Monitor activity and KPIs ▪ Develop streamlined pathway to surgical services ▪ Develop business case to support development of surgical services	Q1 –Q4
Urology Cancer Services	▪ Outreach RAC service established at WRH ▪ Patients pathway and MDM process agreed	▪ Rapid Access Clinics for prostate cancers in CUH established. ▪ Integration of existing service at MUH ▪ Prostate cancer surgery consolidated at CUH for all of HSE South	▪ Monitor activity and KPIs	Q1
Upper GI	▪ Pre-destination of CUH as upper GI cancer centre	▪ Predestination of CUH as upper GI cancer centre	▪ Transfer upper GI Cancer Surgery from MUH to CUH ▪ Monitor activity and KPIs	Q3
Pancreatic Surgery	▪ Satellite centre of the national centre for pancreatic surgery established at CUH, fulfilling all the requirements of the Service agreement for the service	▪ Complete establishment of pancreatic satellite unit in CUH linking into St. Vincent's National Centre	▪ Transfer pancreatic cancer surgical services from MUH to CUH ▪ Establish single MDM ▪ Participation in national oversight committee ▪ Monitor activity and KPIs	Q1
Rectal cancer services	▪ Project team in place planning service move ▪ Equipment purchased	▪ Complete transfer of rectal cancer surgery into CUH from KGH and MUH	▪ Monitor implementation and impacts on other surgical services in the region ▪ Monitor activity and KPIs ▪ Establish single MDM	Q1
Brain Tumour service	▪ Lead consultant neurosurgeon appointed ▪ KPIs agreed and monitoring and review process in place	▪ Joint processes for the operation of service across two sites agreed and implemented	▪ Establishment of joint MDM ▪ Monitor activity and KPIs	Q1 – Q4

Key Result Area	Output 2011	Deliverable 2012	High Level Actions	Target Q Timescale
Head and Neck cancer services		▪ Analyse scope of cancer head and neck services	▪ Establish project team to plan service transfer	Q3
Gynae – oncology	▪ Plan developed to centralise gynae-oncology surgical service at CUH ▪ Commence works on theatres at CUMH	▪ Plan regional centre for Gynae oncology services	▪ Centralise gynae oncology services at CUH ▪ Monitor activity and KPIs	Q3
Skin Cancer Service	▪ National guidelines piloted at CUH ▪ Additional Oncoplastic consultant surgical post approved	▪ Implement national referral and treatment guidelines ▪ Appoint additional consultant Oncoplastic surgeon	▪ Roll out and communication of guidelines and referral pathways ▪ Agree configuration of onco plastic consultant surgeon post in consultation with NCCP, CUH and SIVUH	Q1 Q1
Breast Cancer Services	▪ Recommendations from HIQA audit Implemented ▪ Participate in national referral and triage audit	▪ Maintain Breast standards ▪ Implement national protocols for family risk	▪ Monitor activity and KPIs ▪ Audit links with Kerry service with view to developing early discharge programme for Kerry patients (1 WTE beast care nurse in Kerry)	Q1-Q4
Theatre/ICU/ Support	▪ Additional theatre, ICU and support staff provided to enable cancer surgical throughput in designated centre. New unit with 6 ITU/HDU beds commissioned	▪ Cancer patients have access to appropriate ITU/HDU care	▪ Monitor activity	Q1-Q4
Medical Oncology services	▪ Agreement reached on the provision of Medical Oncology Services across the region	▪ Plan for the centralisation of Medical Oncology Services developed and approved ▪ Participate in review of medical oncology services from a quality assurance and safety perspective ▪ Assist in the development of mechanisms for the management of the cancer drug budget within the Community (demand led) schemes section ▪ Adopt national protocols for drug usage and standardised practice as they become available	▪ Plan approved by RDO and funding secured ▪ Monitor activity and KPIs	Q1
Radiation Oncology services	▪ Participated in the National performance management and monitoring system ▪ Implementation of review recommendations completed ▪ Project for the development of IMRT and Prostate Brachytheapy funded and commenced	▪ 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. ▪ Participate in the development of the National Radiation Oncology Network by: ▪ Implementation of national clinical guidelines and standards ▪ Implement of national performance management and monitoring system ▪ Implement national programme for Prostate Brachytherapy.	▪ Participate in Phase 2 development ▪ Implement IMRT ▪ Implement Prostate Brachtherapy ▪ Adopt national clinical guidelines as they become available and implement tumour specialisation ▪ Monitor activity and KPIS	Q1 –Q4 Q3 Q4 Q1 – Q4
Quality and Safety; Expert Tumour Groups	▪ L ead clinicians participated in national specialist clinical networks	▪ Lead clinicians participation in cohesive national specialist clinical networks established by NCCP for the purpose of clinical audit, sharing of good practice and problem solving		Q1 –Q4

Key Result Area	Output 2011	Deliverable 2012	High Level Actions	Target Q Timescale
		for breast, lung, prostate and rectal cancers		
Quality care in the community	▪ Proportion of electronic GP referrals increased ▪ Practice and community nurse training programme developed. ▪ GP and practice nurse education evenings held	▪ Promulgate use of standardised electronic referral processes developed for common tumours ▪ Enhance smoking cessation training for all health care professionals in partnership with primary care specialists ▪ Participate in delivery of community nurse training programme for cancer care in association with specialist services ▪ Work with local GPs and specialist services to deliver appropriate follow up care for common cancers in the primary care setting as per nationally agreed guidelines and protocols	▪ Develop local policy for the support of patients requiring breast prosthesis ▪ Participate in GP education events ▪ Participate in community nursing education events ▪ Provide brief interventions training	Q1-Q4
Governance Arrangements	▪ Agreed performance management arrangements with NCCP implemented ▪ Clinical leads appointed for Lung, Prostate and Rectal Cancer Services	▪ Continue to consolidate regional and national clinical governance models in collaboration with NCCP ▪ Performance management system in place ▪ Resources to support cancer service moves into CUH identified and agreed	▪ Tumour specific governance groups in place with leads appointed ▪ Quarterly review meetings with CEO and EMB for each group ▪ Audit governance arrangements ▪ Monthly review meetings with CEO/Clinical Director and NCCP ▪ Mechanism for the migration of resources to the cancer centre associated with cancer moves agreed and implemented	Q1-Q4 Q1
PET Scanner CUH	▪ Contact for managed services gone to tender	▪ PET service operational		

National Performance Activity and Performance Indicators

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	National	National	National
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

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
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's 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 nationally for this scheme in 2012.

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 packages enabling those with more complex care needs to remain or return to home. There will also be an ongoing re-focusing of home help services to prioritise personal care provision and essential household duties. We will also work on optimising the provision and quality of residential care.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	83.727	79.991
Kerry	38.004	36.240
Carlow /Kilkenny/Sth Tipp	40.098	38.166
Waterford/Wexford	35.216	33.693
Regional	1.800	1.732
Total	198.845	189.822

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	1,239	1,247
Kerry	395	382
Carlow /Kilkenny/Sth Tipp	557	540
Waterford/Wexford	552	535
Total	2,743	2,704

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 re-allocating funding to increase intermediate care capacity, i.e. step-up / step-down beds, and to maximise 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.

The National Service Plan has identified the following 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 2012. 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 the 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.

Model of Care

With the development of integrated care processes across hospital and community there is a need to ensure that older people with complex care needs are supported appropriately through the developing PCTs and with appropriate access to specialist care by way of Consultant Geriatrician input. Overall there is an increase in the levels of dependency of older people living at home and receiving significant and multi disciplinary service levels. This is leading to an increase in shared care arrangements across hospital and community and such a model of integrated care requires that all components are well coordinated and provide the older person in need of such care with an appropriate pathway to support their choices and needs. This will be the focus of the emerging clinical programme for older people services.

The ongoing roll out and development of the integrated model of care is ensuring that the various options within residential care, particularly in relation to rehabilitation and convalescence will be best utilised, to ensure that they provide value for money and that those in need of such services receive them as a matter of priority.

While there will always be a need for older people to access acute hospital care it is vital that once the acute episode has been addressed, they can access the appropriate service at home or by way of rehabilitation etc to ensure that they can maintain or improve their level of independence.

The requirement for access on referral to specialist medical services including consultant geriatricians or consultants in the psychiatry of old age is crucial to supporting older people to stay at home in their community for as long as possible and also for supporting the decision making process in relation to the need for the older person to access residential care. The developing primary care teams will need access to such specialist services to provide diagnosis and guidance with treatment for the older person.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum

In 2012 we will:

- Provide 3.62m home help hours (4.5% reduction on 2011 outturn). Home Help service provision will be reviewed using the following criteria
  - No current recipient of home help service who has an assessed need for the service will have it fully withdrawn
  - The review will try to ensure that recipients who receive assistance with personal care needs are prioritised and that any reduction of service will be in the lesser priority area of household duties
  - The home help service will be available to new recipients who have a requirement based on assessed need and within the available resources
  - Some recipients may have the level of home help service increased rather than reduced
- Maintain approximately 15,000 clients in receipt of home help services
- Maintain existing levels of home care package services – target of 2,425 people
- Provide over 7,600 day care places in 75 day care centres
- Maximise the reorganisation of rostering, reduction in overtime and agency, and increase skill mix and other measures
- Provide over 2,100 public residential care beds in 40 units (including the new Tralee CNU) providing long stay beds and short term respite, rehabilitation and convalescent care. Having regard for the NSP 2012 and the provision of public residential care for older people predominantly, each of the 4 Areas across the HSE South has undertaken a comprehensive assessment of capacity and resource availability associated with this service for the coming year. The areas undertook the review based on a number of factors :
  - Demand for beds particularly choice of care by applicants for long stay beds through the Nursing Home Support Scheme (Fair Deal) process
  - Estimated number of retirements of care staff to end of February 2012 and to year end
  - Cost of care in the unit and the potential / need to economise through roster changes and skill mix adjustments
  - Audit of compliance of each unit with current and future HIQA environmental standards and in particular Fire Safety Standards and Legislation
  - Review of HIQA inspection reports by unit to identify improvements required to meet standards particularly care related issues
  - Cost of level of agency/cost containment and requirements for 2012

- % occupancy of all public beds (long stay and community supports) and profile and trend of patient use of these beds

Following the analysis and based on the above criteria it is the intention in HSE South to retain the existing 39 public residential units and to open an additional unit in Kerry in 2012, providing a capacity of over 2,100 beds across these 40 facilities.

This would see a reduction of 128 beds from the position at the beginning of the year when there was 2,273 beds available. However, there is potential to have additional capacity available in Cork and Kerry with the opening of Tralee CNU and the full operation of Heather House, Farranlea Road and Ballincollig CNU in Cork.

In addition, in relation to the provision of welfare homes it is proposed to close 10 welfare home type beds in St. Francis Welfare Home Fermoy with the staff in this facility being relocated to Fermoy Community Hospital thereby ensuring no bed closures in Fermoy Community Hospital in 2012. As part of this proposal consideration is being given to the development of an Alzheimer's day service on a two day week basis while also continuing to develop the use of the building for community based services. A consultation process will commence immediately in relation to this proposal.

Cost Management & Employment Control Measures

The budget reduction for older people services in the South amounts to €8.959m which represents a 4.5% reduction. The cost management measures necessitated by the reduced funding available for older people services in 2012 are summarised below. Every effort will be made to ensure that the impact on services is minimised i.e. We will maximise the reorganisation of rostering, reduction in overtime and agency, and increase skill mix and other measures where appropriate, to limit impact on frontline services

- Reduce Home Help Hours – 4.5% reduction on 2011 outturn. This represents a reduction of 170,000 hours - This reduction in hours will lead to a refocusing of the service towards patient care activity and essential domestic duties.
- **Public Residential Beds:**

  Following the comprehensive assessment undertaken utilising the criteria outlined above, the position in relation to bed closures in HSE South has been revised downwards from a proposed minimum figure of 180 to a minimum reduction of 128 public residential care beds with a maximum of 210 in 2012. The successful implementation of our change programme and implementation of the model of care for older people will be a critical factor in enabling HSE South to minimise the impact on public long stay bed provision and full cooperation will be required from all stakeholders if this is to be achieved.

  An important factor in the overall consideration of residential care bed closures was the fact that 101 of the 128 beds proposed for closure are currently vacant due to the demand for the Nursing Home Support Scheme, HIQA environmental standards, staff retirements etc.

  Initial details of bed closures are set out below:

Carlow/Kilkenny & South Tipperary: 60 bed closures

- St. Columba's Hospital (26 beds)
- Sacred Heart Hospital (14 beds – includes 4 respite beds to relocate to Carlow District Hospital)
- Carlow District Hospital (10 beds)
- Castlecomer District Hospital (10 beds)

Cork: 22 bed Closures

- Kanturk Community Hospital – 8 beds
- Midleton Community Hospital – 14 beds

Waterford/Wexford: 15 bed closures

- New Houghton Hospital (2 beds)
- Dungarvan Community Hospital (13 beds)

Kerry: 31 bed closures

- Listowel Community Hospital (17 beds)
- Loher / Dinish Ward, Kerry General Hospital (3 beds)
- St. Columbanus, Killarney (11 beds)

- **Waterford**

  St. Patrick's Hospital: 6 short stay beds were closed in St. Patrick's in Waterford city in October 2011 and these will be reopened on a phased basis in Q1 2012

  Dungarvan Community Hospital: 16 short stay beds were closed in Dungarvan in October 2011. Funding is being provided by HSE South to enable these beds to be reopened on a phased basis in Q1 2012 which is in line with the national policy direction and the overall needs of the area. The overall package will involve the redeployment of 7 staff from WRH to Dungarvan to support the opening of the beds.

  At the same time, as a result of staff retirements in Dungarvan due to the grace period etc. it will be necessary to reduce the number of long stay beds provided by 13 beds. This will be achieved through the reorganisation of existing services in Dunabbey House and an overall reorganisation of the beds in

the area. This shortfall in long stay beds will be compensated over the coming months with the opening of private nursing home beds in Waterford.

To ensure that this overall change is implemented in the most effective manner a specific review of bed usage, required designation and the potential to transfer resources across the service will be undertaken to determine the actual number and type of beds that will be provided in public facilities in the area during 2012. This review will be completed by the end of Q1 2012.

- **Carlow/Kilkenny**
  There are a total of 60 temporary bed closures in the Carlow/Kilkenny area at present - the majority of these beds have been closed for an extended period of time. The existing number of beds continues to meet the demand for both short and long stay care. While the demands placed on the service through staff retirements will be considerable, existing service levels will be maintained through the development of efficient rostering systems and a skill mix model that will continue to meet the needs of older people in care. A continuous review of bed usage will be undertaken to ensure that the current mix of short and long stay beds is appropriate to meet the service needs and this mix may be amended as required.

- **Kerry**
  West Kerry Community Hospital: Currently there are 6 temporary closed beds of the total number of 46 in the hospital, the beds are closed due to staff retirements. A change of rostering arrangements is required and with some additional nursing resource provided through redeployment, it is the intention to reopen all of the 46 beds by end of Q1 2012, matching the level of demand.

  Listowel Community Hospital: The overall bed numbers in LCH are currently at 36 with an overall reduction of 17 beds from the original 53. Following a change of roster and adjusting the skill mix arrangements there is potential to reopen some of the 17 beds in the hospital.

  Killarney Community Hospitals (incl. St Columbanus Home): The reduction in the overall bed number of 11, will see 135 beds remaining in place across the two sites. The 11 beds have been temporarily closed for a number of months, and the current bed numbers remaining match the demand for long stay beds in particular. Though there are a significant number of retirements, resources have been concentrated in the service to minimise bed closures, as the roster arrangements and skill mix measures have been deployed successfully in previous years.

- **Cork**
  Clonakilty Community Hospital: Provision was made in the 2011 service plan for the closure of 16 beds in Clonakilty Community Hospital as part of the overall reorganisation of services in the hospital and having regard to the demand for beds under the Nursing Home Support Scheme. These 16 beds are currently vacant in the hospital and it is intended that these beds would close permanently in 2012. The remaining beds will be reorganised in a more efficient manner supported by a more effective roster arrangement thereby maximising overall service delivery within the hospital and in other public residential care facilities in the vicinity.
  St. Finbarr's Hospital, Cork: A significant transfer of residential beds is being undertaken from the unit as part of the opening of the Farranlea Road CNU - to be completed by March 2012. A review of the remaining services in St. Finbarr's Hospital will also be undertaken. There will be consolidation of the remaining bed numbers in the hospital and the overall bed capacity will be finalised in this context. This may see an overall reduction of bed numbers at St. Finbarr's Hospital.

- **Welfare Home Beds:**
  St. Francis Welfare Home, Fermoy: A consultation process will be undertaken with regard to the future of the residential care services at St. Francis Welfare Home with a proposed closure of 10 welfare home type beds in this facility and the staff being relocated to Fermoy Community Hospital thereby ensuring no bed closures in Fermoy Community Hospital in 2012. As part of this proposal consideration is being given to the development of an Alzheimer's day service on a two day week basis while also continuing to develop the use of the building for community based services. A consultation process will commence immediately in relation to this proposal.
- Revision of rosters and skill mix across Community Hospitals based on a standard model approach - work will be undertaken with the Directors of Nursing to review rosters and skill mix etc. in order to minimise the impact of the moratorium and the reductions in agency usage necessary to operate within available resources. Where changes to rostering arrangements etc. are required, a consultation process will be undertaken with staff representative associations involved under the terms of the public service agreement.
- Reduction in Voluntary Agencies funding – voluntary agencies will be required to identify and implement efficiencies and economies to ensure service provision is maximised and prioritised.
- Efficiencies to be achieved in the following areas:
  - Aids and Appliances and multi disciplinary supplies – maximise the available resource through prioritising provision, availing of all opportunities to procure products as cheaply as possible without

compromising on quality and through careful management of recycling of stock, reviewing criteria and procedures for provision of some items etc.
- Nursing Supplies e.g. reduce the cost of supplying incontinence products to Nursing Homes based on a review of procedures, pricing etc.
- Initiatives in relation to the management of wound care and optimisation of appropriate use of dressings

Service Improvements

- Roll out of Home Care Package approved provider list of voluntary and private home care providers which will introduce clear national minimal standards for the delivery of home care services as part of a home care package.
- Establish regional office for the processing of applications for the Nursing Home Support Scheme – this will assist applicants for the scheme through the provision of information, up date on progress of the application process etc. for the four areas in HSE South.
- Implement National Home Help Guidelines which will introduce a standardised and consistent approach to the delivery of home help services
- Occupational Therapy Project in Dementia Care working in collaboration with carers and the Alzheimer's Association in Cork
- Establish regional group to review rosters and skill mix in public residential units so as to ensure that the services provided are optimised to meet the needs of the residents. This group will be chaired by a member of the Regional Management Team and its work will include the review of beds planned for the Waterford Area and St. Finbarr's Hospital, Cork

Improving our Infrastructure

- Capital projects that are to be completed and / or to become operational in 2012
  - Phased opening (from December 2011) of Farranlea Road Community Nursing Unit, Cork
  - Heather House and Ballincollig Community Nursing Units, Cork to be fully operationalised.
  - Opening of Tralee Community Nursing Unit, Kerry
  - Kenmare Community Hospital, Kerry – ongoing construction of 40 bed community nursing unit which commenced in Nov 2011

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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. HSE South	Ongoing

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	▪ The figure of 180 proposed bed closures in the NSP was based on preliminary estimations of staff numbers retiring and on a broad assessment of potential service reduction. The regional service plan figure of a minimum closure of 128 beds is based on more up to date information on numbers retiring, and on ongoing negotiations with regard to alternative rostering arrangements in key locations which has reduced the overall number of bed closures estimated.	
	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
	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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
Home Care Packages* Total no. of persons in receipt of a HCP	2,345	2,425	2,425
No. of HCPs provided	1,304	1,304	1,304
No. of new HCP clients	1,000	1,184	1,100
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	3.9m	3.79m	3.62m
No. of people in receipt of home help hours (excluding provision of hours from HCPs)	14,700	15,681	15,053
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 under NHSS in long term residential care at end of reporting month	Baseline to be set	6,157	Centralised scheme in 2012 - 23,611
No. and proportion of those who qualify for ancillary state support who chose to avail of it	Baseline to be set	1,004.8	Demand-led
% of complete applications processed within four weeks	100%	100%	100%
Subvention and Contract Beds No. in receipt of subvention	Dependent on uptake of NHSS	320	275
No. in receipt of enhanced subvention	Dependent on uptake of NHSS	240	220
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	2,420	2,170-2,240
Elder Abuse No. of new referrals by region	Demand-led	574	770
No. and % of new referrals broken down by abuse type: i). Physical	Baseline to be set	75	---
ii). Psychological	Baseline to be set	188	---
iii). Financial	Baseline to be set	130	---
iv). Neglect	Baseline to be set	111	---
No. of active cases	New PI for 2011	803	---
% 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

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.

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.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	75.514	70.660
Kerry	22.191	20.743
Carlow /Kilkenny/Sth Tipp	52.428	49.078
Waterford/Wexford	37.361	34.942
Total	187.494	175.423

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	1,026	994
Kerry	314	305
Carlow /Kilkenny/Sth Tipp	777	753
Waterford/Wexford	494	478
Total	2,611	2,530

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.

Notwithstanding the reduction in budgets and staff numbers across the service in 2012, in line with the Programme for Government, the Minister of State with responsibility for Mental Health has ring fenced €35m nationally for investment in mental health services. This funding 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. A national process has been put in place between the HSE, The DoH and the Minister's office to oversee the allocation of the resource, from which it is anticipated that an appropriate allocation of the funding will be provided to HSE South to support the overall change programme being implemented in line with *Vision for Change* and which also will assist in addressing gaps in service that may have arisen. This funding will assist in mitigating the impact of the overall budget reductions including reductions arising as a consequence of the impact of the efficiency, procurement and moratorium savings which will be applied.

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.

HSE South is fully committed to utilising the provisions of the Public Service Agreement to deliver better health outcomes in a more cost efficient service delivery model. We will reorganise existing resources to achieve the optimal match between staffing levels, service activity levels and dependency levels across the working day/week/year.

The National Service Plan has identified the following 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 Intellectual 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.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Reorganisation of Mental Health Services in line with *A Vision for Change*

Across the HSE South, Mental Health services are provided for people of all ages who need specialist assessment, care and treatment for mental illness. The priority for HSE South is to ensure the provision and delivery of a first class mental health service for all. The *'Vision for Change' National Policy document on Mental Health* details a comprehensive model of mental health service provision for Ireland and in keeping with this policy direction, the HSE South plan for Mental Health Services includes a range of measures aimed at improving service user health, independence and experience and, at the same time, continuing to reorganise service delivery to ensure increased efficiency. In line with the modernisation and reorganisation of services envisaged in Vision For Change, HSE South continues to accelerate the programme of closure of old long-stay institutions, reduce dependency on inpatient beds and prioritise the development of community based Mental Health Services across the four areas.

In doing so, our strategic objectives are to:

- Support people's recovery from mental illness so that they can gain as much independence as possible.
- Continue to develop community-based services.
- Provide access to appropriate primary/ community and secondary care services in a timely manner.
- Work in partnership with service users, carers, primary care and colleagues both statutory and voluntary.
- Advance the national and local governance arrangements.
- Develop the workforce, buildings and information systems to support improved and cost-effective care and treatment.

HSE South is committed to ongoing consultation and engagement with all key stakeholders in relation to the development of Mental Health Services including service users and representatives, staff, and local representatives. Consultation and engagement will be ongoing in 2012 and will continue to be a critical element in the development and roll out of plans. Vision for Change advocates a move towards a recovery orientation: 'A recovery approach to mental health should be adopted as a cornerstone of this policy' (A Vision for Change, p. 15). This is where it recognises that the primary knowledge of mental health is with the service users and the secondary knowledge is supported by the providers. HSE South is committed to the development of a recovery orientation in the development of services. The promotion of positive mental health spans all life stages, and in conjunction with early intervention and treatment can facilitate improved outcomes. HSE South Mental Health

Services include a broad range of acute, community and specialised inpatient services for children and adolescents, adults and older people.

Executive Clinical Directorate Model

In line with VFC recommendations 4 Executive Clinical Directors (ECDs) have been appointed in the HSE South. They have been selected to lead on the development of Executive Clinical Directorates in Mental Health based on revised catchment areas serving populations of approximately 300,000 or more as recommended in *Vision for Change*. Within the mental health service, the change management role of Executive Clinical Directors and the related Clinical Directorate will provide a clear focus to drive service quality and the implementation of the recommendations of VFC. The ECD, with the Mental Health Management Team will bring leadership, governance and accountability in shaping the direction of the mental health services within the four areas in HSE South

HSE South Implementation of Vision for Change

In planning the implementation of Vision for Change in HSE South there were significant challenges to be faced in the South East which required urgent reorganisation of the service both to meet the standards of Vision for Change, and to address the deficiencies identified in a number of key reports including the Section 55 Report, the Annual Reports of the Inspector of Mental Health Services and in ongoing engagement with the Mental Health Commission.

In this regard a decision was made to target the South East initially for development. This focus on the South East has resulted in significant levels of progress in the development of Implementation Plans for both Carlow / Kilkenny & South Tipperary and Waterford / Wexford and significant progress has been made to date in the implementation of these plans including the closure of beds in old institutions and transfer of patients to more appropriate settings, infrastructural developments, reduction in acute beds and development of community based services. Given the significant change process which has been undertaken it is important to acknowledge the progress which has been made as both areas are at an advanced stage in the implementation of Vision for Change.

It is important to acknowledge that in progressing the implementation of Vision for Change, choices have had to be made around the prioritisation of developments and in that context HSE South prioritised South Tipperary, Waterford and Wexford over other areas in the region as the need was greater there.

In particular the capital funding to date has been prioritised to these locations to support the change programmes in these locations and we have not had available to us the resources required to finalise the closure of St. Finan's Hospital in Kerry or the development of community based infrastructure in South Lee. At the same time we have made progress across the whole region in terms of the development of teams and some key specialist services.

Reduction in bed complement in line with *A Vision for Change*

A key priority for the HSE South has been to shift the model of care from the old long stay institutions to the development of a comprehensive community based service. This allows a shift in focus of the resources available which can deliver enhanced user outcomes. At the same time we have continued to focus on the reorganisation of acute inpatient services in line with Vision for Change recommendations. Progress is being made on all these fronts including:

- The transfer of the North Tipperary Acute Service from St. Michael's Unit to HSE West was completed in October 2011. 20 beds closed in St. Michael's unit in October 2011.
- St Dympna's hospital in Carlow closed its long stay beds in October 2011 with patients re-accommodated in other more appropriate settings according to their needs.
- Closure of remaining long stay wards in St Canice's Hospital Kilkenny.
- Work is continuing to relocate the patients in St Luke's, South Tipperary and with the completion of the CNU in March 2012 and the Community Residences in June 2012, St Luke's will close as an approved centre.
- Patients currently resident in St Senan's Wexford will be accommodated in the new developments due to be completed in 2012 which include the development of a new CNU & a number of Community Residences.
- St Finan's hospital Kerry will no longer take direct admissions or transfers of patients from the acute unit at Kerry General Hospital. Long stay beds will continue to be reduced with the closure of a female ward and with 10 high dependency beds remaining within the main building. The female patients in the ward that is being closed will transfer to more appropriate accommodation either on site (O'Connor unit or community residences).
- South Lee – St Monica's ward in St Finbarr's Hospital closed its 13 long stay beds.

In respect of HSE South, Vision for Change recommendations in respect of acute inpatient beds of 50 beds per 300,000 population indicate a requirement of 193 acute inpatient beds for the South. At the beginning of 2011 we had 352 beds in place (159 above the recommended number). There are now 301 following the closure of acute beds in St Senan's (31 in April 2011) and the reduction of beds in St Michael's Clonmel (20 in October 2011). In 2012 additional bed reductions are planned so that services can be re-orientated towards the development of the community based model of service.

Development of Community Mental Health Facilities in Primary Care

In the development of Primary Care Centres in HSE South facilities for Mental Health are being accommodated where required. This can be dedicated space in some Primary Care Centres or bookable rooms for visiting clinicians. Centres in a number of areas have been completed and Mental Health Services has dedicated accommodation in locations such as Mallow Primary Care Centre in Cork or Ayrfield Primary Care Centre in Kilkenny, the soon to be developed primary care centre in Kenmare and access to bookable rooms if required in locations such as Gorey Primary Care Centre.

Developments in the following areas are progressing and are at different stages of development: Macroom, Clonakilty, Fermoy, Charleville, Schull, Ballincollig, Blackrock, Listowel, Newmarket, Kilkenny, Callan, Waterford City, Dungarvan, Enniscorthy, New Ross, Tipperary, and Clonmel. As Centres are completed facilities for Mental Health services will be accommodated where required

Service User Involvement

As part of the overall process the development of the service user role is a fundamental component of the model we are developing in the South. Formal arrangements have been put in place with the National Service Users Executive (NSUE) to develop a comprehensive framework for service user involvement over the next few years.

National Clinical Programmes

Implementation of the new national approaches being developed under the leadership of Dr. Ian Daly and Mr. Martin Rogan, Assistant National Director Mental Health Services will support the delivery system with the implementation of Vision for Change. The implementation of such national programmes will assist the service in addressing service variability across each area as well as standardising our approaches and planned outcomes.

Service Quantum

In 2012 we will provide:

- 241 acute inpatient beds – reducing acute inpatient capacity in line with A Vision for Change norms through the reduction of 60 acute inpatient beds
- 20 inpatient Child and Adolescent Mental Health beds
- 317 long stay beds (and an additional 59 rehab beds and 29 low secure beds) representing a reduction of 62 beds
- 709 residential places in low/medium/high support community residences representing a net increase of 41 places
- 267 day hospital places representing an increase of 84 places due to developments in Carlow/Kilkenny/South Tipperary and Waterford/Wexford areas
- 610 day centre places
- 27 General Adult Community Mental Health Teams – including the newly amalgamated CMHTs in Carlow, Kilkenny and South Tipperary
- 13 Child and Adolescent Mental Health Teams, 1 Liaison Psychiatry Team (CUH), 6 Community Rehabilitation Teams, 5 Psychiatry of Later Life Teams
- Accommodate clients in more appropriate care settings. Staff released by the reorganisation will be redeployed to support the development of the community service including the filling of vacancies to agreed levels. This will place increased pressure on acute services which will have to be addressed by an investment in community based services through the additional resource now being provided.

Cost Management & Employment Control Measures in Mental Health Services

The budget reduction for mental health services in the South amounts to €11.455m which represents a 6.1% reduction. There are 124 WTE staff who will leave the service in the context of the grace period 2012. In addition there are a range of cost management measures necessitated by the reduced funding available for mental health services in 2012 which are summarised below. Every effort is made to ensure that the impact on

services is minimised. We will be maximising the reorganisation of rostering, reduction in overtime and agency, and increasing skill mix and other measures to limit the impact on frontline services.

- Staff rearrangements and rostering i.e:
  - introduction of skill mix - this will see the appropriate use of trained health care assistants working closely with nursing staff in the provision of care to those dependent clients who require supported accommodation
  - review rosters and staffing levels,
  - reduce level of rosters,
  - reduce reliance on institutional care by closure of long stay wards & high support hostels (outlined below)
  - reduction in overtime and agency costs across all services.
- Review of nurse management structures – replacement of Night Superintendant roles with enhanced role for frontline managers.
- Review of staffing levels in high support hostels. Any hostels currently employing two nurses on a 24/7 basis
- Targeting of nursing levels by day to meet needs of clients.
- Introduction of standardised policies for 'specialing' clients who require additional attention. Ongoing review of these policies
- The re-organisation of services in line with A Vision for Change will support the development of community services while at the same time reduce the overall cost of services, maximising the benefit to service users.

Acute Beds: reduction of 60

- Kerry General Hospital, Tralee (6 beds)
- St. Michael's Unit, Clonmel (29 beds)
- Cork Services (25 beds)

High Support Beds: reduction of 12

- Caherciveen, (12 beds)

Long Stay Beds: reduction of 10

- St. Finan's, Killarney (10 beds)

Clients will be accommodated in more appropriate care settings. Staff released by these reductions will be redeployed to support the development of the community service including the filling of vacancies to agreed levels. This will place increased pressure on acute services which will have to be addressed by an investment in community based services through the additional resource now being provided.

- Other Proposed Initiatives include efficiencies in overhead costs, voluntary agency spend, drugs expenditure etc.

Outline of 2012 Service Plan Priorities for Each Area

Carlow / Kilkenny & South Tipperary

- Community Mental Health Teams (CMHTs)

  To support the major change programme underway within the Carlow/Kilkenny & South Tipperary area, there is comprehensive development of Community Mental Health Teams to meet the increased demand for community services. CMHTs bring together the key professionals to provide a range of mental health interventions for a defined community. Members of the core Community Mental Health Teams, the Home Based Treatment Teams and the Acute Day Services (Day Hospital) will work in close collaboration to provide a comprehensive community based service. Six allied health professionals will be appointed to Carlow / Kilkenny & South Tipperary area to support the development of community mental health services.

  - **South Tipperary:** The process of amalgamating the three existing CMHTs for Clonmel East, Clonmel West and Cashel into one team commenced on 31st October 2011. A Team Coordinator (as described in a Vision for Change) was appointed on 7th November 2011 to facilitate this amalgamation and to support the continued development of comprehensive Community Mental Health Teams with one point of access.

    A significant milestone will be achieved when the Clonmel East and Clonmel West Community Mental Health Teams will co-locate with the new Acute Day Hospital in Clonmel in May 2012. The existing team base for Cashel/Tipperary CMHT will be maintained at Carrig Oir, Cashel.

  - **Carlow / Kilkenny:** The amalgamation of the two existing CMHTs in Carlow (Carlow North and Carlow South) commenced on 31st October 2011. A Team Coordinator (as described in a Vision for Change) was appointed on 7th November 2011. A further development will be achieved when the CMHT co-locates with the Acute Day Service/Home Based Treatment Team in June 2012 in a facility on the grounds of St. Dympna's Hospital, Carlow which is currently being refurbished.

    The process of amalgamation of the three existing Community Mental Health Teams in Kilkenny (Kilkenny East, Kilkenny West and Kilkenny North) commenced on 31st October 2011. A Team Coordinator (as described in a Vision for Change) was appointed on 7th November 2011. The

Community Mental Health Team will co-locate with the Acute Day Service/Home Based Treatment Team in an existing modern facility on the grounds of St. Canice's Hospital in May 2012.

- ## Acute Day Services (Day Hospital)

The Acute Day Services (Day Hospital) are community services that offer an alternative to inpatient admission for a proportion of service users. Best practice indicates that acute day services (day hospital) facilities are suitable for a quarter to a third of service users who would otherwise be admitted to hospital.

- **South Tipperary:** Development of 2 new Acute Day Services (Day Hospital) in Clonmel and Cashel.
  The acute day services (day hospital) for Cashel became operational in Carrig Oir, Cashel on 31st October 2011

  On the same day, acute day services (day hospital) for Clonmel was established in a temporary location in a refurbished building on the St. Luke's Hospital campus. Construction has commenced on the permanent location for the Day Hospital and CMHT Base in Clonmel, on the St Luke's Hospital campus and is on schedule for completion in May 2012.

- **Carlow and Kilkenny:** The focus in Carlow has been to enhance the existing acute day services (day hospital) on the grounds of St. Dympna's Hospital, Carlow. This is currently operational on a seven day week basis. Staffing at the existing Day Hospital in Carlow was enhanced during October/November 2011 following the closure of St. Patrick's Ward.

  The current five day services at St. Canice's Hospital Kilkenny are being extended to provide a seven day service from 28th February 2012. In the interim the Acute Day Services (Day Hospital) will continue to be provided from the current location in St. Canice's Hospital. Staffing at the Acute Day Services (Day Hospital) has been enhanced following reorganisation of hostel services.

- ## Home Based Treatment Teams (HBTTs)

HBTTs are part of the amalgamated and enhanced community mental health teams and as such are consultant-led multidisciplinary teams, providing a seven day service, which will enable service users to receive treatment in their own home.

- **South Tipperary:** The HBTT for South Tipperary became operational on 31st October 2011 with the redeployment of staff from St. Michael's Unit following the transfer of 20 acute inpatient beds for North Tipperary service users to the HSE Mid West. The Home Based Treatment Team for South Tipperary is now operating on a seven day basis, with agreement to implement the on-call facility on the 26th February 2012. This enables service users to receive treatment in their own home environment and is providing an important alternative to acute inpatient care.

- **Carlow Kilkenny:** The two Home Based Treatment Teams one for Carlow and one for Kilkenny became operational from 31st October 2011. The redeployment of staff to these teams has facilitated the development of an important alternative to acute inpatient care.

- ## Crisis/Respite Accommodation

Respite accommodation will be used for crisis accommodation and acute respite purposes for up to 72 hours. It will offer alternatives to inpatient care for a proportion of those who would otherwise have been admitted to the acute hospital setting.

- **South Tipperary:** Another important element of the development of South Tipperary services will be the opening of a crisis / respite facility which will be provided at the Edel Quinn House, which will be a temporary location while the permanent facility is being built. This is a nine bedded facility on the grounds of St. Luke's Hospital, Clonmel. This facility will be used for crisis accommodation and acute respite purposes. It will offer alternatives to inpatient care for a proportion of those who would otherwise be admitted to hospital. The Edel Quinn building will be available to commence the crisis / respite service from the end of March 2012. The staffing for this facility will be provided following the redeployment of staff on the closure of St. Michael's Unit.

  The permanent building will be constructed in Clonmel and tender documentation for the selection of the design team will be issued on the 13th February 2012.

- **Carlow/Kilkenny:** Respite accommodation services for Carlow / Kilkenny will continue to be provided in a 12 bedded unit at Greenbanks Hostel, Carlow.

- ## Continuing Care & Accommodation Services

Community Nursing Unit (CNU)

To facilitate the closure of the old inappropriate long-stay facilities at St. Luke's Hospital, Clonmel and the relocation of over 40 residents and the related staffing and resources, a new purpose built CNU is currently under construction on the St. Luke's Hospital Campus, Clonmel.

The CNU will open in March 2012 and residents and staff from St. Paul's and St. Mary's Unit in St. Luke's Hospital will transfer to this new premises. As part of this process, the Mental Health Commission requires a reduction of 40 in the number of residents that can be accommodated in St. Luke's Hospital, Clonmel by June 2012. For an initial short transition period, the CNU will be registered under the Mental Health Commission (MHC) with the intention of transferring to full HIQA registration in respect of Services for Older People at an early date. The arrangements in this regard will be agreed with MHC and HIQA in line with normal procedure.

- **High Support Services**
  A comprehensive review of all residents in hostels/support accommodation in the Carlow/Kilkenny & South Tipperary area has been ongoing in 2011. The purpose of this review is to assess residents accommodation needs with a view to providing more independent living accommodation if appropriate.

  South Tipperary: The remaining patients in St. Luke's Hospital, Clonmel (St. Teresa's Unit) will transfer to a newly built High Support Hostel in Clonmel in June 2012. This will be a 12 bed facility supporting the delivery of a community orientated service. Following this transfer, St. Luke's Hospital Clonmel will be closed in line with the recommendation of the Mental Health Commission.

- **Acute In-Patient Provision**
  As community mental health services are further developed in the Carlow/Kilkenny & South Tipperary Area, those with mental health needs will be able to avail of more appropriate services in the community with fewer people requiring admission to hospital.

  The 44 bed acute in-patient unit in St Luke's General Hospital, Kilkenny which fully meets all the requirements as set out in "A Vision for Change" will be the designated approved centre for the Carlow, Kilkenny and South Tipperary Area. This will enable all acute admissions to be managed at a single site. The acute bed allocation in the in-patient unit in St. Luke's General Hospital, Kilkenny is currently being reorganised to accommodate admissions from South Tipperary.

  The development plan for the area indicated that as this change programme is progressed, and community based services are fully implemented, the acute inpatient beds in St. Michael's Unit will no longer be required and it will close as an approved centre. The intention is that all the community based services will be in place by end of March 2012 and this is the target date for St. Michaels to close. No services will cease until alternative community based services are in place.

  This target date will be kept under close review through the governance framework within the HSE, with the Mental Health Commission and DOH to ensure quality and safe outcomes at all times.

  The remaining staff within St. Michael's Unit Clonmel will be redeployed to support the staffing of the Crisis House, Home Based Treatment Teams and the Acute Day Services (Day Hospitals) in Clonmel and Cashel.

Wexford & Waterford

- Re-organisation of Sector Teams – Adult sector teams provide services to the area - including South Kilkenny. These have been initially re-organised from 6 sectors into 4 and a half large sectors to accommodate operationalising this system of patient management with eventual progression to five sectors. These sectors are Waterford West based between Dungarvan and Tramore. The Tramore service will commence in Q2 2012 in a Primary Care Centre. Waterford City is based in Brook House which has been renovated and will open in Q1 2012. Waterford City also provides services to South Kilkenny. Wexford South with 7 day services in Wexford in Summerhill and 5 Day services in Maryville, New Ross. Summerhill is currently being refurbished to be completed in Q2 2012. Wexford North has two 7 day services in Gorey, Tara House and Enniscorthy, CARN House. These centres provide Day Hospital services to each sector.
- Building of Community Nursing Unit named Farnogue Healthcare Centre commenced - completion date Q3 2012. The purpose of this unit is to decant an elderly care ward from St. Senan's Hospital, Enniscorthy and to provide a new base for the Wexford Mental Health Psychiatry of Later Life Team. It will be based on the grounds of Wexford General Hospital.
- A key project in 2012 to advance the closure of St. Otteran's Hospital will be the closure of St. Monica's Ward which is a 27 bed long stay elderly ward and to resettle residents appropriately back to the community including nursing homes, community residences and other mental health facilities. It is expected that this will release a number of nursing staff for redeployment to enhance community services including the Day Hospitals in Brooke House, Dungarvan and Tramore. Brooke House will then operate a 7 day Day Hospital service. Expected completion date Q4
- Tus Nua commenced services in Q4 2011 and will continue to provide services for the Rehabilitation Team in Wexford

- Three High Support Residences are currently under construction and due for completion in Q4 2012. These are :
  - Havenview, a twin unit of 14 beds which will enable the relocation of St. Christopher's Ward from St. Senan's Hospital, Enniscorthy. Havenview will provide care to people with severe to profound Intellectual Disability.
  - Millview, a 12 bedded unit which will enable the relocation of St. Enda's Ward from St. Senan's Hospital. Millview will be a high support residence under the care of the Rehabilitation Team – Underway due for completion end of 2012.
- In 2011 acute services were closed at St. Senan's Hospital and centralised in the Department of Psychiatry at Waterford Regional Hospital for the area. The department in Waterford is a 44 bedded unit and is currently being refurbished to provide enhanced facilities. This will be completed by Q4.
- Following the closure of the remaining mental health units at St. Senan's Hospital remaining staff both clinical and non clinical will be redeployed to augment day hospital and residential services.
- In Q4 2011 Psychiatric Liaison Services commenced in the Emergency Department in Waterford Regional Hospital and the full year benefit of these services will be derived in 2012.
- Development of a Respite House in Enniscorthy to commence Q4 to provide 10 beds for respite care for Waterford/Wexford.
- A consumer panel has commenced for Waterford/Wexford with 18 service user members with the support of National Service Users organisation and this initiative will be further enhanced in 2012
- The management team for Waterford and Wexford Mental Health Services have merged to form one management team for Waterford/Wexford.

Cork

Mental Health Services in Cork will be expediting the implementation of Vision for Change in 2012. This will commence with the establishment of a Project Implementation Group representative of all stakeholders to determine how the service will change to focus on a recovery and community based model of service delivery in Cork. This project implementation group will be provided with an overview of the work undertaken to date by a multidisciplinary group of clinicians and managers across all mental health services in Cork. The group will report by the end of the first quarter with the intention of proceeding with implementation on a phased basis over the reminder of the year.

In 2012, access to services in the community will be enhanced through reorganisation of acute inpatient services and reassigning staff from acute inpatient units to enhance community mental health teams, day hospitals and home treatment and assessment services. To achieve this, consistent with Vision for Change, inpatient services in North Lee and North Cork will be consolidated with a phased reduction of 25 beds. As part of this consolidation, the respective requirement for inpatient beds between Cork North and South Lee / West Cork will be reviewed with the potential for some specialist services to be provided in the Mental Health unit in CUH. A consultation process in relation to this will commence in Q1 with staff, service users and carers with the intention to commence implementation in Q2.

A reorganisation of staff, inclusive of all nursing grades, will facilitate the redeployment of significant numbers of staff to Community Mental Health Services. As part of our programme to reduce admissions and improve service user satisfaction, we will further develop our community services by providing Community Mental Health Nurse cover in all areas on a 7 day week basis. This enhanced service will form part of all existing services in operation, such as Home Based Treatment Teams etc.

In addition to this, management propose to further invest in community services by regularising 3 Advanced Nurse Practitioner posts to ensure formal/seamless links with Community Mental Health Teams and Primary Care.

Service Improvements / Enhancements

- Commence planning for intensive care regional unit (regional forensic unit) as part of a bespoke model with Central Mental Hospital.
- Extend Child and Adolescent Inpatient Unit from eight to twenty beds.
- Complete the strategic plan for the implementation of Vision for Change in Cork.
- Implement new management structures for mental health services in Cork which include one Executive Clinical Director for Mental Health Services in Cork and one Executive Management Team.
- Continue to develop service user involvement in the planning and delivery of mental health services.
- Suicide prevention services - Promote positive mental health and prioritise suicide prevention; in particular, implement outstanding actions in Reach Out- the 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.

- Implement agreed clinical care programmes in mental health.
- Develop effective partnerships with voluntary and statutory agencies to deliver integrated care for service users.

Kerry

- In Kerry there will be a further reduction of 10 beds with the closure of St. Martin's (female) Ward and the subsequent transfer of the patients to more appropriate settings in community residences as well as the adjacent O'Connor home residential unit. This will progress the closure of St. Finan's Hospital and will see that the only remaining patients in the main building of the hospital will be accommodated in a 10 bed male, high dependency unit.
- In 2012 a four bed, high observation area will be developed at the acute unit of Kerry General Hospital. This will support the current policy of the non admittance or transfer of patients to St. Finan's Hospital. A reduction of the overall acute bed numbers from the current 44 to 38 will also be undertaken and this will also allow for the redeployment of nursing staff to community mental health teams in the area.
- A process will also commence that will see the ultimate closure of the supported hostel in Caherciveen in South Kerry with the patients moving to more appropriate accommodation in the community over a period of time. This will also allow for a redeployment of staff to the community mental health team in South Kerry.

Improving our Infrastructure

Capital projects that are to be completed and / or to become operational in 2012:

Location	Capital Project	Target Date
Tipperary South	Provision of a 40 Bed Residential Unit, on the existing site, to accommodate current residents of St Luke's	Q1 2012
Tipperary South	High Support Hostel, Clonmel.	Q2 2012
St John's Enniscorthy	Rehab House – Tus Nua	Q4 2011
St John's Enniscorthy	Mill View 13 place High Support House in grounds of St John's Enniscorthy to rehouse St Sennan's residents	Q4 2012
Clonmel, Tipperary	Day Hospital & Accommodation for Sector Team and Psychiatry for Later Life Team. Funded from sale of lands	Q1 2012
Waterford Regional Hosp	Upgrade Acute MH Unit.	Q2 2012
Wexford	Two Intellectual Disability Houses - Haven View 1 & 2	Q4 2012
Wexford	50 Bed Community Nursing Unit	Q4 2012
Kerry General Hospital	High Observation Unit	Q4 2012

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	▪ 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 60 beds to 241	Ongoing
	HSE South ▪ Closure plans for St. Mchaels Unit , Clonmel will be progressed (29 beds) ▪ Reorganisation of acute unit in KGH to provide high obs. Unit (6 beds) ▪ Closure oin the order of 25 acute inpatient beds in Cork will b e progressed in with VFC and re-organisation of acute services in Cork	Q1 Q4 Q1-Q4
	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	
	▪ 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) HSE South ▪ Review current stock of medium and low support community residences ▪ Conduct comprehensive needs assessment for existing residents ▪ Liaise with local authorities / seek competent partner agencies to operate medium and low support community residences	Q1 Q2 Q3 - Q4
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	

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
Adult Inpatient Services			
No. of admissions to adult acute inpatient units	4,712	4,338	4,338
Median length of stay	11.0	12	12
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	108.9	101.3	93.5
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	33.5	31.9	29.4
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	75.4	69.3	64.0
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	26.4	26.4	20.7
No. of adult involuntary admissions	384	415	415
Rate of adult involuntary admissions per 100,000 population in mental health catchment area	8.85	9.7	8.9
Child and Adolescent			
No. of child and adolescent Community Mental Health Teams	13	13	13
No. of child and adolescent Day Hospital Teams	---	-	-
No. of Paediatric Liaison Teams	---	-	-
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	---	29	29
No. of children / adolescents admitted to adult HSE mental health inpatient units* i). < 16 years ii). < 17 years iii). < 18 years	<100 (National)	130 (National) 4 33 93	80 (National) 0 16 64
No. and % of involuntary admissions of children and adolescents	16 5% (National)	16 5% (National)	16 5% (National)
No. of child / adolescent referrals (including re-referred) received by mental health services	2,795	2,957	2,957
No. of child / adolescent referrals (including re-referred) accepted by mental health services	1,734	1,674	1,674
Total no. of new (including re-referred) child / adolescent referrals offered first appointment and seen	1,729	1,857	1,857
No. and % of new / re-referred cases offered first appointment and seen i). < 3 months	1,134	1,307 61%	70% (National)
ii). > 12 months	283	210 10%	0% (National)

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
No. and % of cases closed / discharged by CAMHS service	New PI 80% of accepted referrals	1,734 97%	1.734 80%
Total no. on waiting list for first appointment at end of each quarter	666	447	465
No. and % on waiting list for first appointment at end of each quarter by wait time i). < 3 months	208	137 31%	139 30%
ii). 3-6 months	136	102 23%	111 24%
iii). 6-9 months	172	104 23%	115 25%
iv). 9-12 months	---	New PI	99 21%
v). > 12 months	150	104 23%	0
No. of suicides in arrears per CSO Year of Occurrence	New PI	National: 506 (2008 validated)	---
No. of repeat deliberate self harm presentations in ED	National: 1,342 1% reduction on 2010	National: 1,348	National: 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

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.

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.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	186.433	179.422
Kerry	1.927	1.854
Carlow /Kilkenny/Sth Tipp	56.180	54.090
Waterford/Wexford	71.676	68.971
Total	316.216	304.337

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	2,161	2,093
Kerry	12	12
Carlow /Kilkenny/Sth Tipp	304	295
Waterford/Wexford	772	747
Total	3,249	3,147

The allocation for disability services nationally 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 nationally 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.

The National Service Plan has identified the following priorities for 2012:

- Maximise the provision of services within available resources.
- Develop and continue a total system reorganisation 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 reorganised 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*.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum

In 2012 we will provide:

- 361,203 * personal assistant / home support hours.
- 2,152 residential places
- Provide respite services for 1,559 service users
- Day place provision for 5,349 service users
- Therapy services and therapeutic support
- Community support services for clients with specific conditions by specialised services i.e. Muscular Dystrophy Ireland
- Home support (children)
- Outreach support services for adults with specific disabilities i.e. Asperger's Syndrome

** negotiations to take place in relation to rates*

Cost Management & Employment Control Measures

The budget reduction amounts to €11.576m which represents a 3.7% reduction. The range and quantum of services to be provided in 2012 (as outlined above) takes account of the reduction in 2012 budget. Notwithstanding a reduction in funding and the assignment of efficiency targets along with a reduction in staff numbers, agencies will be required to re-direct resources to respond to emergency cases in 2012. The cost management measures necessitated by the reduced funding available for disability services in 2012 are summarised below. Every effort is made to ensure that the impact on services is minimised.

- Reduction in funding to voluntary agencies will amount to 3.7% of 2011 revenue funding, a minimum of 2% will be sought from cost efficiencies, with the remaining reduction of up to 1.7% being found from service reductions
- The 2% cost containment reduction will be achieved by maximising the opportunities for agencies cost reduction in areas of non-pay and non-core activity expenditure i.e. management costs, transport costs, shared services costs. In addition, there will be a review of Pre-School supports, high cost services and expenditure on provision by private providers. Some current management and supervisory posts will be redeployed to frontline services. We will also be reviewing staffing levels, reducing overtime and agency costs and increasing skill mix and other measures to limit impact on frontline services.
- All smaller agencies that carry fixed overheads are to examine options for amalgamation/sharing services.
- While every effort is made to minimise the impact of the budget reductions on services without effecting core service delivery, many agencies have indicated that they will note be in a position to absorb the full 3.7% impact of this budget reduction, therefore there may be some service impact in the areas set out below:
  - Potential reduction of up to 6,140 PA Hours (1.7%)
  - Potential reduction of up to 37 residential care places (1.7%) by reducing places from 7 to 5 nights where possible
  - Reduction of 1.7% on core funded respite services
  - Reduction of 1.7% in WTE day places (achieved by reducing number of days / length of stay)
  - Reduction of transport services
- **HSE Services:**
  - Damien House, South Tipperary – Revise rosters to meet service demands and change model of delivery of day services to ensure continuity of the residential services
  - Cease service in Teach Saoirse Community House to consolidate residential services for clients in Wexford
  - Reorganisation of rosters and skill mix in St Raphael's/Grove House (Cork) in line with declining bed numbers/changing needs
- Reduction in Aids and Appliances expenditure
- A review of services provided by Section 38 / 39 Agencies will be carried out in a number of areas.

Service Improvements

- Relocate a further 6 clients on the St Raphael's Campus, Youghal to the new Unit E which is a purpose built challenging behaviour unit on the grounds. Transfer of these clients to more appropriate accommodation will allow for further re-organisation of the service and closure of a dormitory in the main building
- VFM and Policy review - Develop regional and area level implementation plans in line with the outcomes of the National VFM and policy review
- Maintain provision of core services at identified levels while we reconfigure and re-organise services generally
- Progress development of alternative respite care models for greater cost efficiency
- Commence the redevelopment programme of the Grove House 28 bed Residential Service
- Complete the rollout of the Consultative Fora structure with Area level groups to be established across the HSE South
- Continue implementation of the "Time To Move On From Congregated Settings" policy in line with National plan:
  - Implement agreed target date when set, for cessation of new admissions to congregated settings
  - Complete Genio funded projects at selected demonstration sites including St Raphael's Centre
- Progressing Disability Services for Children and Young people:
  - Complete mapping and establishment of implementation groups in HSE South
  - Develop regional and area level implementation plans in consultation with key stakeholders
  - Complete reorganisation in identified lead sites/ areas (West Cork/Kerry)

Key Result Areas

The following Key Performance Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	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
	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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
Day Services No. of work / work-like activity WTE places provided for persons with intellectual disability (ID) and / or autism	460	583	1,578 (National - Regional breakdown to be determined)
No. of persons with ID and / or autism benefiting from work / work-like activity services	951	1,174	3,084 (National - Regional breakdown to be determined)
No. of work / work-like activity WTE places provided for persons with physical and / or sensory disability	12	21	71 (National - Regional breakdown to be determined)
No. of persons with physical and / or sensory disability benefiting from work / work-like activity services	23	34	138 (National - Regional breakdown to be determined)
No. of Rehabilitative Training places provided (all disabilities)	653	653	653
No. of persons (all disabilities) benefiting from Rehabilitative Training (RT)	762	780	780
No. of persons with ID and / or autism benefiting from Other Day Services (excl. RT and work / work-like activities)	14,077 (National)	2,791	12,430 (National - Regional breakdown to be determined)
No. of persons with physical and / or sensory disability benefiting from Other Day Services (excl. RT and work / work-like activities)	3,924 (National)	570	2,581 (National - Regional breakdown to be determined)
Residential Services No. of persons with ID and / or autism benefiting from residential services	2,198	2,015	8,416 (National - Regional breakdown to be determined)
No. of persons with physical and / or sensory disability benefiting from residential services	226	137	708 (National - Regional breakdown to be determined)
Respite Services No. of bed nights in residential centre based respite services used by persons with ID and / or autism	26,706	40,200	139,565 (National - Regional breakdown to be determined)
No. of persons with ID and / or autism benefiting from residential centre based respite services	1,121	1,327	5,115 (National - Regional breakdown to be determined)
No. of bed nights in residential centre based respite services used by persons with physical and / or sensory disability	1,676	1,257	13,782 (National - Regional breakdown to be determined)
No. of persons with physical and / or sensory disability benefiting from residential centre based respite services	819	232	1,220 (National - Regional breakdown to be determined)
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	361,203	1.64m (National - Regional breakdown to be determined)
No. of persons with physical and / or sensory disability benefiting from PA / home support hours	Original Target NSP11 required reclassification due	5,931	11,571 (National - Regional

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
	to definitional issues		breakdown to be determined)
Disability Act Compliance No. of requests for assessments received	1,091	1,180	1,298
No. of assessments commenced as provided for in the regulations	848	1,039	1,188
No. of assessments commenced within the timelines as provided for in the regulations	848	612	1,188
No. of assessments completed as provided for in the regulations	733	1,052	1,188
No. of assessments completed within the timelines as provided for in the regulations	733	161	1,188
No. of service statements completed	733	765	1,010
No. of service statements completed within the timelines as provided for in the regulations	733	479	1,010
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% (National)

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.

Child Protection and Welfare Services

Introduction

HSE South Children and Families Services aim to promote and protect the health and well being of children and families, particularly those who are at risk of abuse and neglect. In this regard, the HSE South is responsible under the Child Care Act, 1991 and other legislation to promote the welfare of children who are not receiving adequate care and protection. Child protection and welfare services are also provided in accordance with the Children Act, 2001 and the UN Convention on the Rights of the Child, ratified in 1992.

A wide range of services are provided, including early years services, family support services, child protection services, alternative care, services for homeless youth, search and reunion (post adoption) services, psychological services, staff training and development, registration and inspection of children's residential centres in the private and voluntary sector and monitoring of children's residential centres. These services are provided directly by us, or indirectly on our behalf under Section 39 of the Health Act, 2004.
We are committed to the principle of supporting families as the basis for ensuring child health and welfare.

The focus of Children and Families Services in 2011 was the improvement in the quality and consistency of services. During 2011 Standardised Processes were introduced in all Social Work teams to address Referral, Intake and Initial Assessment of all reports of welfare or abuse concerns about children. The revised *Children First: National Guidance for the Protection and Welfare of Children* was introduced in July and in September the HSE introduced a Child Welfare and Protection Practice Handbook to support frontline practitioners.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	48.840	50.272
Kerry	8.179	8.399
Carlow /Kilkenny/Sth Tipp	30.192	30.949
Waterford/Wexford	26.208	26.938
Regional	-	-
Total	113.419	116.558

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	449	440
Kerry	64	62
Carlow /Kilkenny/Sth Tipp	269	264
Waterford/Wexford	251	249
Total	1,033	1,015

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum and Service Delivery

Under the *Programme for Government*, fundamental changes as to how child and family services are delivered in Ireland are proposed 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 development of the new children's agency under the aegis of the newly established Department of Children and Youth Affairs. This is particularly relevant as the new agency will assume responsibility for the services presently delivered by the HSE.

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 to support the implementation of the comprehensive change programme which has consolidated all the reform initiatives arising from recent reviews into a co-ordinated change programme.

In 2012 we will:

- Provide Foster Care services for 1,685 children
- Provide direct HSE Residential Care services for 100 children while reducing costs related to private residential care provision and reducing reliance on additional external provision.
- Support an additional 50 Other Care Placements

- Complete 50 Adoption Assessments; Approx 300 Post Placement Reports
- Undertake a total of 700 Early Year Services Inspections
- Process approximately 9,500 referrals to Social Work Services
- Streamline provision of Aftercare Services through standardisation of approach and payments across the region.
- Complete the evaluation of Pilot Out of Hours Social Work Service (Cork)
- Place an emphasis on the reduction in costs associated with agency staffing through management of absenteeism and re-organisation of staff rosters.
- Progress and implement the revised Governance and Accountability arrangement for Children & Family Services
- Implement child protection procedures in line with the revised national guidelines - Children First 2011 – National Guidance for the Protection and Welfare of Children and implement Phase 2 of the Standardised Business Processes.

The National Service Plan has identified the following 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.

Cost Management & Employment Control Measures

Child Protection and Welfare Services have had an increase of €3.139m (2.7%) in budget in HSE South. However, this increase is against a backdrop of budgetary over runs in 2011 and cost management measures are required to reduce the cost base as set out below:

- Reduce costs related to private residential care provision by maximising capacity in HSE services and reduce reliance on additional external provision.
- Establish standardisation of approach and payments across the region for After Care Services.
- Reduction in costs associated with agency staffing through management of absenteeism and re-organisation of staff rosters. An independent review of staff rostering in HSE residential units is currently taking place in order to facilitate a more flexible approach in the services provided. It is envisaged that following the review more efficient rosters will be established providing greater capacity and cost savings.
- Reduction in funding to voluntary agencies in line with national direction
- Back office services efficiencies / reduction in travel expenses, procurement etc.
- Reduction in level of enhanced Foster Care payments and limits on discretionary payments in excess of standard weekly foster care payment. No reduction in service anticipated.
- Reduction in purchase of external professional clinical services.

Service Improvement

- Ongoing review of private residential placements
- Evaluation of Pilot Out of Hours Service Social Work Service (Cork).
- HSE South will progress and implement the revised Governance and Accountability arrangement for Children & Family Services.
- HSE South in line with national direction will regionally implement consistent child protection procedures in line with the revised national guidelines - Children First 2011 – National Guidance for the Protection and Welfare of Children.
- Introduction of Phase 2 of Standardised Business Process in all local areas.

Key Result Areas

The following Key Result Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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
	▪ Increase use of supervision and other protective strategies to maintain children at home safely	Q3

Key Result Area	Deliverable Output	Target Completion Quarter
	▪ 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
	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

Key Result Area	Deliverable Output	Target Completion Quarter
	▪ * 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
	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

Key Result Area	Deliverable Output	Target Completion Quarter
	▪ 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

The following Performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
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% (National)	---	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% (National)	---	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	1,748	1,837	1,929
i). Special Care	<0.2% (National)	0.2%	0.3% (National)
ii). High Support	<0.5% (National)	0.8%	0.5% (National)
iii). Residential General Care (Note: Include special arrangements)	<6.3% (National)	4.7%	<7% (National)
iv). Foster care (not including day fostering)	60% (National)	64.1%	59% (National)

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
v). Foster care with relatives	30% (National)	27.6%	30% (National)
vi). Other care placements	3% (National)	2.6%	3% (National)
No. and % of children in private residential care (Note: Include special arrangements)	New PI	New PI	0% (National)
No. and % of children in foster care private	New PI	New PI	1% (National)
No. of children in single care residential placements	0 (National)	5	0 (National)
No. of children in residential care age 12 or under	0 (National)	7	0 (National)
No. of children in care in third placement within 12 months (all care types)	0 (National)	33	0 (National)
Children in Care in Education			
i). No. of children in care aged 6 to 16 inclusive	New PI	1,119	1,175
ii). No. and % of children in care between 6 and 16 years, in full time education	100% (National)	1,095 97.9%	100% (National)
Allocated Social Workers			
No. and % of children in care who have an allocated social worker at the end of the reporting period	100% (National)	1,826 99.4%	100% (National)
i). No. and % of children in special care	100% (National)	3 100%	100% (National)
ii). No. and % of children in high support	100% (National)	15 100%	100% (National)
iii). No. and % of children in residential general care	100% (National)	87 100%	100% (National)
iv). No. and % of children in foster care	100% (National)	1,170 99.3%	100% (National)
v). No. and % of children in foster care with relatives	100% (National)	504 99.4%	100% (National)
vi). No. and % of children in other care placements	100% (National)	47 100%	100% (National)
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% (National)	1,736 94.5%	100% (National)
i). No. and % of children in special care	100% (National)	3 100%	100% (National)
ii). No. and % of children in high support	100% (National)	15 100%	100% (National)
iii). No. and % of children in residential general care	100% (National)	87 100%	100% (National)
iv). No. and % of children in foster care	100% (National)	1,117 94.8%	100% (National)
v). No. and % of children in foster care with relatives	100% (National)	473 93.3%	100% (National)
vi). No. and % of children in other care placements	100% (National)	41 87.2%	100% (National)
Foster Carer			
Total no. of foster carers	New PI	1,272	1,336
No. and % of foster carers approved by the foster care panel	New PI	1,147 90.2%	1,202 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% (National)	New PI	Baseline to be established in 2012
No. and % of approved foster carers with an allocated worker	100% (National)	1,043 90.9%	100% (National)
Children and Homelessness			
No. of children placed in youth homeless centres / units for more	New PI	New PI	Baseline to be established in

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
than four consecutive nights (or more than 10 separate nights over a year)			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	New PI	121	127
No. of children placed with the Emergency Out of Hours Placement Service	New PI	83	87
No. of nights accommodation supplied by the Emergency Out of Hours Placement Service	New PI	185	194
Early Years Services			
No. of notified early years services in operational areas	4,461 (National)	1,098	1,098
% of early years services which received an inspection	100% (National)	66.4%	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	347	347
% of full day services which received an annual inspection	100% (National)	---	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% (National)	---	100% (National)
No. of prosecutions taken on foot of inspections in the quarter	New PI	---	Demand-led

Palliative Care Services

Introduction

Palliative Care provides the best possible quality of life for patients and their families when their disease is no longer responsive to treatment. Services are provided directly by the HSE and in partnership with voluntary agencies.

The principles of palliative care include:

- A focus on quality of life
- Maintaining good symptom control
- A holistic approach which takes into account the person's life experience and current situation
- Care that encompasses the patient and those who matter to them, including support in bereavement
- Open and sensitive communication with patients, carers and professional colleagues.

Palliative Care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy and radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

In 2001 the report of the Department of Health and Children's National Advisory Committee on Palliative Care outlined that the promotion of a palliative care approach is appropriate for all patients and that a subset of patients with non-malignant disease with complex palliative care needs or multiple medical problems would benefit from specialist palliative care (SPC).

Resources *

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	5.625	5.139
Kerry	0.940	0.861
Carlow /Kilkenny/Sth Tipp	0.532	0.487
Waterford/Wexford	0.933	0.854
Total	8.030	7.341

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork		
Kerry	12	11
Carlow /Kilkenny/Sth Tipp		
Waterford/Wexford	2	2
Total	14	13

** non-acute hospital figures only*

There is a growing awareness in Ireland that palliative care has a role in the management of all life-limiting diseases in all care settings. This is reflected in both policy documents and emerging practices.

More recently, in 2006, the HSE stated its commitment to develop a chronic disease management patient support programme. This is in response to the changing patterns associated with life-limiting diseases and to ensure delivery of appropriate health and care services to an ageing population. The development of such a programme is in line with the work of the World Health Organisation (WHO) whose recommendations include the provision of appropriate palliative care for all patients, regardless of diagnosis.

In March 2010 the Department of Health and Children published the National Policy - Palliative Care for Children with Life-Limiting Conditions in Ireland. In 2011 HSE South contributed to the phased implementation of the National Policy for Palliative Care for Children with Life-Limiting Conditions in Ireland by progressing the appointment of a Children's Outreach Nurse at Cork University Hospital and Waterford Regional Hospital.

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.

During 2012, the focus will be to continue to progress the implementation of agreed national priorities to develop specialist palliative care services in a structured and equitable way, building on the work done to date and in conjunction with our stakeholders. Work will continue on the roll out of the Minimum Data Set to ensure quality data to inform service management and development. This includes the development and collection of additional datasets for acute hospital, bereavement and outpatient services. The development of palliative care services will be supported by the palliative care programme within the Clinical Strategy and Programme Directorate, while continuing to drive efficiencies to ensure that services are maximised.

The priorities for the HSE South in 2012 as identified in the National Service Plan are:

- 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.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum

Specialist Palliative Care services are provided directly by the HSE and in partnership with voluntary agencies via a service level agreement.

In 2012 we will provide:

- 26 Specialist Palliative Care inpatient beds
- 10 Community based Specialist Palliative Care teams
- Specialist palliative care day care services provided in Cork and in Kerry.
- Specialist palliative care services provided in nine acute hospitals throughout the South
- Specialist palliative care outpatient service provided at the acute hospitals and at Marymount Hospice, Cork
- 53 palliative care support beds

Cost Management & Employment Control Measures

The budget reduction for palliative care services in the South amounts to €0.689m which represents a 8.6% reduction. The cost management measures necessitated by the reduced funding available for palliative care services in 2012 are summarised below. Every effort is made to ensure that the impact on services is minimised.

- Reduction in Funding to Voluntary Agencies and HSE services

Service Improvements

- Progress the development of 20 Bed Specialist In-Patient Unit in Waterford Regional Hospital as part of the overall national capital plan
- Plan the development of the Satellite Specialist Palliative Care Unit in Kerry
- Appointment of 1 Children's Outreach Nurse for Life Limiting Conditions Service for Cork and Kerry
- Appointment of 1 Children's Outreach Nurse for Life Limiting Conditions Service for Waterford, Wexford, South Tipperary and Carlow / Kilkenny
- Examination of staffing options
- Complete needs assessment for respite facilities for children with life-limiting conditions and their families in HSE South
- Develop an end of life care plan for continuing care facilities and nursing homes

Key Result Areas

The following Key Result Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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
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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
Waiting Times Inpatient			
i) Specialist palliative care inpatient bed within 7 days	92% (National)	100%	100%
ii) Specialist palliative care inpatient bed within 1 month	100%	100%	100%
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% (National)	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)	99%	97%	97%
Inpatient Units			
No. of patients in receipt of treatment in specialist palliative care inpatient units	62	60	60
No. of admissions to specialist palliative care inpatient units	480	465	465
No. of discharges, transfers from the specialist palliative care inpatient unit			
i). Discharges	71	28	28
ii). Transfers	305	112	112
iii). Deaths*	---	270	---
Community Home Care			
No. of patients in receipt of specialist palliative care in the community	816	866	866
Day Care			
No. of patients in receipt of specialist palliative day care services	73	83	83
Community Hospitals			
No. of patients in receipt of care in designated palliative care support beds	27	59	59
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	30	31	31
ii). Specialist palliative care services in the community (home care)	171	179	179

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 Services

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.

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.

Resources

FINANCE – HSE SOUTH

Area	2011 Budget €m	2012 Budget €m
Cork	12.750	11.930
Kerry	0.491	0.459
Carlow /Kilkenny/Sth Tipp	1.804	1.684
Waterford/Wexford	4.198	3.950
Total	19.243	18.023

WTE Ceiling – HSE SOUTH

Area	Dec 2011	Projected Dec 2012
Cork	69	68
Kerry	7	7
Carlow /Kilkenny/Sth Tipp	7	6
Waterford/Wexford	18	17
Total	101	98

The National Service Plan has identified the following 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.

Embedding Quality and Patient Safety into Service Delivery

Quality and Patient Safety (QPS) will continue to be embedded into service delivery by the active participation of representative staff in the Area QPS committees, Patient Safety Culture survey, HIQA National Standards preparation, prevention of healthcare associated infections, incident management and continuous updating of the facility's risk register. The service will continue to promote service user involvement in committees and decision making.

Service Quantum

HSE South Social Inclusion services improve access to mainstream services, target services to marginalised groups, address inequalities in access to health services and enhance the participation and involvement of socially excluded groups and local communities in the planning, design, delivery, monitoring and evaluation of health services.
In 2012 we will provide:

Drug and Alcohol Services

- 7,500 treatments for substance misuse, an increase of 2,000. This reflects additional service developments in 2011
- 22 community based detoxification beds
- 115 residential rehabilitation beds, an increase of 2 beds

- 28 step down beds

Homeless Services

- 766 beds/units in 41 homeless facilities in HSE South
- 7 women's facilities/refuges
- 8 emergency men's hostels
- 18 transitional /supported living facilities
- 8 long term residential facilities.

Traveller Services

- 2 Traveller Health Units.
- 12 Traveller Primary Healthcare projects
- 48 Traveller Community Health Workers
- 4 Traveller Men's Projects

Cost Management & Employment Control Measures

The budget reduction for social inclusion services in the South amounts to €1.22m which represents a 6.3% reduction. Efficiencies will be achieved in non pay expenditure in core budgets and regional committee core budgets. In addition, there will be some reduction in Voluntary Agencies funding.

Service Improvement 2012

- Roll out of Needle Exchange Programme
- Development of HSE South Harm Reduction Policy
- Roll out of Nurse Prescribing in Addiction Services
- Continued implementation of Rehabilitation Strategy
- Commencement of QUADS
- Review of Electronic Patient System
- Review of Clinical Governance Model
- Implementation of Community Development Project mainstreaming initiative
- Enhancement of Homeless Action Team (HATs)
- Development of combined Homeless Tenancy Outreach Support and Mental Health Outreach Support Service in Cork
- Roll out of Traveller Screening Initiatives
- Pilot initiative re Diabetes and Cardio-vascular Disease in the south east.
- Pilot healthy lifeskills training in men's hostels in south east
- Roll out of Key Worker initiative.

Key Result Areas

The following Key Result Areas (KRAs) have been included in the National Service Plan for delivery in 2012:

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
	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

Key Result Area	Deliverable Output 2012	Target Completion Quarter
	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

The performance activity and indicators have been included in the National Service Plan for delivery in 2012:

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
Methadone Treatment			
No. of clients in methadone treatment (outside prisons)	275	323	350
No. of clients in methadone treatment (prisons)	500 (National)	564 (National)	520 (National)
Substance Misuse			
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	--- 100% (National)	604 99%	1,260 100% (National)
No. and % of substance misusers (under 18 years) for whom treatment has commenced within two weeks following assessment	--- 100% (National)	46 94%	105 100% (National)
Homeless Services			

	Expected Activity / Target 2011	Projected Outturn 2011	Expected Activity / Target 2012
	South	South	South
No. of individual service users admitted to statutory and voluntary managed residential homeless services who have medical cards	New PI for 2011 75%	386 89.6%	386 ---
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% (National)
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% (National)
Needle Exchange No. of pharmacists recruited to provide Needle Exchange Programme	---	New PI for 2012	45 in Q1 (National) 65 in Q3 (National)
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	1,650 (National) 10% proportion of targeted population in each region

Appendix 1 Financial Information

INTEGRATED SERVICES/ OPERATIONAL AREA	2012 Budget €
Cork Integrated Services Area	
Cork University Hosp	233.483
Bantry General Hospital	15.738
Mallow General Hospital	15.481
Ancillary Services	2.597
Network Mgr	12.000
Mercy University Hospital	50.997
South Infirmary Victoria Hosp	42.386
North Lee	91.949
South Lee	86.637
North Cork	72.178
West Cork	210.434
Cork Dental Hospital	1.787
Cork ISA Total	**835.667**
Waterford / Wexford Operational Area	
Waterford Regional Hospital	126.709
Wexford General Hospital	44.164
Regional Acutes	2.053
Network Manager	1.285
Wexford	84.900
Waterford	104.275
Waterford / Wexford OA Total	**363.386**
Carlow / Kilkenny / South Tipperary Operational Area	
St. Luke's Hospital/ Kilcreene	51.662
South Tipp General Hosp	42.469
South Tipperary	86.931
Carlow /Kilkenny	118.353
SE Regional PCSS Services	1.273
Carlow / Kilkenny / South Tipperary OA Total	**300.688**
Kerry Integrated Services Area	
Kerry General Hospital	65.162
Kerry	91.063
Kerry ISA Total	**156.225**
Unallocated	
Regional Services	17.465
RDO/HR	16.524
RDO Total	**33.989**
Total	**1,689.955**

Appendix 2 HR Information

WTE Ceiling vs Actual No. of WTEs in HSE South at end of December 2011 – by Service

HSE South WTE - Service Plan 2011	Ceiling End December 2011	Actual End December 2011	Variance
Acute Hospital Services	10,437	10,623	186
Ambulance Services	416	410	(6)
Primary and Community Services	11,688	11,444	(244)
Portion of Ceiling to be allocated	176	0	(176)
ISD	**22,717**	**22,477**	**(240)**
Corporate	681	667	(14)
QCC/Population Health	267	259	(8)
HSE South	**23,665**	**23,403**	**(262)**

No. of WTEs in HSE South at end of December 2011 – by Grade

HSE South Grade Category	Actual End December 2011
Medical/ Dental	1,812
Nursing	8,538
Health & Social Care Professionals	3,392
Management/ Admin	3,203
General Support Staff	2,865
Other Patient & Client Care	3,593
Total	**23,403**

Impact of Moratorium and Exit Schemes in HSE South – by ISA / Service / Grade

ISA Area / Grade	Retirement / Resignations		VER/VRS	
	WTE	Headcount	WTE	Headcount
Cork ISA				
Medical/Dental	2.9	5		
Nursing	147.48	180		
Health and Social Care Professionals	12	14		
Management/Admin	16.14	23	47.51	58
General Support Staff	23.84	32	44.32	49
Other Patient and Client Care	24.39	33		
Cork ISA Total	**226.75**	**287**	**91.83**	**107**
Kerry ISA				
Medical/Dental	.17	1		
Nursing	40.99	49		
Health and Social Care Professionals	3.9	4		
Management/Admin	2.95	4	15.4	19
General Support Staff	7.21	9	10.62	14
Other Patient and Client Care	4.01	5		
Kerry ISA Total	**59.23**	**72**	**26.02**	**33**
Waterford / Wexford Operational Area				
Medical/Dental	1	1		
Nursing	80.5	98		
Health and Social Care Professionals	13.77	15		
Management/Admin	10.13	13	32.93	37
General Support Staff	17.21	33	35.45	45
Other Patient and Client Care	6.19	9		
Waterford / Wexford Operational Area Total	**128.8**	**169**	**68.38**	**82**
Carlow/Kikenny/South Tipperary Operational Area				
Medical/Dental	.5	1		
Nursing	80.15	96		
Health and Social Care Professionals	5.4	6		
Management/Admin	11	14	36	40
General Support Staff	21.48	28	38.61	44
Other Patient and Client Care	10.62	18		
Carlow/Kilkenny/South Tipperary Operational Area Total	**129.15**	**163**	**74.61**	**84**
Corporate and QCC / Population Health				
Corporate	8.63	9	33.08	36
QCC / Population Health	5.66	7	3.1	4
TOTAL HSE SOUTH	**558.22**	**707**	**297.02**	**346**

Impact of Moratorium and Exit Schemes in HSE South – by ISA / Service / Grade

ISA Area / Grade	Retirement / Resignations		VER/VRS	
	WTE	Headcount	WTE	Headcount
HSE South Medical / Dental	6.72	11		
HSE South Nursing	250.62	318		
HSE South Nursing (Mental Health)	99.5	106		
HSE South Health and Social Care Professionals	36.07	40		
HSE South Management/Admin	46.22	60	162.52	188
HSE South General support Staff	72.37	105	133.5	157
HSE South Other Patient and Client Care	46.72	67	1	1
Total All Grades - HSE South	558.22	707	297.02	346

Appendix 3 Health Sector PSA Implementation Plan

Summary description of HSE South Health Service Initiatives

The Public Service Agreement 2010-2014 will ensure that the Irish Public Service continues its contribution to the return of economic growth and economic prosperity to Ireland. This will be done by working together to build an increasingly integrated Public Service which is leaner and more effective, and focused more on the needs of the citizen. The Parties to this Agreement recognise that to achieve this, in the context of reduced resources and numbers, the Public Service will need to be re-organised and public bodies and individual public servants will have to increase their flexibility and mobility to work together across sectoral, organisational and professional boundaries.

Public Service Agreement: Summary list of initiatives

This document sets out a summary list of the agreed Public Service Agreement initiatives for the Health Sector at two levels;

- National: National priorities that will be delivered in a standardised way across the country (in accordance with principles agreed in the PSA)
- Regional: Initiatives specific to each region/ locality (in accordance with national priorities)

The list of initiatives provides summary information including;

- PSA reference number.
- A one line summary of the change proposed.
- The PSA measure the initiative addresses. The list of 15 measures is set out in the next column.
- The sponsor for each initiative (National Director/Assistant National Director/ RDO).
- 1The timeframes associated with implementation
- The impact on staff in terms of type of staff, numbers redeployed or reduced etc.
- The impact on services and the targeted benefits

*Targeted benefits would include both qualitative and quantitative measurements, e.g. reduction in head count, monetary savings, productivity improvements, safeguarding quality of service, clinical performance, service delivery timeframes – faster access to services, better health outcomes, more cost efficient services, expansion of roles and direct referral pathways for all professionals.

Public Service Agreement: Measures

1. Redeployment/ reassignment
2. Integrated Patient Centred Care
3. Changes to Organisational Structures
4. Multi-disciplinary working and reporting (to extend beyond professional boundaries particularly in community services)
5. Non Pay cost reductions - via partnership
6. Revised cross cover and on-call tier reductions for example with NCHD grades in achieving compliance with EWTD.
7. Risk/Quality/Safety - better management (protocols, audit, care pathways, etc)
8. Evidence based performance measurement- drive continuous improvement efficiency / effectiveness
9. Merit based and competitive promotion policies
10. Strengthening individual, professional and statutory accountability for senior managers and clinicians
11. Centralisation of functional, transactional, support services and other services
12. Extended Working Day (8am-8pm) – where identified to meet service requirements
13. Extended working arrangements up to and including 24/7 emergency services – where identified to meet service requirements
14. Rostering arrangements including skill mix – to achieve the optimal match between staff levels, service activity levels and patient dependency levels across the working day/ week/ year
15. Medical Laboratory Service Modernisation

PSA Initiatives – Cork Area

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
Cork PCC	Mental Health	Revised rostering arrangements, introduction of skill mix and comprehensive structured annual leave	Q2	1,2,14
Cork PCC	Mental Health	Within a comprehensive 24 hour integrated management model implementation of revised nurse management arrangements at night	Q2	1,2, 14
Cork PCC	Mental Health	Expansion of community based services, including CMHGs, access to home based treatment and role out of community based model of care in line with VFC. Alignment of acute inpatient bed numbers with norms in VFC and associated staff reassignments	Q3	1,2,4, 7, 8, 13,14
Cork PCC	Mental Health	Introduction of expanded risk assessment protocols in community settings	On-going	7
Cork PCC	Mental Health	Participation in training	On-going	7
Cork PCC	Mental Health	Participation in development and implementation of care pathways	On-going	4,7, 8
Cork PCC	Disability	HSE services - Revised rostering arrangements, introduction of skill mix and comprehensive structured annual leave	Q1	1,2,14
Cork PCC	Older People	Implementation of Home Help hours target hours in line with 2012 target levels	Q1	1, 13
Cork PCC	Older People	Review and implement findings on staffing levels, rostering and skill mix in all hospitals	Q1	1,2, 4, 14
Cork PCC	Older People	South Lee - St. Finbarr's Hospital – Changes in work practices for establishment of a New Rapid Access Elderly Care referral OPD clinic in A&TC.	Q2	1,2,4, 7,8,14
Cork PCC	Older People	South Lee - St. Finbarr's Hospital - Changes in work practices for Establishment of a 10 bedded designated Stroke Rehabilitation service	Q1	1,2,4, 8,14
Cork PCC	Older People	Midleton Community Hospital - Medication Review System to be introduced by MDT at Midleton Community hospital to ensure the most appropriate therapeutic medication intervention are used for residents at the hospital.	On going	4 ,7
Cork PCC	Older People	Dunmanway Community Hospital - Pilot programme on performance coaching / management for all staff at Dunmanway Community Hospital to be carried out.	Q4	
Cork PCC	Older People	South West Cork Community Hospitals - Continence Wear Initiative. Staff at Castletownbere Community Hospital who have been trained in continence management will deliver a 2 day training programme to staff in the other community hospitals in the area.	Q4	5
Cork PCC	Older People	North Lee / North Cork – changes in models of service deliver for Wound Care Clinics	Q2	2,5, 7,8
Cork PCC	Older People	North Lee / North Cork - Podiatry: Working in partnership with voluntary groups on pilot initiatives to target high risk diabetic patients in conjunction with Diabetes Federation of Ireland, including access to hospital laboratory facilities, vascular services, etc.	Q1	2,5,7
Cork PCC	Children and Families	Eliminate (Reduction +/-) agency spend in Child Residential Unit through implementation of recommendations of independent review of fostering arrangement and revised rostering arrangements, introduction of skill mix and comprehensive structured annual leave	Q1	1,2,4, 14
Cork PCC	Children and Families	North Lee / North Cork - School vaccination & HPV vaccination clinics to be centralised in a number of locations	Q2	1,2,5, 7, 8,11
CUHG	Hospital Services	CASS Project Phase 1: Reorganisation of Clinical Administration Support Services - Medical and Surgical	Q1	1, 3, 11

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		Services. This involves a change in both work processes and administrative structures to maximise staff resources through centralisation of functions where possible. Restructuring and staff reassignment is also in line with pending clinical directorate restructuring and national OPD projects including the GP Referral project. DDVR Technology: The introduction and piloting/utilisation of Digital Dictation and Voice Recognition technology in selected areas is a complementary aspect of this project.		
CUHG	Hospital Services	CASS Project Phase 2: Reorganisation of Clinical Administration Support Services. This involves monitoring and review of Phase 1 and an assessment of the potential for reorganisation and reassignment within the remaining clinical areas and the wider clerical/administrative grouping.	Q2	1, 3, 11
CUHG	Hospital Services	Dietetics: Introduction of insulin pumps for diabetic children; integrated hospital and community outreach diabetes services based in Mallow hospital	Q1	2, 4
CUHG	Hospital Services	Physiotherapy: Reorganisation of service delivery pilot with senior physiotherapist in CUH A&E operating as a first contact practitioner in Mercy A&E. Proposal submitted regarding the introduction of Physiotherapy assistants in CUH through retraining.	Q4	1, 2,14
CUHG	Hospital Services	Radiation Oncology Services: Introduction of 10-6 pm shift for 2 machines in radiotherapy; weekly QA moved to pre-9am; Introduction of electronic booking process and E charts.	Q4	2,5, 13
CUHG	Hospital Services	Medical Records: Changes to ward plan and the introduction of paperless diagnostic results providing scope to reassign staff resulting from efficiencies. Policy to support movement of charts between hospitals. Enhanced use of technology to view all patient records.	Q4	1, 2,5
CUHG	Hospital Services	Medical Physics: Service improvements including the introduction of a brachytherapy prostate seed program for prostate cancer patients and an Intensity Modulated Radiation Therapy program for cancer patients. Process and Safety improvements including exploring new way of delivering treatment planning service with NCCP; Introduction of Q-Pulse for departmental policies and procedures; Monitoring of eye doses for staff involved in logical Interventional procedures.	Q4	2,7
CUHG	Hospital Services	Procurement: Point of use stock management through the utilisation of Kanban Stock Management Systems.	Q4	5
CUHG	Hospital Services	Laboratories. ICT and Work Process Improvements and Staff Reorganisation: Development of integrated electronic databases, tracking and ordering systems, fully auditable electronic POCT service, and LEAN based procedures and processes - facilitating integration and more efficient deployment of staff.	Q4	1, 5
CUHG	Hospital Services	CUMH: Reorganisation of work areas and reorganisation of work/staff to maximise resources - including in OPD and reception areas.	Q4	1, 3
CUHG	Hospital Services	OPD: Development of Work Processes and Procedures and Reorganisation of Clerical/administrative support services to facilitate efficiency improvements, the centralisation of functions, and the implementation of changes in line with national OPD initiatives and reorganisation of acute services including: Central Referral and Appointment management/scheduling; Central waiting list validation and management; Streamlining and consolidation of clinic preparation, management and delivery under single Governance; Dedicated neurology rooms in line with National	Q4	1, 2,3, 5, 7, 11

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		Neurology clinical care programme; Incorporation of additional new consultant led clinics within existing resources. Participation in pilot for new national GP referral project. Working with SIVUH in relation to the functioning of incoming OPD-related cardiac services under reorganisation.		
CUHG	Hospital Services	Acute Medical Unit: Implementation of medical assessment component in Q1 2012 with the introduction of acute surgical assessment to follow in Q2 2012 and further compliance to the National Clinical Care Programme. Involves the internal deployment of staff and skill mix opportunities	Q4	1,2, 3, 4,7
CUHG	Hospital Services	Implement the directorate model for the CUH group with clinical directors etc.		1, 2,3, 4, 7, 10
CUHG	Hospital Services	Nursing & Midwifery Rosters: Extension of the ED Computerised nurse rostering system to allow improved utilisation of the nursing resource. Pre-Operative Assessment to facilitate same day admission for surgery and increase bed management efficiencies.	Q4	1, 2, 14
CUHG	Hospital Services	Pharmacy Services: Assess the possibility of repatriating an element of the current compounding services into the Hospital	Q4	5
CUHG	Hospital Services	Radiology Services: Implementation of the Labour Court recommendations		6, 12
CUHG – MGH	Hospital Services	Mallow General Hospital: Implementation of the re-organisation of services for acute Hospitals including emergency care, elective surgery and diagnostics	Q4	1,2,3,7,10,14
CUHG – MGH	Hospital Services	Medical Roster Revision -Reduce Intern out of hours and reduction in reliance of Medical Registrar agency plus no consultant physician cover upon commencement of 4th consultant physician	Q1	6
CUHG – MGH	Hospital Services	Pathology Restructuring	Q2	1,15
MUH	Hospital Services	Centralised administrative support service	Q4	1, 2, 5,11
MUH	Hospital Services	Implementation of the national Radiography agreement	Q3	6
MUH	Hospital Services	Implementation of the Acute Medicine Programme in accordance with the National AMP Recommendations, in addition to the final outcome of the GIM Working Group.	Q2	1,2,7
BGH	Hospital Services	Radiography Department - Implementation of the Labour Court recommendations	Q4	12, 13
BGH	Hospital Services	Review staffing arrangement in the Nursing Department, Non Nursing & Administration Revised rostering arrangements, reassignment introduction of skill mix and comprehensive structured annual leave,	Q4	1,2,14
BGH	Hospital Services	Review of catering services including meal times for patients and serving system	Q4	5,14
	All service areas	Management / Administrative functions - re-configuration and reassignment of management & administration, local manpower planning to be undertaken to maximise efficiencies through revised working arrangements and introduction of IT	2012	1,2,3,5,11, 14
Cork PCC	Primary Care	Reassignment of South Lee SLT Manager as SLT Manager for Cork South	Q1	17
Cork PCC	Primary Care	Delivery of community SLT to adult clients to transfer to the Assessment & Treatment Centre (ATC) in St. Finbarrs Hospital.	Q1	2,3
Cork PCC	Primary Care	SLT - Joint working and sharing caseloads across Clonakilty (West Cork) and Bandon (South Lee) in delivery of Parent training programme for late talkers.	Q2	2, 3
Cork PCC	Primary Care	SLT - Introduction of new protocol for recording staff diaries and facilitating robust mechanism for management of client	Q1	7

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		appointments in West Cork		
Cork PCC	Primary Care	Wait list initiative for paediatric OT service West Cork	Q3	2. 8
Cork PCC	Public Analyst Lab	Organisation of a specialised Analytical Chemistry Service in collaboration with the FSAI and Dublin & Galway Public Analyst's Laboratories	On going	3,7,8
Cork PCC	Public Analyst Lab	New Food Sampling and Analysis Programme agreed with FSAI and EHS in December 2011 in use from January - December 2012	On going	7
Cork PCC	Public Analyst Lab	New Cosmetics sampling and analysis programme agreed in December 2012 between the EHS and IMB for use from January - December 2012.	On going	2,7
Cork PCC	Public Analyst Lab	Continued collaboration with the IMB and EHS on cosmetics monitoring and reaction to consumer alert notifications relating to chemical contaminants in cosmetics.	On going	2
Cork PCC	Public Analyst Lab	Multi-parameter chemical analyses of food samples to continue In 2012 (new areas identified for multi-parameter testing).	On going	2
Cork PCC	Public Analyst Lab	Continuation of 2011 DEMOCOPHES programme involving mercury analyses of hair samples from participants in the programme in Dublin and Leitrim	Q2	2
Cork PCC	Public Analyst Lab	Identification of new analytical methods for food and water monitoring	On going	
Cork PCC	Public Analyst Lab	Identification and development of new analytical methods for cosmetics monitoring	On going	2
Cork PCC	Public Analyst Lab	Validation of new analytical methods for food and water monitoring	On going	2
Cork PCC	Quality and Safety	Public Health Microbiology Laboratory, SFH - Extension to INAB scope of accreditation	Q4	2, 7
Cork PCC	Quality and Safety	Public Health Microbiology Laboratory, SFH - Collaborating with other official food microbiology laboratories at a national level to devise a standard reporting format for results	Q3	7
Cork PCC	Quality and Safety	Public Health Microbiology Laboratory, SFH - Collaborating with other official food microbiology laboratories at a national level to devise a standard test suite	Q3	7
Cork PCC	Quality and Safety	Public Health Microbiology Laboratory, SFH - Development of microbiological testing services for therapeutic waters from hospitals in the region (previously outsourced)	Q4	2
Cork PCC	Primary Care	South Lee PHN Service - Due to available resources restructuring of areas was carried out into defined area teams with a balanced skill-mix to enable services to be prioritised and delivered in an effective and timely manner and to ensure that the clinical risk to both patient and staff is minimised. Ongoing	Q1-Q4	1, 2,3, 6, 16
Cork PCC	Primary Care	South Lee PHN Service - Integration of the New Born Hearing Screening Protocol to the Home Birth Service to ensure a seamless referral system incorporating all community births.	Ongoing	2, 4, 7
Cork PCC	Management and Administration Function, South Lee	Centralising and merging of administrative departments such as immunisations staff with asylum seekers and clinic A staff to provide cross cover during leave. This will enable cross cover arrangements within the available resources including the provision of clerical support to HPV Ongoing reviews of work practices in this area to achieve efficiencies, cover and improved staff satisfaction. ongoing.	Q4	1,2,14
Cork PCC	Care group children, Management and	Limited resources available – reviewing existing processes throughout childcare manager's office, Pathways and social work – have identified options in relation to improved filing of closed files, a new approach to archived files (potential	Ongoing	5

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
	Administration Function South Lee	savings identified) other process also under review.		
Cork PCC	Management and Administration Function South Lee and West Cork	Reconfiguration of management structure in Cork ISA into two operational areas and teams.	Q1-Q4	1,2,3,4,7,8,10,11, 14
Cork PCC	All care groups - Cork South	Assessment and realignment of administrative supports moving into primary care team and network structures.	Q1-Q4	1,2,11, 14
Cork PCC	All care groups - Cork South	Review and realign current standing committee structures including RAGs, Early Intervention fora etc. to streamline allocation processes.	Q1-Q4	2
Cork PCC	All care groups, Schemes Department, financial support	Commence work on reconfiguring schemes and financial support functions across Cork ISA including payroll.	Q1-Q4	5,11
Cork PCC	Older persons, disability - Home Support Service Cork South	Home Support Manager roll to be rolled out across Cork South	Q1-Q4	1,2,7,8
Cork PCC	Care group older persons, disability. Home Support Department South Lee	Home Support Function to be reorganised and the Home Support Manager to take on West Cork home support services remit. This department will also continue to roll out the National Home Care Package Guidelines. The staff also monitor HCPs and assisted living services.	Q1-Q4	1,2,5,7,8
Cork PCC	All care groups - Cork South	Establish liaison with Acute Services with regard to discharge planning where home supports are required.	Q1-Q4	2,8
Cork PCC	Disability	Streamlining and centralising Assessment of Need (Disability Act) process across Cork ISA – one central point of application.	Q1-Q4	2,7,8
Cork PCC	Primary Care	Reconfigure OT and Physiotherapy departments across Cork ISA to ensure rotation of students across whole county.	Q1-Q4	1,2,4,8
Cork PCC	All care groups (except mental health) - Cork South	Service contracts manager – focus on streamlining processes for SLA and GA, also elimination of duplication and ensuring consistency of approach to voluntary sector providing services under s.38 and 39 of the health act.	Q1-Q4	2,3 4,5,11
Cork PCC	Cork South General Manager's Office	Streamlining of staff working areas through LEAN Project to ensure easy accessibility and cross cover	On-going	1,3,5
Cork PCC	Cork South General Manager's Office	Updating of filing systems currently in place through LEAN Project to ensure accuracy of records stored and archiving of old files	Complete/On-going	5
Cork PCC	Cork South General Manager's Office	Streamlining of general office area through LEAN Project to ensure all structures are easily identifiable and accessible	Complete/On-going	5
Cork PCC	Primary Care	Out patient Occupational Therapy assessments and treatments now available in new OT Assessment centre including Hand Injury Clinic, Wheelchair and seating assessments, Wheelchair repair clinic, Initial community assessments, Community Mental Health Assessments	Q1-Q4	2,4,8
Cork PCC	Disability Services	Pilot Reconfiguration of clinical management structure in HSE Cork residential ID services in response to changing staff resources	Q1-Q4	1,3,7
Cork PCC	Disability Services	Appropriate reassignment of admin/ management resources to support regional co-ordination of services	Q1-Q4	1,2,7
Cork PCC	Primary Care	Currently reconfiguring all West Cork PHNs and Community	Q1-Q4	1,2,4,7,8,14

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		Nurses in line with Primary Care Geomapping. Home Help Coordinators and Asst Directors of PHN already reconfigured		
Cork PCC	Older persons	All Public Health Services are reconfigured to Primary Care Teams. Each Network with an Assistant Director for line manager.	Q1-Q4	2,11
Cork PCC	All care groups - PHN services	Wound Clinics are run by a Clinical Nurse Specialist and Pre diabetes clinics are run in all Primary Care teams and available to all.	Q1-Q4	2,8
Cork PCC	Leased premises	Assessment of current leased premises HSE South to maximise value for money	Q1-Q4	5
Cork PCC	All care groups - PHN Supplies, Cork ISA	Examine related budget, product and processing to achieve value for money, economies of scale and savings	Q1-Q4	5
Cork PCC	All care groups - Incontinence Wear, Cork ISA	Examine incontinence wear products, budget, governance and processes with a view to achieving VFM, best practice and savings	Q1-Q4	5
Cork PCC	St. Finbarrs Hospital	St. Finbarr's Hospital - Change to rostering arrangements – Assessment &Treatment Centre to include later finish times to extend OPD clinics	Q1	1,2,13,14
Cork PCC	St. Finbarrs Hospital	St. Finbarr's Hospital - Establishment of a New Rapid Access Elderly Care referral OPD clinic in Assessment &Treatment Centre	Q2	1,2,13,14
Cork PCC	St. Finbarrs Hospital	St. Finbarr's Hospital - Alteration of MTA rostering arrangements to maximise contact time with hospital inpatient services - elimination of accrual of additional hours	Q3	1,2,14
Cork PCC	St. Finbarrs Hospital	St. Finbarr's Hospital - Establishment of a 10 bedded designated Stroke Rehabilitation service	Q1	1,2 ,14

PSA Initiatives – Kerry Area

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
Kerry PCSS	Mental Health	Revised rostering arrangements, redeployment of staff, introduction of skill mix and comprehensive structured annual leave, supported by IT	Ongoing from 2011 Service Plan Q1-Q2	1,2,14
Kerry PCSS	Older People	Implementation of Home Help hours target hours in line with 2012 target levels	Q1- ongoing	1,13
Kerry PCSS	Older People	Review of service provision across all community hospital services - Revised rostering arrangements & review skill mix to maximise bed usage & reduce reliance on agency staffing.	Ongoing from 2011 Service Plan Q1-ongoing	1, 2, 14
Kerry PCSS	Older People	Reconfiguration of PHN & RGN staff to ensure core elements of service are provided, with the reduced staffing levels	Q1-ongoing	1, 2
KGH	Hospital Services	Medical - reduction in Consultant Locums in the following areas * *General Surgery, Medicine, Anaesthetics*	Q1-Q4	6
KGH	Hospital Services	All services– Revised rosters, introduction of skill mix, and assignment flexibility e.g. in Phlebotomy, Laboratory, Portering,	Q1-Q4	1,2,5,8, 13,14

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		Catering, Radiology, Cleaning, CSSD		
KGH	Hospital Services	Nursing - Revised rostering arrangements, introduction of skill mix and comprehensive structured annual leave	Q1 -Q4	1,2, 14
KGH	Hospital Services	National Clinical Programmes – changes in models of care and introduction of revised rosters, skill mix and assignments to implement the clinical programmes and achievement of performance targets established by SDU	Q1-Q4	1,2, 7,8,14
KGH	Hospital Services	Divisional Structures – reorganisation of service delivery model to an integrated divisional structure, to improve clinical governance within the hospital	Q4	1, 3,4, 10
KHA	All service areas	Management / Administrative functions - re-configuration and reassignment of management & administration, local manpower planning to be undertaken to maximise efficiencies through revised working arrangements, and introduction of IT	Q1-Q4	1,2,4,5,7,8

PSA Initiatives – Waterford / Wexford Area

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
Wexford LHO	Mental Health	Continuation of implementation of VFC - restructuring and reorganisation in the Wexford area	Q1	3,14
Wexford LHO	Mental Health	Development of out-reach clinics for Child & Adolescent Psychiatry Services	Q1	2
Wexford LHO	Mental Health	Redeployment/Reassignment of staff from Wexford Mental Health Services with closure of wards in St. Senan's and transfer to new development 'Tus Nua', Enniscorthy.	Q4	1,3,14
Wexford LHO	Mental Health	Revised cross cover and on-call tier reductions - NCHDs removed from on-call on week-ends to become more compliant with EWTD	Q1	6
Wexford LHO	Mental Health	Reassignment of support staff to other patient focus roles e.g. Occupational Therapy Aide duties	Q1	1,4, 14
Wexford LHO	Mental Health	Support development and participation in Consumer Panel for Waterford/Wexford Mental Health Services in to have more patient centred care	Q3	2
Wexford LHO	Mental Health	Development of Key Worker role- provision of information to clients regarding services	Q4	2
Wexford	Disability Residential ID Services	Relocation of clients and staff to new house, 12 Km approx from Enniscorthy. Involving revised rosters	Q1	1,3, 14
Wexford	Disability Residential ID Services	Closure of Day Services attached to St John of God House, Enniscorthy with relocation of clients and staff to the new Millbrook Day Centre, 1 Km approx from original service. This also involved implementation of new rosters	Q1	1,3,14
Wexford LHO	Disabilities	Redeployment of DSA as Coordinator Early Intervention Services and expansion of role. Improved multidisciplinary team working re Autism Spectrum Disorder and Early Intervention Team	Q1	1
Wexford LHO	Residential ID Services	Provision of Catering Services by St John's Hospital Catering Service to 6 residential homes and 1 day centre for people with intellectual disabilities within existing resource	Q1	11
Wexford LHO	Older People	Provision of on call service by Home Help Coordinators for 2 months to support the SDU during December & January. Second	Q1	13

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		call provided by General Manager & TDO		
Wexford LHO	Older People	Redeployment of staff to meet service level needs in St. John's Community Hospital	Q1	1
Wexford LHO	Older People	Review of rostering arrangements including skill mix to maintain ongoing service provisions	Q1	1, 14
Wexford LHO	Older People	Reassignment of range of duties nursing & portering staff in New Houghton Hospital	Q1	1, 14
Wexford LHO	Children & Families	Redeployment of DSA as Clerical officer to Support the Immunisation Team	Q1	1
Wexford LHO	Children & Families	Relocation of breast feeding support clinic from rented premises to Ely Hospital	Q1	5
Wexford LHO	Primary Care	Relocation of medical, nursing, clerical & EHO staff with closure of St John of God House and part of St Senan's Hospital to other part of St Senan's Hosp	Q1	1,14
Wexford LHO	Primary Care	Workforce Planning within Physiotherapy Services to improve productivity per clinical area	Q1	2
Wexford LHO	Primary Care	Improved services to patients with chronic conditions within Physiotherapy Services with provision of “back school” in Wexford County	Q1	1, 2
Wexford LHO	Primary Care	Redeployment of Physiotherapy staff to address backlog in Waiting list	Q1	1
Wexford LHO	Primary Care	Extension of services to GPs within existing resources involving Acute and Non acute service providers	Q1	2
Wexford LHO	Primary Care	Development of chronic knee programme within Physiotherapy services - evidence based within existing resources	Q1	1,8
Wexford LHO	Primary Care	Further development of new role of Physio Therapy Manager 3 to manage acute and non acute services in Co. Wexford within existing resources	Q1	1, 2, 3
Wexford LHO	Primary Care	Review of patient registers in the 4 sectors, validation of waiting lists, improved data collection mechanisms to enable service delivery analysis	Q1	2,7, 8
Wexford LHO	Primary Care	Expansion of Home Care Packages to week-ends - extended working arrangements to include Saturday work	Q1	1,13
Wexford LHO	Primary Care	Expansion of Primary Care teams, enhanced multi-disciplinary working, relocation of staff to other premises	Q1	1, 2,4
Wexford LHO	Primary Care	Assessment of Need for Psychology within Primary Care - redeployment of staff	Q1	1, 2
Wexford LHO	Primary Care	Development of a register for XPERT (Dietic Programme) for Wexford within existing resources	Q1	1
Wexford LHO	Primary Care	Enhanced ICT provision through provision of software and training towards evidence based performance measurement	Q1	7, 8
Wexford LHO	Primary Care	Multi-disciplinary working to improve integrated patient centred care, development of seminar for GPs and Pharmacists to improve Team Working with Substance Misuse team	Q2	1, 2, 7
Wexford LHO	Primary Care	Developing Community Engagement Programme	Q2	2
Wexford LHO	Primary Care	Commencing process of Community Needs Assessment within Primary Care	Q2	2,4
Wexford LHO	Primary Care	Provision of Enuretics clinics - within existing resources	Q1	2
Wexford LHO	Primary Care	Reassignment of staff to service level needs within Public Health Nursing Services	Q1	1
Wexford LHO	Primary Care	Rationalisation of Health Centres and relocation of staff to central services	Q1	1,11
WRH	Hospital Services	Revised rostering arrangements, introduction of skill mix and comprehensive structured annual leave	Ongoing	14
WRH	Hospital Services	Implementation of the Acute Medical Programme (AMP) -will contribute to reduction in Average Length of Stay (ALOS) for	Q2	1,2,4,5, 6,7,8, 14

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
		Acute Medicine in line with NSP 12/SDU targets		
WRH	Hospital Services	Efficiencies - Demand Management Regional Laboratory Services - Community and Hospital	Q1	2, 4, 5, 7, 8, 15
WRH	Hospital Services	Efficiencies in Medical Pay Budget –Minimisation of agency, locum cover limited to 1:3 rotas – restructuring of replacement consultant posts	Q1	1, 2, 4,6,7,8, 14
WRH	Hospital Services	Clerical / Admin - Reorganisation of Clerical/Administration staff to facilitate the continued provision of secretarial support services to medical staff in WRH and to provide secretarial support services to existing, new consultants and services and to ensure admin support to clinical area including cross-cover to cover short-term absences.	Q2	1, 3, 6,7,8,10, 14
WRH	Hospital Services	Support Services - Review of Portering/Attending support services to maximise efficiency and utilisation of staffing resource	Q2	1, 2, 3, 8, 14
WRH	Hospital Services	Support Services - Review of current theatre porter service to ensure that theatres are fully supported and in line with TPOT initiative	Q2	1, 2, 3, 8, 14
WRH	Hospital Services	Realignment of staff all grades & disciplines to support rollout of national clinical Programmes (NDQCC) – Acute Medicine Programme, and all clinical programmes including new Corporate and Clinical Governance Structures and Reporting arrangements as set out in NSP 2011. The National Clinical Programmes will require changes in working practices across all grades and disciplines but will have a specific impact on Clinical staff and Depts., Medical, Nursing and H&SCPG, Pharmacy and all support staff grades.	Q4	1,2, 3, 4, 6, 7, 8,10, 11, 12, 14
WRH	Hospital Services	Reorganise catering service delivery model to support service level needs	Q4	1,3, 7, 11
WGH	Hospital Services	Radiology Department - Extend the Working Day and review on call arrangements for Clinical Staff in line with the Extended Working for Radiography Grades Agreement	Q1	12,13,14
WGH	Hospital Services	Technical Services Department - Review of rosters and on call agreements with a view to introducing an extended working day.	Q1	14
WGH	Hospital Services	Administration - Temporary reassignment of staff to Ambulance Service	Q1	1
WGH	Hospital Services	Physiotherapy Department - Extended working day to facilitate early morning/late afternoon/early evening appointments in Physiotherapy	Q1	12,13,14
WGH	Hospital Services	Theatre Department - Further revision of nursing roster and on call arrangements within the Theatre Department.	Q1	13, 14
	All service areas	Management / Administrative functions - re-configuration and reassignment of management & administration, local manpower planning to be undertaken to maximise efficiencies through revised working arrangements and introduction of IT	2012	1,2,5

PSA Initiatives – Carlow / Kilkenny & South Tipperary Area

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
Carlow / Kilkenny LHO	Mental Health	Reorganisation Nurse Management revision of on-call system in Carlow,	Q1	6, 14
Carlow / Kilkenny LHO	Mental Health	- In line with National Strategy 'Vision for Change', Carlow/Kilkenny Mental Health Service has been reorganised through a comprehensive Hostel review process and the closure of St. Patrick's Ward at St. Dympna's Hospital, Carlow.	Q1	1, 3, 4, 13
Carlow / Kilkenny LHO	Mental Health	Integrated management of Consultants annual leave in Carlow/Kilkenny Mental Health Services.	Q1	6, 13, 14
South Tipperary LHO	Mental Health	Minimisation of NCHD overtime and on call	Q2	6, 13
South Tipperary LHO	Mental Health	Integrated management of locum replacement for annual leave of Consultants. Potential savings from integrated approach to management of annual leave for the five Consultants in South Tipperary Mental Health Services. Child & Adolescent services to be maintained in current format to ensure ongoing service delivery.	Q2	6, 13, 14
South Tipperary LHO	Disability	Damien House Services revised rosters to include the introduction of 'sleep-overs' to meet service demands	Q1	1, 14
South Tipperary LHO	Disability	Damien House Services Reassignment of duties to support day services due to reorganisation of services in dedicated day service house	Q1	1, 6
South Tipperary LHO	Disability	Home Care Support Implementation of hours in line with 2012 target levels	Q1	1
Carlow / Kilkenny LHO	Older People	Home Help Services Implementation of Home Help hours target hours in line with 2012 target levels	Q1	1, 13
Carlow / Kilkenny LHO	Older People	Consolidation of Elderly Care Beds in Carlow / Kilkenny (Long-Stay Re-organisation and consolidation of Elderly Long Stay beds in Sacred Hospital, Carlow & St. Columba's and associated changes to rostering and skill mix	Q1	1, 2, 14
Carlow / Kilkenny LHO	Older People	Consolidation of Elderly Care Beds in Carlow/Kilkenny (District Hospitals-This proposal consolidates the provision of community support beds (respite, convalescence and associated changes to rostering and skill mix	Q1	1, 2, 14
South Tipperary LHO	Older People	Home Help Services: Home Help Services Implementation of Home Help hours target hours in line with 2012 target levels	Q1	1, 13
South Tipperary LHO	Older People	Consolidation of District Hospital services in South Tipperary i.e. St. Brigid's Hospital Carrick-on-Suir and St. Teresa's Hospital, Clogheen and associated changes to rostering and skill mix	Q1	1, 5 & 14
South Tipperary LHO	Older People	Long-Stay Elderly Beds South Tipperary- Consolidation of provision of Long Stay Elderly care beds and associated changes to rostering and skill mix	Q1	1, 5 & 14
Carlow / Kilkenny LHO	Older People	Reorganisation of Public Health Nursing services	Q1	1, 3
Carlow / Kilkenny LHO	Children and Families	Reduction Agency Costs & greater efficiency in Staff Rosters and skill mix	Q1	12, 13, 14

Location	Area of Modernisation	One line description of Change	Timeframe	PSA Health Sectoral Agreement Section 2.9 Measures 1-15
Carlow / Kilkenny LHO	Children and Families	Restructuring of Children and Families Psychology Services.	Q1	1, 4, 13
SLGH and Kilcreene	Hospital Services	Surgical Programme implementation of programme involving the internal deployment of staff and skill mix opportunities	Q1	8, 10, 14
SLGH and Kilcreene	Hospital Services	Acute Medical Programme. implementation of programme involving the internal deployment of staff and skill mix opportunities	Q1	8, 10, 14
SLGH and Kilcreene	Hospital Services	Laboratory, Equipment, Radiology, Transport & Contract savings. - New automation being introduced for blood transfusion. This will reduce overtime required for B	Q1	15
SLGH and Kilcreene	Hospital Services	Limited Consultant Cross-cover of leave for Radiology and all specialities where there is a greater than 1:3 ratio.	Q1	6, 12
SLGH and Kilcreene	Hospital Services	Revise NCHD rotas further to provide for a cost-effective delivery of NCHD on-call services across all specialities	Q1	6, 12, 14
SLGH and Kilcreene	Hospital Services	Radiography and Laboratory Payroll Costs. - Reduction in costs in line with nationally agreed Laboratory & Radiology agreements	Q3	12, 13, 14
SLGH and Kilcreene	Hospital Services	Administrative efficiencies - Overtime & Agency reductions. This involves changes to staff rostering, planned annual leave to tie in with seasonal reductions, flexibility in assignment of duties	Q1	1, 11, 12
SLGH and Kilcreene	Hospital Services	Support Staff: Reorganisation of work rosters under the PSA in portering, catering, housekeeping and maintenance services	Q1	14
STGH	Hospital Services	National Clinical Programmes Refocusing patient management pathways to match National performance requirements, Clinical Programme initiatives involving the internal deployment of staff and skill mix opportunities	Q1	8, 10, 14
STGH	Hospital Services	Workforce Planning/Reorganisation - STGH is engaged in an ongoing process of reorganisation and redeployment of staffing resources	Q1	1, 4, 13
STGH	Hospital Services	Full-year effect of 2011 changes to NCHD rosters reducing actual hours paid, unrostered overtime, rostered overtime and agency usage across all specialities.	Q1	6,14
STGH	Hospital Services	Radiography on-call.- Reduction in costs in line with impending national Radiology agreement	Q2	6
All Locations	All service areas	Management / Administrative functions - re-configuration and reassignment of management & administration, local manpower planning to be undertaken to maximise efficiencies through revised working arrangements and introduction of IT	2012	1,2,5