Health Service

National Service Plan 2014

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Our Service Priorities

System Wide Priority Areas

Quality and Patient Safety
- Patient experience
- Preventing Health Care Associated Infections (HCAI)
- Medication management

National Clinical Strategy and Programmes
- Quality
- Patient flow
- Chronic disease prevention and management
- Demographic planning

Service Priority Areas

Acute Services

Acute Hospital Services
- Patient safety and quality
- Access to services
- Integrated care through strategic reform
- Financial allocation and human resource planning

National Cancer Control Programme
- National medical and haemato-oncology
- Hereditary cancer programme
- Designated Cancer Centres
- Quality and safety standards

Palliative Care
- Adult palliative care
- Quality, efficiency and effectiveness
- Community based paediatric palliative care

Primary Care

Primary Care
- Primary care teams
- Health and social care networks
- GP services for children aged 5 years and under
- Alignment of national clinical strategy, programmes and primary care

Social Inclusion
- Substance misuse
- Hepatitis C
- Homelessness
- Ethnic and cultural diversity

Primary Care Reimbursement Service
- Medical Cards and GP Visit Cards: efficient provision and probity
- Guideline changes: Medical Cards and GP Visit Cards for persons aged 70 and over; persons returning to work
- Drug reference pricing and generic substitution

National Ambulance Service
- Ambulance response times
- Quality and patient safety measures
- A single National Control Centre over two sites

Health and Wellbeing
- Chronic disease prevention addressing tobacco use, diet, physical inactivity, alcohol misuse and mental wellbeing
- Immunisation, child health and screening
- Enforcement of legislation to protect health and wellbeing
- Infectious diseases, environmental health threats and emergency management
- Healthy Ireland framework

Mental Health
- A clinical programme to establish a standard model of care to progress A Vision for Change
- Positive mental health and improved approach to suicide prevention
- Operational barriers addressed to improve service effectiveness

Social Care

Disability Services
- Implementation Framework – Value for Money and Policy Review
- People moving from institutional settings to homes in the community
- Reconfiguration of day services and young people leaving school / rehabilitation programmes
- Disability services for children and young people (0 – 18s)
- Service user involvement and quality in the development of services
- Management and information systems

Services for Older People
- Comprehensive home and community services to enable older persons to live independently at home
- Service improvement programme and integrated models of care for older people
- Service user engagement programme
- Single assessment tool implementation
- Keep older people well

The Health Service is committed to safe, quality care underpinned by clinical effectiveness
This is reflected in the priority areas above which highlight the service delivery focus in 2014
These priority areas are further detailed in each of the sections within this Plan

Contents

Introduction

This National Service Plan 2014 (NSP2014) is the first annual plan presented by the Directorate of the Health Service (hereafter in this Plan referred to as the Health Service), following the enactment of the *Health Service Executive*[1] *(Governance) Act 2013*. It sets out the type and volume of services, as required under legislation, which will be provided within the funding provided by Government.

The Plan is also the first since the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (The Francis Report)* in February, the findings of which highlighted, in the starkest of ways, the need for a renewed collective commitment to providing the highest quality care in the safest of healthcare environments. The 'Keogh Report' which followed this Enquiry again identified poor standards of patient care in a further 14 hospital trusts in England. The Report set out through eight clear ambitions the help and support that was needed to assist healthcare providers in accelerating improvements in the quality of care they provide while also tackling some of the causes of poor care. Similar findings and recommendations were also echoed in both the Health Service and Health Information and Quality Authority (HIQA) investigations into the safety, quality and standards of services provided to patients, resulting from the death of Ms. Savita Halappanavar at Galway University Hospital. While this Plan for 2014 sets out both the type and volume of services to be delivered by the Health Service for the money provided to it by the Oireachtas, it also has threaded through it a requirement that at a time of further financial contraction, it is especially important to ensure that providing the best level of care for patients and service users, must be at the forefront of planning for and management of services.

This commitment is also a central theme of *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015* which will be further progressed through the period of this Plan.

The core purpose of the Health Service is therefore to provide effective, safe, high quality health and personal social services to the population of Ireland. In this context the National Service Plan sets out the work of the Health Service in 2014 in the areas of:

- Quality and patient safety
- The reform of services
- The services that will be delivered across the full range of acute hospital, community, personal and social care services

The Plan also describes the funding framework for 2014 together with the staffing levels available to deliver these services across the country. In preparing the Plan, a considerable focus was placed on the need to ensure that while budgets are being reduced across all services, we are aiming at the same time to maximise efficiencies and ensure that we maintain sustainable levels of service with quality and patient care at the heart of everything we do.

Quality and Patient Safety

Underpinning the delivery of all our services is the commitment to ensuring high quality and safety. This will remain an important focus in 2014. In particular the Health Service will:

- Ensure that each Director and the managers and clinicians within their areas of service are responsible and accountable for ensuring the provision of safe, quality services
- Support quality improvement initiatives across the health services that aim to enhance patient safety
- Improve the experience of patients and service users within the health services
- Ensure that standards, policies and guidelines are understood and appropriately implemented by Health Service staff
- Put in place a comprehensive set of quality and safety indicators to measure the quality and safety of our services

All Health Service staff, individually and collectively, have a responsibility for the quality of the services they deliver to the patients and service users in their care, and must integrate a commitment to quality and safety into their core work and practice.

[1] *The Health Service Executive (HSE) was established under the Health Act 2004 and is the statutory body responsible for the provision of health and personal social services in Ireland.*

Our Funding

Financial context 2014

The Health Service is facing the most severe financial challenge in 2014 resulting from a reduction to its funding base and a significant additional savings target being required. Budget 2014 means that the Health Service will have an overall gross Vote reduction of *€272m* and a savings target of *€619m* for 2014. This challenge comes at a time when the demand for health services is increasing every year, which in turn is driving costs upwards. The following are some of the drivers of demand and cost.

- The population has grown by 8% since 2006.
- The number of people over 65 years of age increased by 14% since 2006.
- The current economic downturn and high unemployment rate means that more individuals than ever have Medical Cards. As of September 2013, more than 1.8 million Medical Cards were in circulation, covering 40.6% of the population. This is an increase of almost 590,000 or 46% since the start 2008.
- Chronic disease continues to increase and the number of adults with chronic conditions is expected to increase by 40% by 2020. Currently 61% of adults are overweight and the estimated economic cost of obesity alone per annum is approximately €1.13 billion (bn). Dealing with the consequences of the use and misuse of alcohol which contributes to the chronic disease burden, costs the State €3.7bn annually. Between €1bn and €2bn per annum of the health budget is spent on treating tobacco related disease.
- Advances in the development of medical technologies which, while they improve patient outcomes, are highly cost-intensive. Examples include developments in interventional radiology, a new drug for cystic fibrosis, new oral anti-coagulant drugs and developments in orthopaedic implants.

Income and receipts in 2014

With increased demand continuing to put an upward pressure on costs, it is important to recognise that while the majority of funding for health services comes from the Exchequer, there are also other significant contributors to funding. The general public will contribute *€386 million (m)* in hospital charges in 2014 and *€124m* for prescription charges, (rising from €81m in 2013). In addition *€524m* will come from staff in the form of pension levy receipts and pension contributions. Other amounts bring the total to *€1.541bn*.

Voluntary hospitals and voluntary bodies are also separately generating their own income from other sources and are funded on a net basis from the Health Service Vote.

Incoming receipts for 2014 consists of the following:

	€m
1. Pension levy receipts and pension contributions from staff	524
2. Statutory charges in public hospitals, long-stay charges and charges for maintenance in private and semi-private accommodation in public hospitals	386
3. Prescription charges	124
4. Receipts from other EU states for services provided	181
5. Excise duties on tobacco products	167
6. Other receipts	159
Overall total:	1,541

Approach to meeting the financial challenge in 2014

The gross current voted estimate for the Health Service (including Children and Families) in 2014 is *€13.120bn*. Between 2008 and 2013 the Health Service budget has reduced by *€3.3bn (22%)*. Additional savings totalling *€619m* are required in 2014, which will bring the total level of reductions to almost *€4bn* over 6 years.

In its initial assessment of health service requirements for 2014, the Health Service approved a formal submission to the Department of Health (DoH) reflecting the need to sustain safe services at the current levels, while at the same time responding to:

- Known cost pressures
- Demographic requirements

- Critical service priorities
- *Programme for Government* commitments
- Service developments and quality initiatives

There is an underlying projected deficit of €419m including full year cost of 2013 developments; this is in addition to savings targets of €619m.

Since Budget day, the Directorate has been actively assessing what is achievable and deliverable in 2014, within the constraints of the financial and human resources available. In doing this we were faced with some stark choices. In broad terms, development of the Plan entailed consideration of:

- Either reducing or closing services
- Exploring ways in which the 2014 budget could be managed in order to maximise the financial resources available and to minimise the impact of the overall budgetary reduction on patients and front line services

The Directorate has, as a priority, decided to put forward a plan that protects core services in 2014 and has therefore adopted a multi pronged approach to budget management. The specific elements of the financial management approach for 2014 will involve the following:

1. In line with the published Abridged Estimates Volume (AEV), a reduction in the pension lump sum provisions will be used to offset, in part, the incoming deficit from 2013.
2. Making use of the time related savings which will arise in 2014.
3. Additional budget adjustments and cost containment measures of ***€129m*** have also been identified. These include savings in the areas of procurement €30m, shared services €10m, value for money €10m, hospital reconfiguration €7.5m, energy efficiency savings €15m and full delivery of the 2013 cost containment plans of €56.5m for hospitals (this does not reduce budgets for 2014 for these hospitals)
4. In relation to the ***€619m*** savings identified in the AEV a number of specific actions are being taken as set out below:
    - Pay and flexibility reductions totalling ***€268m*** are required in 2014. Of this €268m, *Haddington Road Agreement* actions will facilitate up to €140m in reductions, €108m relates to unspecified savings and €20m is in respect of employment control. In addition €150m reductions were also specified in 2013 and these must be delivered in 2014 bringing the overall challenge to €418m. The delivery of these reductions is a central component of the NSP 2014. A national assurance process has been put in place to work with service managers to identify and implement measures to deliver these savings. Managers will maximise the provisions of the *Haddington Road Agreement* in a way that delivers savings and ensures that services are delivered in the most cost effect and efficient manner. Progress on delivery will be monitored closely
    - Of the total €268m, ***€108m*** relates to unspecified pay savings and will be held centrally pending a separate process.
    - A further ***€80m*** related to the *Haddington Road Agreement* are also being held centrally, in the first instance, and will be allocated to individual services following an assessment of the most appropriate allocation of the savings across each service location. The health service is extremely diverse and pro rata allocation of this portion of the *Haddington Road Agreement* savings would not support optimal achievement of savings
    - The AEV contained a figure of €113m in respect of new probity measures for PCRS. Following a review it has been ascertained that this level of savings cannot be delivered from probity within the current guidelines. Therefore an allocation of €47m has been made within the Revised Estimate Volume, €3m will be included in addition to the existing €20m identified for probity, and €63m will be utilised from the pension budget. These three elements account for the €113m set out in the original AEV.

By adopting this budget management approach, it will be possible to allocate funding of ***€304m***, of which ***€178m*** will be invested in a number of critical service developments and to meet some demographic pressures and Programme for Government initiatives (see Appendix 1). A further ***€126m*** will be provided on a once off basis to address the full year costs of 2013 in 2014.

This approach however is not without risks, particularly in respect of the reduced pension lump sum provision. If the number of staff retiring is greater than the number of pensions provided for, there will be insufficient funding available. This will be kept under review.

It remains clear that 2014 will be an extremely demanding year for the Health Service and it will face specific challenges, many of which are identified within the Plan. However the Plan aims to ensure that we continue to deliver high quality, safe services across the country and to minimise the impact of the contracting resources on these services. The

approach to budget management as set out will be a critical component of the overall health service management strategy for the year and offers the best option to allow the Health Service sustain the core level of service provision.

Reforming the way we deliver our services

Future Health: The Reform Programme

In 2012, the Minister for Health published *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015.* This framework, based on commitments in the *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years with a focus on the four pillars of reform: Structural, Financial, Service, and Health and Wellbeing.

A Health Reform Programme Board has been put in place in the DoH to provide a central overarching coordinating function to drive the reform programme. This ensures that a structured service-wide approach is taken to implementation with all of the various work streams pulling together to achieve the overall reform objective.

Delivery of the first phase of the reform of health structures has already commenced with the establishment of the Health Service in July 2013, as the precursor to the Healthcare Commissioning Agency. Services are now organised into Divisions covering acute hospitals, primary care, social care, mental health, and health and wellbeing services. In 2014 there will be a focus on establishing the new hospital groups and community organisations that will eventually become Independent Trusts.

2014 will see further progress being made on the implementation of administrative reform through:

- Preparing for the establishment of the Healthcare Commissioning Agency and beginning to model the split between the purchaser and providers of service. A commissioning framework will be developed to support this
- The establishment of Hospital Groups and development of new community, personal and social care services structures
- The new Patient Safety Agency will be established on an administrative basis in advance of its establishment on a statutory basis
- The transfer of responsibilities for children and family services from the Health Service to the new Child and Family Agency in 2014
- The phased implementation of a 'money follows the patient' (MFTP) approach across acute hospitals. In the first phase, the hospitals currently part of the Casemix programme will, from January 2014, have their inpatient and day case activity funded on the basis of activity completed and the achievement of predetermined activity targets subject to an overall budgetary ceiling. A new National Pricing Office will be established on an administrative basis and will have responsibility for the pricing / tariff function

Healthy Ireland

The 2013 edition of *Health at a Glance* by the Organisation for Economic Cooperation and Development (OECD) shows that Ireland continues to make substantive headway in improving health outcomes. Mortality due to cancer fell by 21%, ischemic heart disease by 59% and cerebrovascular disease by 54% between 1990 and 2011. In all three instances, the rate of decline was greater than the OECD average. Life expectancy in Ireland has increased by a full four years since 2000 to reach 80.6 years today, over the OECD average of 80.1 years.

During 2013 the government published a major policy, *Healthy Ireland, a Framework for Improved Health and Wellbeing 2013-2025*. *Healthy Ireland* sets out a whole of government and cross sectoral approach to addressing the challenges of an ageing population, together with the demands being placed on health services resulting from the growth in the incidence of chronic illness.

Chronic diseases such as cancer, cardiovascular and chronic respiratory disease and diabetes are the leading cause of mortality, accounting for 60% of deaths worldwide and 76% of deaths in Ireland. Managing ill health resulting from chronic conditions including obesity and their risk factors is expensive and is a major driver of healthcare costs. Chronic disease is generally preventable and its increase is largely attributable to behavioural factors that can be addressed and modified. At least 30% of cancers and 80% of heart disease, stroke and Type 2 diabetes can be prevented through regular physical activity, a healthy diet and non use of tobacco products.

Healthy Ireland supports action to:

- Increase the proportion of people who are healthy at all stages of life

- Reduce health inequalities
- Protect the public from threats to health and wellbeing
- Create an environment where individuals and sectors of society can play their part in achieving a healthy Ireland

A priority for 2014 will be the development of a three year health service implementation plan for *Healthy Ireland*.

National Clinical and Integrated Care Programmes and National Cancer Control Programme

Central to the significant transformation that is underway across the health services is the work of the National Clinical Programmes. These clinically led Programmes provide a strategic approach to the reform of a broad range of services in the acute, community and social care sectors. The Programmes are modernising the way in which services are provided through standardising the delivery of high quality, safe and efficient services. During 2014 there will be a focus on designing and implementing a number of integrated care models that span acute, mental health, primary care, social care and health and wellbeing services.

The National Cancer Control Programme will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally.

Financial reform

Financial reform continues to be a priority for the Health Service and a multi year financial development project commenced in 2013. Work will continue in 2014 to develop and implement a common chart of accounts and integrated financial management system.

Shared services

The development of shared services in both the wider public service and the health services is a key priority for Government. A *Health Shared Services Strategy* will reflect the ambition of the Health Reform Programme to ensure that in line with modern business practices, our health and social services have access to a range of common business support services on a shared basis. Implementation of this strategy will be a focus of work in 2014.

Our Workforce

The staff of the Health Service, nurses, clinicians, health and social care professionals, clerical, administrative and general support staff, continue to be its most valuable resource. Without them, it would not be possible to deliver the wide range of services delivered every day across the country. The Health Service is committed to ensuring a culture where the work of staff is valued and understood by the communities served. Fundamental therefore to the reform of the health services through the clinical programmes or the structural reforms, is the requirement to continue building the expertise and skills of staff at all levels in leadership, process change and management. This will remain a focus in 2014.

This development of the workforce will take place against the backdrop of the Health Service requirement to reduce its workforce to approximately *98,000* whole-time equivalents (WTEs) in 2014. This would mean a net reduction of *2,600 WTEs*. Approximately *500* new service development posts will also be provided for under this Plan and this, coupled with the ongoing recruitment process for key front line staff, means that the Health Service would be required to reduce overall staff numbers by approximately *3,600 WTEs* in the course of this Plan.

The planned reduction in 2014 will be on top of a reduction of *12,505 WTEs* or *-11%* from the peak of employment in the Health Service in 2007.

In relation to the range of pay and productivity measures under the *Haddington Road Agreement*, all health service managers will be expected to review their current service delivery models to maximise the provisions of the Agreement to ensure that services are delivered in the most cost effective and efficient manner. Hospital CEOs, Area Managers, CEOs of voluntary agencies and service managers at all levels have responsibility to directly engage with their staff, and be accountable for the delivery of the *Haddington Road Agreement* within their own organisations and workforce.

Health and Safety at Work

The *Safety, Health and Welfare at Work Act, 2005* sets out the duties of employers and their employees regarding safety and health in the workplace. The Act places duties of care on employers to manage and conduct their undertakings so that they are safe for employees. In turn, the 2005 Act requires that employees work in a safe and responsible manner and cooperate with their employer in order to comply with the law.

In 2013 a review of health and safety performance was undertaken across the Health Service. The purpose of the review was to assess whether the current occupational health and safety policy, procedures, resources and system of management are aligned and fit for purpose. Developing a full suite of performance indicators will be a key priority in 2014 and the findings of this review will continue to be implemented during the year.

Children First

During 2014 an implementation plan for 'Keeping Children Safe' will be developed to ensure that the safety and wellbeing of children is protected and promoted in accordance with the *Children First Bill 2012* when enacted, and other relevant legislation. In addition, a Health Service National Level Oversight Group will be established and progress reports on implementation will be submitted to the Department of Health High Level Group.

Risks to the Delivery of the National Service Plan

Given the significant financial challenges facing the Health Service, set out below are some of the key risks to the delivery of the Plan. While every effort will be made to mitigate these risks, it will not be possible to eliminate them in full.

- Continued implementation of the Reform Programme requires a clear road map for the changes to be implemented in 2014 and beyond. Building the organisational capacity to deliver this change, effective planning will be essential to ensuring the overall governance and stability of services across the country in the midst of these changes.
- In the event that that budget for pension lump sums is not sufficient to pay the numbers of staff retiring there will be an unfunded liability for the Health Service. Given the risk involved, implementation of this approach will be closely monitored throughout the year as part of the Financial Reporting process.
- The €63m against the elimination of the €113m probity measure will require a further process to consider the allocation required for pensions in this context. This process will involve the Departments of An Taoiseach, Health and Public Expenditure and Reform with a view to agreeing realistic and detailed implementation plans to achieve the 2014 savings targets.
- Unspecified pay savings of €108m remain to be allocated and will be the subject of a separate process. Until a plan is in place setting out how these savings might be achieved, they pose a risk to the overall approach to financial management in 2014.
- Continued demographic pressures and the increasing demand for services over and above the planned levels for 2014.
- The Health Service Children and Family services will transfer to the new Child and Family Agency from the 1st January 2014. In decoupling children and family services from the Health Service it will be essential to ensure at all times the focus remains on the safety and wellbeing of children as this separation takes place.
- In the absence of significant capital investment to bring public long stay residential care facilities in line with HIQA standards, there may be a reduction in residential care capacity, with a resulting increase in hospital and community waiting times. Meeting new HIQA standards within the Disability sector will also pose a significant challenge given the current budgetary constraints.

Accountability

The enactment of the *Health Service Executive (Governance) Act 2013* has strengthened the accountability arrangements between the Health Service and the Minister for Health. In this context, a Directorate has been established as the governing body for the Health Service. The Director General as Chair, and seven Directors have been appointed. A formal scheme of delegations is also in place which clearly defines the line of accountability for each service area.

The National Service Plan is the annual contract between the Health Service and the Minister. It sets out the type and volume of services to be provided within the budget allocated. The National Plan is supported by Operational Plans which set out the detail in relation to the services to be delivered by each service Division (Acute, Health and Wellbeing, Primary Care, Mental Health and Social Care) and by the National Ambulance Service. Each Director is accountable for delivery of the plan in their area of responsibility. This includes an explicit requirement to deliver a balanced budget.

As part of the overall accountability framework for the Health Service, a sub group of the Directorate has been established as the National Planning, Performance and Assurance Group. Over the course of 2014, implementation of the Plan will be monitored on a monthly basis. In particular, the assurance process will monitor how the health services are delivering the Plan with a specific emphasis on quality, activity, financial performance and managing our workforce. A formal monthly Performance Assurance Report will be prepared for the Minister and published.

On an annual basis the Health Service produces and publishes its annual report which includes the Annual Financial Statements for the Health Service.

A formal governance framework is also in place to manage the funding relationship with the non statutory sector. All funded agencies are required to enter into and sign formal and comprehensive service agreements or grant aid agreements.

Conclusion

It is acknowledged that the Plan has been formulated in the context of what will be one of the most financially challenging years yet faced by the Health Service. The implications of the combined budget reductions and additional savings targets mean that a specific financial management strategy is required in 2014, the aim of which will be to ensure that the impact of the budgetary challenge on services is kept to a minimum.

- The main elements of this strategy include an approach to budget management that will reduce the level of provision being made for pensions. The savings achieved from pensions will be used to fund, in 2014, the incoming deficit from 2013.
- It will be very challenging in 2014 to fully meet all of the growing demands being placed on the health services. In particular, some service priorities and demographic pressures may not be met. However the budget management approach outlined above has allowed the Health Service to invest in a number of significant and critical service priority areas in 2014.
- The required savings target of €108m of unspecified pay savings is the subject of a separate process which will involve the Departments of An Taoiseach, Health and Public expenditure and Reform with a view to finalising realistic and detailed implementation plans to achieve the 2014 savings targets.

Implementation of the Health Service Reform Programme will also be a key priority for 2014. In this context the work of the National Clinical Programmes will also be progressed to ensure that real improvements in the way we deliver our services continue to be implemented. This important work will be supported by the continued implementation of the *Haddington Road Agreement*, which will afford us the opportunity to achieve greater efficiencies across all of our services.

Finally, while 2014 will be a very challenging year on many fronts, it will be with the commitment and dedication of all our staff that the Health Service will be able to meet these challenges and to deliver high quality services to the people who depend on them.

Tony O'Brien
Director General
Chairman of the Directorate
16th December 2013

Reform

Context for Health Service Reform

In 2012, the Minister for Health published *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015.* This framework, based on commitments in the *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years with a focus on the four pillars of reform: Structural, Financial, Service, and Health and Wellbeing.

The scope and scale of the reform programme cannot be underestimated. It represents one of the most significant programmes of reform in the history of the Irish health service, and will only succeed with the active and sustained support of all key stakeholders both within and outside the health service. Change of this scale and nature requires time, careful planning and execution and will require a detailed information and consultation process with our staff and staff representative organisations.

Critical Success Factors

- Clear direction – The government plan for reform has given us a clear direction. The staff who work in the health service are key to making reform work, under the clear and consistent direction provided by the Directorate.
- Achievable plan – To achieve the objectives of reform there must be a realistic and achievable plan. This plan must be coordinated and integrated, and be resourced with the appropriate business, project, and change management expertise.
- Culture change - Reform requires a culture that values and respects staff, that reflects fair accountability, trust, high quality leadership at all levels, clear and effective governance and management structures, empowerment of staff, constructive performance management, and a commitment to learning.
- Communications and stakeholder engagement - Communication is an essential enabler of change. Key stakeholders such as staff, patients, representative and professional bodies and others should feel part of the change, and that their views are listened to.

Health Service Reform Portfolio

The Health Service is in the process of developing an integrated portfolio of reform programmes, which will comprise of specific and prioritised programmes and projects in all key domains of the reform programme, and that will address the change management requirements arising from the programmes. The portfolio will include the following key programmes:

- A sustained emphasis on quality and patient safety in both service provision and commissioning; supplemented by the creation of a new Patient Safety Agency
- Integration of Health and Wellbeing and prevention to service delivery models and reform programmes to address the rise in chronic disease and to improve population health
- Design and development of integrated models of care within and across all divisions of the health service, supported by a new governance and organisational model for National Clinical Programmes. One of the major priorities will be to enable the transition of care from acute to primary care in line with best clinical practice, in the first instance in relation to chronic disease management. Reforms that are specific to care groups, for example the Value for Money (VfM) and Policy Review of Disability Services, are listed in the relevant section of this document
- Establishment of Hospital Groups as a transition to Hospital Trusts
- Integrated Service Area (ISA) Review
- Performance Assurance Model

- Money Follows the Patient
- Transitioning to a commissioning model on an incremental basis
- Strategic Human Resource Management
- Leadership and Management Development Programme, aligned with organisational design and development
- Strategic communications
- Information and Communication Technology (ICT) Strategy and Informatics. This will include the appropriate preparatory work during 2014, in relation to business and ICT systems and supports, to underpin the planning and roll out of system health identifiers for patients, organisations and professionals, pending the passing of appropriate legislation
- Finance Operating Model Reform
- Shared Services Reform

Risks to the reform programme currently identified are:

- The capacity and capability to bring clarity to, plan and coordinate the integrated aspects of these programmes
- Availability of sufficient expert project management and change management resources, and to release clinical and management staff to drive these reform programmes
- Pressure on the system to deliver day-to-day services while simultaneously delivering a reform programme of great scale and depth
- Loss of experienced management and clinical personnel
- Impact of 2014 budget and diversion of resources to deliver same

The Minister for Health has requested and authorised the Directorate to progress significant elements of the health reform programme on an administrative basis. This section of the Plan describes this process.

Money Follows the Patient (MFTP)

MFTP Phase 1 will be implemented on a phased basis in 2014. The key goal of MFTP Phase 1 is the phased introduction in 2014 of MFTP within hospitals currently part of Casemix. A Steering Group has been established and is overseeing the implementation plan, key elements of which are:

- A shadow funding exercise is underway for selected hospitals (one from each Hospital Group) to compare actual 2013 activity against target activity and to assess variance
- A communication and engagement process with hospitals in December 2013, with a key input being learning from the shadow funding exercise
- Design of rule set, approach to cashing and activity targets for MFTP 2014
- Action plan to ensure hospital preparedness for MFTP Phase 1
- Developing the strategy and plan for MFTP Phase 2 for the period 2015-2016, including outpatient activity
- Establishing a Pricing Information Office on an administrative basis to support MFTP

Development of Commissioning Function

It is the intention of the Health Service to gradually transition to a commissioning model (which will be developed in accordance with the policy set out in *Future Health*) on an administrative basis as both provider and commissioner capabilities strengthen, with the clear aim of achieving the greatest progress possible on a commissioner / provider split prior to the introduction of the statutory functions. This will reduce the risk at the point of statutory transition.

During 2014, the reform programme for the development of the commissioning model will, inter alia, address:

- The development of a phased implementation of the commissioning function. This is likely to consist of a number of stages, beginning with the introduction of a commissioning arrangement between the Chief Operating Officer and each of the Divisional National Directors from January 2014

- The development of a robust commissioning and provider framework, which allows for the purchasing of services and which provides assurance that the services are provided at the level and quality required
- The design and development of the formal contractual arrangements to support the commissioning framework
- The definition and provision of the data and information architecture necessary to support the commissioning framework
- The development of the skills required of those who will have commissioning responsibilities regarding the management of performance contracts

Hospital and Community Healthcare Organisations

The creation of Hospital Groups and Community Healthcare Organisations is a detailed process that will require separate programmes of work. However, given their relationship to each other and to the programme to develop a commissioning function, these programmes will also be subject to a co-coordinating governance structure under the auspices of the overall reform programme.

Hospital Groups Transitioning to Trusts

Following the Ministerial appointment of Chairpersons for each of the Hospital Groups, the Health Service is proceeding to appoint Group Chief Executives to each of the Groups. The West / North West Hospitals Group, UL Hospitals Group and Children's Hospital Group already have Group CEOs in position. It is expected that the remaining Group CEOs will be in place by the end of Quarter 1, 2014.

In line with the recommendations of an independent report on the development of Groups to independent Trusts, the Health Service intends to develop a Memorandum of Understanding (MOU) with each Hospital Group. This will set out the working arrangements between the Health Service and the Groups during the transition phase. The MOU will detail key issues including reporting and accountability arrangements and the delegation of authority between the Health Service, the Hospital Groups and the interim Hospital Boards.

Within the overall reform portfolio, a programme for the implementation of Hospital Groups will provide the overall governance, project management and progress reporting within the Health Service for the implementation of hospital groups. A Strategic Advisory Group, which is being established by the Minister for Health, will recommend criteria for evaluation of the strategic plans of Hospital Groups.

Community Healthcare Organisations

It is expected that the Integrated Service Area (ISA) review, initiated in Quarter 2, 2013, that will set out the new Community Healthcare Organisations with associated governance and organisational arrangements, will be signed off by the beginning of Quarter 1, 2014.

Within the overall reform portfolio, a programme for the implementation of Community Healthcare Organisations will provide the overall governance, project management and progress reporting within the Health Service for their implementation.

Internal Management Structures

An end-state and a clear transition plan for a number of enabling functions must be established prior to the statutory establishment of the Healthcare Commissioning Agency and independent Hospital Trusts and Community Healthcare Organisations.

The overall reform portfolio will contain a number of programmes specific to these functions, including:

- The development and implementation of a shared service strategy.
- The Office for Government Procurement will be established in Quarter 1, 2014 which will mean the current procurement function in the Health Service will be reconfigured to take responsibility for the nationally identified procurement categories

- A key programme within the overall reform portfolio is the development of a strategy in relation to human resources within the health service
- In line with the recent Government decision to establish eHealth Ireland under the leadership of a Chief Information Officer (CIO), the Directorate will commence the appointment of the CIO by way of public competition, in consultation with the DoH, before the end of 2013, with a view to the position being filled in early 2014. The Office of the CIO along with the entity 'eHealth Ireland' will be established, in line with the recent Government decision, initially on an administrative basis within the System Reform Group (SRG) of the Health Service

Patient Safety Agency

In advance of its establishment by legislation, an interim Patient Safety Agency will be formed on an administrative basis within the Health Service. It is intended to establish a multi-stakeholder board for the Patient Safety Agency and to commence the appointment process for a Chief Executive in the first half of 2014.

Health and Wellbeing

The Health and Wellbeing Division will establish a working group, with cross-divisional representation to outline each phase required to establish a Health and Wellbeing model for commissioning. The aim will be to identify the most effective model that will deliver real health improvement gains in our population in the context of a healthcare commissioning environment. Work has already commenced on Phase 1, which consists of defining and identifying Health and Wellbeing resources and services to bring together under a single structure within the Division, including, for example, Environmental Health and Health Promotion and Improvement. Most recently the Directorate has made the decision to transfer Health Screening to Health and Wellbeing. Further, it has been agreed that Health and Wellbeing will be embedded into all national clinical programmes. This is already underway with the changes agreed to the governance and organisation of the clinical programmes. All phases will be overseen by a cross-divisional group and will be closely aligned with the work of the Directorate to oversee the development of a healthcare commissioning agency.

Accountability Arrangements

These reforms are being progressed on an administrative basis within the existing accountability provisions in the *Health Act 2004* and the *Health Service Executive (Governance) Act 2013*. Notwithstanding the establishment of Groups, Areas and other bodies on an administrative basis, it should be understood that until such time as pending legislation is enacted, the accountability arrangements set out in the aforementioned legislation pertain.

To ensure appropriate accountability governance and management arrangements for these changes, the System Reform Group (SRG) has been set up within the Office of the Director General of the Health Service. The National Lead for Transformation and Change leads the System Reform Group and reports directly to the Director General. The SRG is responsible for establishing the System Reform Portfolio, which will be the mechanism by which all of the strategic reforms identified in this document will be defined, coordinated and reported.

The SRG is currently working to establish the governance, scoping, management, benefits realisation, planning and reporting arrangements to be applied to all programmes within the remit of the Health Service.

Each individual programme or project within the overall reform portfolio will operate within the programme management approach established by the SRG. Responsibility for the delivery of individual programmes will rest with the 'business owner' of the programme.

A governance framework has been put in place for the Health Reform Programme to co-ordinate implementation in a planned, coherent manner so that all critical dependencies are managed effectively and benefits realised are carefully tracked along the way. The governance arrangements include a Programme Management Office (PMO) and a Health Reform Programme Board, in the DoH and a Systems Reform Group in the Health Service.

Quality and Patient Safety

Quality and patient safety is the responsibility of all staff and is core to service provision and will be embedded in service delivery across the healthcare Divisions.

Quality and patient safety goals will be delivered by a combination of strong management and clinical leadership with clear accountability for quality in the service delivery Divisions, and effective programmes and initiatives driven by all Divisions and the planned Patient Safety Agency.

The patient charter, *You and Your Health Service*, is an indication of our commitment to inform and empower service users to actively look after their own health and to influence the quality of healthcare in Ireland. The voice of the patient and the voice of staff will be central to all that we set out to achieve.

The key focus areas for quality and patient safety in 2014 are:

- Commitment to supporting the development of an open and transparent culture with defined accountability for quality and safety
- Clear governance and accountability for quality and safety at all levels of the Health Service and Divisions
- Improving the patient experience within health services
- Supporting quality improvement throughout the health system to improve outcomes and reduce patient harm
- Ensuring that standards, policies and guidelines are understood and appropriately implemented
- The development and use of a comprehensive set of quality and safety indicators to measure the quality and safety of our services and take appropriate action to improve poor performance including medication safety, healthcare associated infections (HCAI) and the national early warning score (NEWS)
- Ensuring that there is robust risk assessment (from a patient safety perspective) of any reconfiguration of services required to meet financial and staffing constraints
- Continued development of the controls assurance process that requires all managers to provide assurance on their accountabilities for clinical and social services to the same level as is required for financial accountability

Embedding the Quality and Safety Agenda

The operational management of quality and safety within the care delivery Divisions will have clear lines of accountability for quality and safety from front line providers to National Directors. This includes systems for performance management, quality measurement, assurance, audit, risk management, and learning from user complaints and adverse events. Each Division will appoint a lead for quality and patient safety to support the National Director in ensuring that these systems are in place, the quality and patient safety priorities are acted upon, and the desired outcomes are achieved across all services. The Quality and Patient Safety Leads in each Division will collaborate with the leads for other divisions, the Clinical Programmes, Quality and Patient Safety Division and the new Patient Safety Agency. They will be ensuring integrated quality and patient safety work / business plans are developed for each Division that are in line with national priorities; monitoring and evaluating the implementation of the plans and reporting to National Directors; and providing ongoing support to the services within their Division to achieve the quality and patient safety objectives.

The service delivery Divisions will be provided with strong patient safety and quality improvement support and assurance functions that will work with staff and service users at local, regional and national level. These functions will provide the leadership, quality improvement focus and support required for long term improvement in healthcare quality and safety.

A decision has been made to establish a Patient Safety Agency which will be formed and located, initially, within the Health Service. The agency will be in effect for 2014 and therefore elements of the work outlined may be delivered through this new agency. Programmes and initiatives supported by the quality and patient safety functions will include improving governance and accountability, clinical leadership and quality improvement capability, patient experience and collaborative working. The Programme to reduce HCAIs and reduce antibiotic consumption will continue. The capacity and capability of services to manage and learn from complaints, adverse events and incidents will be a priority and the training of management and staff will continue in 2014.

In 2014, additional investment (€0.860m and 1.5 WTEs) will be made in the Diploma in Leadership and Quality in Healthcare for managers and clinical leaders; collaborative development; HCAI programme; and patient advocacy.

Our ability to provide assurance on the quality of our services will be strengthened with the continued development of Clinical Audit (National Office for Clinical Audit and Quality and Patient Safety Audit); the ongoing National Quality Assurance Programme in Histopathology and Radiology; new assurance programmes for maternity and other services; and the development and reporting of quality indicators.

Clinical Effectiveness

The implementation of the clinical effectiveness agenda, which the Health Service considers a key component of patient safety and quality, is a key priority. The incorporation of national and international best available evidence promotes healthcare that is up to date, effective and consistent. Quality assured national clinical guidelines and national clinical audit are quality improvement processes which are critical elements of the clinical effectiveness agenda.

The approach to delivering results will focus particularly on working with, and supporting, front-line staff. The people who deliver our services will be central to identifying and implementing collaborative approaches to improving healthcare quality. This will support and complement the work of the clinical programmes and the quality improvement approaches undertaken by the professional colleges, draw on international experience and develop international partnerships.

The Health Service will continue to work effectively with all stakeholders including the regulators to influence collective efforts to build on good practice, eradicate poor practice and improve the quality of care. This will ensure a system wide approach to learning from serious incidents in a timely, appropriate manner with clear ownership and accountability for implementation of recommendations within national and local structures.

Measuring the Quality of Service Delivery

The patient safety and quality agenda is a priority across all Divisions in order to lead and deliver quality improvement and clinical effectiveness initiatives and measures. One of the key focus areas for 2014 is the measurement of the quality of the services which we deliver.

In 2014 significant new quality indicators will be developed, measured, reported, and the outcomes acted on to improve services. The list in Appendix 3 reflects some of the key quality measures that will be reported and / or developed in 2014. This initial set of quality indicators is mainly acute hospital centred and our early priority is to advance measurement in all Divisions through close collaboration across the Health Service. The full set of performance indicators in this Plan contains many indicators that are relevant to quality and are shown in Appendix 4.

Operating Framework 2014

THE FUNDING POSITION

The 2014 gross current Budget Day Estimate for the Health Service (including Children and Families) is €13.120bn (Table 1). This reflects a reduction in the gross estimate of €272m or 2%. The reduction includes new spending of €304m and savings targets of €619m.

Following budgetary reductions of €3.3bn since 2008, the 2014 reductions of €619m bring the total to €3.92bn over six years. Reductions on this scale in a public health system with increasing demographic pressures obviously pose considerable challenges and risk for the delivery of this estimate.

Financial Performance

In addition to the required savings targets of €619m, there are also underlying incoming deficits from service levels provided in 2013 which need to be addressed in 2014. The forecast position for the Health Service for 2013 is a shortfall in the region of €219m but this forecast deficit is being alleviated by in-year once off savings which will not arise or be available again in 2014. The resultant situation is that the health system has to deal with underlying deficits of €419m prior to addressing any additional savings targets in 2014.

The Health Service is required to impose significant expenditure reduction targets for 2014. There is an inherent risk that if the savings are not achieved within agreed timeframes and new costs are incurred that there will be a growing deficit. The Health Service must take actions to address this carry forward deficit of €419m in addition to savings targets of €619m and still provide budget to deliver agreed activity levels and cost increases due to demographic, technological and clinical advancements. Any slippage in delivery of these budgetary reductions will have an adverse effect on our 2014 financial position. In light of this fact, certain savings targets will be held centrally and not allocated to services in the first instance until such time as a full examination of the measures required to deliver these savings has been completed.

Additionally, development and other initiatives will be specifically targeted towards the latter half of 2014 to allow the Health Service flexibility around the utilisation of resources, to allow savings to be utilised on specific services on a timing delayed basis. In addition to the broader risks outlined above, some additional risks include potential claims for compensation under the *Haddington Road Agreement*, non pay inflation for new health technologies in addition to other non pay items, as well as the increased demand for services due to ageing population and recession.

Significant cost reductions have been achieved in recent years through pay and staff numbers management, as well as negotiating price reductions with drug companies and other suppliers. In 2014 extensive further savings will be required in pay through the *Haddington Road Agreement*, further reductions in drug prices through Reference Pricing legislation, and other challenging savings throughout the year to deliver on the plan.

Pay and Pay Related Expenditure

Payroll reductions totalling €268m are required. The additional reduction for 2014 (€268m) includes €140m facilitated by the *Haddington Road Agreement*, €108m in unspecified pay savings and €20m in respect of the Employment Control Framework (ECF). This is in addition to a 2013 budget reduction target of €150m from which delivery of €104m is expected in 2013. Delivering against these targets is a central component of our overall budget management plan for 2014. A national assurance process and support team have been established. This team will work with service managers to ensure that measures which will deliver savings are identified and implemented at the earliest possible time.

Unspecified pay savings of ***€108m*** will be held centrally and have not been allocated to individual services as provider budget reductions, pending a separate process. In addition a further ***€80m*** related to *Haddington Road Agreement*, which is within the original design specification, is also being held centrally, in the first instance, and will be allocated to individual services following the national assurance process.

In line with the published AEV, a reduction in the pension lump sum provisions will be used to offset, in part, the incoming deficit from 2013. This approach however is not without risks, particularly in respect of the reduced pension

lump sum provision in 2014. If retirements are in excess of that provided in the estimate there is no further provision in the estimate for additional lump sums payments.

Primary Care Schemes

Primary Care Schemes through the Primary Care Reimbursement Service (PCRS) include a cost reduction challenge of €294m in 2014 as well as the cost reduction target of €353m applied in 2013. While reference pricing and prescription charges will deliver reductions, the plan for 2014 will involve comprehensive reviews of client eligibility to ensure that those entitled to cards receive them and retain them.

The Estimate provided to the Health Service is laid out in Table 1. The measures relate predominately to reductions in pay and primary care schemes and will require considerable management focus to deliver in 2014.

Programme for Government

The Estimate specifies €37m for GP services for children aged 5 years and under and €20m for mental health services.

Demographic, Critical Services and Incoming Pressures Funding

€247m has been provided in the Estimate in respect of demographic, critical and incoming service pressures within the health service. Demographic pressures include the age of the population and other trends within the population such as births. €126m has been provided to address incoming deficits.

Table 1: Budget Framework

Gross Current Estimate 2014	€m
2013 Revised Estimates Volume (REV)	13,392.6
Unavoidable Pressures	
Demographic pressures (see Appendix 1)	62.4
Maintenance and expansion of critical services (see Appendix 1)	58.6
Incoming service pressures	126.4
Total Unavoidable Pressures on Gross	*247.4*
Programme for Government	
Mental Health	20.0
GP services for children aged 5 years and under	37.0
Total Programme for Government	*57.0*
Savings Measures	
Community (Demand-Led) Schemes (Table 6)	-294.0
Pay and Pay-Related Expenditure (Table 9)	-268.0
Other Savings Measures (Table 2)	-36.4
Total Savings Measures *	-598.4
REV Transfer from Vote 38	21.8
Total Gross Current Estimate (including Children and Families)	13,120.4
2013 Statutory Income Target (Appropriations-in-Aid)	1,453.2
2014 Income Adjustments (Table 3)	-35.6
2014 Statutory Income Target	1,417.6
Net Current Estimate 2014	11,702.8

* Total savings measures of €619m is detailed in Table 4

Table 2: Other Savings Measures

Other Savings Measures	€m
Nurse Bank	-12.0
Legislation to charge all private patients in public hospitals (Voluntary Hospitals)	-14.4
NHSS - A Fair Deal – Full year effect of adjusting the asset-based contribution – Legislation in 2013	-10.0
Total	-36.4

Note: The NHSS increased asset contribution was included in the Abridged Estimates Volume at €10m, and will be corrected in the Revised Estimates Volume to €3m

Table 3: Changes to Statutory Income Targets as a result of the Estimate 2014

Changes to Statutory Income Target (Appropriations-in-Aid)	€m
2013 A-in-A Target	1,453.2
Reversal of 2013 statutory hospital income target	-31.2
Loss of income from EU Receipts (UK agreement)	-30.0
Collection of EU charges	5.0
Licensing of Tobacco retailers (Dependent on new legislation)	5.0
2014 statutory Hospitals income target	15.6
Total Adjustments	-35.6
Total A-in-A Estimate 2014	1,417.6

Table 4: The reductions required in the Health Service in 2014

Unavoidable Pressures	€m
Primary Care Reimbursement Service (PCRS)	-294.0
Pay and Flexibility Measures	-268.0
Other Savings Measures	-36.4
Total Reductions	-598.4
2014 Statutory Income Target – Refer to note below	-20.6
Total Reductions	-619.0

Note: The 2014 statutory income target includes €15.60m for statutory hospitals and a further €5m for the licensing of tobacco retailers. The latter target is dependent on the introduction of new legislation. The statutory target excludes the voluntary income target to charge all private patients in public hospitals which is included in other savings measures - Table 2.

Table 5: Additional allocations based on published Estimate

Unavoidable Pressures	€m
Demographic pressures	62.4
Incoming service pressures	126.4
Maintenance and expansion of critical service priorities	58.6
Subtotal	247.4
Programme for Government	
Mental Health	20.0
GP services for children aged 5 years and under	37.0
Sub-total	57.0
Grand total	304.4

Community (Demand-Led) Schemes

Primary Care Reimbursement Service continues to face significant financial challenges and increased demand for services. The National Service Plan makes provision of €35m for an expected additional 60,000 medical cards being awarded during 2014. Almost 2 million people are now covered either by a Medical Card or a GP Visit Card. Under the *Health Act, 1970* (as amended), Medical Cards are provided to persons who are, in the opinion of the Health Service unable without undue hardship to arrange GP services for themselves and their dependants. The Act requires the Health Service to have regard to a person's, and his / her spouse's / partner's, overall financial situation in view of their reasonable expenditure in the assessment for a Medical Card. While people with specific illnesses such as cancer are not automatically entitled to Medical Cards, the Health Service can apply discretion and grant a Medical Card where a person's income exceeds the weekly income amounts set out in the Health Service Medical Card National Assessment Guidelines. Health service medical officers are involved in the decision making process regarding expenditure associated with care of a condition, where the application of discretion arises. In these cases, social and medical issues are considered when determining whether or not undue financial hardship exists for the individual in arranging GP or other medical services.

In certain circumstances, a Medical Card can also be provided on emergency grounds, for a period of six months, where a patient is in urgent need of medical care that they cannot afford.

The Health Service is committed to ensuring that everyone who is entitled to a Medical Card or GP Visit Card receives one, however it is also important to stress that the Medical Card system is founded on the 'undue hardship to arrange GP services' test. The *Health Act, 1970* provides for Medical Cards primarily on the basis of means and the Health Service must operate within the parameters of the law.

Given the number of cards in circulation and the cost to the State, it remains a priority of the Health Service to ensure that the highest level of probity is applied to the issuing of cards and to the making of payments to service providers on behalf of card holders. Various types of review are undertaken including audits of service providers, reviews of eligibility on expiration of the card, risk based reviews based on specific criteria such as cards being inactive for specified periods and structured random reviews of eligibility.

The AEV contained a figure of €113m in respect of new probity measures for PCRS (see Table 6). Following a review it has been ascertained that this level of savings cannot be delivered from probity within the current guidelines. Therefore an allocation of €47m has been made within the Revised Estimate Volume, €3m will be included in addition to the existing €20m identified for probity, and €63m will be utilised from the pension budget. These three elements account for the €113m set out in the original AEV.

The following table shows the gross provision for Community Schemes of €2,433m which is a net reduction of €87m on the 2013 budget (3.5%).

A €50m savings target has been adjusted from the budget for reference pricing of drugs and €43m for further prescription charges. In addition there are also policy measures to reduce the Medical Card income threshold for persons aged 70 years and over.

Table 6: The Community (Demand-Led) Schemes

	€m
GROSS REV 2013	2,520.0
Estimates Measures	
Medical Cards	35.0
GP services for children aged five years and under	37.0
Dental Treatment Services Scheme	12.0
Full Year Cost of 2013	60.0
Sub-total	144.0
IPHA / APMI Agreement	-28.0
Full year effect of FEMPI fee reductions	-37.0
Full year impact of increase in prescription charges	-4.0
Full year effect of income thresholds and probity	-23.0
Generic substitution and drug reference pricing	-50.0
Reduce Income Thresholds for the over 70s Medical Card (€900 p.w. couple and €500 p.w. single)	-25.0
Additional delisting of drugs from the GMS reimbursable drugs	-10.0
Instead of retention of full medical card on return to work, give GP Visit Card	-11.0
Increase prescription charge to €2.50 per item with €25 cap	-43.0
Medical card probity	-113.0
Revised Estimate Provisions	47.0
Subtotal*	-297.0
Adjustment to base funding	63.0
Other Adjustments	3.0
Total estimates adjustment	-87.0
GRAND TOTAL	2,433.0

*An additional €3m target has been given under Income and Probity measures

Income

In 2013 the Health Service had a target for increased revenue from private inpatients in public hospitals. The new private inpatient charges will come into operation on 1 January 2014 with a target of increasing revenue by €30m in 2014. Other changes to income targets are shown below in Table 7a. Legislation will be required in order for the Health Service to licence tobacco retailers.

Table 7: 2014 Income targets in respect of statutory and voluntary hospitals

Care Group	Statutory hospitals €m	Voluntary hospitals €m	Total €m
Reversal of 2013 Income Target	31.2	28.8	60.0
2014 Income Target	-15.6	-14.4	-30.0
2014 Net Income Target	15.6	14.4	30.0

Table 7a: Changes in Income

	€m
Licensing of Tobacco retailers (Dependent on new legislation)	5.0
Collection of EU charges	5.0
NHSS - A Fair Deal – Full year effect of enactment of the Health Amendment Act 2013 adjusting asset contribution	10.0
Total	20.0

Note: The NHSS increased asset contribution was included in the Abridged Estimates Volume at €10m, and will be corrected in the Revised Estimates Volume to €3m

Nursing Homes Support Scheme (NHSS) – A Fair Deal

The provision of funding for long-term residential care is shown below. An amount of €23m is being allocated from the subhead to enhance the provision of home-based care. No additional funding is being provided for new places in 2014. This will require careful management of NHSS applications as existing places become vacant.

Table 8: The Nursing Homes Support Scheme – A Fair Deal

Nursing Homes Support Scheme	€m
2013 REV	974.3
Adjustments	
Full year effect of adjusting the asset-based contribution – Legislation in 2013 *	-3.0
Cost of Care Reductions (Efficiency targets)	-3.0
Haddington Road Agreement	-6.1
Employment Control Framework	-0.4
Movement of funding to elderly community support services	-23.0
Total	938.8

Note: The NHSS increased asset contribution was included in the Abridged Estimates Volume at €10m and will be corrected in the Revised Estimates Volume to €3m

Pay-related reductions

The 2014 Estimate includes reductions of €268m for pay and flexibility measures. The budget reduction applied to the Health Service in 2013 was €150m, making a total of €418m under the *Haddington Road Agreement* and unspecified pay measures.

Table 9: Pay and Pay-Related Expenditure

Pay cost adjustments – Haddington Road Agreement Pay and Flexibility Arrangements	€m
Haddington Road Agreement	-140.0
Unspecified pay savings	-108.0
Employment Control Framework	-20.0
Total	-268.0

Table 10 illustrates the gross funding allocation for the HSE for 2014 by care programme.

Table 10: 2014 Financial Position

Income and Expenditure 2014 Allocation	Pay	Non-Pay	Income	Total
Statutory	€m	€m	€m	€m
Hospitals	1,752.3	873.0	0.0	2,625.3
Community Services	1,874.6	2,356.6	0.0	4,231.1
Total Statutory	3,626.8	3,229.6	0.0	6,856.4
Voluntary				
Hospitals	1,490.3	678.2	-489.9	1,678.7
Community Services	460.2	85.8	-103.8	442.2
Total Voluntary	1,950.6	764.0	-593.7	2,120.9
Hospitals	3,242.6	1,551.2	-489.9	4,303.9
Community Services	2,334.8	2,442.4	-103.8	4,673.4
Primary Care Reimbursement Service	12.6	2,420.5	0.0	2,433.0
Children and Families	218.8	317.8	0.0	536.7
Corporate	83.5	120.4	0.0	203.9
Statutory Pensions	572.8	0.0	0.0	572.8
National Services	46.3	153.8	0.0	200.1
National Cancer Control Programme	2.4	8.6	0.0	11.0
Ambulance Service	103.0	35.5	0.0	138.5
Health and Wellbeing	99.7	134.6	0.0	234.3
Repayment Scheme	0.0	8.0	0.0	8.0
Unapplied Funding	0.0	0.0	0.0	-195.2
Grand Total	6,716.5	7,192.8	-593.7	13,120.4

The establishment of the new service Divisions in 2013 meant that, for the first time, as part of the service planning process for 2014, there was the opportunity to redistribute resources across each of the care groups and new service Divisions. In the past, because primary, community and social care services were managed on an integrated basis regionally, it was possible at the end of each year to off set deficits in one care group from surplus funds in another, so that overall the regional budget was balanced. For example, a surplus in the area of mental health might be used to meet a year end deficit in services for older persons. The same approach was adopted nationally to balance the global budget for the health services. This rebalancing happened on a year to year basis.

One objective in establishing the new service Divisions was to give each care group more certainty about their overall resource base which would allow them plan more rationally for 2014 and future years. This means that the same flexibility to balance surplus funds and deficits on an annual basis will no longer exist. However it was critical that in redistributing the resources for 2014, an approach to balancing current surpluses and deficits be put in place. This is particularly true of mental health services which are expected to have a significant once off surplus at the end of 2013 and social care services which will have a deficit in the region of €53m. Accordingly regional and local (ISA) level budgets for each Division will be set out at a high level by each service Division with support from the Finance Division and will require approval of the relevant National Director.

Table 11: 2014 Financial Resources by Division

Division	NSP 2013[1]	Change	2013 Budget Restated[2]	2014 Budget Reduction	2014 Additional Funding	Programme for Govern-ment	2014 Budget	% change
	€m	€m	€m	€m	€m	€m	€m	%
Acute[3]	4,117.0	168.8	4,285.8	-78.0	96.1	0.0	4,303.9	0.4%
PCRS[4]	2,562.0	-42.0	2,520.0	-297.0	173.0	37.0	2,433.0	-3.5%
Primary Care[5]	514.0	213.3	727.3	-7.9	6.2	0.0	725.6	-0.2%
Social Care	2,925.0	116.5	3,041.5	-31.3	45.0	0.0	3,055.3	0.5%
Health and Wellbeing[6]	146.0	82.4	228.4	-0.1	6.1	0.0	234.3	2.6%
Mental Health[7, 7a]	733.0	24.9	757.9	-12.1	0.0	20.0	765.8	1.0%
Children and Families	541.0	-3.0	538.0	-6.8	5.5	0.0	536.7	-0.2%
Ambulance Service	135.3	0.0	135.3	-0.4	3.6	0.0	138.5	2.3%
Multi Care Group	477.0	-363.7	113.3	-1.1	9.4	0.0	121.5	7.3%
Other	77.0	-65.9	11.1	1.7	-9.5	0.0	3.3	-70.6%
Total	12,227.3	131.4	12,358.7	-433.1	335.3	57.0	12,317.9	-0.3%

Notes to Table 11

[1] The 2013 budget has been restated from figures published in NSP2013 to take account of changes as a result of the Revised Estimates Volume, unapplied savings measures and other funding in addition to significant work undertaken in 2013 to develop more meaningful and accurate budgets, particularly in relation to the 'Multi Care' Area.

[2] Please note that the budgets above will be adjusted during the year to take account of reductions which have not as yet been allocated. These include the following: €80m *Haddington Road Agreement*; Procurement savings €30m; Shared Services savings €10m; Acute hospital reconfiguration €7.5m; VfM disability €5m; and section 38 and 39 (outside disability) €5m. Further savings of €15m will be required in relation to Energy.
The required savings target of €108m of the unspecified pay savings is the subject of a separate process which will involve the Departments of An Taoiseach, Health and Public expenditure and Reform with a view to finalising realistic and detailed implementation plans to achieve the 2014 savings targets.

Such adjustments will take place when the reviews which are underway to determine the appropriate measures and service areas are complete.

[3] Acute Services includes Palliative Care and Cancer Programme investment.

[4] The reduction under PCRS reflects targeted Government efficiencies / savings.

[5] Primary care budget excludes local and regional drugs taskforce funding which has been included in National Services

[6] Health and Wellbeing includes screening services from 2014.

[7] The net budget for St. John of Gods of €81m is included in Social Care. Approximately 25% of this budget relates to Mental Health. This split is indicative and subject to review and agreement between the respective Divisions.

[7a] Development and other initiatives will be phased in over 2014 to allow flexibility around the utilisation of available resources.

Budget Adjustments and Cost Containment Measures

Table 12: 2014 Health Service Budget Adjustments and Cost Containment Measures

Additional 2014 Health Service Budget Adjustments and Cost Containment Measures	€m
Description of Cost Containment Measures	
Energy	15.0
Disability Services – Value for Money savings	5.0
Section 38 and 39 agencies excluding disability services	5.0
Procurement	30.0
Shared Services	10.0
Acute hospital reconfiguration	7.5
Acute hospitals – cost containment	56.5
Total	129.0

Acute Services

Acute hospital services are projected to have a 2013 overrun of €190m which will be carried into 2014 and will need to be addressed in 2014. Table 13 illustrates the budget movement within the Acute Sector. It should be noted that in addition to the incoming overrun and savings measures outlined in Table 13, acute hospitals will be required to meet the full value of cost containment plans amounting to *€56.5m* which were put in place in 2013 in addition to a reconfiguration target of €7.5m.

Table 13: 2014 Acute Services Budget Movement

Other Savings Measures	€m
2014 Funding	
Demographics	7.70
Adjustment to base	50.00
Maintenance and expansion of critical services	38.37
Subtotal – 2014 funding	*96.07*
2014 Budget Adjustments	
2014 Haddington Road Agreement Budget Reduction	-60.02
New entry consultants	-2.55
Consultants – historic and current rest day arrangements	-3.00
Incentivised career break	-3.23
Reduction in management grades	-0.45
Employment Control Framework	-11.16
Reversal of 2013 Voluntary Hospital Income Target	28.80
Legislation to charge all private patients in public voluntary hospitals	-14.40
Nurse Bank	-12.00
Subtotal – 2014 adjustments	*-78.00*
Net total – 2014 funding and adjustments	18.07

Children and Family Services

The provision in this plan for Children and Family Services is €536m. Significant work has been undertaken to move this service to the new Child and Family Agency with effect from 1 January 2014. The funding within the Health Service Vote will move to the Vote of the new Department of Children and Youth Affairs.

Allocations

Following the approval of NSP2014 by the Minister, the Health Service will allocate budgets to budget holder level. The basis of allocation will reflect the reductions in the Estimate.

Agencies funded under Section 38 and Section 39 of the Health Act

Funding of section 38 and section 39 agencies is conditional on compliance with all schedules drawn up as part of service level arrangements including disclosure of salary scales applicable to staff in the organisation and, in the case of section 38, full compliance with public service pay scales.

Money Follows the Patient (MFTP)

In 2014 a 'money follows the patient' (MFTP) approach to hospital funding will be implemented on a phased basis in the country's hospitals participating in the Casemix Programme. From the 1st January, payments will be made to the participating hospitals based on their levels of inpatient and day case activity. They will continue in the initial phases to be block funded for costs related to areas other than inpatient and day case activity.

A phased approach to implementation is being applied in order to minimise the risks associated with changing the funding model and to ensure that hospital finances are not destabilised. Subsequent phases of implementation will lead to more hospital activity, such as outpatient attendances being funded on a MFTP basis. This prospective funding model will effectively replace the retrospective funding adjustment model currently in place under Casemix.

Considerable preparatory work has already been undertaken in advance of the introduction of this new funding approach. In particular:

- A pilot 'money follows the patient' project was undertaken in the orthopaedics specialty. Learning from this pilot is being incorporated into the wider implementation
- A shadow funding exercise commenced for eight hospitals in 2013 to demonstrate for these hospitals what the financial implications of any variance from their activity targets would be in a "live" MFTP system
- A patient-level costing project within 15 hospitals. This approach underpins the move away from block grants, by giving hospitals a greater understanding of the actual costs for different procedures
- Public nursing homes no longer receive a 'block grant' for their services, but receive monthly payments for individual named clients registered under the Nursing Homes Support Scheme. Similarly, under the Medical Card Scheme, doctors, pharmacists and dentists are paid for the services they provide to named clients

To support a service wide approach to implementing 'money follows the patient' an Implementation Team will be established in 2014, under which a commissioning framework will be developed in accordance with the policy set out in *Future Health*.

Procurement

The Health Service is setting a procurement savings target in 2014 of €30m. This follows on from significant savings achieved over the last four years. The Health Service will continue to work actively with the Office for Government Procurement (OGP) during 2014 to support it in setting up an effective national office to drive value in procurement across the public sector. Should any of the areas included in the €30m plan move to the OGP, the Health Service will facilitate their transition. A further target of €10m has been set for shared services. The Health Service will examine the possibility of delivering this saving through the capital programme and associated revenue costs. A group will be established to look for savings in the area of major equipment purchase and maintenance costs to contribute to this savings area. An assessment of the achievability of the €40m savings in total will be completed by the end of 2013 at which stage further decisions can be made if required. Both of these targets will be held in central budgets nationally subject to their achievement as the year progresses.

Budgets have not yet been adjusted to take account of procurement and shared services savings requirements. This will be applied when the review exercise is completed.

Human Resources (HR)

The delivery of high quality healthcare is dependent on the quality of all staff who work in the health services. Improving quality and patient safety is supported by the HR function through workforce planning focused on staff competence, staff training and performance management. Working collaboratively and effectively with all relevant stakeholders, HR will play a central role in a number of key organisational design and development deliverables to ensure the success of the Health Reform Programme.

To achieve these objectives HR will support the organisation to ensure:

- Implementation of change will support and enhance the delivery of high-quality, safe and sustainable services
- Appropriate governance arrangements are in place at all times during the process
- Structural reforms will not lead to duplication or the creation of unnecessary management tiers or numbers
- A clear focus on the development and improvement of frontline services
- Support for the services in the delivery of performance management / improvement
- A high level of collaboration and consultation with stakeholders, including the staff associations, on the design and implementation of the health structures

Change impacts on every aspect of our culture, i.e. the way we work, the way we relate to each other and how we plan and deliver services for the benefit of patients, service users and local communities. To support this change there will be standardisation, streamlining and integration of the HR Functions across the public health sector in a single coordinated Human Resource Management Function embracing statutory and voluntary hospitals, and voluntary primary and community sectors.

A key strategic focus for HR in the short and medium term will be to ensure the objectives of the reform programme are delivered, as required, against a backdrop of ever decreasing financial and human resources in a standardised, efficient and effective manner in line with Government policy.

The Workforce Position

Government policy on public service numbers requires that, by the end of 2014, the health service operates with a workforce of approximately 98,000 whole-time equivalents (WTEs).

It is forecast that the numbers in employment at the end of 2013 will number 100,600 WTEs therefore a net reduction of 2,600 WTEs would be required during 2014 to meet the target. Development posts associated with an increase in service delivery and new developments in 2014, numbering approximately 500 WTEs, as well as recruitment in process at the end of 2013 in respect of approved and funded new service developments, but yet not activated on payroll, brings the gross reduction required to 3,600 WTEs.

These reductions are in addition to an overall reduction of 12,505 WTEs (-11%) since September 2007.

The reduction in employment in 2014 will be managed through: natural turnover (retirements and resignations) and such other targeted measures; a targeted redundancy programme; the Incentivised Career-Break Scheme; and the grace period retirement option up to the end of August 2014. All schemes will be implemented, taking into consideration the need to protect frontline services.

There will be a focused approach to the management of the staffing resource in order to deliver on the service objectives of this plan, while controlling payroll and related costs. The *Haddington Road Agreement* is the key enabler to further reduce the cost of labour, deliver cost reductions and payroll savings and to manage the change agenda in 2014. Patient care is at the heart of any health service, therefore it is essential that the Health Service maximises all of its available resources.

Public Service Stability Agreement 2013-2016, the Haddington Road Agreement

The *Haddington Road Agreement* provides significant enablers and provisions to extract cost and reduce the overall cost base in health service delivery in the context of the reform and reorganisation of the health services as set out in *Future Health* and the Public Service Reform Plan of November 2011. The targeted additional savings under the *Haddington Road Agreement* for the 2014 National Service Plan is €140 million. There is a separate unspecified payroll reduction target of €108m together with an ECF savings target of €20m.

In delivering the range of pay and productivity measures to enable the public health sector to contribute to the Government's Economic Strategy it is important that all health service managers review their current service delivery models to maximise the provisions of the *Haddington Road Agreement* with a requirement that services are delivered in the most cost effective and efficient manner. It is essential that cost reductions are identified, implemented and are sustainable on an ongoing basis. Hospital CEOs, ISA managers, CEOs of voluntary agencies and service managers at all levels have responsibility to directly engage with their staff, and be accountable for the delivery of the *Haddington Road Agreement* within their own organisations and workforce.

The *Haddington Road Agreement* enablers available to support the required action include:

- Work practice changes for identified health disciplines
- Systematic reviews of rosters, skill-mix and staffing levels
- Increased use of redeployment
- Further productivity increases
- Introduction of the Nursing / Midwifery Graduate Programme
- Introduction of the Support Staff Intern Scheme
- Voluntary redundancy which is targeted, arising from restructuring and review of current service delivery methods and the Incentivised Career Break
- A focused approach to addressing staff absenteeism and implementing revised new sick leave arrangements which become effective from the 1st January 2014
- Greater use of shared services and combined services, coupled where necessary, in terms of costs and efficiency, to the use of external sourcing in order to deliver cost-effectiveness and best value for money, while protecting frontline service delivery
- Greater integration of the human resources functions of the statutory and voluntary sectors to remove duplication, achieve better efficiencies and allow for greater use of shared services within and across emerging structures

A national assurance and support process has been established to engage with service managers in order to monitor and support the delivery of sustainable cost reductions as required under the *Haddington Road Agreement*, against a back-drop of identified specific targeted savings to be delivered in 2014. The group will work with managers at all levels to maximise the provisions of the *Haddington Road Agreement* and to ensure that such measures are identified and implemented at the earliest possible time.

The Assurance Group will deliver a standardised methodology for the assessment, measurement and reporting on all of the enablers with the *Haddington Road Agreement*, and identify a suite of options for services to maximise the benefits to ensure an evidence based approach which will deliver the greatest efficiencies possible from the available resources.

Specific site visits will be an integral part of the modus operandi of the Assurance Group. The permanent members of the Group will be HR and Finance supported by the relevant Service Managers.

European Working Time Directive

The Health Service is committed to full implementation of the European Working Time Directive (EWTD) for Non-Consultant Hospital Doctors (NCHDs) by end 2014. This will require introduction of revised rosters for both NCHDs and Consultants, changes to medical, nursing and other work practices, reallocation of clinical tasks to the most appropriate member of staff, redeployment of staff and, in those settings where these have been implemented but not secured full compliance, targeted recruitment and allocation of resources. In addition, in some settings, achieving full compliance will require reorganisation of acute services. Such reorganisation will be aligned with changes underway to the governance and management of hospitals services as part of the introduction of Hospital Groups and the implementation of the Smaller Hospital Framework.

In the period to and including January 2014, the management of compliance will focus on the elimination of continuous shifts in excess of 24 hours and the related allocation of resources to recruitment, redeployment and other measures required to implement same. EWTD Implementation Groups will be established in each hospital to progress change. A joint national group, comprising the Health Service, DoH and Irish Medical Organisation (IMO) has been established to oversee verification and implementation of agreed measures.

During this period the Health Service will begin national publication of current and cumulative compliance with a maximum 24 hour shift and EWTD requirements and ensure best practice in achieving compliance is replicated nationally.

In the period from February 2014 to end December 2014, the focus will be on progressing compliance with an average 48 hour working week, daily breaks, daily rest and weekly rest.

In some settings, large-scale changes are required to achieve full compliance and the Health Service is committed to determining how best to progress these in conjunction with the IMO under the auspices of the Labour Relations Commission.

Each hospital is required to:

- Prioritise the implementation of EWTD compliance as part of its service plan for 2014
- Establish a local EWTD Implementation Group to progress actions agreed as part of the verification and implementation process
- Report NCHD working hours and rosters
- Facilitate the introduction of electronic time and attendance systems

Employment Control

The challenge for the health service in 2014 is to achieve the overall reduction in staff numbers in a managed way, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed. In addition to reductions resulting from normal staff turnover, full use will be made of other mechanisms which can be used in a targeted way to contribute to the achievement of the necessary overall reduction.

Accountability at service manager level, for the employment control ceiling will be assigned to each budget-holder to ensure that there is clarity on the level of reduction to be achieved in the course of the year. Any adjustments to these ceilings will only be made to take account of specific service development needs and in the context of the overall employment target being achieved.

Reconfiguration and integration of services, maximum utilisation of additional contracted hours as provided for in the *Haddington Road Agreement*, reorganisation of existing work and redeployment of current staff will need to underpin the employment control framework in order to implement Government policy on public service numbers and costs within budgetary allocations. The 2014 employment control framework will also address workforce issues such as overtime and agency usage and costs, cost of allowances, and cost of absenteeism. Current health service staff numbers, by Division (as of September 2013), are set out in Appendix 2.

Agency and Overtime Policy

It will be the responsibility of all managers to minimise the instances of overtime and agency. Specific financial ceilings for the total spend will be integral to the overall approach in the management of agency and overtime costs. The additional hours' element of the *Haddington Road Agreement*, the Graduate Nurse Programme and the Support Staff Intern Scheme, coupled with redeployment will deliver major savings in the overall pay bill.

Workforce Planning

The necessary reduction in the size of the health workforce must be accompanied by planning for the future needs of the service. The effective management of our human resources requires an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and upskilling the workforce, providing for professional and career development and creating supportive and healthy workplaces.

Training and Development

The changing management structures at the levels below the Directorate will begin to be rolled out in 2014 and this will require significant leadership development and support for these emerging management teams, in addition to other training and development needs of the workforce. This is critical to the delivery of *Future Health* in supporting the emerging new structures and management teams and supporting change across the workforce in 2014.

Conclusion

The staff in our health service are our largest and most important resource. The first priority for any health service must always be to seek to provide safe services while continuously striving to improve the quality, ease of access and cost effectiveness of those services within the limits of available resources. Various reports in recent times, including those in relation to the events at the Mid Staffordshire Trust, have re-emphasised the need to ensure that performance indicators around safety and quality are brought at least on a par with other indicators around resource management, access, and activity volumes. Indeed there is an increasing expectation that health services must be able provide assurance around the levels of staff available in its services at any given time. Since September 2007, the health service has reduced by over 12,500 staff or around 11%. In order to operate within the staff ceiling, the numbers must reduce by a further 3,600 staff over the next 12 months. Consideration must be given to assess the exceptional challenges involved in finding appropriate exit mechanism for such a high volume of staff to safely provide the services expected of us with 3,600 less staff. These issues will require close attention in the early part of 2014 and will inform the approach to employment control during the years ahead.

Operational Service Delivery

Acute Services Division

Introduction

As part of the new Health Service structure, health and social care services are delivered through service divisions. One of these is the Acute Services Division. This section of the Plan covers Acute Hospitals; National Clinical Strategy and Programmes; the National Cancer Control Programme; and Palliative Care Services

Finance	2014 Budget €m
	4,303.9
Full details of the 2014 budget are available in Table 11 page 20	

Quality and Patient Safety

Necessary focus for Acute Hospitals Service Division in 2014 relating to Quality and Safety will be:

- Access in relation to emergency department (ED) / outpatient department (OPD) / admission
- Clinical performance
  - Compliance with specific diagnosis / treatment care pathways and patient care protocols
  - Hospital mortality
- Healthcare Associated Infection (HCAI)
- Medication management
- Training and development

Acute Hospitals

The implementation of the Government's decision to re-organise the acute hospitals system will be guided by the DoH's *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*.

The Health Service strategic reform programme aims to move from the current hospital centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity which is safe, timely, efficient, and as close to home as possible. The opportunities for development of the acute hospital system will focus not only on the development of acute hospital services but also on maximising staff potential within the hospital sector.

Acute hospitals will be required in 2014 to meet the full value of cost containment plans amounting to €56.5m which were put in place in 2013 in order to address the incoming deficit issues. A 2014 *Haddington Road Agreement* target of €60m and a reconfiguration target of €7.5m have also been applied. However, provision for an additional €50m for acute hospitals has been made in 2014, to meet the full year costs of the demand for services which emerged in 2013.

Summary of Service Delivery

- There are forty-eight acute hospitals in the Irish public hospitals system with a bed complement of 13,576 (11,513 of which are inpatient and 2,063 of which are day beds / places). A wide range of emergency, diagnostic, treatment and rehabilitation services are provided on these sites. Serving a population of 4.59 million, over 1.4 million people receive either inpatient or day case treatment each year.
- Planned levels of scheduled care treatments have been reduced, specifically elective patient discharges (3% reduction) and day care attendances (3% reductions). Combined inpatient and day care reductions are 2%. Associated national access wait time target for adult patients has been set at 8 months.
- There are over 1.1 million attendances at 33 adult EDs each year; of these, over 400,000 people are admitted on an emergency basis.
- Across the 19 maternity units, there are nearly 70,000 births each year.

Key Priorities with Actions to Deliver in 2014

- Ensure patient safety and quality in acute hospitals.
  - Using the *National Standards for Safer Better Healthcare*, ensure hospitals undertake related self-assessments as a necessary measure for continuous quality improvement.
  - Ensure the National Early Warning Score (NEWS) system is fully implemented across all acute hospitals.

- Continue initiatives enabling optimum standards of infection control and hygiene (Healthcare Associated Infections).
- Progress quality indicators in relation to Medication Management and Safe Surgery practices.
- Develop organ donation and transplantation services and address additional need in the Donor and Transplantation Programme. (€2.92m and 19 WTEs)

- Ensure access to services.
  - Ensure access to services in relation to waiting times for emergency or unscheduled care, and scheduled care in public hospitals, including outpatient and diagnostic services.
  - Progress Outpatient (OPD) Quality Improvement Programme, particularly in relation to necessary data integrity and operational control.
  - Target additional capacity and capability in areas which continue to experience increased service demand, particularly in the areas of access across ED, inpatient day care and OPD services. (€30m)
  - Special Delivery Unit will continue supporting and enabling performance improvement particularly in relation to unscheduled care access.
  - Provide a service to undertake bilateral cochlear implants (sequential and simultaneous implants). (€3.22m and 14.5 WTEs)
  - Address children's needs in respect of narcolepsy. (€0.57m)
- Implement a model of integrated care through strategic reform.
  - Full implementation of seven Hospital Group constructs:
    - Dublin North East
    - Dublin Midlands
    - Dublin East
    - South / South West
    - West / North West (already established)
    - University Limerick Hospitals (already established)
    - Children's Hospital Group (already established)
  - Direct development of necessary Group service reconfiguration and integration plan.
  - Continue to implement the Small Hospitals Framework.
  - Progress development of new children's hospital with particular focus on necessary integration of paediatric services.
  - Target necessary patient centred improvements in maternity care, using the Health Service and Galway HIQA reports. (€1.48m and 6.5 WTEs)
- Utilise best models of financial allocation and human resource planning.
  - Continue implementation of all elements of the *Haddington Road Agreement* to ensure maximum value for money and cost reduction opportunities.
  - Develop and implement a sustainable approach to NCHD recruitment and progress toward compliance with the European Working Time Directive (EWTD). (€3.1m)
  - Begin the phased implementation of a 'money follows the patient' approach to funding acute hospitals as part of the preparatory step for Universal Health Insurance (UHI) implementation.

National Clinical Strategy and Programmes

- Further implement national clinical models of care to improve quality, optimise patient flow, integrate chronic disease prevention and management and address demographic pressures.
  - Acute Medicine Programme
    - Support Acute Medical Assessment Unit (AMAU) functions towards 24 / 7 in model 4 hospitals.
    - Implement the National Early Warning Score (NEWS) and associated COMPASS training programme.
    - With the national surgery and older persons programmes, agree patient flow and hospital capacity models to facilitate sustainability of clinical access standards and care quality.
  - Older Persons
    - Develop a necessary national model of care document that complements the acute model of care in relation to the management of the frail elderly pathway in primary care.
  - Obstetrics
    - Develop necessary National Model of Obstetric Care delivery

- Surgery
  - Roll out access to NQAIS (National Quality Assurance Intelligence System) to all acute hospitals.
  - Provide support and guidelines for management of day cases, minor operations and OPD procedures.
- Chronic Diseases
  - Develop a chronic disease framework.
  - Progress cross border paediatric congenital cardiac surgery and cardiology services.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014
Macro-environment Activity Expected no. of inpatient discharges*	591,699
Expected no. of day case discharges	797,328
Emergency Care - New Emergency Department attendances - Return Emergency Department attendances - Other presentations	 1,093,187 89,371 108,490
Expected no. of emergency admissions**	402,202
Elective Inpatient Admissions	99,973
Outpatient Attendances	2,571,115
New: Return Ratio	1:2
Expected no. of births	67,889
Access Inpatient and Day Case Waiting Times - No. of adults waiting > 8 months for an elective procedure (inpatient) - No. of adults waiting > 8 months for an elective procedure (day case) - No. of children waiting > 20 weeks for an elective procedure (inpatient) - No. of children waiting > 20 weeks for an elective procedure (day case)	0
Colonoscopy / Gastrointestinal Service quality indicator - No. of people waiting > 4 weeks for an urgent colonoscopy - No of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	0
Emergency Care - % of all attendees at ED who are discharged or admitted within 6 hours of registration - % of all attendees at ED who are discharged or admitted within 9 hours of registration - Reduction of trolley waits	 95% 100% 10%
HIQA Tallaght Report - No. of patients who re-attend the ED with the same clinical condition within 7 days - No. of patients being cared for in inappropriate care - % of patients who leave the ED without completing their treatment	 < 5% < 5% < 5%
Outpatients (OPD) No. of people waiting longer than 52 weeks for OPD appointment	0

Performance Indicator	Expected Activity / Target 2014
Acute Medical Patient Processing % of medical patients who are discharged or admitted from Acute Medical Assessment Unit (AMAU) within 6 hours AMAU registration	95%
In-house processing ALOS Medical patient average length of stay	5.8
Surgical patient average length of stay	5.3
ALOS for all inpatients	5.6
ALOS for all inpatient discharges excluding LOS over 30 days	4.5
Stroke Care % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	50%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%
Surgery % of elective surgical inpatients who had principal procedure conducted on day of admission	85%
Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%
Hospital Mortality Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	National average or lower
Re-Admission % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%
Medication Management % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	Hospital variance with national baseline
Delayed Discharges - Reduction in bed days lost through delayed discharges - Reduction in no. of people subject to delayed discharges	10% reduction

Performance Indicator	Expected Activity / Target 2014
Quality and Patient Safety **Healthcare Associated Infections** Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool	90%
Patient Experience % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	100%

Performance Indicator	Expected Activity / Target 2014
Operational Control **Compliance with EWTD** - < 24 hour shift - < 48 hour working week	 100% 100%
National Early Warning Score (NEWS) % of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	95%
% of all clinical staff who have been trained in the COMPASS programme	> 95%
National Standards % of hospitals who have commenced first assessment against the NSSBH	95%
% of hospitals who have completed first assessment against the NSSBH	95%
MFTP % of HIPE coding episodes completed within 30 days of discharge	> 95%

* Same day discharges as reported in 2013 are not included in the total for 2014 ** The number of hospitals reported in this category has increased for 2014

Additional quality and patient safety indicators in development – please see Appendix 3

National Cancer Control Programme (NCCP)

Since its establishment in 2007, the NCCP has been steadily implementing cancer policy as outlined in *A Strategy for Cancer Control in Ireland, 2006* using a programmatic approach to the management of hospital and community based cancer services across geographical locations and traditional institutional boundaries.

Finance	2014 Budget €m
	11.0
Excludes €3.8m for National Medical and Haemato-Oncology Programmes, which is included in the Acute budget for 2014	

Key Priorities with Actions to Deliver in 2014

- Implement the **National Medical and Haemato-Oncology Programmes**. (€3.8m)
  - Implement the national medical oncology and haemato-oncology programme comprising multidisciplinary human resources, evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology review processes for oncology drugs, and related molecular tests and the introduction of a nationally funded oncology drug budget. Develop and support a national plan for treatment-related molecular testing.
- Develop a **National Cancer Drug Management Programme** including predictive molecular oncology tests.
- Strategic review of **new developments and technologies** relating to cancer, including policy with regard to European wide specialisation and how best to make full use of centralisation in the interests of resource utilisation and service quality.
- Support the **Hereditary Cancer** Programme.
  - Support access to identification of genetic risk and surveillance in well population at risk. Agree appropriate referral pathways from primary care for patients considered at increased hereditary risk of breast, bowel or ovarian cancer. Develop GP referral guidelines to support these pathways, consulting with the ICGP, and disseminate to all GPs in the country, make available online, incorporate into e-learning modules.
- Further support the **Eight Designated Cancer Centres** and Letterkenny Satellite within current resources.
  - Centralise oncology surgical services in line with national policy to maintain continued improvements in diagnosis, surgery and multi-disciplinary care. Support existing national networks for site specific cancers and develop networks for gynaecological and neuro-endocrine tumours and for sarcomas.
  - Support capacity / capability requirements in relation to Dublin Midlands Gynaecological Services.
- Address **Quality and Safety Standards** and **Deliver Quality Care in the Community**.
  - Progress the work of national expert Tumour Groups comprising expert leads in relevant clinical disciplines to develop and promulgate national clinical practice guidelines. Collaborate with all stakeholders to ensure

public, patient, and professional policies, safety, and standards are nationally developed and maintained across the scope of cancer services.

- Develop professional staff knowledge, through education, research and 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. Progress the development of GP referral guidelines and pathways to facilitate early diagnosis of cancer. Participate in national groups to address chronic disease and health promotion initiatives. Develop a comprehensive survivorship programme to address communication issues and information needs of both cancer survivors and healthcare professionals.

Key Indicators of Performance

Performance Indicator / Activity	Expected Activity / Target 2014	Performance Indicator / Activity	Expected Activity / Target 2014
Symptomatic Breast Cancer Services 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.	13,200 95%	Prostate Cancers 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	2,673 90%
Lung Cancers 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	2,565 95%	Radiotherapy No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	4,546 90%

Palliative Care Service

Palliative care is an approach that improves the quality of life of patients, and their families, facing the challenges associated with life-limiting illness.

The Health Service will continue to work towards the implementation of the recommendations contained in national policy / strategic documents. In 2014 we will remain engaged with the voluntary sector to address the gaps identified in home care and specialist inpatient services.

The vision for the future is that palliative care will be a gradual and natural increasing component of care from diagnosis to death. We will ensure that patients with a life-limiting condition, and their families, can easily access a level of high quality palliative care service that is appropriate to their needs, regardless of age, care setting, or diagnosis.

Key Priorities with Actions to Deliver in 2014

- Ensure service provision for adult palliative care by addressing service gaps.
  - Ensure improved capacity and capability for Dublin North East in relation to palliative care ambulatory and inpatient services, specifically staged opening and usage of St. Francis Hospice, Blanchardstown (24 beds). (€1m)
- Develop the quality, efficiency and effectiveness of generalist and specialist palliative care services through process and quality improvements.
- Develop and integrate community based paediatric palliative care services.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Inpatient Units - Waiting Times Specialist palliative care inpatient bed provided within 7 days	94%	Day Care No. of patients in receipt of specialist palliative day care services	331
Community Home Care - Waiting Times i). No. of patients in receipt of specialist palliative care in the community ii). Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non-Acute hospital)	3,050 82%	Paediatric Services Total number of children in the care of the Children's Outreach Nursing service	New PI 2014

National Ambulance Service

Introduction

The Ambulance Service delivers pre-hospital emergency care on a national basis. Major reconfiguration of the control centres is underway which will result in a single National Emergency Control Centre operating on two sites during 2015. This will significantly improve response times and service to patients.

Finance	2014 Budget €m
	138.5
Full details of the 2014 budget are available in Table 11 page 20	

A more effective model of patient transfer service delivery, known as the Intermediate Care Service (ICS) has been set up to provide a service to patients who need to move between hospitals or other care facilities. This facilitates a safe and timely transfer for non-emergency patients when transferring between hospitals within the healthcare system or moving to step down facilities in the community. The ICS will ensure that emergency ambulance personnel are available to focus on the core function of the delivery of pre-hospital emergency care. Of the 82 Intermediate Care Vehicles envisaged in the *National Plan for Intermediate Care Service*, 36 were put in place in 2013. The full operationalisation of the resources recruited and trained in 2013 will contribute to improved response times to patients who require emergency care and transportation. This is a key performance improvement area in 2014.

Quality and Patient Safety

Quality of service and patient safety are core principles for the National Ambulance Service. Key elements of ensuring this are the introduction of systematic clinical audit of patient care records and the focus on improving both response times and clinical outcomes.

The National Ambulance Service will use the *National Standards for Safer Better Healthcare* to focus its efforts on delivering quality services and ensuring patient safety.

Key Priorities with Actions to Deliver in 2014

- Improve services to patients by improved ambulance response times.
  - Implement the Performance Improvement Action Plan throughout the country including measures to: eliminate 'on call' cover arrangements; increase dynamic deployment of resources; and implement the National Control Centre. These will contribute to safer working practices and improved response times. Identify measure and develop reports on the impact on response times from the replacement of on-call with 24 / 7 cover.
  - Develop appropriate response time performance indicators, dashboard and review mechanisms at a national, area and station level, including a quarterly review forum focused on identifying key performance issues and sharing improvement initiatives / approaches.
  - Develop a control centre performance dashboard focused on call time targets, dispatch time targets and call taking and dispatch accuracy targets.
  - Operationalise WTEs recruited to Immediate Care Services in 2013. Intermediate Care Services will reduce the need for Emergency Ambulances to perform non-urgent transfers, enhancing the service to improve response times (Action 33 of *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015).*
  - Manage the operation of Emergency Aeromedical Service (EAS) in line with Ministerial direction.
- Implement Quality and Patient Safety actions.
  - Develop clinical outcome indicators to provide a balanced set of key performance indicators of service delivery to be integrated with response time and call / dispatch accuracy metrics.
  - Introduce systematic clinical audit of patient care records. Evaluate the benefits of introducing an electronic patient care reporting system.

- Roll out the national Appropriate Hospital Access Programme, informed by the recommendations of National Clinical Strategy and Programmes.
- Commence and evaluate the 'Treat and Refer' Clinical Practice Guideline Trials.

- Put in place a National Control Centre over two sites.
  - Implement the National Ambulance Service Control Centre Reconfiguration Project reducing from nine sites to a single centre over two sites, with associated staff and ICT integrated enabling solutions *(*Action 33 of *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015).* (€3.6m and 43 WTEs)

Service Activity

Service Area	2013 Activity	2014 Activity
Estimated total call volume	300,000	305,000
Vehicles	494	534
Operational staff hours	2,000,000	2,200,000

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Emergency Response Times % of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	> 80%	Clinical Outcome Return of spontaneous circulation (ROSC) at Emergency Department in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using the Utstein comparator group calculation	40%*
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	> 80%		

** KPI validation on newly developed performance indicators will be conducted over Q1 and Q2. KPI performance reporting will commence Q3.*

Primary Care Division

Introduction

The development of the Primary Care service is a key element of the overall Health Reform programme. The core objective is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings, while ensuring that services are:

- Safe and of the highest quality
- Responsive and accessible to patients and clients
- Highly efficient and represent good value for money
- Well integrated and aligned with the relevant specialist services

Finance	2014 Budget €m
Primary Care Services	725.6
PCRS	2,433.0
Total	3,158.6

Full details of the 2014 budget are available in Table 11 page 20.

Primary Care budget excludes local and regional drugs taskforce funding which has been included in National Services.

Quality and Patient Safety

Quality and Patient Safety is a key priority for the Primary Care Division reflected in the decision to appoint a Quality and Patient Safety Lead to support the implementation of HIQA *Quality Standards for Safer Better Healthcare* in Primary Care. This person will drive quality improvement initiatives within Primary Care and will work with service providers on:

- The development of quality indicators
- The implementation of investigation report recommendations
- Conducting audits of performance

A Framework to meet the requirements of the Quality Standards across Primary Care services will be developed. Primary Care will work with the Quality and Patient Safety Division to develop quality indicators across all services and take appropriate action where performance does not meet identified targets.

Primary Care

The Primary Care Strategy defined primary care as being *'an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing'.* Over the last number of years, work has been underway to realise the vision for primary care services whereby the health of the population is managed, as far as possible, within a primary care setting, with the population very rarely requiring admission to a hospital. This approach is now aligned with the *Healthy Ireland* framework, noting the importance of Primary care to the delivery of health improvement gains. The primary care team (PCT) is the central point for service delivery which actively engages to address the medical and social needs of its defined population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

Key Priorities with Actions to Deliver in 2014

- Deliver appropriate health services to meet primary healthcare needs through primary care teams and health and social care networks.
  - Consolidate all health and social care networks and working arrangements.
  - Re-engineer primary care work processes and practices and models to maximise clinician-to-patient time and reduce patient waiting times for assessment and / interventions.
  - Improve service access through the procurement of an additional 21 primary care centres.
  - Develop an electronic patient management system which will facilitate integrated care within primary care services and across the wider health services.

- Provide additional primary care services.
  - Implement a universal GP service, without fees at the point of use, for all children aged 5 years and under. (€37m)
  - Enhance the services of existing Community Intervention Teams with an increased emphasis on helping people to avoid hospital admission or return home earlier; this will be done through redeployment and reconfiguration of existing resources.
  - Review the provision of INR testing (a test for blood clotting) in community settings, targeting areas where INR testing in the community setting is low.
- Address specific service challenges in areas such as:
  - The discharge of special care babies from hospital using packages of care in the community for babies with tracheotomies. (€1.2m)
  - Optimise the management and provision of Community (Demand-Led) Schemes, including aids and appliances, through a dedicated project which will manage delivery within resources, maximise efficiencies and put this service on a sustainable footing.
- Ensure integration with National Clinical Strategy and Programmes

  Expand chronic disease prevention and management in primary care to include quality initiatives, optimising patient flow and developing integrated management of chronic diseases.
  - Diabetes
    - Align the existing primary care diabetes care initiatives to the nationally agreed model of care with the support of the Diabetes Clinical Programme.
  - Respiratory Programmes
    - Prepare for the implementation of the agreed model of asthma structured care in primary care.
    - Develop a model of care including guidelines for the management of Chronic Obstructive Pulmonary Disease (COPD) including spirometry in primary care with National Clinical Strategy and Programmes.
  - Ophthalmology
    - Review primary care ophthalmology services in collaboration with the Ophthalmology Clinical Programme.
  - Radiology Services
    - Improve GP access to diagnostic tests.
- Improve specific primary healthcare provision.
  - Dental and Oral Health
    - Ensure at least 5% of all primary care Dental Treatment Services Scheme (DTSS) approvals for complex care are for vulnerable adults. This will especially focus on complex care patients such as those with cancer.
    - Commence the implementation of anti-microbial guidelines across a range of dental settings.
    - Undertake a baseline compliance assessment in relation to HIQA standards and commence planning for their implementation.
    - Reduce the waiting time for orthodontic treatment.
  - Community Oncology
    - Progress the prostate e-learning project for GPs (jointly with the Irish College of General Practice), and nurse e-learning projects including breast, prostate and lung cancers, smoking and psychological wellbeing projects.
    - Implement the Community Oncology Nursing Programme (on receipt of National University and An Bord Altranais accreditation).
  - Audiology
    - Continue to implement the National Audiology Review recommendations.
    - Implement the bilateral simultaneous and sequential cochlear implant programme in collaboration with acute services.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Quality and Patient Safety Healthcare Associated Infection: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	< 21.7	Primary Care Physiotherapy and Occupational Therapy Wait List Management Occupational Therapy - No. of patients waiting over 16 weeks for an assessment	< 10%
Community Intervention Team Activity by Source - ED Hospital Avoidance - Early Discharge - GP Referrals - Community Referrals	5,976 6,104 2,140 600	Physiotherapy – No. of patients waiting over 12 weeks for an assessment	< 10%
		Orthodontics Reduce waiting times of those waiting for assessment	90% assessed within one year
Chronic Disease - Diabetes No. of existing primary care diabetes initiatives aligned to the nationally agreed model of care	10	Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade 4 and 5)	< 5%

Please note:

- Public Health Nursing PIs for child health are reported under Health and Wellbeing Section
- Community Intervention Team Data reflects a new PI for 2014 and a data validation process will be carried out in 2014 in line with targets set

Social Inclusion

Social Inclusion plays a key role in supporting equity of access to services and provides targeted interventions to improve the health outcomes of minority groups which encompass Irish Travellers, Roma, and other members of diverse ethnic and cultural groups, such as asylum seekers, refugees and migrants, lesbian, gay, bisexual and transgender service users.

Specific interventions are provided to address addiction issues, homelessness and medical complexities. Members of these groups characteristically present with a complex range of health and support needs which require multi-agency and multi-faceted interventions. The Health Service promotes and leads on integrated approaches on different levels across statutory and voluntary sectors. A critical success factor is the continued development of integrated care planning and case management approaches between all relevant agencies and service providers.

Key Priorities with Actions to Deliver in 2014

- Achieve improved health outcomes for persons with addiction issues.
  - Deliver on the national policy objectives of the *National Drugs Strategy 2009-2016*, with specific reference to progressing implementation of relevant actions on early intervention, treatment and rehabilitation.
    - Implement recommendations from Health Service Opioid Treatment Protocol.
    - Implement recommendations of Tier 4 (Residential Addiction Services Report) within the context of available resources.
    - Evaluate the Pharmacy Needle Exchange Programme and make recommendations.
    - Finalise the implementation plan for the National Overdose Prevention Strategy.
- Prioritise and implement Health Service actions in the Report of the Steering Group on a *National Substance Misuse Strategy*.
- Implement recommendations of the *National Hepatitis C Strategy* according to updated time frames and in line with existing resource constraints.
- Implement the specific health aspects of a housing-led approach to homelessness in line with the new *National Homelessness Policy Statement*.
- Improve access to services for people from diverse ethnic and cultural backgrounds within the context of the Health Service *National Intercultural Health Strategy*.
- Improve health outcomes for members of the Traveller Community in line with the *All-Ireland Traveller Health Study*.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Opioid Substitute Treatment No. of clients in opioid substitute treatment (outside prisons)	9,100	Pharmacy Needle Exchange No. of unique individuals attending pharmacy needle exchange	700
Substance Misuse No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	1,260 100%	Homeless Services No. and % of individual service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	1,700 85%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	105 100%		

Primary Care Reimbursement Service

The Primary Care Schemes are the infrastructure through which the Irish health system delivers a significant proportion of primary care to the general public. Scheme services are delivered nationally by Primary Care Contractors – General Practitioners, Pharmacists, Dentists and Optometrists / Ophthalmologists.

Services are provided to 3.4m people in their community through 6,855 Primary Care Contractors. The Primary Care Schemes include:

- General Medical Services (GMS) – Medical Card Scheme including GP Visit Cards
- Drug Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Services Scheme (DTSS)
- High Tech Drug Arrangements
- Primary Childhood Immunisation Scheme
- Community Ophthalmic Scheme
- Health (Amendment) Act 1996
- Methadone Treatment Service
- Immunisation for certain GMS eligible persons
- European Economic Area (EEA)

Key Priorities with Actions to Deliver in 2014

- The first phase of the introduction of a **universal GP service** in Ireland will commence during 2014. This will make available a GP service, without fees, to approximately 420,000 children aged 5 years and under. By the end of 2014, approximately one-half of the national population will have access to GP services without fees at the point of use.
- Implement revised **Guidelines** for Medical Cards and GP Visit Cards for persons aged 70 and over.
- Implement **new arrangements** for retention of Medical / GP Card for persons returning to work.
- Implement the revised **prescription charge** arrangements.
- Assess the **eligibility** of new applicants and review the eligibility of existing cardholders in line with health policy, regulations and the service level arrangements governing the administration of the GMS Scheme.
- Reimburse **primary care contractors** in line with health policy, regulations and the service level arrangements governing the administration of the Schemes throughout 2014.
- Progress a number of **key projects** to support the strategic priorities of the organisation as follows:
  - Drug Reference Pricing / Generic Substitution: Implement drug reference pricing and generic substitution to include determining appropriate reference prices
  - Medicines Management Programme: Promote more cost effective prescribing by GPs and implement improved GP access to analysis of prescribing
  - Revenue and Department of Social Protection Interfaces: Integrate Revenue and Department of Social Protection data with PCRS infrastructure
- **Probity measures**: The AEV contained a figure of €113m in respect of new probity measures for PCRS. Following a review it has been ascertained that this level of savings cannot be delivered from probity within the

current guidelines. Therefore an allocation of €47m has been made within the Revised Estimate Volume, €3m will be included in addition to the existing €20m identified for probity, and €63m will be utilised from the pension budget. These three elements account for the €113m set out in the original AEV.

Probity measures will:

- Focus on eligibility for services in order to ensure that those who are eligible to access services under the schemes continue to do so. In this regard, reviews of eligibility will be conducted in a risk-assessed manner in relation to approximately one million medical card holders during 2014
- Establish data sharing arrangements with both the Revenue Commissioners and the Department of Social Protection
- Continue to focus on claims for services from primary care contractors to ensure reasonableness and accuracy of all such claims
- Increase the use of data analysis to support inspection functions

Key Indicators of Performance

Performance Indicator / Activity	Expected Activity / Target 2014	Performance Indicator / Activity	Expected Activity / Target 2014
Medical Cards No. of persons covered by medical cards as at 31st December	1,875,707	GMS No. of prescriptions	21,639,388
		No. of items	66,432,920
GP Visit Cards No. of persons covered by GP visit cards as at 31st December	402,138*	No. of claims – special items of service	946,957
		No. of claims – special type consultations	1,242,077
		No. of treatments – DTSS (routine)	1,354,079
		No. of treatments – DTSS (complex)	68,338
% of properly completed medical / GP visit card applications processed within the 15 day turnaround	90%	Long Term Illness No. of claims	944,288
		No. of items	3,059,492

* GP Visit Card expected activity / target 2014 includes provision for GP services for children aged 5 years and under

Health and Wellbeing Division

Introduction

Health and Wellbeing provides people with knowledge, services and supports to help them live healthier and more fulfilled lives. Health and Wellbeing encompasses Public Health, Health Protection, Child Health, National Screening Programmes, Health Promotion and Improvement, Environmental Health, Emergency Management and Health Intelligence.

Finance	2014 Budget €m
	234.3
Full details of the 2014 budget are available in Table 11 page 20	

National frameworks and strategies such as *Future Health*, and *Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2025* underline the commitments at national level and service wide to increasing the proportion of people who are healthy at all stages of life; reducing health inequalities, protecting the public from threats to health and wellbeing and creating an environment where individuals and all sectors of society can play their part in achieving a healthy Ireland. The effects of chronic disease are targeted through addressing health inequalities and lifestyle health determinants such as smoking, alcohol misuse, physical inactivity and obesity.

Existing statutory commitments will be delivered in 2014 as will key priorities and actions as set out in national, regional and local area plans. The key priorities set out below do not reflect all of the work of Health and Wellbeing services; rather they represent the key areas around which collective efforts will be focused in 2014. Significant emphasis will be placed on measuring and monitoring all Health and Wellbeing activities and the impact of this work.

Quality and Patient Safety

The fundamental aim and objective of the Division is to improve health and wellbeing. This will be carried out by:

- Developing a set of quality indicators in 2014 that reflect the degree to which the work of the Division can be assured to be delivering quality services and programmes e.g. in areas such as health protection, health promotion, immunisation and child health screening
- Ensuring that the Health Intelligence function as it develops into a broader Knowledge Management function, continues to provide data and information supports to guide service development and improvement
- Working with other Divisions to continue to support service delivery against quality performance indicators such as those in the area of antibiotic prescribing, amongst others

A Quality Lead will be appointed within the Division to ensure that a quality focus is embedded across the work programmes of the Division.

Key Priorities with Actions to Deliver in 2014

- Reconfigure and realign work practices, programmes and teams to deliver against the actions in *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025*.
  - Develop a cross-divisional 'health services' 3 year implementation plan and work programme for *Healthy Ireland*.
  - Review workforce capacity commencing with community dietetics and community nursing services.
  - Review programmes, funding strategies and activities on a phased basis across the Division to ensure they are a) evidence-based, sustainable and cost effective; b) orientated to promote health and reduce disease among communities and populations most at risk; and c) appropriately aligned to the work plans of the other Divisions.
  - Develop Health Intelligence with the support of internal and external partners.
- Reduce the chronic disease burden of the population.
  - Continue to deliver on priority areas including tobacco, diet and nutrition, including supporting package of obesity reduction programmes (€0.1m), alcohol misuse, physical activity, positive mental health promotion and good sexual health through the key settings and targeted at key at risk groups.

- Produce an Implementation Plan for recommendations pertaining to the Health and Wellbeing Division identified in both the Steering Group report on National Substance Misuse Strategy and Tobacco Free Ireland.
- Integrate and develop a one-stop model for all smoking cessation services in the Health Service. (€0.1m)
- Work across Divisions and with National Clinical Strategy and Programmes to ensure Health Service reforms result in a greater focus on disease prevention and self care.

- Develop more integrated and efficient service delivery models for the health of the population.
  - Develop and implement a model for child health screening and development in conjunction with the Primary Care Division.
  - Develop a new model for the delivery and governance of immunisation services.
  - Continue to prevent, control, and manage infectious diseases, especially tuberculosis (TB), sexually transmitted diseases, and vaccine preventable diseases.
  - Deliver screening programmes to the population in conjunction with the National Cancer Control Programme (NCCP), within existing resources: Cervical Check and BreastCheck.
  - Continue roll out of the first round of BowelScreen, which commenced in late 2012. (€2.0m)
  - Deliver Diabetic RetinaScreen (screening and treatment), which commenced in early 2013. (€4.5m)
  - Review the coordination, effectiveness and impact of sexual health services and preventative work, including the work of the Crisis Pregnancy Programme. (€0.05m)
- Enforce legislation and promote activities to assess, correct, control, and prevent those factors in the environment which can potentially adversely affect the health of the population.
  - Enforce the *Public Health (Tobacco) Act* and other tobacco control legislation, targeting activities on areas of least compliance.
  - Develop and put into effect an implementation and enforcement plan for the enactment of the Public Health Sunbeds legislation.
  - Implement the service contract with the Food Safety Authority of Ireland (FSAI).
  - Set out new service requirements and arrangements through Memoranda of Understanding with the Environmental Protection Agency, Irish Medicines Board and the Child and Family Agency.
- Coordinate the Health Service planning and response to major emergencies in conjunction with other response agencies.
  - Reconstruct the Health Service Crisis Management Teams at local and regional levels to provide for a membership of all Divisions ensuring a coordinated health response.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Immunisations and Vaccines % of children 24 months of age who have received the MMR vaccine	95%	Cancer Screening No. of women who attend for breast screening	140,000
% children 12 months of age who have received the 6-in-1 vaccine	95%	Tobacco Control No. of frontline healthcare staff trained in brief intervention smoking cessation	1,350
% children 24 months of age who have received 3rd dose of MenC	95%		
% first year girls who have received third dose of HPV vaccine by August 2014	80%	No. of smokers who received intensive cessation support from a cessation counsellor	9,000
Child Health % newborn babies visited by a PHN within 48 hours of hospital discharge	95%	Chronic Disease Prevention % of PCTs *in School Growth Monitoring Sites* trained in Health Service – ICGP Weight Management Treatment Algorithm for Children	70%
% of children reaching 10 months who have had their child development health screening before 10 months	95%	Food Safety No. of planned, and planned surveillance inspections of food businesses	33,000

Social Care Division

Introduction

Finance	2014 Budget €m
Social Care	2,116.6
NHSS	938.7
Total	3,055.3

Full details of the 2014 budget are available in Table 11 page 20

The establishment of the Social Care Division to support the ongoing service requirements of older people and people with disabilities is a fundamental step in moving forward with the design and implementation of models of care across both these Care Groups to support and maintain people to live at home or in their own community and to promote their independence and lifestyle choice in as far as possible. Older people with care needs must be provided with a continuum of services such as home care, day care and intermediate residential care to avoid unnecessary acute hospital admissions and have their required treatments and supports delivered within their local community at primary care level in as far as possible. People with disabilities must have access to the supports they require to achieve optimal independence and control and to pursue activities and living arrangements of their choice. Supports for both groups must be responsive to service user needs and be provided flexibly at the least possible unit cost to build a sustainable system into the future.

A key function of the Social Care Division is to:

- Organise and deliver the required and appropriate services safely to approved standards
- Reconfigure the available resource through a comprehensive reform process by increasing productivity changing traditional cost structures and developing new service models of delivery in the process
- Continue to reform staff level requirements, skill mix, staff attendance patterns and rosters within the context of the *Public Service Agreement 2010-2014*

Quality and Patient Safety

The Social Care Division will be focusing on improving the quality of the services and supports provided for older people and people with disabilities and on ensuring that their safety is a fundamental priority. This will be reflected in the continuing emphasis on the residential care standards applying to services for older people and a drive to implement the new HIQA standards applying to residential services for people with disabilities in addition to internal measures applied to our services. Both sets of standards are inspected by HIQA.

Disability Services

In 2014, the focus will be on supporting people with disabilities to achieve their full potential including living as independently as possible. Our aim is to ensure that people with disabilities are heard and involved in all stages of the process to plan and improve services. This model implies that peoples' strengths and personal goals will inform the development of their care plans and their decisions will be supported by the provision of clear information and advice. The potential of local communities and social networks to sustain people in their own homes and communities will be maximised and a wider range of high quality options will be available to support them. Eventually, people will have increased control of their own resource through a 'money follows the patient' approach.

The National Implementation Framework for the recommendations of the *Value for Money and Policy Review of the Disability Services Programme* provides an important mechanism for the implementation of significant change in disability services. This includes changes to the governance, funding and focus of provision, intended to positively impact on the way in which people with disabilities are supported to live the lives of their choice. Given the decreasing budget and staff complement, significant realignment and reconfiguration of existing resources will be required as new and sustainable models of service are implemented to meet the changing needs of service users and increased demographic pressures.

Key Priorities with Actions to Deliver in 2014

In line with the priorities for 2014 as set out in the National Implementation Framework relating to the Value for Money and Policy Review of Disability Services:

- Streamline governance arrangements and maximise optimum efficiency by implementing a reconfigured governance and accountability framework for the disability service programme including revised Service Arrangements / Grant Agreements
  - Produce targeted plans to identify and implement efficiency measures across all agencies including skill mix and rostering efficiencies
  - Introduce specific measures to achieve efficiencies through a focused approach to procurement and shared service models as well as the introduction of new and sustainable models of person centred service. Target savings of €5m for section 38 and section 39 agencies
  - Commence process to reduce Average Unit Costs in line with the VfM and Policy review
- Continue to drive migration towards a person-centred model of services and supports
  - Implement the relevant policy reports including:
    - *Time to move on from Congregated Settings* - aimed at supporting people to move from institutional settings while continuing to provide for those requiring emergency residential placement
    - *New Directions - Personal Support Services for Adults with Disabilities* - reconfiguring day services. Provide for the emerging needs of the estimated 1,200 additional young people leaving school and Rehabilitation Training Programmes using a newly developed, streamlined approach, and for emergency cases (€10m and 50 WTEs)
    - *Progressing Disability Services for Children and Young People (0-18s) Programme*. (€4m and 80 WTEs) Engaging in the development of a service framework to support the provision of pre-school services for children with a disability informed by cross-sectoral discussion
  - Collaborate with DoH and voluntary partners in evaluating existing demonstration projects in order to establish a firm evidence base to inform future migration towards the new service model
  - Ensure the wide dissemination of the learning gained from successful projects
- Build on the mechanisms employed in the National Consultative Forum structures to ensure enhanced service user involvement in the development of disability services
  - Produce plans to identify a range of methodologies to ensure service user involvement
- Enhance the quality of services used by people with disabilities
  - Improve the quality of disability services by implementing the National HIQA Standards for *Residential Services for Children and Adults with Disabilities*
  - Work with service providers to meet the requirements of *Children First*
- Improve management and information systems for disability services
  - Continue to work with the DoH on the Strategic Information Framework
  - Review the methodology for setting targets. Develop the current output focused performance indicator (PI) set to incorporate more outcome based PIs
  - Commence development of a web-based system to support easier service user access to information and advice
  - Develop a standardised assessment of need process in 2014 which will inform the development of a new resource allocation model in the future

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
0-18s Programme Proportion of Local Implementation Groups which have local implementation plans for progressing disability services for children and young people	25 of 25	Quality In respect of agencies in receipt of €5m or more of public funding, the percentage which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF.	100%
Disability Act % of assessments completed within the timelines as provided for in the regulations	100%	Respite Services No. of bed nights in residential centre-based respite services used by people with disabilities	243,260
*Personal Assistant Hours No. of PA hours delivered to adults with a physical and / or sensory disability	1.3m	Congregated Settings Facilitate the movement of people from congregated to community settings under the auspices of the following: - Genio-funded projects - Housing Strategy for People with a Disability - Other	150
*Home Support Hours No. of Home Support hours delivered to people with disabilities	2.4m		
Day Services % of school leavers and RT graduates who have received a placement which fully meets their needs	100%		

*A review of the methodology for the collection of PA and Home Support Hours will be undertaken in 2014

Services for Older People

During 2014, the priority for Services for Older People will be the development of an integrated model of care with a strong emphasis on home care and other community support services as well as intermediate and rehabilitation services, in order to avoid hospital admission or, where acute care is required, to support early discharge through appropriate and timely services, while maximising access to appropriate quality long term residential care when it becomes necessary. Our intention is to maximise the potential of older people, their families and local communities to maintain people in their own homes and communities within a sustainable model based on the principles of 'money follows the patient'.

As there are no new additional resources, in 2014, in order to meet the challenge of the needs of the increasing ageing population within existing resources, innovative approaches to our service delivery model are required. Our plan will begin the process of strategic realignment of the model of care moving resource from the Nursing Homes Support Scheme (NHSS) – A Fair Deal to development of home care and community support services. While there will be an increase in waiting times for long stay residential care, there will be increased options available to support older people to remain at home, including those with dementia at risk of admission to residential care.

Key Priorities with Actions to Deliver in 2014

- Provide comprehensive home care and community support services, to enable older persons to live independently, in their own homes, for as long as possible and develop a more integrated model of care.
  - A review of home care and community support services will be undertaken in conjunction with key stakeholders.
  - A service improvement programme will be implemented to ensure standardised delivery of home help and home care packages.
  - A national standardised approach will be developed around the allocation of resources to integrated service areas (ISAs) for home care and community support services, building on the framework for 'money follows the patient', commenced by the Nursing Homes Support Scheme - A Fair Deal (NHSS).
  - The Home Help agreement will be implemented across each ISA in line with the Labour Court recommendations.
  - A tender process will be undertaken for the contracting for home care packages to support the implementation of the service delivery model.

- Strategic re-alignment of the Model of Care towards home care and community support services.
  - Allocate €23m from NHSS as a first step in aligning the model of care towards home and community support services.
  - Stage 1 in 2014 will target €10m of the funding to support acute hospitals service pressures by commissioning priority ISAs, (where service pressures on delayed discharges and community placements are most challenging) to provide additional individualised intensive HCPs, providing a greater range and level of services to the older person and their families, including short stay care if required, and to commission a number of demonstration sites to work to develop the integrated model of care working with approved providers who can deliver enhanced combinations of appropriate services including dementia specific options.
  - This initiative will provide approximately 190 Intensive Home Care Packages (IHCPs) at any time, benefiting approximately 250 people in a full year.
  - Stage 2 will target €3m of the funding to commission at selected ISA sites additional intermediate care and community support beds to provide a greater range of options to avoid admission to acute hospitals, support early discharge, reduce delayed discharges and, where appropriate, provide rehabilitation services to support the older person in returning to their home.
  - This initiative will provide approximately 25 intermediate / transitional care beds with 650 people benefiting, together with 20 beds to provide for more complex cases benefiting 130 people.
  - Stage 3 will involve the allocation of €10m to address funding shortfalls in the provision of public short stay beds, to secure this important service into the future. In parallel, we will establish a funding and commissioning type payment model for 'short stay beds' based on the 'money follows the patient' approach already applied to NHSS – A Fair Deal.
- Manage the Nursing Homes Support Scheme – Long Term Residential Care.
  - Provide quality long term residential care services for older people who require it through the NHSS Scheme.
  - Implementation of the Action Plan for the provision of public long stay residential care services in order to maximise compliance with HIQA standards within available capital funding.
- Develop a Service User Engagement Programme.
  - Increase our engagement with key stakeholders, advocacy groups and the voluntary sector to develop a strong user engagement and participation process to support the development of an integrated model of care.
- Implement a Single Assessment Tool (SAT).

  The first phase implementation will commence in 2014 with a minimum of 50% of all new entries to NHSS, home care packages and home help schemes assessed by the SAT in the last quarter of 2014, with full implementation in 2015.
- Implement approaches to Keeping Older People Well.
  - Work with DoH in implementing the National Positive Ageing Strategy.
  - Work with DoH on the finalisation and roll out of the Dementia Strategy.
  - Support the Health Service / Genio Dementia Project in the development of dementia community based services in selected sites.
  - Health pilot sites / early adapters for falls prevention and bone health to be formed within each region.
  - Implementation of *Protecting our Future – Report of the Working group on Elder Abuse*.
- Develop Service Improvement Programmes to support the development and implementation of the integrated models of care for older people.
  - Develop and implement an outcome measurement framework, including development of protocols for regular monitoring of PIs and outcomes.
  - Support our public residential units in further identifying and implementing efficiency measures, to reduce cost of care.

- Continue to work with HIQA and apply improvement measures through its monitoring and implementation of HIQA standards across services for older people.
- Streamline governance arrangements and maximise optimum efficiency.
- Strengthen community hospital governance through amalgamation on a geographical basis of nurse management structures.
- Implement cost effective models of skill mix and rostering with a view to reducing cost of care and increasing efficiencies in public long stay facilities target savings of €3m from NHSS.
- An efficiency target of €1.7m is being allocated to section 38 and section 39 voluntary sector agencies in the services for older people domain.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Home Care Packages Total no. of persons in receipt of a HCP	10,870	NHSS No. of persons funded under NHSS in long term residential care during the reporting month	22,061 (at Dec 2014)
Intensive Home Care Packages No. of persons in receipt of an intensive HCP at a point in time (capacity)	190	Public Beds No. of NHSS Beds in Public Long Stay Units	5,400
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10.3m	Elder Abuse % of active cases reviewed within six month timeframe	80%

Mental Health Division

Introduction

The establishment of the Mental Health Division delivers on a key recommendation of the *Report of the Expert Group on Mental Health Policy - A Vision for Change* (2006).

Finance	2014 Budget €m
	765.8
Full details of the 2014 budget are available in Table 11 page 20	

The Mental Health Services Division carries operational and financial authority and accountability for all mental health services with the core objectives of:

- Providing high quality services by implementing *A Vision for Change* to deliver a modern, recovery focused, clinically excellent service built around the needs and wishes of service users, carers and family members
- Supporting an improvement in the mental health of the population and in our approach to suicide prevention
- Implementing the Health Reform programme fully within mental health services in a way which ensures they are properly integrated with other health and social services

The mental health division provides a specialised secondary care service for children and adolescents, adults, older persons, those with an intellectual disability and mental illness as well as a range of suicide prevention initiatives. Services are provided in a number of different settings including the service user's own home. The modern mental health service is integrated with primary care, acute hospitals, services for older people, services for people with disabilities, and with a wide range of non health sector partners.

The 2006 government policy for mental health *A Vision for Change* indicates a requirement for 12,240 Whole Time Equivalent (WTE) staff by 2016 which compares to the 9,065 in place at the end of September 2013. There are approximately 457 new posts currently in the recruitment process relating to prior year ring-fenced funding and a further 250-280 new posts that are planned for recruitment in 2014.

The provision in Budgets 2013 and 2014 of ring-fenced investments of €35m and €20m, in mental health, is enabling the continued strengthening of our community teams, increased suicide prevention resources and clinical programme development and implementation. The €20m for 2014 will allow us commit to between 250 and 280 posts. New spend in 2014 related to the €35m and €20m will need to be phased in order to live within the overall available resource. The recruitment process for these new posts will commence in the first quarter of 2014, with all posts targeted to be in place in 2014. The posts and other developments related to the €35m allocated for 2013 will continue to come on stream and are targeted to be completed in Quarter 2 of 2014.

Quality and Patient Safety

The priorities outlined for 2014 represent a practical approach to improving the quality and safety of our mental health services over time. In 2014 the Mental Health Division will form a dedicated unit to review serious incidents involving mental health service users. The Mental Health Quality and Patient Safety Unit will focus on the policies, practices and procedures relating to serious incidents in the mental health sector. This unit will support notification, investigation and training and will act as a national resource to disseminate learning and enhance current risk management processes.

A Vision for Change describes a recovery focused model of care which is not overly reliant on the provision of beds. Our model of residential care is a key aspect of the overall quality of our service. At the end of 2012 there were in excess of 2,000 non-acute beds including circa 750 in long stay continuing care and circa 200 community hostels and other residences. This number of continuing care and community residence beds needs to move on a phased basis, supported by the continued investment in community teams, towards the approximately 1,300 continuing care and community residence beds recommended in *A Vision for Change*. We will also continue to focus on reducing any residual over reliance on acute inpatient beds.

The Performance Framework for the Mental Health Division has prioritised as a key quality metric that 75% of all admissions of children to mental health acute inpatient units should be to age appropriate Child and Adolescent Acute Inpatient Units. We have also prioritised the identification of additional quality metrics with the medium to long term goal of moving to more outcome focused quality metrics.

Key Priorities with Actions to Deliver in 2014

We will continue to progress the key multi-annual priorities from previous years including implementing the Access Protocol for 16 and 17 year olds to Child and Adolescent Mental Health Services (CAMHS) and reconfiguring the General Adult Community Mental Health Teams (CMHT) to serve populations of 50,000 as recommended in *A Vision for Change*. Key deliverables in 2014 include:

- Develop an implementation plan for last 3 years of *A Vision for Change* – A Standard Model of Care

  During 2014 we will focus on developing a major work stream within the mental health clinical programme which will seek to address a variety of issues which have existed for some time and have been raised during the initial engagement process with internal and external stakeholders. These include (indicative not exhaustive list):

  - Reduce variation – over time provide a relatively standard level of basic service regardless of location
  - Access to, egress from and flow through the service – general care pathways – out of hours access
  - How mental health can best support and integrate with primary care, acute hospitals and other services
  - Local Team Standard Operating Procedures – Team coordinators, central referrals, core basic assessment by team members, case load management, authorised officers, assisted admissions, etc.
  - Involving service users, carers and family members – moving from consultation to co-production
  - Over arching model of care – making step change in recovery focus and enhancing clinical excellence
  - Change management plan – get to desired level of acute and non-acute beds, day hospital versus day centre, etc.
  - Mental health access and quality metrics – including access to for example psychological therapies and development of outcome focused key performance indicators

- Promoting positive mental health and improving suicide prevention
  - Develop a new strategic framework to build on and enhance the implementation and governance approach associated with suicide prevention based on the learning from *Reach Out – Irish National Strategy for Action on Suicide Prevention 2005-2014*
  - Continue to implement the outstanding actions in *Reach Out.*
  - Invest in additional suicide prevention resource

- Begin to address foundational issues within mental health services
  - Develop an initial workforce plan for 2014 to bring greater certainty around essential replacements
  - Streamline recruitment to allow for more local control and specialisation where appropriate
  - Develop an initial training and development strategy for Mental Health
  - Build national capacity to respond in a standardised way to serious adverse incidents
  - Assess baseline and create phased improvement plan(s) in relation to Mental Health staff accommodation, equipment, assessment tools, etc.
  - Commence key projects to address ICT gaps including:
    - National Mental Health Information System (MHIS) – (4 to 5 year project)
    - E- Rostering solution for Mental Health (2 year project)
    - ICT fundamentals in Mental Health (current baseline and improvement plan – 1 year)
    - Interim data gathering solution (6-9 months project)

  This is intended to free up senior clinical and management time and energy to focus on developing and implementing a standard model of care.

Approach to Cost Reduction

The main resource available to the mental health service is our staff and consequently our costs are approximately 90% pay related. The *Haddington Road Agreement* provides us with a major opportunity to safely and significantly reduce our costs without reducing our services or further reducing the pay rates of our individual staff members. The expectation is that the vast bulk of any savings within mental health will be those that can be facilitated via the *Haddington Road Agreement* and therefore our number one priority in terms of cost reduction is to fully maximise all elements of the *Haddington Road Agreement*. A process is in train to ensure that all our local services can demonstrate with robust

evidence the full extent of savings that can and will be achieved under the *Haddington Road Agreement* without reducing services. As part of this we will also focus on savings that can be achieved through changes in our model of care in terms of reducing our over reliance on community beds and any residual over reliance on acute beds. In approaching any reduction in beds we will be conscious of the need for such changes to be properly consulted on and planned in order to ensure continuity and safety of our services. It should be noted that the timing and realisation of cost reductions following on from these types of initiatives can be impacted by both the need for transition arrangements and adequate periods of consultation in moving to these new models of care.

Key Indicators of Performance

Performance Indicator	Expected Activity / Target 2014	Performance Indicator	Expected Activity / Target 2014
Adult Mental Health Services % of General Adult Community Mental Health Teams serving a population of circa 50,000 (range of 45,000 to 60,000) as recommended in *Vision*	≥ 60%	Child and Adolescent Community Mental Health Services Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units.	≥ 75%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Teams	≥ 75%	% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	≥ 75%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	≥ 95%		

Children and Families

Introduction

Government is committed to fundamental changes in the delivery of children and family services which include the imminent establishment of the Child and Family Agency. Establishment of the Child and Family Agency is provided for in the Child and Family Agency Bill, 2013 and plans are in place to commence the Agency from the start of 2014.

Finance	2014 Budget €m
	536.7
Full details of the 2014 budget are available in Table 11 page 20	

Substantial progress has been made in 2013 within the Health Service in support of the *Programme for Government* commitment to establish the Child and Family Agency. This support will be continued as the Agency becomes a separate legal entity, with a particular focus on successful business continuity. In particular, the Health Service will support the Agency through the provision of range of administrative and corporate supports on a shared service basis, as provided for under a joint Memorandum of Understanding. The Health Service will also collaborate closely with the Child and Family Agency in the management of those children and families with needs that require services for which both organisations are responsible; this ongoing collaboration will be supported by a jointly agreed protocol.

Detailed plans outlining activity levels and performance targets and indicators will be further elaborated in the new performance management arrangements between the Department of Children and Youth Affairs and the Child and Family Agency. Overall planned service activity levels will be similar to existing levels. This will include provisions for approximately 6,500 children in care, for approximately 40,000 referrals to child welfare and protection services (comprising approximately 19,000 reported child abuse concerns and 21,000 referrals of welfare concerns) and a range of family support, domestic violence and community based interventions with families. Pre school inspection will cater for some 4,700 pre school providers. As referenced in the Government's 2014 Expenditure Report the total budgetary provision for the Child and Family Agency will be set out in the Revised Estimates Volume to be published before the end of the year. The Children and Families element will be based upon the existing 2014 current expenditure estimate of €536.4m, subject to any agreed adjustments. Employment levels are as agreed in the Census validation process undertaken to date and will also be subject to any agreed adjustments.

The Health Service will retain very important responsibilities to promote and protect the welfare of children who avail of its services or come to its attention in the course of delivering upon its responsibilities. In particular, this will include full implementation of consistent child protection procedures in line with the national guidance *Children First: National Guidance for the Protection and Welfare of Children*. Appropriate governance arrangements will be put in place at national and local level to implement, monitor and report on *Children First* in the health sector. This will include the development of an overall plan for the implementation of *Children First* by the Health Service and the agencies / services (funded or procured) providing services under section 38 and 39 of the *Health Acts*.

Capital Infrastructure

Included in the 2014 Budget figure is an amount of €1m for minor Capital works. As with the Current Expenditure items, the Due Diligence process which is yet to be completed may identify further adjustments to overall Capital allocations and will be included in the Revised Estimates Volume.

Supporting Service Delivery

Shared Services

Introduction

Shared Services is the health business services platform for the Health Service. It is a key tenet of the current *Programme for Government* in both the wider public service and the health environment. During the latter part of 2013, a Shared Services Strategy was developed for the Health Service. This strategy reflects the ambition of the Health Reform Programme to ensure that in line with modern business practices, the operational health and social services have access to a range of common support business services on a shared basis. This will allow the operational services to focus its management attention on its core business in the knowledge that its support functional needs will be delivered by a competent Division which will drive efficiency and quality whilst adhering to legislative and regulatory requirements.

Shared Services will strive to ensure that key support functions are modernised and developed in line with best practice but also in a way which meets the individual customer needs. The functional areas of the Division are Finance and Human Resources (HR) Shared Services, Estates, Information, Communication Technology (ICT), Enterprise Resource Planning (ERP) and Procurement. The shape and structure of the Shared Services will be based on emerging practice from other sectors and will require building on a number of individual components which have developed in a centralised fashion but without the necessary enabling infrastructure and technology. High standards as appropriate will be set within the available resource and will be monitored. Considerable work will be required in 2014 and beyond to develop this into a fit for purpose shared service entity with significant organisational and cultural change required by both the new Division and the corporate and operational divisions of the retained organisation.

Key Actions to Deliver on 2014 Priorities

Develop an implementation plan for the new Shared Services Strategy and commence the sourcing of solutions for our customers to include:

- Undertake a joint exercise with Corporate Finance, Corporate HR and Operations to determine the services to be delivered respectively by Shared Services and the retained organisation
- Commence implementation of the Shared Services Strategy including the advancement of the required enabling technology and infrastructure
- Transition Shared Services functions to a single finance, procurement and HR platform
- Transition Children and Family Services processes to Shared Services
- Ensure that the Shared Services element of the recruitment process is delivered in line with organisational and customer needs
- Work with the Office for Government Procurement to ensure that end to end procurement processes are delivered in line with customer requirements
- Work with Corporate Finance and Procurement in the retained organisation to deliver on a systems solution in line with the Finance Reform Programme
- Continue the development of a service culture, focusing on organisation and client needs, the development of Service Agreements and a centralised communication function
- Continue day to day operations of existing functional services whilst undergoing a significant reform programme
- Manage the delivery of the Health Service Capital Plan (detailed further below) and ensure that it strategically supports the National Service Plan and longer term sectoral strategic plans
- Manage the ICT plan (detailed further below) in line with Health Service priorities
- Improve communications, collaboration, consistency of data and access to systems by implementing the ICT Infrastructure and Operations Strategy and the Integrated Services Framework
- Work collaboratively across the public health sector in establishing the National Health Sustainability Office towards ensuring compliance with national goals, targets and regulations and to effect savings through implementation of sustainability measures. The areas of focus will include water, waste and energy. The Sustainability Office will also focus upon the wider issues of sustainability arising in relation to Health and Wellbeing. Shared Services will work collaboratively with the Health and Wellbeing Division on developing this agenda. The health system faces energy cost growth of an estimated €15m in 2014. The work of the

Sustainability Office will focus on assisting the services in contributing to this cost growth that arises from anticipated growth in energy prices

Saving Targets in 2014

The Health Service is setting a procurement savings target in 2014 of €30m. This follows on from significant savings achieved over the last four years. The Health Service will continue to work actively with the Office for Government Procurement (OGP) during 2014 to support it in setting up an effective national office to drive value in procurement across the public sector. Should any of the areas included in the €30m plan move to the OGP, their transition will be facilitated. A further target of €10m has been set for shared services. The possibility will be examined of delivering this saving through the capital programme and associated revenue costs. A group will be established to look for savings in the area of major equipment purchase and maintenance costs to contribute to this savings area. The procurement function of the Health Service assists the services in saving money, it is dependent upon the on-going availability of clinical and frontline service personnel to focus on improved buying to achieve the targets set.

An assessment of the achievability of the €40m savings in total will be completed by the end of 2013 at which stage further decision can be made if required. Both of these targets will be held in central budgets nationally subject to their achievement as the year progresses.

Portfolios of goods / services targeted for savings in 2014	€m
Medical and surgical devices	7.2
Medical technologies equipment	5.0
Professional services Health Service	5.1
Hotel / facilities services	5.4
Professional services / transport	7.3
Total:	30.0

The Health Service has made significant savings in procurement over the last number of years. The savings in 2010 were €106m, in 2011 €74m, in 2012 €50m and in 2013 €47m.

Estates and Capital Programmes

The Capital Plan for the multi-annual period 2014-2018 supports the Government's priorities as set out in the *Programme for Government* and *Future Health*. A 2014 capital allocation of €381m has been received including an ICT amount of €40m. The main priority in 2014 will be the prudent management of the capital allocation, the maintenance of the Health Service's property portfolio and compliance with all regulatory and statutory requirements.

For 2014, the Health Service Capital Plan 2014-2018 also includes the progressing of the following projects: the Children's Hospital, the Central Mental Hospital, the National Plan for Radiation Oncology, the relocation of the National Maternity Hospital and investment in mental health and primary care infrastructure. Provision has also been made to progress projects that support the national clinical programmes, the national reconfiguration of acute hospital services and the delivery of intermediate care for older people services.

Information and Communication Technology

Information and Communication Technology (ICT) together with the wider information and informatics agenda are critical to the success of the *Programme for Government* and the health reform agenda, including enactment of essential legislation such as the *Health Identifiers Bill.* ICT is a key enabler of the patient safety and quality agenda in terms of data management and quality improvement measures across a range of areas. The Health Service will work with the DoH on the recently Government approved document *An eHealth Strategy for Ireland*.

In 2014 the Health Service's allocated ICT capital allocation amounts to €40m. The ICT plan will continue to be reviewed and refined to ensure that the necessary information, technical and governance infrastructure are progressed to implement the reform programme, including 'money follows the patient', UHI and integrated care. The Health Service requires significant additional investment in information technology to meet its information needs.

ICT will support hospital groups in 2014 by improving ICT services. A number of significant service supporting projects will be advanced in 2014 including: implementing approved hospital clinical systems, the national patient administration system in the south-east and mid-west regions, deployment of the medical laboratory information system on hospital sites, the deployment of corporate systems including the health insurance claims management system, and a single integrated financial system. In addition, procurement and deployment of the computer aided dispatch system and infrastructure to support the national reconfiguration of the ambulance service will be progressed as will implementation of the single assessment tool for older people.

Appendices

Appendix 1: Funding for Service Developments 2014

The developments outlined in this Appendix will come on stream in a phased basis throughout the course of 2014.

a). Programme for Government commitments

Area	Initiative	Funding €m	WTE
Primary Care / PCRS			
GP services for all children aged 5 years and under	Implement a universal GP service, without fees at the point of use, for all children aged 5 years and under	37.0	-
Mental Health Services			
Programme for Government funding for mental health	The continued strengthening of our community teams, increased suicide prevention resources and clinical programme development and implementation	20.0	250-280*
	TOTAL	€57.0m	250-280*

*As the costings will vary, depending on health professional required, a range of WTEs is provided

b). Demographic requirements

Area	Initiative	Funding €m	WTE
Acute / Cancer / Palliative Care			
Organ Donation and Transplantation Services	Address the additional need in the Donor and Transplantation Programme based in Beaumont, St. Vincent's, and the Mater hospitals.	2.92	19
Medical Oncology / Haemato-Oncology Programme	Access to new cancer drugs to support rate of growth of oncology drug use and companion testing.	3.80	-
Meeting access and service deficits in Dublin North Palliative care	24 inpatient beds in St. Francis Hospice, Blanchardstown to meet population requirements.	1.00	-
Primary Care			
Special Care Babies in the Community	Discharge of special care babies from Children's Hospital using packages of care in the community for babies with tracheotomies	1.20	-
PCRS			
Medical Cards	Provide up to 60,000 additional cards phased in throughout the year.	35.00	-
Disability Services			
0-18s Programme	Required increase in services for all disabilities including autism to reduce waiting lists	4.00	80
Emergency Placements and School Leavers	Additional places for school leavers, those leaving training, and emergency residential placements	10.00	50
Health and Wellbeing Services			
Diabetic Retinopathy	Screening and treatment	4.50	-
	TOTAL	€62.42m	149

c). Critical service priorities

Area	Initiative	Funding €m	WTE
Acute Hospital including inpatient and outpatient waiting lists			
Increase capacity / address waiting lists	Target additional capacity and capability in areas within acute services which continue to experience increased service demand, particularly in the areas of access across ED, inpatient, day care and OPD services	30.0	-
Health Reform including 'money follows the patient'			
Health reform	Upfront funding towards implementation of the Reform programme, *Future Health* and 'money follows the patient' across the Health Service	7.0	10
Quality and Patient Safety			
QPS	QPS initiatives	0.86	1.5
Acute, cancer and palliative care services			
Bilateral Cochlear Implants	Provide a service to carry out sequential and simultaneous implants	3.22	14.5
Narcolepsy National Paediatric Service	Addressing children's needs in respect of narcolepsy	0.57	-
Galway Maternity Report	Implement recommendations from the Health Service and Galway HIQA report	1.48	6.5
EWTD	Develop and implement a sustainable approach to NCHD recruitment and progress towards compliance with European Working Time Directive	3.10	-
National Ambulance Service			
NAS Control Centre Reconfiguration Project	Put in place a National Control Centre over two sites.	3.60	43
Health and Wellbeing			
Health Promotion and Improvement: Obesity	Support for package of obesity reduction programmes.	0.100	-
Health Promotion and Improvement: Tobacco Control	Improve effectiveness of smoking cessation services	0.100	-
Health Promotion and Improvement: Crisis Pregnancy Programme - Sexual Health	Reduce negative sexual health outcomes	0.050	-
National Screening Programmes: Colorectal Screening	Continue the roll out of BowelScreen	2.00	-
Risk Reduction			
Clinical quality and risk	Requirements to minimise risk across a range of services	6.50	-
	TOTAL	€58.58m	75.5
	OVERALL TOTAL (a, b and c)	€178.0m	474.5-504.5**

**Programme for Government costings for Mental Health: As the costings will vary, depending on health professional required, a range of WTEs is provided

Appendix 2: HR Information

Section 38 Agencies

Service	WTE Dec 2012	WTE Sept 2013	Adjusted Ceiling Sept 2013	Projected Outturn Dec 2013	Projected Ceiling 1 Jan 2014
Health Service	65,687	64,898	64,840	65,115	64,318
Voluntary Hospitals	21,846	21,659	20,570	21,731	20,404
Voluntary Agencies (Non-Acute)	13,973	13,708	13,622	13,754	13,512
S38 Agencies	35,819	35,367	34,191	35,485	33,916
Portion of Ceiling to be allocated	-	-	710	-	704
Total Health Services	101,506	100,266	99,741	100,600	98,938

Note: the above indicative ceilings are subject to revision and are for guidance only.

Divisional breakdown

Service	WTE Dec 2012	WTE Sept 2013	Adjusted Ceiling Sept 2013	Projected Outturn Dec 2013	Projected Ceiling 1 Jan 2014
Acute Services	48,905	48,496	47,038	48,658	46,659
Ambulance Services	1,551	1,571	1,522	1,576	1,510
Community and Non-Acute Services	43,654	42,873	43,264	43,016	42,915
Children and Family Services	3,501	3,465	3,471	3,477	3,443
Portion of Ceiling to be allocated	-	-	846	-	839
Corporate and Shared Services	2,671	2,615	2,436	2,623	2,416
Health and Wellbeing	1,225	1,246	1,165	1,250	1,156
Total Health Services	101,506	100,266	99,741	100,600	98,938

Note: the above indicative ceilings are subject to revision and are for guidance only.

Regional breakdown

Service	WTE Dec 2012	WTE Sept 2013	Adjusted Ceiling Sept 2013	Projected Outturn Dec 2013	Projected Ceiling 1 Jan 2014
Dublin Mid-Leinster	31,268	30,739	30,544	30,842	30,298
Dublin North-East	20,941	20,597	20,404	20,666	20,239
South	22,080	21,874	21,907	21,947	21,730
West	23,827	23,632	23,566	23,711	23,376
National	3,390	3,424	3,118	3,435	3,093
Children and Family Services	-	-	60	-	60
Portion of Ceiling to be allocated	-	-	143	-	142
Unallocated	-	-	203	-	202
Total Health Services	101,506	100,266	99,741	100,600	98,938

Note: the above indicative ceilings are subject to revision and are for guidance only.

Divisional breakdown by staff category (as of September 2013)

	Medical / Dental	Nursing	Health & Social Care	Manage-ment / Admin.	General Support Staff	Other Patient & Client Care	Total	Projected Dec. 2013 Outturn
Acute Services	6,364	19,483	5,998	7,340	5,747	3,564	48,496	48,658
Ambulance Services	1			48	19	1,503	1,571	1,576
Community and Non-Acute Services	1,849	14,403	6,354	5,172	3,612	11,483	42,873	43,016
Children and Family Services	1	32	2,706	460	46	221	3,465	3,477
Corporate and Shared Services	24	113	17	2,084	361	16	2,615	2,623
Health and Wellbeing	142	31	633	382	16	41	1,246	1,250
Total Health Services	8,380	34,063	15,708	15,486	9,801	16,828	100,266	100,600

Note 1: Source Health Services Personnel Census
Note 2: All figures are expressed as wholetime equivalents

Appendix 3: Quality and Patient Safety Indicators

National			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Complaints (Quarterly) % of complaints investigated within legislative timeframe	75%	63%	75%
Primary Care Division			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Healthcare Associated Infection: Medication Management (Bi-annually) Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	23	27	< 21.7
Acute Division			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
HIQA Tallaght Report (Quarterly) % of patients who leave the ED without completing their treatment	< 5%	4.1%	< 5%
No. of patients who re-attend the ED with the same clinical condition within 7 days	New PI 2014	New PI 2014	< 5%
No. of patients being cared for in inappropriate care	New PI 2014	New PI 2014	< 5%
Medication Management (Quarterly) % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	New PI 2014	New PI 2014	To be established
Healthcare Associated Infections Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	< 0.060	0.06	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used (Quarterly)	< 2.5	2.4	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital (Bi-annually)	83.7	85	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used) (Bi-annually)	25	25	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool (Bi-annually)	90%	87%	90%
Time to hip surgery (in hours) (Monthly) % of emergency hip fracture surgery carried out within 48 hrs (pre-op LOS: 0,1 or 2)	95%	83%	95%
Hospital Mortality (Annually) Standard mortality rate for inpatient deaths by hospital and clinical condition	New PI 2014	New PI 2014	National average or lower
Patient Experience (Annually) % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	New PI 2014	New PI 2014	100%
National Early Warning Score (NEWS) (Quarterly) % of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	New PI 2014	New PI 2014	95%
% of all clinical staff who have been trained in the COMPASS programme	New PI 2014	New PI 2014	>95%
National Standards (Quarterly) % of hospitals who have commenced first assessment against the NSSBH	New PI 2014	New PI 2014	95%
% of hospitals who have completed first assessment against the NSSBH	New PI 2014	New PI 2014	95%

System Wide – PIs in development
Performance areas: Data detail, collection and targets in development in 2014
Patient Experience
HCAI
Medication Management
Patient falls incidence No. of patients (in all settings) who have a new fall per month (rate graded as per health service Risk Matrix impact table by 1,000 bed days)
Pressure ulcers incidence No. of patients who develop a new pressure ulcer (Grade 2-4) per month
Acute Division – PIs in development
Performance areas being developed through CompStat with the aim of reporting from Quarter 2
In-Hospital Fractures Rate of in-hospital fractures for patients aged 16 years and over
Rate of in-hospital fractures for patients aged under 16 years
Accidental Puncture or Laceration Rate of accidental puncture or laceration for patients aged 16 years and over
Rate of accidental puncture or laceration for patients aged under 16 years
Foreign body left during procedure Rate of foreign body left during procedure for patients aged 16 years and over
Rate of foreign body left during procedure for patients aged under 16 years
Post operative wound dehiscence Rate of postoperative wound dehiscence for patients aged 16 years and over
Rate of postoperative wound dehiscence for patients aged under 16 years
Transfusion reaction Transfusion reaction for patients aged 16 years and over
Transfusion reaction for patients aged under 16 years
Performance areas: Data detail, collection and targets in development in 2014
GP Referral Triage % of GP referrals to OPD triaged within the 0-7 days target
Post Operative PE / DVT
Post Operative Haemorrhage / Haematoma
Post Operative Respiratory Failure
Post Operative Sepsis
Patient Observations

Appendix 4: Performance Measures 2014

Acute Division			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Activity (Monthly) Expected no. of inpatient discharges	600,887	594,791	591,699
Expected no. of day case discharges	830,165	821,988	797,328
Emergency Care - New ED attendances - Return ED attendances - Other presentations	---	1,093,187 89,371 108,490	1,093,187 89,371 108,490
Expected no. of emergency admissions	380,090	402,202	402,202
Elective inpatient admissions	New PI 2014	103,065	99,973
Outpatient attendances	New PI 2014	2,747,826	2,571,115
New: Return Ratio	1:2	1:2.6	1:2
Expected no. of births	71,096	67,899	67,899
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Inpatient and Day Case Waiting Times (Monthly) No. of adults waiting > 8 months for an elective procedure (inpatient)	0	1,463 Based on Sept. static performance only	0
No. of adults waiting > 8 months for an elective procedure (day case)	0	2,810 Based on Sept. static performance only	0
No. of children waiting > 20 weeks for an elective procedure (inpatient)	0	588 Based on Sept. static performance only	0
No. of children waiting > 20 weeks for an elective procedure (day case)	0	431 Based on Sept. static performance only	0
Colonoscopy / Gastrointestinal Service (Monthly) No. of people waiting > 4 weeks for an urgent colonoscopy	0	0	0
No. of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	0	1,482	0
Emergency Care (Monthly) % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	68%	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%	82%	100%
Reduction of trolley waits	New PI 2014	New PI 2014	10%
HIQA Tallaght Report (Quarterly) No. of patients who re-attend the ED with the same clinical condition within 7 days	New PI 2014	New PI 2014	< 5%
No. of patients being cared for in inappropriate care	New PI 2014	New PI 2014	< 5%
% of patients who leave the ED without completing their treatment	< 5%	4.1%	< 5%
Outpatients (OPD) (Monthly) No. of people waiting longer than 52 weeks for OPD appointment	0	84,423 Based on Sept. static performance only	0
Acute Medical Patient Processing (Monthly) % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	95%	Not reported 2013	95%
ALOS (Monthly) Medical patient average length of stay	5.8	6.8	5.8
Surgical patient average length of stay	5.3	4.6	5.3
ALOS for all inpatients	5.6	5.6	5.6
ALOS for all inpatient discharges excluding LOS over 30 days	4.5	4.5	4.5

Acute Division, contd.			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Stroke Care (Bi-annually) % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	9%	11.8%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	50%	59.6%	50%
Acute Coronary Syndrome (Quarterly) % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%	81.9%	70%
Surgery (Monthly) % of elective surgical inpatients who had principal procedure conducted on day of admission	85%	66%	85%
Time to Surgery (Monthly) % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%	83%	95%
Hospital Mortality (Annually) Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	New PI 2014	New PI 2014	National average or lower
Re-Admission (Monthly) % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%	10.7%	9.6%
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%	2%	< 3%
Medication Management (Quarterly) % of medication errors causing harm / no harm / death reported to CIS – as a % of bed days or population	New PI 2014	New PI 2014	Hospital variance with national baseline
Delayed Discharges (Monthly) Reduction in bed days lost through delayed discharges	10% reduction	247,777	10% reduction
Reduction in no. of people subject to delayed discharges	10% reduction	658	10% reduction
Healthcare Associated Infections Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	< 0.060	0.06	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used (Quarterly)	< 2.5	2.4	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital (Bi-annually)	83.7	85	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used) (Bi-annually)	25	25	25
% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool (Bi-annually)	90%	87%	90%
Patient Experience (Annually) % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	New PI 2014	New PI 2014	100%
Compliance with EWTD (Monthly) - < 24 hour shift - < 48 hour working week	New PI 2014	New PI 2014	100% 100%
National Early Warning Score (NEWS) (Quarterly) % of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	New PI 2014	New PI 2014	95%
% of all clinical staff who have been trained in the COMPASS programme	New PI 2014	New PI 2014	> 95%
National Standards (Quarterly) % of hospitals who have commenced first assessment against the NSSBH	New PI 2014	New PI 2014	95%
% of hospitals who have completed first assessment against the NSSBH	New PI 2014	New PI 2014	95%
MFTP % of HIPE coding episodes completed within 30 days of discharge	New PI 2014	New PI 2014	> 95%
Acute Division (Palliative Care)			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Community Home Care (Monthly) No. of patients in receipt of specialist palliative care in the community	2,948	2,953	3,050
Day Care (Monthly) No. of patients in receipt of specialist palliative day care services	331	324	331

Acute Division (Palliative Care), contd.			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Paediatric Services (Monthly) Total no. of children in the care of the Children's Outreach Nursing service	New PI 2014	New PI 2014	New PI 2014
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Inpatient Units – Waiting Times (Monthly) Specialist palliative care inpatient bed provided within 7 days	92%	94%	94%
Community Home Care – Waiting Times (Monthly) Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non-Acute Hospital)	82%	81%	82%
Acute Division (National Cancer Control Programme)			
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Symptomatic Breast Cancer Services (Quarterly) 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	13,200 95%	14,476 > 95%	13,200 95%
Lung Cancers (Quarterly) 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	2,565 95%	2,624 90%	2,565 95%
Prostate Cancers (Quarterly) 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	2,673 90%	1,563 54%	2,673 90%
Radiotherapy (Quarterly) No. and % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	90%	3,972 81%	4,546 90%
National Ambulance Service			
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Response Times (Monthly) % of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	> 70%	69.5%	> 80%
% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	> 68%	65%	> 80%
Clinical Outcome (Quarterly) Return of Spontaneous Circulation (ROSC) at ED in bystander witnessed Out of Hospital Cardiac Arrest (OHCA) with initial shockable rhythm using the Utstein comparator group calculation **KPI validation on newly developed performance indicator will be conducted over Q1 and Q2. KPI performance reporting will commence Q3*	New PI 2014	39%	40%*
Primary Care Division			
Expected Service Activity	**NSP 2013 Activity**	**Projected Outturn 2013**	**Expected Activity 2014**
Community Intervention Team Activity by Source (Quarterly) - ED / Hospital avoidance - Early discharge - GP referrals - Community Referrals	New PI 2014	New PI 2014	5,976 6,104 2,140 600
Chronic Disease – Diabetes (Quarterly) No. of existing primary care diabetes initiatives aligned to the nationally agreed model of care	New PI 2014	New PI 2014	10
Performance Targets	**NSP 2013 Target**	**Projected Outturn 2013**	**Target 2014**
Orthodontics (Quarterly) Reduce waiting times of those waiting for assessment	New PI 2014	New PI 2014	90% assessed within one year
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade 4 and 5)	New PI 2014	New PI 2014	< 5%

Primary Care Division, contd.			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Quality and Patient Safety Healthcare Associated Infection: Medication Management (Bi-annually) Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	23	27	< 21.7
Physiotherapy and Occupational Therapy Wait List Management (Quarterly) Occupational Therapy – No. of patients waiting over 16 weeks for an assessment	New PI 2014	New PI 2014	< 10%
Physiotherapy – No. of patients waiting over 12 weeks for an assessment	New PI 2014	New PI 2014	< 10%
Primary Care Division (Social Inclusion)			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Opioid Substitute Treatment (Monthly) No. of clients in opioid substitute treatment (outside prisons)	New PI 2014	New PI 2014	9,100
Pharmacy Needle Exchange (Quarterly) No. of unique individuals attending pharmacy needle exchange	---	700	700
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Substance Misuse (Quarterly) No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	1,260 100%	1,024 96%	1,260 100%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	105 100%	74 100%	105 100%
Homeless Services (Quarterly) No. and % of individual service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	1,839 75%	1,577 76%	1,700 85%
Primary Care Division (PCRS)			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Medical Cards (Monthly) No. persons covered by medical cards as at 31st December	1,921,245	1,890,465	1,875,707
GP Visit Cards (Monthly) No. persons covered by GP visit cards as at 31st December	265,257	127,697	402,138
GMS (Monthly) No. of prescriptions	20,864,890	20,631,372	21,639,388
No. of items	65,307,106	63,338,311	66,432,920
No. of claims – Special items of Service	883,796	924,287	946,957
No. of claims – Special Type Consultations	1,217,992	1,229,781	1,242,077
No. of treatments – DTSS (routine)	1,127,410	1,328,466	1,354,079
No. of treatments – DTSS (complex)	54,357	67,076	68,338
Long Term Illness (Monthly) No. of claims	923,794	912,296	944,288
No. of items	3,020,807	2,955,838	3,059,492
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Medical / GP Visit Cards (Monthly) % of properly completed medical / GP visit card applications processed within the 15 day turnaround	90%	90%	90%
Health and Wellbeing Division			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Cancer Screening (Quarterly) No. of women who attend for breast screening	140,000	140,000	140,000
Tobacco Control (Monthly) No. of frontline healthcare staff trained in brief intervention smoking cessation	1,350	1,150	1,350
No. of smokers who received intensive cessation support from a cessation counsellor	9,000	8,500	9,000

Health and Wellbeing Division, contd.			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Food Safety (Quarterly) No of planned, and planned surveillance inspections of food businesses	New PI 2014	New PI 2014	33,000
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Health Protection (Quarterly) % children 24 months of age who have received the **Measles, Mumps, Rubella** (MMR) vaccine	95%	92%	95%
% children 12 months of age who have received the **6-in-1** vaccine	95%	91%	95%
% children 24 months of age who have received 3rd dose of **MenC**	95%	86%	95%
% first year girls who have received third dose of **HPV** vaccine by August 2014	80%	85%	80%
Child Health (Quarterly) % **newborn babies** visited by a PHN within 48 hours of hospital discharge	95%	86%	95%
% of children reaching 10 months who have had their **child development health screening** before 10 months (monthly)	95%	88%	95%
Chronic Disease Prevention (Quarterly) % of PCTs in Monitoring sites trained in Health Service – ICGP Weight Management Treatment Algorithm for Children	New PI 2014	New PI 2014	70%
Social Care Division (Disability Services)			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Personal Assistant Hours (Quarterly) No. of PA hours delivered to adults with a physical and / or sensory disability	PI amended – not comparable	1.3m	1.3m
Home Support Hours (Quarterly) No. of Home Support hours delivered to people with disabilities	PI amended – not comparable	2.4m	2.4m
Congregated Settings (Quarterly) Facilitate the movement of people from congregated to community settings under the auspices of the following - Genio-funded projects - Housing Strategy for People with a Disability - Other	New PI 2014	New PI 2014	150
Respite Services (Quarterly) No. of bed nights in residential centre-based respite services used by people with disabilities	246,263	243,260	243,260
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
0-18s Programme (Bi-annually) Proportion of Local Implementation Groups which have Local Implementation Plans for progressing disability services for children and young people	100%	6 of 25	25 of 25
Disability Act (Quarterly) % of assessments completed within the timelines as provided for in the regulations	PI amended – not comparable	27%	100%
Day Services (Report Sept onwards – Bi-annually) % of school leavers and RT graduates who have received a placement which fully meets their needs	New PI 2014	New PI 2014	100%
Quality (Bi-annually) In respect of agencies in receipt of €5m or more of public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF	New PI 2014	New PI 2014	100%
Social Care Division (Services for Older People)			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
Home Care Packages (Monthly) Total no. of persons in receipt of a HCP	10,870	11,020	10,870
Intensive Home Care Packages (Monthly) No. of persons in receipt of an intensive HCP at a point in time (capacity)	New PI 2014	New PI 2014	190
Home Help Hours (Monthly) No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10.30m	10.30m	10.30m

Social Care Division (Services for Older People), contd.			
Expected Service Activity	NSP 2013 Activity	Projected Outturn 2013	Expected Activity 2014
NHSS (Monthly) No. of persons funded under NHSS in long term residential care during the reporting month	22,761	23,000	22,061
Public Beds (Monthly) No. of NHSS Beds in Public Long Stay Units	Subject to viability plan	5,390	5,400
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Elder Abuse (Quarterly) % of active cases reviewed within six month timeframe	New PI 2014	New PI 2014	80%
Mental Health Division			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Adult Mental Health Services % of General Adult Community Mental Health Teams serving a population of circa 50,000 (range of 45,000 to 60,000) as recommended in *Vision* (Quarterly)	New PI 2014	New PI 2014	≥ 60%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Teams (Monthly)	New PI 2014	New PI 2014	≥ 75%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams (Monthly)	New PI 2014	New PI 2014	≥ 95%
Child and Adolescent Community Mental Health Services Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units (Quarterly)	New PI 2014	New PI 2014	≥ 75%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams (Monthly)	> 75%	73%	≥ 75%
Corporate Services			
Performance Targets	NSP 2013 Target	Projected Outturn 2013	Target 2014
Finance (Monthly) Variance against Budget: Income and Expenditure	≤ 0%	To be reported in Annual Financial Statements 2013	≤ 0%
Variance against Budget: Income collection / Pay / Non Pay / Revenue and Capital Vote	≤ 0%		≤ 0%
HR (Monthly) Absenteeism rates	3.5%	4.12%	3.5%
Variance from approved WTE ceiling	≤ 0%	1.7% 2,623	≤ 0%

Appendix 5: Capital Infrastructure

This appendix outlines capital projects that were completed in 2012 / 2013 but not operational, projects due to be completed and operational in 2014 and also projects due to be completed in 2014 but not operational until 2015.

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
Primary Care Division										
Dublin Mid Leinster	South Wicklow / Carnew	Primary Care Centre, by lease agreement	Q4	Q1 2015	0	0	0	0	0	0
	Bride Street / Liberties, Dublin (Meath Hospital)	Primary Care Centre, by lease agreement	Q1	Q1	0	0	0	0	0	0
	Wicklow Town	Primary Care Centre, by lease agreement	Q3	Q3	0	0	0	0	0	0
	Baggot Street / Sandymount, Dublin	Primary Care Centre, by lease agreement	Q4 2013	Q2	0	0	0	0	0	0
	Donnybrook / Ranelagh, Dublin	Primary Care Centre, by lease agreement	Q3	Q3	0	0	0	0	0	0
	Kilnamanagh / Tymon, Dublin	Primary Care Centre, by lease agreement	Q4	Q1 2015	0	0	0	0	0	0
	Clane, Co. Kildare	Primary Care Centre, by lease agreement	Q4 2013	Q1	0	0	0	0	0	0
	Rathangan / Monasterevin, Co. Kildare	Primary Care Centre, by lease agreement	Q2	Q2	0	0	0	0	0	0
	Athlone, Co. Westmeath	Primary Care Centre, by lease agreement	Q4 2013	Q1	0	0	0	0	0	0
Dublin North East	Summerhill, Meath	Primary Care Centre, by lease agreement	Q2	Q3	0	0	0	0	0	0
	Corduff, Dublin	Primary Care Centre to be developed on Health Service owned site	Q4	Q1 2015	0	0	6.00	7.20	0	0
	Laytown / Bettystown, Co. Meath	Primary Care Centre, purchase and fit-out	Q4	Q4	0	0	2.00	3.00	0	0
South	Carrigtwohill, Co. Cork	Primary Care Centre, by lease agreement	Q3	Q4	0	0	0	0	0	0
	Kinsale, Co. Cork	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
West	Limerick City (Market 1 and 2 - Garryowen)	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
	Limerick City (Castletroy)	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
	Swinford, Co. Mayo	Primary Care Centre, by lease agreement	Q4	Q4	0	0	0	0	0	0
	Loughrea, Co. Galway	Primary Care Centre	Q4	Q4	0	0	0.50	0.50	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
West *contd.*	Manorhamilton, Co. Leitrim	Primary Care Centre	Q4	Q1 2015	0	0	0.20	0.72	0	0
	Carrick-on-Shannon, Co. Leitrim	Primary Care Centre, by lease agreement	Q4	Q1 2015	0	0	0	0	0	0
	Derrybeg / Bunbeg, Co. Donegal	Primary Care Centre, by lease agreement	Q2	Q3	0	0	0	0	0	0
Acute Division										
Dublin North East Hospital Group	Beaumont Hospital, Dublin	Provision of a second catheterisation laboratory	Q2	Q3	1	1	1.54	1.54	0	0
		Renal transplant unit (phase 1)	Q4	Q1 2015	0	0	3.70	5.00	0	0
	Connolly Hospital, Blanchardstown, Dublin	Acute medical assessment unit (MAU)	Q2	Q2	0	8	0.45	0.65	0	0
	Rotunda Maternity Hospital, Dublin	Electrical distribution system upgrade and completion of the boundary wall, stabilisation works and mortuary upgrade	Q1	Q1	0	0	0.50	1.30	0	0
	Our Lady of Lourdes Hospital, Drogheda	Refurbishment of the former nurses home, purchased from the METR allocation in 2011, to provide a medical education centre	Q1	Q4	0	0	1.00	1.60	0	0
Dublin Midlands Hospital Group	St. James's Hospital, Dublin	Campus wide electrical infrastructure upgrade	Q1	Q1	0	0	0.90	3.60	0	0
	Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital, Tallaght (AMNCH)	Emergency department (ED) expansion and upgrade	Q4	Q4	0	0	2.60	4.50	0	0
		Upgrade of Reverse Osmosis (RO) water system for the renal unit	Q4 2013	Q1	0	0	0.25	5.00	0	0
	Temple Street Hospital, Dublin	Interim works including an ECG room, an admissions unit and cochlear implant / audiology facility	Q1	Q3	0	0	0.85	4.00	0	0
Dublin East Hospital Group	Wexford General Hospital	Construction of a new obstetrics unit and delivery suite	Q1	Q2 / Q3	1	0	1.52	16.82	0	0
		Fire alarm upgrade	Q1	Q1	0	0	0.25	1.25	0	0
	National Maternity Hospital, Holles Street, Dublin	Construction of a new neo-natal intensive care unit (ICU)	Q4	Q1 2015	0	25	3.00	5.00	0	0
	Our Lady's Hospital, Navan	Upgrade of existing facility to provide ED and urgent care accommodation	Q2	Q2	0	0	0.65	0.85	0	0
	St. Luke's Hospital, Kilkenny	Construction of new ED, MAU, day service including endoscopy (including medical education unit)	Q2	Q3	11	14	6.47	28.50	0	0
South / South-West Hospital Group	Waterford Regional Hospital	Campus wide hospital infrastructure upgrade	Q1	Q1	0	0	0.60	1.60	0	0
	Cork University Hospital	MRI and CT project	Q4	Q4	2	0	0.38	2.72	0	0
		Construction of a new helipad	Q4	Q1 2015	0	0	1.40	1.80	0	0
		Provision of a temporary decant ward (50 bed) to facilitate future ward upgrade programme	Q4	Q4	0	50	3.75	4.05	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
South / South-West Hospital Group *contd.*	Cork University Hospital	Acute respiratory care and cystic fibrosis inpatient unit	Q3	Q4	0	15	0.26	0.61	0	0
	South Infirmary / Victoria University Hospital, Cork	Ophthalmology outpatient department (OPD) relocation	Q4	Q1 2015	0	0	0.75	2.00	0	0
	Bantry General Hospital, Co. Cork	Construction of new MAU	Q4	Q4	8	0	1.00	1.15	0	0
West / North-West Hospital Group	Letterkenny General Hospital, Co. Donegal	Emergency works (following flooding) *(Costs to be recouped from insurance company)*	Phased completion throughout 2014	Phased opening from 2014	0	0	1.90	4.36	0	0
		OPD expansion (orthopaedics, ante-natal and pharmacy)	Q1	Q2	0	0	1.00	1.24	0	0
		Construction of medical education and training facility	Q4	Q4	0	0	0	0	0	0
	Mayo General Hospital, Castlebar	Renal unit refurbishment and upgrade	Q1	Q1	0	0	0.10	1.80	0	0
	Merlin Park University Hospital, Galway	School of podiatry (phase 2), the provision of a minor procedures unit	Q1	Q1	0	0	0.20	11.80	0	0
		Rehabilitation unit	Q4	Q4	0	25	1.20	1.20	0	0
	University College Hospital, Galway	Upgrade of campus wide utility infrastructure to facilitate other major developments	Q4 2013	Q1	0	0	0.80	4.59	0	0
		Modular ward block (75 beds)	Q4	Q4	0	75	8.00	8.00	0	0
		Clinical research facility	Q4	Q4	0	0	0.85	0.85	0	0
	Roscommon General Hospital	Provision of endoscopy unit	Q4	Q1 2015	0	2	2.29	3.10	0	0
	Sligo General Hospital	Construction of medical education and training facility	Q4	Q4	0	0	0	0	0	0
University of Limerick Hospital Group	University Hospital, Limerick	Completion of ED (shell space construction with fit out commencing early 2014)	Q4	Q1 2015	3	0	4.00	8.00	0	0
		Infrastructural upgrade (including electrical distribution system) to facilitate present and future developments	Q1	Q1	0	0	0.30	8.50	0	0
	Nenagh Hospital, Co. Tipperary	New theatre block	Q1	Q2	2	0	0.66	5.60	0	0
Acute Division – National Cancer Control Programme										
Dublin North East Hospital Group	Mater Misericordiae university Hospital, Dublin	Relocation of the oncology day unit and drug compounding facility	Q1	Q2	0	0	1.50	2.75	0	0
West / North –West Hospital Group	Letterkenny General Hospital, Co. Donegal	Oncology day unit expansion*	*	*	0	1	1.90	4.36	0	0
		*Plans for relocation of oncology day ward, Letterkenny delayed arising from recent flooding of ED. It is not possible at this time to indicate when the relocation will be completed.								

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
Acute Division – Palliative Care										
West / North-West Hospital Group	Ballina District Hospital, Co. Mayo	Provision of a level II (2 bedded) palliative care facility (co-funded by the Roscommon Mayo Hospice Group)	Q2	Q3	2	0	0.08	0.33	0	0
Health and Wellbeing										
National Cancer Screening Services	Breast Check	Upgrade and replacement of equipment	Q4	Phased from 2015	0	0	1.65	9.45	0	0
National Ambulance Service										
National Ambulance Service	Rivers Building, Tallaght and Ballyshannon campus	Provision of a National Ambulance Control and Call Centre and National Ambulance HQ at the Rivers Building Tallaght and upgrade of Ballyshannon Ambulance HQ to provide backup and support to the Tallaght Centre	Q4	Q4	0	0	8.85	13.76	43	3.60
	Loughglynn, Galway	Conversion of a vacated Garda Station to an ambulance station	Q2	Q2	0	0	0.10	0.10	0	0
Social Care Division – Services for Older People										
Dublin Mid-Leinster	Baltinglass Community Hospital, Co. Wicklow	Refurbishment and upgrade (to achieve HIQA compliance)	Q4 2013	Q1	0	62	0.27	2.30	0	0
Dublin North East	Cuan Ros Community Nursing Unit and House, Navan Road, Dublin	Refurbishment and upgrade (to achieve HIQA compliance)	Q1	Q2	0	46	0.50	1.85	0	0
	Virginia Healthcare Unit, Co. Cavan	Refurbishment and upgrade (to achieve HIQA compliance)	Q2	Q2	0	50	1.00	3.10	0	0
	St. Mary's Hospital, Castleblaney, Co. Monaghan	Refurbishment and upgrade (to achieve HIQA compliance)	Q4	Q4	0	75	2.50	3.50	0	0
	St. Oliver Plunkett Hospital, Dundalk, Co. Louth	Refurbishment and upgrade (to achieve HIQA compliance)	Q4	Q4	0	40	1.70	2.50	0	0
South	Schull Community Hospital, Co. Cork	Refurbishment and upgrade (to achieve HIQA compliance)	Q2	Q3	0	17	1.00	1.10	0	0
West	Keel, Achill Island, Co. Mayo	Provision of a day hospital / day centre	Q4	Q4	0	0	1.40	2.75	0	0
	Regina House, Kilrush, Ennis, Co. Clare	Refurbishment and upgrade (to achieve HIQA compliance)	Q4	Q4	0	20	0.65	0.95	0	0
	Ennistymon Community Hospital, Co. Clare	Refurbishment and upgrade (to achieve HIQA compliance)	Q4	Q4	0	20	0.45	0.85	0	0

	Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2014 Implications	
							2014	Total	WTE	Rev Costs €m
Social Care Division – Disability Services										
West	Ballinasloe, Co. Galway	Provision of a high support hostel accommodation	Q4	Q4	0	8	0.40	0.50	0	0
South	Fethard, Co. Tipperary	Provision of a high support hostel accommodation	Q4	Q4	0	10	0.43	1.05	0	0
Mental Health Division										
Dublin Mid-Leinster	St. Loman's Hospital, Mullingar, Co. Westmeath	Replacement of St. Edna's ward to provide a 20 bed special behavioural unit and up to 24 replacement beds	Q3 2013	Q1	0	44	0.30	6.00	0	0
Dublin Mid-Leinster *contd.*	Mullingar, Co. Westmeath	12 bed high support hostel	Q2	Q3	0	12	0.30	0.70	0	0
	Cherry Orchard Mental Health Unit, Ballyfermot, Dublin	Refurbishment of existing office accommodation to provide accommodation for a community mental health facility and other accommodation	Q2	Q3	0	0	0.20	1.20	0	0
	Clonskeagh, Dublin	Community mental health unit	Q3	Q3	0	0	1.00	1.00	0	0
	High support Hostel Crumlin, Dublin	Construction of 17 bed high support hostel	Q1	Q2	0	17	1.50	3.00	0	0
Dublin North East	St. Itas, Portrane, Dublin	Provision of mental health residential accommodation in Carraige House, Maryfield Avenue, Dun Na Ri and Glebe House for existing residents of St Ita's, Portrane	Q1	Q1	0	25	0.13	3.00	0	0
South	Cork University Hospital	50 bed acute inpatient unit	Q4	Q1 2015	0	50	8.80	15.00	0	0
		Acute mental health unit	Q4	Q1 2015	0	50	8.30	15.00	0	0
	Kerry General Hospital, Tralee	Upgrade and extension to the acute mental health unit including high observation unit	Q2	Q3	0	4	0.055	2.00	0	0
	Enniscorthy, Co. Wexford	Provision of a 10 bed crisis housing unit	Q4	Q1 2015	10	0	1.10	1.75	0	0
	Clonmel, Co. Tipperary	Provision of a 10 bed crisis housing unit	Q4	Q4	0	10	1.20	1.75	0	0
West	Community Mental Health Unit, Donegal	Refurbishment of Rowanfield House to provide a community mental health unit for the area	Q4	Q4	0	0	1.23	2.05	0	0
	Community Mental Health Team (CMHT) base, Donegal	Development of CMHT base in Donegal Town	Q3	Q4	0	0	1.1	2.00	0	0
	Community Mental Health Unit, Tuam, Co. Galway	Provision of a community mental health team base and a day hospital	Q3	Q3	0	0	0.50	2.50	0	0
	Nazareth House, Sligo	Upgrade of existing building to provide accommodation for child and Adolescent mental health day services	Q1	Q1	0	0	1.36	3.47	0	0
	Unit 5B, Mental Health Acute Inpatient Unit, Limerick	Completion of refurbishment works in Unit 5B, mental health acute inpatient unit, Limerick	Q4 2013	Q1	0	0	1.40	8.00	0	0
	CMHT base, Loughrea, Co. Galway	CMHT base in Loughrea	Q1	Q2	0	0	0.50	0.50	0	0

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