Health Service Executive

National Service Plan 2015

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Service Priorities

System Wide Priorities

- Improve quality and patient safety with a focus on:
  - Service user experience
  - Development of a culture of learning and improvement
  - Patients, service users and staff engagement
  - Medication management, healthcare associated infections
  - Serious incidents and reportable events
  - Complaints and compliments
- Implement Quality Patient Safety and Enablement Programme
- Implement the Open Disclosure policy
- Implement a system wide approach to managing delayed discharges
- Continue to implement the Clinical Programmes
- Develop and progress integrated care programmes
- Implement *Healthy Ireland*
- Implement *Children First*
- Deliver on the system wide Reform Programme

Service Priorities

Health and Wellbeing

- Reduce the chronic disease burden by addressing key modifiable risk factors
- Enhance and improve service delivery models for the health of the population
- Protect the population from threats to their health and wellbeing
- Deliver population-based screening programmes

Primary Care

Primary Care

- Improve access to primary care services and reduce waiting lists and waiting times
- Implement models of care for chronic illness management
- Implement service integration measures to reduce the reliance on acute hospitals and reduce the number of delayed discharges
- Extend the coverage of community intervention teams and improve access to primary diagnostics
- Enhance oral health and orthodontic services
- Roll out the community oncology programme

Social Inclusion

- Improve health outcomes for persons with addiction
- Contribute to reductions in levels of homelessness
- Enhance the provision of primary care services to vulnerable and disadvantaged groups

Primary Care Reimbursement Service

- Extend access to GP care, without fees, to children under 6 years and adults over 70 years
- Introduce service improvements in relation to medical card eligibility assessment and manage medical card provision and reimbursement
- Develop further the medicine management programme

Acute Services

Acute Hospitals

- Improve patient safety and quality
- Improve access to hospital services
- Implement hospital reform programme and enhance service developments
- Support work of National Clinical Strategy and Programmes

National Cancer Control Programme

- Implement national medical and haemato-oncology programmes
- Enhance medical, surgical, radiation and community oncology services
- Develop hereditary cancer services

National Ambulance Service

- Finalise the Control Centre Reconfiguration Project
- Drive clinical excellence
- Foster a culture of strong performance management
- Deploy the most appropriate clinical resources safely, quickly and efficiently

Palliative Care

- Provide effective and timely access for adult palliative care
- Integrate palliative care structures
- Progress quality improvement
- Develop children's palliative care services

Mental Health

- Ensure the views of service users are central to the design and delivery of services
- Design integrated evidence based, recovery focused services
- Deliver timely, clinically effective and standardised safe services
- Promote the mental health of the population including reducing loss of life by suicide
- Enable the provision of services by trained and engaged staff as well as fit for purpose infrastructure

Social Care

Disability Services

- Implement *Value for Money and Policy Review*
- Reconfigure day services for school leavers and rehabilitative training
- Improve therapy services for children (0-18s)
- Enable people to move from congregated settings
- Continue to drive service improvement

Services for Older People

- Nursing Homes Support Scheme
- Provide public residential services
- Provide a range of home supports
- Roll out the dementia strategy
- Promote positive ageing
- Initiate a system wide approach to managing delayed discharges
- Progress the single assessment tool
- Implement a funding model for public, short-term and intermediate care

Supporting Service Delivery

- Implement the HSE Accountability Framework
- Deliver on the Finance Reform Programme
- Deliver the HSE Capital and ICT Capital plans
- Deliver on workforce planning and agency conversion
- Ensure compliance with Service Agreements

Contents

Executive Summary

Introduction

The National Service Plan for 2015, as required under legislation, sets out the type and volume of services, which will be provided across the health services within the funding allocated by Government and taking into consideration:

- Quality improvement and patient safety
- Reform of the health services
- The quantum of services to be provided.

Following the establishment of the Health Service Executive (HSE) Directorate over 12 months ago, the HSE is continuing a journey of change and reform as set out in the Government policy document on health reform *Future Health: A Strategic Framework for the Reform of the Health Service 2012-2015*. Service improvement and ensuring that quality and patient safety is at the heart of health service delivery, are central to health service reform. This emphasis seeks to ensure that people's experience of the health service is not only safe and of high quality, but also caring and compassionate.

Having reflected on the lessons learned in recent reports and investigations including *Mid Staffordshire (The Francis Report),* the HSE and other reports into maternal care in Galway and into perinatal deaths at Portlaoise Hospital, the HSE is committed, more than ever before, to fostering a health system devoted to a culture of continuous learning and improvement, where patients' needs come first and where the value of patient centred care are communicated and understood at all levels in the organisation.

Fostering such a culture demands that patients and service users are put before other considerations, fundamental standards are observed, non-compliance is not tolerated, and all staff commit to full personal engagement to achieve this objective.

In order to deliver on this, the HSE has redesigned its national Quality and Patient Safety functions. The aim of these changes is to enhance both quality improvement and quality assurance, taking account of patient and service user needs and choices. It will also create an environment within which patients, service users and staff are involved, their opinions sought and their voice is heard.

The delivery of better quality care also requires that the HSE puts in place the most effective clinical care pathways that are integrated across acute, community and residential care settings. This is necessary to ensure that patients and service users are supported at all stages of the care journey and in the setting that is most appropriate to their needs. To deliver on this and as part of the health service reform programme, seven Hospital Groups and nine Community Healthcare Organisations are being established. Delivery of the National Clinical Programmes will take place through these new structures. Work will continue in 2015 to ensure that these integrated clinical programmes are embedded as part of the operational service delivery system.

The HSE welcomes the increase of €625m[1] in the total financial resources available to the health service during 2015 as part of a two year programme to increase health funding. After many years of significant financial reductions, this additional resource will assist in the allocation of more realistic budgets enabling the health services to maintain the current levels of services. It also provides funding for the extension of Breastcheck up to the age of 69 years, specific developments in disability services, mental health and primary care and a range of supports to alleviate the pressures arising from delayed discharges from acute hospitals. Outside of the specific funding provided however, it will not be possible to put in place any additional new service developments which would increase overall health expenditure.

The allocation of more realistic budgets brings with it a requirement for greater accountability to ensure services are delivered within the budget provided. To give effect to this the HSE has put in place an enhanced

[1] A further €10m is being targeted in projected once-off increased revenues.

governance and accountability framework for 2015 which makes explicit the responsibilities of all managers to deliver on the targets set out in the National Service Plan across the balanced scorecard domains of Quality and Patient Safety, Access to Services, Finance and Human Resources (HR). The new Accountability Framework describes in detail the means by which the HSE and in particular Hospital Groups and Community Healthcare Organisations will be held to account in 2015 for their efficiency and control in relation to service provision, patient safety, finance, and HR.

Quality Improvement and Quality Assurance

Quality improvement and patient safety is everybody's business and must be embedded in all work-practices across all services. This will continue to be a key focus in 2015 through:

- Setting clear targets and delivery objectives for patient safety and quality improvements across all services.
- Having mechanisms in place to measure the patient's personal experience.
- Quality improvement and patient safety being routinely monitored through key performance indicators.
- Enabling a framework for engaging with patients, service users and their advocates.
- Enabling and developing a culture of learning and improvement.
- The implementation of an enhanced quality assurance framework.

International best practice points to the need for quality and patient safety functions to be robust at corporate level to support staff to embed a culture of quality and safety within their services and where patients, service users and staff are involved and consulted. In this context, the HSE has redesigned its national Quality and Patient Safety function and has established a Quality and Patient Safety Enablement Programme (Schedule 2).

Enablement in this context refers to an approach that provides the means, opportunity and authority for service users and providers to develop the skills and confidence necessary to improve the quality and safety of services. The overall goal of the HSE Quality and Patient Safety Enablement Programme is to improve the quality of services with measurable benefits for patients and service users. The four key objectives which underpin the programme are as follows:

Objective 1: Services must subscribe to a set of clear quality standards that are based on international best practice.

Objective 2: Services must be safe and that there must be a robust level of quality assurance.

Objective 3: Services must be relevant to the needs of the population.

Objective 4: Patients must be appropriately empowered to interact with the service delivery system.

In implementing these arrangements, the HSE will ensure an approach that focuses on the needs of the population and which will in particular:

- Equip services to deliver quality and safe care.
- Identify and implement quality models of care.
- Measure and manage performance in relation to quality and safety.
- Provide assurance and verification in relation to performance on quality and safety and put in place intervention measures where these are required.
- Ensure that quality standards and arrangements are enforced.

As part of the overall Quality and Patient Safety Enablement Programme, the process for identifying, reporting on and following up on Serious Reportable Events (SREs) has also been strengthened.

During 2014 a number of new key quality indicators and standards for measuring the patient experience were developed and further work will take place during 2015. A range of service improvement initiatives have been undertaken as part of the National Quality Improvement Programme. One such example involved large scale collaboration between the HSE and the Royal College of Physicians aimed at reducing the incidence of

avoidable pressure ulcers across the Dublin North East region by 50% over a six month period. The outcome results show that a 73% reduction was achieved with very significant benefits to patients. The learning from this initiative will be shared across the rest of the country during 2015.

Funding

The Letter of Determination received by the HSE on 31st of October 2014 provides an increase of €625m or 5.4% in funding for 2015, bringing the total net revenue budget to €12,131m. When account is taken of the 2014 projected net expenditure deficit of €510m this allows for health service net costs to increase by €115m. A further €10m is being targeted in projected once-off increased revenues.

€35m of this increase is in respect of mental health services which will be made available to the HSE in 2015 as the agreed developments come on stream. Also within the Programme for Government funding there is an additional €10m for the Nursing Homes Support Scheme in 2015, as part of the €25m initiative related to delayed discharges.

This very welcome but modest increase in resourcing is part of a two year programme to put health service budgets on a more sustainable footing. A minimum savings target of €130m has been set by the Department of Health (DoH) for 2015 along with an increased income collection target of €10m. This €140m in savings and extra revenue when secured will be used to support specific targeted service priority improvements.

It has not been possible to secure funding for the full amount of the HSE's 2015 Estimates requests, and there are some additional service pressures which will fall to be addressed in future years. Some service pressures arising from increased demand will have to be addressed in 2015 through additional cost savings and revenue measures. This will be in addition to the €140m in savings and extra revenue referenced above.

Assuming delivery of the minimum savings target outlined above, it is estimated that the residual financial challenge is €100m and mitigating measures will be put in place to address this challenge.

The HSE Vote is being amalgamated with the Vote of the Department of Health with effect from 1st January 2015 as part of the health reform programme. This brings with it a number of changes including the introduction of a 'first charge' whereby any over run from 2015 onwards will fall to be dealt with by the HSE in the subsequent financial year. This places further emphasis on the need for all services to operate within the available resource limit in 2015 or face the prospect of having to deal with any overrun as a first charge on their resources the following year.

The key components of meeting the financial challenge in 2015 include:

- Governance – through an enhanced efficiency and accountability framework.
- Pay costs – integrated managed reductions in cost and wholetime equivalents (WTEs) associated with direct staff, agency and overtime.
- Non pay costs – through delivering procurement (price) savings.
- More detailed budget setting – pay (broken down by direct, agency and overtime), non-pay and income limits set in addition to the traditional net expenditure budget.
- Income generation and cash collection – significant additional focus on these two related areas.

Accountability Framework

The HSE is the statutory body tasked with the responsibility for the delivery of health and personal social care services in Ireland. In discharging its public accountabilities, the HSE has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it has a range of other accountability obligations to the Oireachtas and to its Regulators.

The HSE recognises the critical importance of good governance and of continually enhancing its accountability arrangements. In this regard, and in the context of the establishment of the Hospital Groups and Community Healthcare Organisations, the HSE is strengthening its accountability arrangements and is putting in place a new Accountability Framework (Schedule 1).

This enhanced governance and accountability framework for 2015 makes explicit the responsibilities of all managers to deliver on the targets set out in the service plan across the balanced scorecard for access to services, the safety of those services, finances and workforce. The new Accountability Framework describes in detail the means by which the HSE, and in particular Hospital Groups and Community Healthcare Organisations, will be held to account in 2015.

A key feature of the new Accountability Framework will be the introduction of formal Performance Agreements. These Agreements will be put in place at two levels. The first level will be the National Director Performance Agreement between the Director General and each National Director for services. The second level will be the Hospital Group Chief Executive Officer (CEO) Performance Agreement and the Community Healthcare Organisation Chief Officer Performance Agreement, which will be with the National Director Acute Hospitals and relevant National Directors for community services respectively.

Another feature of the Accountability Framework will be explicit arrangements for escalating areas of underperformance and specifying the range of interventions to be taken in the event of serious or persistent underperformance.

The HSE also provides funding of more than €3 billion annually to the non-statutory sector to provide a range of health and personal social services which is governed by way of Service Arrangements and Grant Aid Agreements. A new Service Arrangement and Grant Aid Agreement will be put in place for 2015 and will continue to be the principal accountability agreement between the Divisions, Hospital Group CEOs and Community Healthcare Organisation Chief Officers and Section 38 and 39 funded Agencies. Revised processes will also be in place for managing the contractual relationship with each individual agency.

Health Service Reform

2015 is an important year in the ongoing reform of the HSE, with a particular focus on a) key infrastructural changes such as Hospital Groups and Community Healthcare Organisations; b) service improvements in areas such as integrated care and services for people with a disability; and c) strategic enablers such as the individual health identifier. The following are the key reform programmes being progressed:

- Establish and develop Hospital Groups, including the National Children's Hospital.
- Establish and develop Community Healthcare Organisations.
- Develop clinically led, multidisciplinary, patient centred Integrated Models of Care Programmes. This will also involve the alignment of key enablers including ICT, HR and Finance.
- Continue to develop and implement ICT reform in line with the eHealth Strategy under the leadership of the Chief Information Officer, who takes up position in December 2014.
- Continue to develop and implement the reform of Human Resource Management.
- Continue to develop and implement activity-based funding.
- Develop and implement the new finance operating model.
- Develop and incrementally implement the individual health identifier.
- Continue to develop service-specific reform programmes within the Divisions.
- Continue to embed health and wellbeing goals and key performance indicators throughout all reform programmes.

Community Healthcare Organisations

The publication in October 2014 of the *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group* provides a framework for new governance and organisational structures for community health care services. An extract from the report states that *'In 2014, more than half of our total health spend on operational services is in the community healthcare sector. This sector is significant and the reform of these structures will facilitate a move towards a more integrated health care*

system, improving services for the public by providing better and easier access to services, services that are close to where people live, more local decision making and services in which people can have confidence.'

The new governance and organisation structures being put in place to enable integrated care involve actions to:

- Establish nine Community Healthcare Organisations to deliver an integrated model of care.
- Develop 90 Primary Care Networks, averaging 50,000 population with each Community Healthcare Organisations having an average of 10 networks to:
  - Support groups of Primary Care Teams.
  - Enable integration of all services for a local population.
  - Support prevention and management of chronic disease at community level.
- Reform of social care, mental health and health and wellbeing services to better serve local communities through:
  - Standardise models and pathways of care while delivering equitable, high quality services.
  - Support primary care through the delivery of rapid access to secondary care in acute hospital and specialised services in the community.

An intensive communication and engagement process is underway including feedback to all those involved in the original consultation, together with other staff and partners in the wider health service.

A national Steering Group will oversee the implementation of the report's recommendations and a high level implementation plan is in development. The first step in this will be the appointment of Chief Officers who are expected to take up responsibility in January 2015.

The National Cancer Control Programme

The National Cancer Control Programme (NCCP) will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally. Having made significant progress in services and standards for breast, lung, rectal and prostate cancers, there will be additional emphasis on head and neck, melanoma, neuro-endocrine and other tumour types in 2015.

National Clinical and Integrated Care Programmes

The National Clinical Programmes are central to the transformation underway across the health services. These programmes continue to modernise the way in which services are provided through standardising the delivery of high quality, safe and efficient services by introducing new ways of working which ensures that care is delivered in an integrated way for the individual patient and service user.

The HSE is committed to developing five Integrated Care Programmes (ICPs) that will provide the HSE with the capability of designing and implementing clinically-led, multi-disciplinary integrated models of care. These are:

- Patient flow
- Older persons
- Chronic disease prevention and management
- Children's health
- Maternal health

The ICP project teams will work across services, developing and implementing key priority work streams within each programme. Integrated models of care will improve outcomes for patients and create access to better, more integrated care outside of hospital. They will also reduce unnecessary hospital admissions and enable effective working of professionals across provider boundaries. These integrated models will also contribute to improved efficiency across the whole health system.

Integrated Approach to Delayed Discharges

In response to the growing challenge of providing services to an ageing population, and to address delayed discharges, an integrated care approach will be implemented across the continuum of care inclusive of home, community, hospital and residential services. In 2015, €25m is being provided to augment the response to these challenges across the country and particularly in the Dublin Area where the problem is most acute. The funding will be targeted at the following range of measures:

- €10m will be used to support an additional 300 long stay care places under the Nursing Homes Support Scheme (NHSS) reducing the waiting time for funding under this national scheme to 11 weeks in January 2015.
- €8m is being provided to increase access to short stay beds across the Dublin area. This will allow for transitional and rehabilitation services to be provided across a total of 115 additional beds targeting over 540 discharges from acute hospitals in 2015. This additional bed provision will include 65 beds that will come on stream in 2015 through the commissioning of the former Mount Carmel Hospital as a dedicated community hospital for Dublin.
- €5m of the funding will provide 400 additional Home Care Packages benefiting 600 people in the course of the year.
- €2m is being allocated to expand the community intervention team services in primary care across Dublin allowing for full coverage of this service across the city. The additional teams will deal with 2,000 referrals per team per annum.

In addition to the specific targets to be achieved through these initiatives there will be an integrated care approach developed to meet the needs specifically of frail elderly patients across acute hospital and community services. The approach will be to maintain older people in their own homes and communities for as long as possible, by providing a range of supports to avoid hospital admission and, when admitted, to support discharge of older people from acute hospitals. This will be delivered through a planned integrated approach to their care needs provided by appropriate teams.

Specific governance and management arrangements will oversee the implementation of this initiative across Acute Hospital, Primary Care and Social Care Divisions, in conjunction with National Clinical Programmes, the detail of which will be included in the operational plans for each Division.

While the mix of options outlined will improve the position in relation to delayed discharges and ameliorate the impact likely to be experienced during the peak winter period, the sum of €25m has limited potential to deal with the increased demand associated with people living much longer than even a decade ago, with increasing levels of chronic disease and dependency on health and other social services. In particular, the NHSS will increasingly struggle to meet the demand for funding for long-term residential care.

Healthy Ireland

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

Chronic diseases such as cancer, cardiovascular and chronic respiratory disease and diabetes are the leading causes of mortality, accounting for 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. It is estimated that most of the major chronic diseases will increase by approximately 20% by 2020. Chronic disease is generally preventable and its increase is largely attributable to behavioural factors that can be addressed and modified. Throughout 2015 one of the key objectives for the HSE will be to target and change behaviours which will decrease the burden of chronic disease and enable people to live healthier lives.

Health Business Services (HBS)

The development of a shared services organisation to support the health service is a key component of the current Health Reform Programme. The *Health Business Services Strategy 2014-2016* was approved by the HSE Directorate in 2014 and its implementation will continue throughout the organisation in 2015.

Workforce

The staff of the HSE is its most valuable resource. The HSE will continue to support its staff in developing a culture of compassion and caring in order to deliver high quality effective and safe services to patients and service users. Central to this is the requirement to engage with staff so that their voice is heard thereby enabling a highly motivated workforce where training and development needs are met. During 2015 one of the key priorities will be the development of a workforce plan.

The Department of Health has now delegated greater autonomy and discretion for the HSE to manage staffing levels within the overall pay framework. This will greatly assist in reducing the reliance on agency staff which is very costly and is one of the HSE key priorities for 2015.

Other priorities are to:

- Develop a robust workforce plan including profiling of the current workforce and projected workforce requirements up to 2018.
- Reduce reliance on agency and overtime including the conversion of agency usage to permanent staffing in line with agreed processes.
- Address staff recruitment and retention.

Health and Safety at Work

The Safety, Health and Welfare at Work Act 2005 sets out the duties of employers and their employees in relation to 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.

2015 will see the consolidation and further development of the national Health and Safety Support Function established in 2014. Key delivery areas will include policy, training, information and advice, inspection and auditing.

Children First Implementation

The HSE has significant responsibilities under *Children First: National Guidance for the Protection and Welfare of Children.* A *Children First* Implementation Plan was developed in 2014 which sets out the key actions needed to ensure the compliance of the health services under legislation and national policy. The plan applies to all services and funded agencies and includes the promotion of the safety and welfare of children, the development of guidance and procedures for staff and ensuring that HSE staff are supported to work effectively with other key State agencies in relation to the protection and welfare of children. In addition, it is expected that the *Children First Bill,* will be enacted shortly, which will place key provisions of *Children First* on a statutory footing. When this is finalised almost 70,000 staff across the HSE and funded services will require training in relation to obligations under the Act.

A national *Children First* Lead has been appointed and a HSE Children First Oversight Committee established, together with *Children First* implementation groups at Division and Area levels. Progress reports on the implementation of the plan will be submitted to the Health Sector Children First Oversight Group during 2015.

Risks to the Delivery of the National Service Plan

In identifying potential risks to the delivery of this service plan, it is acknowledged that while every effort will be made to mitigate these risks, it will not be possible to eliminate them in full.

- Continued or accelerated demographic pressures over and above those already planned for in 2015.
- Insufficient capacity of the Nursing Homes Support Scheme to meet current and estimated additional requirements for residential nursing home care.
- Meeting of Health Information and Quality Authority (HIQA) standards for both public long stay residential care facilities and the disability sector.
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce.
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints.
- The potential of pay cost growth which has not been funded.
- Management capacity risk including financial management, given the scale of change underway.
- Risks associated with the delivery of procurement savings.
- Financial risks associated with statutory and regulatory compliance in a number of sectors.
- Cash risk related to the requirement to reach agreement with the private health insurers in relation to a set of revised payment terms.
- Lack of contingency funding to deal with unexpected service or cost issues.

Conclusion

The HSE welcomes the modest increase in the budget received for 2015 as part of a two year funding programme which will assist with the allocation of more realistic budgets to hospitals and community healthcare organisations. It is acknowledged however that it will not be possible to put in place any additional or new service developments, other than those specifically provided for in the Letter of Determination. Whilst this will be challenging in an ever increasing demand led service, the HSE will continue to work towards maximising the delivery of services while at the same time ensuring that quality and patient safety remains at the core of the delivery system. This will be supported by the introduction of the 2015 Accountability Framework, which will ensure that all managers are accountable for delivering services against target and within the financial and human resources available.

Tony O'Brien

Director General

Chairman of the HSE Directorate

18th November 2014

Quality and Patient Safety

The HSE is committed to putting in place a quality, patient safety and enablement programme to support high quality, evidence based, safe effective and person centred care. Quality improvement, quality assurance and verification, will underpin the HSE approach to quality and patient safety in 2015, as is essential in times of constrained resources and change.

Leadership, including clinical leadership, is essential to embed a quality ethos in all services delivered and funded by the HSE and extends from the Directorate, the service Divisions and across the health and social care services. The appointment of Chief Executive Officers to the Hospital Groups and to the Community Healthcare Organisations paves the way for strong leadership so that quality is at the core of all we do.

Quality and patient safety priority areas for 2015 are:

- Proactive approach to service user and staff engagement.
- Improvement against the *National Standards for Safer Better Healthcare*.
- Ensure Hospital Groups and Community Healthcare Organisations have clear structures to govern and deliver quality care.
- Quality improvement capacity building and quality improvement collaboratives.
- The development and use of appropriate quality performance measures.
- Monitoring of quality improvement and patient safety through key performance indicators.
- The implementation of a quality assurance and verification framework.
- The management of Reportable and Serious Reportable Events in accordance with HSE protocol.
- Management of the HSE Risk Register.

Strategic Priorities for 2015

Person Centred Care

- Develop strong partnerships with patients and service users to achieve meaningful input into the planning, delivery and management of health and social care services to improve patient and service user experience and outcomes.

Effective Care

- Continue the implementation of the National Early Warning Score (NEWS) and Irish Maternity Early Warning Score (IMEWS) processes to improve early recognition and take action to care for deteriorating patients. This includes effective communication through the ISBAR communication process (Identify-Situation-Background-Assessment-Recommendation).
- Ensure that patients or service users are responded to and cared for in the appropriate setting including:
  - Home, community and primary care settings.
  - Acute settings with a focus on reducing the number of patients on trolleys and patients experiencing delayed discharge.
- Implement the National Clinical Guideline - Sepsis Management.
- Support the work of the National Clinical Effectiveness Committee and the implementation of the National Clinical Effectiveness Committee guidelines.
- Implement the recently published National Surgical Clinical Programme guidelines on ambulatory care.

Safe Care

- Continue quality improvement programmes in the area of Healthcare Associated Infections (HCAI) and implement the national guidelines for Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium

difficile and Sepsis, and the *National Standards for the Prevention and Control of Healthcare Associated Infections* with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms.

- Continue quality improvement in Medication Management and Safety.
- Implement HSE Open Disclosure policy across all health and social care settings.

Improving Quality

- Develop models of frontline staff engagement to improve services.
- Build capacity (Diploma, methodologies and toolkits).
- Develop further quality improvement collaboratives in key services.
- Lead, in consultation with the services, a programme focused on the improvement of hydration and nutrition for service users.
- Provide Healthcare Quality Improvement Audits.
- Agree and implement a strategic approach to improving quality and patient safety to support the HSE in continuing to deliver on its overall priority on quality and patient safety.

Assurance and Verification

- Implement measurable performance indicators and outcome measures for quality and risk.
- Develop quality and risk performance standards.
- Ensure routine assessment and reports on key aspects of quality and risk indicators.
- Implement the National Adverse Events Management System (NAEMS) across all services.
- Implement remedial actions where required.
- Put in place an auditable control process and mechanism for serious events requiring reporting and investigation.
- Ensure that recommendations from investigations and reports are appropriately implemented.
- Develop and maintain the Corporate Risk Register.
- Manage complaints and ensure that learning is used.
- Support the use of the National Quality Assurance Information System (NQAIS) facilities developed by the National Surgical Clinical Programme to monitor surgical activity across all hospitals.

Key Performance Indicators (KPIs)

During the year, all services will work towards measuring the structures and processes to produce measurable improvements in patient experience, effectiveness, safety, health and wellbeing and assurance for quality and safety within their services. The performance indicators in the table below are a subset of performance indicators based on strategic priorities.

Strategic Priority Area	KPI	Performance Measure / Target	Division
National Standards for Safer Better Healthcare (NSSBH)			
Healthcare Standards	Implementation and action plan for NSSBH	Quarterly report	Acute, Primary Care and NAS
Person Centred Care			
Service User Engagement	All Divisions, Hospital Groups and Community Healthcare Organisations to have a plan in place on how they will implement their approach to patient / service user partnership and engagement	Phased over 2015	All
Staff Engagement	Develop engagement strategy based on employee engagement survey and enhance engagement with staff	Implemented by Q4	HR and Quality Improvement

Strategic Priority Area	KPI	Performance Measure / Target	Division
Open Disclosure	All hospitals and Community Healthcare Organisations will have participated in level 2 briefings by end of Quarter 3	100%	Quality Improvement
Effective Care			
National Clinical Effectiveness Committee National Guidelines	% of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	100%	Acute Division
	% of hospitals with full implementation of IMEWS in all clinical areas of acute hospitals and maternity hospitals	100%	Acute Division
Reduction in delayed discharges	Delayed discharges • reduction in bed days lost • reduction in the number of people whose discharge is delayed	10% reduction 15% reduction	Acute, Primary Care and Social Care Divisions
ED experience	% of all attendees at ED who are in ED > 24 Hours	0%	Acute Division
Hospital Mortality Data	Hospital Standardised Mortality Rates	To be reported	Acute Division
Quality Improvement Audits	Number of audits completed	20	All
Safe Care			
Healthcare Associated Infections	Consumption of antibiotics in community setting (defined daily doses per 1,000 inhabitants per day)	< 21.7	Primary Care
	Rate of new cases of Clostridium difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5	Acute Division
Medication Safety	% of medication errors reported (as measured through the State Claims Agency)	Target to be determined in 2015	Acute Division
Pressure ulcer prevention	The Nursing and Midwifery Division will lead, in partnership with the Quality Improvement Division, the development of a performance indicator on 'pressure ulcer incidence' with the aim of reporting by Quarter 3, 2015		
Falls prevention	The Quality Improvement Division will lead, in partnership with the Nursing and Midwifery Division, the development of a performance indicator on 'falls prevention' with the aim of reporting by Quarter 3, 2015		
Implementation of recommendations	Assurance framework in place and used in all acute hospitals to monitor implementation of priority report recommendations	100%	Acute Division
Quality Assurance			
Serious Reportable Events	% of serious Reportable Events being notified within 24 hours to designated officer	99%	All
	% of mandatory investigations commenced within 48 hours of event occurrence	90%	All
	% of mandatory investigations completed within 4 months of notification of event occurrence	90%	All
Reportable Events	% of events being reported within 30 days of occurrence to designated officer	95%	All
Health and Wellbeing			
Healthcare worker vaccination	Flu vaccination take up by healthcare workers • Hospitals • Community	40%	All
Quality Improvement			
Capacity Building	Number of participants completing the Diploma	100	Quality Improvement
Quality Improvement Collaboratives	Number of major collaboratives completed	2	Quality Improvement
Governance for Quality and Safety			
Quality and Safety Committees	Quality and Safety committees across all Divisions at Divisional, Hospital Group and Community Healthcare Organisation	100%	All

Financial Framework

The letter of net non-capital expenditure dated 31st October received by the HSE references an additional €625m in funding. The letter indicates a provision of €12,131m which is €590m or 5.1% up on 2014 plus a further €35m for mental health bringing the total potential funding to €12,166m or an increase of 5.4%.

This €625m additional financial resource to the HSE has been made up as follows:

1. Additional exchequer funding of €305m (see increase from Revised Estimates Volume (REV) Dec 2013 to Abridged Estimates Volume (AEV) Dec 2014)
2. Increase in non-exchequer funding of €320m (once-off. There is provision for an additional €10m revenue target which brings the increased projected once-off revenues to €330m).

In NSP2014 the key budget figures per division were presented on a gross (Pay and Non pay - Vote) basis. The HSE Vote is being disestablished from the 1st January 2015 and being amalgamated with the Vote of the Department of Health. Accordingly for 2015 and future years the HSE will receive a letter of net non-capital expenditure. In this plan the budget figures are presented on a net basis (pay and non-pay less income – accruals based expenditure). See table 6 on page 66.

Incoming Deficit - €510m

The funding provided in 2015 will enable the HSE to deal with the 2014 level of unfunded costs. Service deficits from 2014 will be funded but this will not be at 100% in all cases. This will reflect that fact that an element of 2014 costs should not recur in 2015. This primarily relates to the level of agency cost growth during 2014 which it is not intended to fully fund in 2015.

It is important to note that the 2014 projected net €510m deficit is comprised of a number of individual service deficits and some limited surpluses. The setting of more realistic budgets for 2015 requires a 'zero base' approach to be taken to ensure that any residual surplus funds are allocated to the ongoing support of services and therefore cannot be utilised to generate new spend in 2015 or thereafter.

Existing Level of Service (ELS) - €66.6m

Table 1, Appendix 1 sets out the funding being provided to off-set the growth in costs associated with existing level of services (ELS). ELS in general refers to services already in place or commenced during the year and to costs that are already being incurred to some extent in the current year but which will rise in 2015. This can relate to the extra costs in a full year of a newly opened or expanded service, including costs associated with newly recruited staff who were not on payroll for the full 12 months of 2014.

The €23.9m related to acute hospitals covers a range of items and will be allocated in further detail within the acute hospitals operational plan. Within this €23.9m a sum of €5m will be reprioritised to enable mitigation of a number of clinical risks.

Cost Pressures - €32.6m

Table 2, Appendix 1 sets out the funding being provided to off-set a number of unavoidable cost pressures. This includes costs associated with renal dialysis, maternity services and diabetes clinical programme developments in relation to podiatry services. A significant element of the total is being provided to address cost pressures within our disability services including:

- 2015 day places for school leavers - €12m full year costs with €6m relevant to 2015
- Expansion of therapy services for 0-18 year olds - €6m full year costs with €4m relevant to 2015
- Pay and general cost pressures within disability services - €6.5m pay and €3.5m general

Curative Hepatitis C Drug Treatment - €30m

An additional sum of €30m is being provided in 2015 towards the costs of new drug therapies for those suffering from Hepatitis C. This is a very welcome development given that the drugs in question can provide an effective treatment for a significant number of those suffering from this condition. The price settled with the manufacturers will be an important factor in determining the pace at which progress can be made in publicly funding this treatment. Clinical prioritisation will be a key feature of the governance framework being put in place. Further details, including in relation to advance arrangements for those in greatest clinical need, are set out within the chapter on primary care services.

Programme for Government Priorities - €134.1m

Table 3, Appendix 1 sets out the various elements of this funding and the related priorities. Within the Primary Care Division funding has been provided, totalling €51m, which will cover:

- Provision to all under 6s of GP care that is free at the point of use
- Provision to all over 70s of GP care that is free at the point of use
- The full year costs of the 2013 primary care posts (recruited largely in 2014)

There is a provision of €25m to commence an initiative to address patients whose discharge from acute hospitals is delayed due a lack of capacity within our community support services:

Service Area	Programme for Government €	Expected Delivery 2015
NHSS (long stay residential care)	€10m	300 places
Short stay beds in Dublin area	€8m	115 beds
Home care packages	€5m	600 additional people
Community Intervention Teams	€2m	4 teams
Total	€25m	

There is a provision of €23m to cover the full year cost of 2013 / 2014 mental health priority posts. In addition there is a further additional €35m held by the Department of Health for priority new developments in 2015. This €35m funding will be made available to the HSE once these developments are agreed early in 2015 and the costs related to these come on stream, bringing to €125m the amount of funding prioritised for mental health since 2012.

Within the Health and Wellbeing Division, provision is made for the preparatory phase of the extension of BreastCheck screening to women in the 65-69 years age range.

Savings and Extra Revenue Targets - €140m

In order to fund the specific provisions set out above a minimum savings target of €130m has been set for 2015 (see Budget Framework, page 14). This includes:

- €95m - savings within procurement including drugs and medicines prices.
- €30m - minimum targeted reduction in agency and overtime costs
- €5m - savings target within acute hospitals associated with clinical audit and special investigations.

In addition a minimum target has been set to improve income generation by €10m across a range of acute hospital and other headings including collection of EU income. Further details in relation to these targets will be set out in the operational plans of the relevant divisions.

HSE Prioritised Initiatives - €22.7m

Table 4, Appendix 1 sets out the items within this €22.7m. While a significantly more manageable funding level has been achieved for 2015 it has not been possible to secure the full amount sought for a range of priority items including demographic and critical service pressures. The Directorate has identified a relatively small amount of resource within 2015 which it will use to progress a limited number of items otherwise unfunded within the overall 2015 Estimates bid. These have a cost of approximately €22.7m which represents 0.18 of 1% of the overall HSE budget and will have a full year additional cost of a further €9m.

This is seen as a prudent investment despite the overall financial challenge faced, given the wide range of priority initiatives which it will progress in 2015.

Budget Framework

Estimate 2015	€m	€m
2014 Incoming Base Funding	11,540.9	11,540.9
Projected 2014 Deficit	510.1	510.1
2014 Projected Spend / Opening Base 2015		12,051.0
Programme for Government		
Mental Health (full year costs of 2013 and 2014 posts)	23.0	
Delayed Discharges Initiative	25.0	
Free GP care for children under 6 years of age	25.0	
Primary Care developments	14.0	
Free GP care for over 70s	12.0	
BreastCheck	0.1	
Total Programme for Government	*99.1*	*99.1*
Other Additional Funding		
Existing Level of Service Funding	66.6	
Funded Cost Pressures	32.6	
Funding for Other Priorities - Hepatitis C	30.0	
Total Other Additional Funding	*129.2*	*129.2*
Service Priority Funding		
HSE Prioritised Initiatives	22.7	22.7
Savings Measures		
Procurement and Drug Price Savings	-95.0	
Agency and Overtime Reduction	-30.0	
Hospital Clinical Audit / Clinical Investigations	-5.0	
Total Savings Measures	-130.0	-130.0
Income Generation / Collection - EU / Hospital Charges	-10.0	
Total Savings Measures and Income Measures	-140.0	-140.0
Other Technical Adjustments	-30.9	
Total Adjustments	-170.9	-170.9
Total 2015 Net Determination	590.0	12,131.0
Net Increase 2015 versus 2014		590.0
Increase in Net Determination Funded as Follows		
Increase in Exchequer Funding		305.0
Increase in Non Exchequer Funding - Once Off		320.0
Mental Health (Held by Department of Health for Priority 2015 Developments)		-35.0
Total Funding Increase		590.0

* Total additional funding as per 2015 Letter of Determination is €625m including €35m for Mental Health priority new developments

Approach to Financial Challenge - circa €100m

In governance terms the enhanced efficiency and accountability framework referenced in the Executive Summary represents a key element of the approach for 2015 and is intended to provide the necessary additional management focus to facilitate meeting the financial challenge in 2015.

In light of the above, it is intended before year end following completion of our operational plans, despite the complexities which are exacerbated by data and systems constraints at national level, to issue budgets for 2015 to HSE and HSE funded main service providers that, in addition to setting a net expenditure level, also set out:

- Pay budget incorporating
  - Direct Pay financial limit and indicative average WTE staffing level
  - Agency financial limit and indicative average WTE staffing
  - Overtime financial limit and indicative average WTE staffing
- Non Pay Budget
- Income Budget

An element of 2015 budgets will be notified to service providers in the first instance on a once-off basis to reflect the once-off nature of a portion of the funding supporting the HSE's budget, i.e. the €320m referenced on page 12. It is important that our hospital and community services understand that their financial performance in 2015 will have a direct bearing on the ability to secure recurring funding in 2016 given that the costs that will be supported by this €305m are ongoing in nature.

It will be necessary, in order to address this financial challenge, to identify and deliver additional savings and revenue generation above and beyond the minimum €130m / €140m outlined.

Pay and Pay Related Savings including Agency and Overtime

There will be a significant additional focus on all pay costs which includes costs related to directly employed staff, overtime and agency staff. Despite the system and data constraints the HSE will begin to take a more integrated approach to the management of all staffing costs. Initially focused on acute hospitals and other areas with high agency usage this will involve setting limits on the costs and hours (initially expressed as WTEs) for each category of staff.

In light of the additional unfunded pay cost growths expected in 2015 it will be necessary to achieve savings in agency and overtime significantly beyond the €30m minimum savings included in the €130m overall minimum savings target outlined.

This will require an exceptional targeted effort across the organisation and within all funded agencies. Preliminary modelling, which will be validated as part of the operational planning process, indicates that to achieve net pay savings of up to €60m the HSE needs to reduce agency and overtime costs by up to €140m through a combination of non-replacement and replacement while limiting the related growth in directly employed staff pay costs to circa €80m. In WTE terms, this draft data indicates a need to reduce the equivalent of 2,000 WTEs of agency staff (53% reduction) and replace that with 1,700 WTE of directly employed staff (including graduate nurse and intern support staff) thereby managing with approximately 300 WTE less staff. The figures above are based on a comparison of average staffing levels between 2013 and 2014.

For acute hospitals their growth in staffing during 2014 indicates a requirement to make additional staffing reductions, beyond this net 300, to bring staffing levels down from their current levels (based on end of September data) to the average for 2014.

The above is in the context of agency costs in 2014 rising by a projected €77m above 2014 levels i.e. from €259m to €336m with €61m (79%) of this relating to medical agency. It is clear that a key risk to this approach is the capacity to recruit and retain health professionals and this risk is greatest within the medical area both for

consultants and non-consultant hospital doctors. Close attention will be paid to seeking to mitigate and monitor this risk.

Income focus

Growing income generation and improving cash collection are key features of managing the overall financial challenge for 2015. It is expected that efforts to reduce agency costs will assist in increasing pension related income, and additional income generation in acute hospitals and community services will be targeted. The initial focus will be on acute hospitals where over 50% of the HSE's income is generated and a zero based income review is currently underway. This is examining income targets and actual delivery for 2013 and 2014 across all hospitals with a view to setting revised targets for 2015. Further detail will be included in the operational plans of the relevant divisions.

Financial Risk Areas

All services will need to operate within the planned cost level for 2015 in order for the HSE to deliver a breakeven position and there is extremely limited scope to address any over run in one area by compensating under spends in another area.

Primary Care Reimbursement Service (PCRS) and State Claims Agency

There are a number of expenditure headings in respect of which, due to their legal or technical nature, the plan has been prepared on an agreed basis i.e. should actual costs vary from the amounts provided it will not impact on the funding available for other areas of service provision.

1. PCRS incorporating local demand led schemes - €2,486m available to HSE
2. State Claims Agency (SCA) - €96m available to HSE. This relates to the cost of managing and settling claims which arose in previous years and is a statutory function of the SCA. The HSE is focused on improving the safety and quality of services on an ongoing basis which should positively impact the cost of future claims.

Pensions - €434m available to HSE

Pensions provided within the HSE and HSE funded agencies (Section 38), cannot readily be controlled in terms of financial performance and are difficult to predict. There is a strict requirement on the health service, as is the case across the public sector, to ring fence public pension related funding and costs and keep them separate from mainstream service costs. This plan has been prepared on the basis that, as in prior years, pension related funding issues will be dealt with separately from the general resource available for service provision. Pension costs and income will be monitored carefully and reported on regularly.

Pandemic Vaccines and Emergency Management

Pandemic vaccines and emergency management were previously covered by contingency funding held by the HSE in the sum of €7.5m and €5m respectively. These contingency funds are not available to the HSE in 2015 as they have been utilised as part of setting out an overall more realistic budget framework. In the event that costs are incurred that typically would have been addressed via these contingency funds then this will need to be addressed in discussion with the Department of Health. This plan has been prepared on the basis that such discussions will take account of the fact that costs of this type will generally be urgent in nature and cannot impact on the level of funds available for the services to be provided under this plan.

EU Cross Border Directive - €1m

A sum of €1m has been provided to address costs specific to the EU cross border directive. Any costs incurred beyond this will need to be addressed within the relevant division.

Management of Cash Risk Items

The management of the cash position will continue to be a focus in 2015 particularly in light of the disestablishment of the HSE Vote from 1st January and its amalgamation with the vote of the Department of Health.

There are a number of prior year items, including historic deficits within funded agencies and accelerated cash collection targets that will need to be addressed in 2015 through our overall cash management process pending a more sustainable solution being agreed for future years. Discussions with private health insurers are underway in order to put in place an improved payment process. In this context the health service is committed to the principle of developing and implementing full electronic claiming and this will be progressed in 2015.

Activity Based Funding (ABF)

The new Activity-Based Funding (Money Follows the Patient) of hospital services commenced in 38 hospitals during 2014 with the setting of activity targets for inpatient and day-case work. The system is complex and is being carefully implemented on a phased basis, working with the colleges and the hospital groups. A Strategic Framework and Implementation Plan has been prepared and the 2015 elements of this will be rolled out. As part of the development of the ABF programme, the HSE will design pricing structures to move appropriate work from inpatient to daycase setting.

Specifically in 2015 the following actions will be undertaken:

1. Conversion of hospitals from block grants to ABF allocations with transition payments
2. Evaluation of hospital benchmarking in relation to transition payments
3. Continuation of work on the development of an outpatient classification system
4. Development of a Data Governance Framework
5. Research on community classification systems in other jurisdictions

Workforce

Introduction

The staff of the health services continue to be its most valuable resource. Staff are central to improvement in patient care, productivity and performance. A culture of compassionate care and a sense of belonging among staff will create and embed an organisation-wide approach to delivering a high quality, effective and safe service to our patients and clients.

Recruiting and retaining motivated and skilled staff is a key objective in 2015. This has to be delivered in an environment of significant reform and against a backdrop of significant reductions in the workforce over the past seven years, longer working hours, reductions in take-home pay and other changes in the terms and conditions of employment for staff.

The effective management of the health services' workforce will underpin the accountability framework in 2015. This requires that the HSE has the most appropriate workforce configuration to deliver health services in the most cost effective and efficient manner to maximum benefit.

The role of Human Resources (HR), working across the health system, will be to ensure that the organisation and the workforce has the ability, flexibility, adaptability and responsiveness to meet the changing needs of the service while at the same time ensuring a consistent experience of HR is delivered by a unified HR function. In collaboration with all stakeholders, work will continue in 2015 on the HR strategic intent and emerging operating model to ensure the organisation's strategic HR goals, initiatives and projects are delivered to best serve the needs of patients and service users.

The Workforce Position

At the end of 2014 there were approximately 97,000 WTE positions in place delivering health services. This figure rises to over 102,000 WTEs when including home helps, graduate nurses on the special graduate programme and the support staff intern scheme. As well as the basic pay for this level of workforce an amount equivalent to an additional 8% of the pay bill was expended in agency and overtime.

Employment controls in 2015 will be based on the configuration of the workforce that is within funded levels. The funded workforce also includes agency, locum and overtime expenditure. The aim is to provide for a stable workforce which will support the continuity of care required for safe, integrated service delivery.

Management of the workforce in 2015 must transition from an employment control framework, with its particular focus on a moratorium on recruitment and compliance with employment ceilings, targets and numbers, to one operating strictly within allocated pay frameworks. At the same time services must be delivered to the planned level and service priorities determined by Government addressed. This requires an integrated approach, with service management being supported by HR and Finance. It further requires finance and HR workforce data, monitoring and reporting to be aligned.

The grace period retirement option has been extended to the end of June 2015. This and other exit mechanisms will be used to facilitate reconfiguration of the workforce to create capacity for enhancing services, without incurring further costs. Planned service developments under the Programme for Government and prioritised internal initiatives will require targeted recruitment in 2015.

Reform, reconfiguration and integration of services, maximising the enablers and provisions contained in the *Haddington Road Agreement*, the implementation of service improvement initiatives and reviews, the reorganisation of existing work and redeployment of current staff will all contribute to delivering a workforce that is more adaptable, flexible and responsive to the needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes. The funded workforce can be further reconfigured

through conversion of agency, locum and overtime expenditure, where appropriate and warranted, based on cost and this can also be utilised to release additional required savings.

HSE staff numbers by Division, as of September 2014, are set out in Appendix 2.

Reducing Agency and Overtime Costs

The cost and reliance on agency staff must be reduced in 2015 to meet specified targets up to €140m (see Financial Appendix 1). A range of processes to contain and control the frequency and cost of agency staffing across both HSE and HSE funded services in the period from late 2014 into full year 2015 have been introduced. In the Acute Hospitals Division these include central reporting of agency staff, implementation of existing Medical Council and contractual requirements, confining purchasing to national agency contract rates, replacement of agency staff by fixed purpose employment contracts, and a focus on retention of graduate nurses. Similar measures were introduced in mental health services with the addition of agencies being able to draw on existing panels for nursing and midwifery vacancies. In Social Care services a data collection exercise has supported deployment of Service Improvement Teams and the identification of options and target savings.

Other supports to assist better management of the workforce and costs may include:

- Greater use of e-rostering and time and attendance systems
- The development of an e-management strategy for the effective management of the workforce and its costs and leading to an integrated and unified technology platform in time.
- The option of the creation of staff banks, based on geographical or service clusters, initially if approved, on a pilot basis to provide evidence based evaluations.

All these measures and actions are to assist the most cost effective service delivery and to ensure the targeted savings from 2014 levels, particularly in agency expenditure, are achieved throughout 2015 as success here will determine capacity for targeted investment elsewhere in the health services.

2015 Developments and Other Workforce Additions

This plan provides specific additional funding in 2015 under *Programme for Government* for service development posts in Mental Health Services and Primary Care, as set out in Appendix 1, which is in addition to the initial pay allocations. The approval, notification, management, monitoring, and filling of these new posts will be in line with previous process for approved and funded new service developments specified in National Service Plans. Prioritised initiatives with a funding envelope of over €22.7m (Appendix 1), with the associated number of WTEs, are also proposed.

The Haddington Road Agreement

The *Haddington Road Agreement* (Public Service Stability agreement 2013-2016) continues to provide 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 HSE as set out in *Future Health* and the Public Service Reform Plans of 2011 and 2013. It will continue to assist clinical and service managers to more effectively manage their workforce through the flexibility measures it provides.

The *Haddington Road Agreement* enablers and provisions include:

- Work practice changes for identified health care workers
- Systematic reviews of rosters, skill-mix and staffing levels
- Increased use of redeployment
- Further productivity increases

- Further development of the Nursing / Midwifery Graduate Programme
- Further development of the Support Staff Intern Scheme
- Targeted voluntary redundancy arising from restructuring and review of current service delivery
- Continue improvements in addressing absence rates
- Greater use of shared services and combined services focussed on efficiencies and cost effectiveness
- Greater integration and elimination of duplication of the human resources functions of the statutory and voluntary sectors

Workforce Planning

Future Health commits the Department of Health and the HSE to work together to implement an approach to workforce planning and development that includes recruiting and retaining the right mix of staff, training and up-skilling the workforce, providing for professional and career development and creating supportive and healthy workplaces. Action 46 in *Future Health*, is being addressed through the Strategic Reform Programme to support the HSE in achieving a number of the objectives identified for reform:

HSE Reform Strategic Objectives

- Provide fair and timely access to quality care in the right place
- Develop effective governance and management / organisational arrangements
- Implement a relevant and effective resource allocation system
- Optimise available resources to maximise performance and productivity
- Have a motivated capable staff, in adequate numbers and in appropriate settings

The *Strategic Workforce Planning and Development Framework* will be published in Q2 and the subsequent deployment of a workforce planning and development operating model across the whole health service by Q4.

The consultation process and engagement with the DoH will be supported by internal analysis of existing workforce intelligence data, profiling current workforce and workforce reporting capability as follows:

- Workforce data intelligence
- Profiling of current workforce
- Workforce requirements report

Workforce Development Planning

Human resources development, a multi-disciplinary and integrated approach to workforce development planning is designed to ensure staff are highly motivated and retain high levels of job satisfaction, whilst delivering effective and compassionate care. Effective performance management and supporting the learning and development needs for all staff at all levels are central to enabling staff '*to be what they can be*'.

Action to support new emerging senior teams and to further build managerial capacity include a *Coaching and Mentoring Framework* and structured, *Multidisciplinary (accredited) Leadership and Management Development Programmes,* succession management, new leadership programmes at senior management level and an integrated approach to middle management development. It is planned to expand the number of FETAC Level 5 modules available to support staff in 2015 on a pathway towards achieving a Major Award. Programmes will continue to be based on identified service need.

One example of measures to support workforce development and associated staff retention is where the HSE is working with the DoH and other stakeholders to progress the recommendations of the *Strategic Review of Medical Training and Career Structure (MacCraith Report).* In 2015 this will include:

- Regular reporting to the Minister for Health on implementation progress, through the relevant structures

- Reporting of Non-Consultant Hospital Doctors (NCHD) and Consultant retention rates in the public health system on a quarterly basis through the *Performance Assurance Report*, commencing in March 2015.

The HSE's actions in this area will be underpinned by a strong emphasis on performance management at all levels in the health system with frequent manager / staff engagement in developing a culture of teamwork, communication and innovation. Underperformance must be addressed in a timely and supportive manner to ensure such staff are brought back to an effective level of performance.

Attendance Management and Absence Management

This continues to be a key priority area and service managers and staff with the support of HR will continue to build on the significant progress made over recent years in improving attendance levels. The performance target for 2015 remains at 3.5% absence rate.

Employee Engagement

In order to find out the views and opinions of staff, the first ever Irish public health sector wide anonymous and confidential employee engagement survey was conducted between September and November 2014, which included all staff employed across both the statutory and voluntary sector. The data generated will be used to improve the working lives of staff, leading to better care for patients, and will provide a benchmark to build from in 2015, and in future years, to shape organisational values and culture. It will also form part of a health sector wide approach to the continued development and implementation of best practice HR policies and procedures. A comprehensive employee engagement strategy will be developed and implemented from the results of the survey in 2015. HR will also work with the Quality Improvement Division to ensure enhanced engagement with staff, particularly in front line services.

European Working Time Directive

The HSE is committed to maintaining and progressing compliance with the requirements of the European Working Time Directive (EWTD) for both NCHDs and staff in the Social Care sector. Key performance indicators in each case include:

- Maximum average 48 hour week
- 30 minute breaks
- 11 hour daily rest / equivalent compensatory rest
- 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest
- A maximum 24 hour shift (in relation to NCHDs only)

Actions to achieve EWTD compliance in relation to NCHDs will be progressed by the Acute Hospital and Mental Health Divisions. Actions to progress compliance in relation to social care staff will be progressed by the Social Care Division.

To date, progressing EWTD compliance for NCHDs has required introduction of revised rosters for both NCHDs and Consultants, changes to medical, nursing and midwifery, and other work practices, redeployment of staff and, in those settings where these have been implemented but not secured full compliance, targeted recruitment and allocation of resources. These measures are almost complete and in 2015 the focus will be on achieving full EWTD compliance by reallocation of clinical tasks to the most appropriate member of staff, introduction of electronic time and attendance systems and reorganisation of acute services, supported by new management structures for hospitals services being progressed under Hospital Groups. In some settings, large-scale changes to existing acute hospital services are required to achieve full compliance and the HSE is committed to engaging and consulting with staff as they are progressed, including with the Irish Medical Organisation (IMO) under the auspices of the Labour Relations Commission. In addition, the joint national

group, comprising the HSE, Department of Health and IMO established in 2013 will continue to oversee verification and implementation of agreed measures. Separately, the HSE will continue 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.

To support EWTD compliance for NCHDs, the HSE is also working with the DoH and other stakeholders to progress recommendations of the *Strategic Review of Medical Training and Career Structure (MacCraith Report)*. This will include measures to develop the career structure for approximately 900 doctors in service posts and 260 doctors in community and public health settings

Regarding Social Care sector staff, the HSE is committed to achieving EWTD compliance in respect of staff who are required to engage in sleepovers at their work location as part of the provision of care in a residential setting on a 24 hour 7 day per week basis. Achieving full EWTD compliance will require significant restructuring of the way in which such services are delivered over the course of 2015.

Health and Safety at Work

2015 will see the consolidation and further development of the national Health and Safety Support Function established in 2014. Key delivery areas will include policy, training, information and advice, inspection and auditing.

Operational Service Delivery

Health and Wellbeing

Introduction

Improving the health and wellbeing of Ireland's population is a Government priority and is one of four pillars of healthcare reform. Within the HSE, Health and Wellbeing is responsible for driving and coordinating the health service response to this agenda. Collaborative working will ensure that all reforms, strategic and service developments are orientated to help people to stay healthy and well, reduce health inequalities and protect people from threats to their health and wellbeing.

2015 Budget €m	
Health and Wellbeing	201.2

Full details of the 2015 budget are available in Table 5 page 65

In 2015, the focus is to build on the cooperation and momentum generated over the last 12 months. In particular, the focus will be on the key modifiable risk factors for chronic disease and ill-health such as tobacco, alcohol misuse, physical inactivity, obesity and wellbeing. These will be tackled through excellent governance and cross-divisional accountability frameworks, leadership, the further implementation and embedding of *Healthy Ireland* principles and actions across the organisation and the strengthened management arrangements in place between Health and Wellbeing and the Clinical Strategy and Programmes Division.

Existing statutory commitments will be delivered in 2015 as will key priorities and actions as set out in service and operational plans. The enabling role of Health and Wellbeing in translating *Healthy Ireland* into tangible and impactful actions across HSE settings will remain a key priority. The new management structures of the Community Healthcare Organisations and the consolidation of the new Hospital Group structures present further opportunities to mainstream these actions as part of core business in 2015. This will be supported by Health and Wellbeing service reforms and reconfiguration work through the implementation of its workforce planning recommendations and its continued development as a responsive, dynamic and performance focused delivery system notwithstanding its resource and ICT challenges.

Quality and Patient Safety

Key actions have been identified for 2015, aligned with the Quality Improvement programme, which include commitments to (i) the development of a Quality Profile framework for application within all services, (ii) ensuring all relevant sub-divisions and business units have appropriate governance structures in place to address quality and safety issues, and (iii) developing and implementing quality indicators in 2015 building on the work undertaken to date.

The HSE is committed to implementing the Complaints Policy and will respond to any complaints within the timeframes set out. Within the services, relevant assurance processes and programmes will be implemented, to benchmark performance against other systems and jurisdictions as appropriate.

Key Priorities with Actions to Deliver in 2015

Continue to implement *Healthy Ireland*

- Progress the HSE's *Healthy Ireland* Implementation Plan.
- Integrate prevention, early detection and self-management care into the Integrated Care Programmes.
- Support the delivery of the broader Health and Wellbeing *Healthy Ireland* agenda through collaborative working, joined-up planning opportunities and strategic partnerships with key external partners including Local Authorities.
- Strengthen health and wellbeing management and capacity within the new Community Healthcare Organisations.

- Strengthen the operating model of the Division by implementing essential-only integrated workforce planning recommendations across health and wellbeing services, e.g. Health Promotion and Improvement and Public Health.
- Embed health and wellbeing indicators within HSE reform programmes and projects.

Work to reduce the chronic disease burden of the population

- Tobacco Control and Substance Misuse
  - Further *Tobacco Free Ireland* by implementing priority actions with a particular focus on the continued roll out of the Tobacco Free Campus policy.
  - Reduce tobacco usage within the general population by undertaking a range of training, intervention, surveillance, evaluation, enforcement of legislation and social marketing activities in line with the recommendations of *Tobacco Free Ireland*.
  - Progress the implementation of the *National Substance Misuse Strategy* including the community mobilisation pilot on alcohol initiatives in five drug task force areas and the further development of a coordinated approach to prevention and education interventions in alcohol between all stakeholders including third level institutions.
  - Prepare for the future roll out of the relevant provisions outlined in both tobacco and alcohol legislation in consultation with the Department of Health and in line with existing resources.
- Obesity: Tackle obesity levels by undertaking a range of training, surveillance, programme, evaluation and social marketing activities amongst children and adults, in partnership with General Practitioners, acute and community healthcare professionals, schools and other key stakeholders.
- Physical activity: Implement priority recommendations from the National Physical Activity Plan in partnership with relevant stakeholders, with a particular focus on health inequalities.
- Positive Ageing: Promote positive ageing and improve physical activity levels by undertaking a range of initiatives including research, communications and social marketing activities and educational programmes in partnership with other Divisions and stakeholders.
- Mental Health Promotion: Promote and improve mental health and wellbeing by undertaking a range of interventions in partnership with other Divisions and stakeholders including the implementation of relevant recommendations from the new Strategic Framework for Suicide Prevention
- Dementia: Implement a nationwide support and social marketing campaign for people with dementia and their carers, working in collaboration with a range of partners, to create well informed, positive attitudes to dementia, increase readiness in health services and communities to support people with dementia, and create better understanding of brain health in general.
- Sexual Health: Implement priority recommendations from the National Sexual Health Strategy in partnership with relevant stakeholders and within available resources
- Knowledge Management: Further develop a knowledge management function to support greater use, analysis and development of data and evidence for the HSE.

Develop, refine and integrate service delivery models for the health of the population

- BreastCheck
  - Deliver breast screening to women aged 50-64 through the BreastCheck Programme.
  - Commence screening process for age-extension of the BreastCheck Programme. *(Programme for Government €0.1m)*
- Deliver cervical screening to eligible cohort of women thorough the CervicalCheck Programme.
- Complete first round of screening of the eligible cohort through the BowelScreen Programme.
- Commence annual screening to eligible cohort through the DiabeticRetinaScreen Programme.

Child Health

- Provide national oversight to the implementation of child health priorities in partnership with primary

care in line with outcome one of *Better Outcomes Brighter Futures*.
- Develop a framework for the implementation of a model for child health screening and development in partnership with primary care.
- Complete action plan to progress breastfeeding in Ireland within the *Healthy Ireland* framework and across the Primary Care and Acute Hospital Divisions as well as with the community and voluntary sector.

- Immunisation
  - Improve national immunisation uptake rates in partnership with Primary Care.
  - Implement changes to Primary Childhood Immunisation Programme and Schools Immunisation Programme.
  - Progress the implementation of a national child health and immunisation IT System.
  - Improve influenza vaccine uptake rates amongst staff in frontline settings (acute and long-term care in the community).
  - Improve influenza uptake rate amongst persons aged 65 and over.

Protect the population from threats to their health and wellbeing

- Provide epidemiological expertise, advice and support to key external stakeholders and provide statutory surveillance, management, investigation and control of infectious diseases.
- Provide responses to public health incidents including outbreaks of infectious disease, chemical, radiation and environmental incidents.
- Implement the service contract with the Food Safety Authority of Ireland
- Enforce HSE environmental health statutory responsibilities, focusing on areas of greatest non compliance and prioritising the implementation of the *Public Health (Sunbeds) Act, 2014*.
- Fulfil emergency management legislative requirements, in addition to interagency obligations under the Framework for Major Emergency Management and support services and functions in their planning and response to major emergencies.
- Support the Department of Health in the development of a climate change adaptation plan for the health sector.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Immunisations and Vaccines % of children 24 months of age who have received the MMR (measles, mumps and rubella) vaccine	95%	CervicalCheck No. of women screened (no. of unique women who have had one or more smear tests in a primary care setting)	271,000
% children 12 months of age who have received the 6-in-1 vaccine	95%	BowelScreen No. of clients invited (no. of first invitations sent to individuals in the eligible age range 60-69 known to the programme)	200,000
% children 24 months of age who have received 3rd dose of MenC (meningitis C) vaccine	95%		
% of first year girls who have received third dose of HPV (Human Papillomavirus) vaccine	80%	Diabetic RetinaScreen No. of clients screened (no. of individuals known to the programme aged 12+ with diabetes who have been screened)	78,300
% of health care workers who have received one dose of seasonal Flu vaccine in the 2014-2015 influenza season (acute hospitals and long-term care facilities in the community)	40%		
% uptake in Flu Vaccine for > 65s	75%	Tobacco No. of smokers who received intensive cessation support from a cessation counsellor	9,000

Performance Indicator	Expected Activity / Target 2015
Child Health % newborn babies visited by a PHN (public health nurse) within 72 hours of hospital discharge	97%
% of children reaching 10 months who have had their child development health screening before 10 months	95%
% of babies breastfed (exclusively and not exclusively) at (i) first PHN visit and (ii) 3 month PHN visit	(i) 56% (ii) 38%
BreastCheck No. of women screened (no. of women 50-64 who have had a mammogram)	140,000

Performance Indicator	Expected Activity / Target 2015
% of new facilities opening smoke free in primary care, mental health and social care	100%
No. of sales to minors test purchases carried out	480
No. of frontline healthcare staff trained in brief intervention smoking cessation	1,500
Environmental Health – Food Safety No. of planned, and planned surveillance inspections of food businesses	33,000
Environmental Health – Sunbeds No. of inspections of establishments	400
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Primary Care Services

Introduction

The development of primary care services 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

2015 Budget €m	
Primary Care	747.6
Social Inclusion	125.7
PCRS	2,485.8
TOTAL:	3,359.1

Full details of the 2015 budget are available in Table 5 page 65

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 patients 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. Primary care will play a central role in co-ordinating and delivering a wide range of integrated services in collaboration with other Divisions. The primary care team (PCT) is the central point for service delivery which actively engages to address the medical and social care needs of the population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

A key priority for 2015 is the implementation of the recommendations of *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, 2014,* including the establishment of CHOs. New measures for enhanced control and accountability for primary care services will be implemented. These will strengthen the accountability framework and outline explicit responsibilities for managers at all levels.

Quality and Patient Safety

The Primary Care Division is committed to promoting a 'quality and safety' culture by ensuring effective governance, clear accountability and robust leadership. Quality and patient safety is the responsibility of all staff, from frontline to senior management.

The *National Standards for Safer Better Healthcare* provide an outline of what can be expected from healthcare services. The implementation of these standards will help to realise improvements for service users by creating a common understanding of what constitutes a safe, high quality primary care service.

The operational management of quality and safety within the Division will have clear lines of accountability from frontline services to the National Director. Priorities for 2015 are to:

- Implement the framework for governance, quality and risk within primary care to ensure services are safe and provided to the highest standard of care.
- Implement the integrated quality and safety business plan, which will provide support to primary care services in the achievement of quality and patient safety objectives. *(Programme for Government Primary Care Funds €0.025m)*

Cross cutting areas which will be a focus for primary care in 2015 include the appropriate use of antimicrobials, including the introduction of arrangements for the control and prevention of HCAIs / AMR (antimicrobial resistant).

Primary Care Services

Key Priorities with Actions to Deliver in 2015

2015 Budget €m	
Primary Care	726.0
Drugs Task Force	21.6
TOTAL	747.6

Full details of the 2015 budget are available in Table 5 page 65

Improve and standardise access and provision of appropriate primary care services through primary care teams (PCTs) and network services

- Strengthen PCT and primary care network services in line with organisational reform.
- Implement agreed clinical and management governance arrangements to support the discharge of complex patients to their homes.
- Implement agreed guidelines and protocols to better manage the Community (Demand-Led) Schemes, including the provision of aids and appliances in primary care. This will support the delivery of services within available resources and maximise efficiencies.
- Implement appropriate measures to reduce agency expenditure across primary care services.

Implement revised management and clinical governance structures to support primary care service delivery.

- Implement the recommendations of *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, 2014,* by establishing the CHOs and their management structures including the primary care network governance structures.
- Establish a strong management and governance structure to support the implementation of the multi-annual public health plan for the pharmaceutical treatment of patients with Hepatitis C. This structure will establish a register of patients and will provide for monitoring and reporting of patient outcomes. Arrangements have been put in place to provide new drug therapies under an early access programme for patients prioritised on the basis of clinical need.
- Restructure the provision of GP Training to include the restructuring and management of the GP Training Programmes on a cost neutral basis.
- Implement the initial phases of the Health Identifier Project.
- Implement the *Children First* programme in primary care settings

Provide improved and additional primary care services at PCT and network level

- Community Intervention Teams:
  - Expand the coverage of Community Intervention Teams (CITs) with a particular focus on hospital avoidance and earlier discharge from acute hospitals in the greater Dublin area. *(Programme for Government – Delayed Discharge Funds €2m)*
  - Enhance the services of existing CITs to include additional Outpatient Parenteral Antimicrobial Therapy (OPAT) services with an increased emphasis on helping people to avoid hospital admission or to return home earlier.
- Implement the recommendations of the Primary Care Eye Services Review 2014. *(Programme for Government Primary Care Funds €1m)*
- Extend pilot ultrasound access project to additional primary care sites on a prioritised basis. This is a first step in a programme to extend the availability of diagnostics to support management of patients in general practice. *(Programme for Government Primary Care Funds €0.7m)*
- Pilot the provision of additional minor surgery services in agreed primary care settings and sites. *(Programme for Government Primary Care Funds €0.5m)*
- Review the existing GP Out of Hours Co-Op services with a view to maximising efficiencies.
- Extend within existing resources the GP Out of Hours services to areas currently not covered.

- Primary Care Medicines Management Programme
  - Expand the Primary Care Medicines Management Programme (MMP) to ensure safe, quality and cost effective prescribing in primary care.
  - Promote appropriate antibiotic use in primary care settings.
  - Develop an International Normalised Ratio (INR) demonstration model in primary care to provide more accessible, better managed and more cost effective services to patients requiring anticoagulation services.
- Community Oncology
  - Roll out phase three of the National Cancer Control referral project. This will commence with the electronic GP referral form for pigmented lesion in eight hospitals targeted nationwide.
  - Develop and implement a GP and Dentist referral tool kit for suspected head and neck cancer.
- Oral Health and Orthodontics *(Programme for Government Primary Care Funds €1m)*
  - Provide improved access to orthodontic treatment for children, including those requiring orthognathic / oral surgery, by utilising effectively the resources provided and reducing waiting times.
  - Provide dental care for patients with cancer and other complex care conditions, including those who require routine or urgent general anaesthetic services.
  - Implement microbial prescribing and HIQA infection control standards.

Ensure cross divisional integration

- Implement priority actions from the *Healthy Ireland* Implementation Plan in partnership with Health and Wellbeing.
- Work with Acute Care, Palliative Care and Social Care to provide integrated hospital discharge initiatives utilising CITs to provide flexible, responsive, high quality care in patients' homes and places of residence.
- Progress with the Mental Health Division the Counselling in Primary Care (CIPC) services to facilitate quick access by patients to counselling services and work towards locating more community mental health services in primary care centres.

National Clinical Programmes

- Work with the Clinical Programmes to develop and progress the priority workstreams of the five Integrated Care Programmes (Patient Flow, Older Persons, Chronic Disease Prevention and Management, Children's Health and Maternal Health) which will improve integration of services, access and outcomes for patients.
- Align the primary care diabetes initiatives to the Diabetes Model of Care with the support of the Clinical Programme and augment existing podiatry services to deliver the model of care.
- Work with the Clinical Programmes on the roll out of the chronic disease programmes by the appointment of 12 Nurse Specialists and/or Allied Health Professionals and the implementation of Integration and Self Care Projects in Respiratory Disease and Heart Failure.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015		Performance Indicator	Expected Activity / Target 2015
Community Intervention Teams Activity:			Healthcare Associated Infections: Medication Management	
Admission avoidance (includes OPAT)	1,165		Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	< 21.7
Hospital avoidance	17,728			
Early discharge / wards (includes OPAT)	4,123			
Other	2,910			
Total	25,926			

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Physiotherapy % of referrals seen for assessment within 12 weeks	80%	Nursing, Podiatry, Ophthalmology, Audiology, Dietetics and Psychology No. of patient referrals	New PI 2015
Occupational Therapy % of referrals seen for assessment within 12 weeks	80%	Existing patients seen in the month New patients seen in the month	Baseline to be determined 2015
Orthodontics % of referrals seen for assessment within 6 months	75%	GP Activity No. of contacts with GP Out of Hours	959,455
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%	Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Social Inclusion

Social Inclusion plays a key role in supporting access to services and provides targeted interventions to improve the health outcomes of minority groups such as 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.

2015 Budget €m	
Social Inclusion	125.7
Full details of the 2015 budget are available in Table 5 page 65	

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

Key Priorities with Actions to Deliver in 2015

- Achieve improved health outcomes for persons with ***addiction issues***.
  - Progress the integration of Drug Task Force Projects and developments within the wider addiction services in line with objectives of the *National Drug Strategy 2009-2016*.
  - Implement priority actions from *National Drugs Strategy 2009-2016*. *(Programme for Government Primary Care Funds €2.1m)*
    - Implement the clinical governance framework for addiction treatment and rehabilitation services.
    - Implement the outstanding prioritised recommendations of the *Opioid Treatment Protocol*, including the development of an audit process across the full range of drug services. This will incorporate person-centred care planning through the Drug Rehabilitation Framework and increase opioid substitution treatment patient numbers.
    - Implement prioritised recommendations of the Tier 4 Report (*Residential Addiction Services*).
    - Implement referral and assessment for residential services using a shared assessment tool agreed between the HSE and service providers in line with the Drug Rehabilitation Framework.
    - Implement the findings of the evaluation of the *Pharmacy Needle Exchange Programme.*
    - Develop joint protocols for integrated care planning between mental health services and drug and alcohol services.

- Support the Implementation Plan to reduce *Homelessness*, approved by Government in May 2014, with particular attention to health related recommendations.
  - Ensure arrangements are in place so that homeless persons have immediate access to primary care services and that discharge protocols are in place and working effectively, covering discharge from acute hospitals and mental health facilities.
- Implement the prioritised recommendations of the *National Hepatitis C Strategy 2011-2014.*
- Improve health outcomes for ***vulnerable groups*** with particular emphasis on Travellers, Roma, asylum seekers, refugees, homeless service users and women and children experiencing violence.
  - Implement actions aimed at improving Traveller and Roma health, including the roll out of the Asthma Education project and enhancing access to primary health services.
  - Enhance current structures and processes to ensure a comprehensive response to the health and care needs of asylum seekers and refugees with particular reference to people living in the direct provision system and those refugees arriving in Ireland under the Government refugee resettlement programme
  - Implement strategies aimed at addressing gender based violence, including support for the anticipated National Office for the Prevention of Domestic, Sexual and Gender-based Violence (Cosc): *National Strategy on Domestic, Sexual and Gender-based Violence, 2010-2014* and Ireland's *National Action Plan for Implementation of UNSCR (United Nations Security Council Resolution) 1325, 2011-2014.*
  - Strengthen governance and related structures to support the prevention of human trafficking, including the provision of training for staff to ensure appropriate recognition, response and referral.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Opioid Substitution Treatment No. of clients in receipt of opioid substitution treatment (outside prisons)	9,400	Homeless Services % 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	85%
No. of clients in receipt of opioid substitution treatment (prisons)	490		
% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%	Needle Exchange No. of unique individuals attending pharmacy needle exchange	1,200
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	100%	Health (Amendment) Act – Services to persons with state acquired Hepatitis C No. of Hepatitis C patients offered assessment of need	1,440
Traveller Health No. of people who received awareness raising and information on type 2 diabetes and cardiovascular health	20% of the population in each Traveller Health Unit	No. of Hepatitis C patients to be reviewed	820
		Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Primary Care Reimbursement Service (PCRS)

The Primary Care Schemes are the means through which the health system delivers a significant proportion of primary care services. Scheme services are delivered by Primary Care Contractors e.g. General Practitioners, Pharmacists, Dentists, Optometrists and/or Ophthalmologists.

2015 Budget €m	
PCRS	2,485.8

Full details of the 2015 budget are available in Table 5 page 65

Key Priorities with Actions to Deliver in 2015

- Improve the General Medical Services (GMS) Scheme on foot of the report of the *Medical Card Process Review* and the *Report of the Expert Panel on Medical Need for Medical Card Eligibility, 2014* (Keane Report) in consultation with the Minister and the Department of Health.
- Implement strengthened management and accountability within the Primary Care Reimbursement Service (PCRS) in respect of primary and community services.
- Assess eligibility of new applicants for medical cards and GP visit cards and review eligibility of existing cardholders in line with health legislation, policy, regulations and service level arrangements governing administration of the GMS Scheme.
- Implement the first two phases of the introduction of a universal GP service making available a GP service without fees to all children aged under 6 years and to all persons over 70 years. *(Programme for Government €25m for Under 6s and €12m for Over 70s)*
- Process applications for medical cards and GP visit cards within the agreed turnaround time.
- Reimburse primary care contractors in line with health policy, regulations and the service level arrangements governing the administration of the schemes.
- Implement a number of strategic projects to support organisational and divisional priorities, e.g.
  - Examine claims for services from primary care contractors under the Community Schemes to ensure their reasonableness and accuracy.
  - Increase the use of advanced data analysis to support inspection functions.
  - Provide new drugs and medicines in accordance with agreements and legislation.
  - Arrange for reimbursement of newly licensed treatments to specified Hepatitis C patients on the basis of clinical need as defined in the multi-annual public health plan for the pharmaceutical treatment of Hepatitis C.
  - Implement postcodes in the national client index, the Medical Card Scheme and throughout PCRS systems and infrastructure in readiness for the expected launch of post code usage in Quarter 2.
  - Implement drug reference pricing and generic substitution to include reviewing existing drug reference prices on a rolling twelve monthly basis.
  - Support the work of the HSE Medicine Management Programme (MMP) to improve quality and safety and cost effective prescribing behaviours.
  - Integrate exchange of data from the Office of the Revenue Commissioner and from the Department of Social Protection with the Medical Card Scheme.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Medical Cards No. of persons covered by medical cards as at 31st December	1,722,395	% of properly completed medical / GP visit card applications processed within the 15 day turnaround	90%
GP Visit Cards No. of persons covered by GP visit cards as at 31st December	412,588*	% medical card / GP visit card applications, assigned for Medical Officer review, processed within 5 days	90%

** Includes GP visit cards to be issued to the under 6 years of age and over 70 years of age cohort (who are not currently covered)*

Acute Services

Introduction

2015 Budget €m	
Acute Hospitals	3,999.9
NCCP	15.1
TOTAL:	4,015.0

Full details of the 2015 budget are available in Table 5 page 65

The implementation of the Government's decision to reorganise the acute hospital system is a key priority in the reform of acute hospitals. The Hospital Groups will continue to develop and progress the recommendations and associated governance and management arrangements of the report *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts.* There are forty eight acute hospitals that form the seven Hospital Groups that provide the broad range of inpatient, outpatient, emergency and diagnostic services providing acute services for a population of almost 4.6m. The analysis of demographic change shows that Ireland is ageing faster than the rest of Europe. It is this growth in ageing which has the highest impact on demand for services.

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

The National Clinical Programmes are entering a new phase. Based on international evidence and the learning of the successes and the challenges to date together with the challenges that exist for patients and staff, the programmes are being restructured into five Integrated Care Programmes (ICPs). The Acute Hospital Division will support the development and implementation of the ICPs in 2015.

Quality and Patient Safety

Patient safety and quality across all hospital services is at the centre of all decisions and actions taken. The Acute Hospital Division uses a balanced scorecard approach of access, safety, finances and workforce to the measurement of performance of hospitals. It uses a number of performance indicators to look at performance in terms of service delivery and quality.

Quality of service delivery is measured against compliance with specific protocols and pathways:

- Healthcare Associated Infections (HCAI)
- National Early Warning Score (NEWS)
- Medication Safety
- Safe Surgery
- Compliance with the *Standards for Safer Better Healthcare* (HIQA), 2012
- National Adverse Events Management System (NAEMS)
- National Clinical Guidelines and National Clinical Audit

The control and prevention of HCAIs/AMR, with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, will be underpinned by the implementation of HIQA Prevention and Control of Healthcare Associated Infections (PHCAI) standards. The key priority areas of service user involvement and staff engagement will receive particular focus in line with the Quality and Patient Safety Enablement Programme

Access is monitored in respect to Emergency Department (ED), outpatient and inpatient services by way of waiting times for the service. A focus in 2015 will be to adhere to National Treatment Purchase Fund (NTPF) guidelines in relation to scheduling of patients for surgery.

Acute performance indicators will continue to be strengthened with a focus on embedding improved performance against existing measured performance indicators (PIs) and the development of more PIs. In

2015, the Acute Hospitals and the National Ambulance Service will develop a performance indicator in relation to clinical handover of patients in ED that will be based on the National Clinical Effectiveness Committee clinical handover guideline. It is anticipated that this indicator will be reported by year end 2015. Other areas of performance will also be pursued including an indicator on the seven day re-admission to ED with the same clinical condition and in conjunction with the Nursing and Midwifery Division an indicator on pressure ulcer incidence and an indicator on falls prevention.

Acute Hospitals

In 2015 the main priority areas of focus to improve patient outcomes and experience are:

2015 Budget €m	
Acute Hospitals	3,999.9

Full details of the 2015 budget are available in Table 5 page 65

- Progress the appointment of Hospital Group Management Teams and the development of Hospital Group Strategic Plans.
- Roll out the phased implementation of the Activity Based Funding (Money Follows the Patient) model. This covers inpatient and day case work in hospitals.
- Work with the Social Care Division to address the issue of delayed discharges.
- Integrate paediatric services across the three children's hospitals.
- Progress the development of a national model of care for maternity services.
- Progress implementation of the Major Trauma Network Implementation Plan within current resources.
- Progress the priorities of the National Cancer Control Programme.

Summary of Service Delivery

Activity based funding data indicates that complexity of cases is rising. The demographic profile of emergency admissions supports the demographic trend that the very elderly (85 years and over) population is growing by about 4.5% per annum in recent years with the use of hospital bed days by the very elderly (85 years and over) up on average over 6% between 2011 and 2013. The number of delayed discharges in hospitals is expected to increase by 24% by year end in comparison with 2013.

Key Priorities with Actions to Deliver in 2015

Improve patient safety and quality in acute hospitals

- Continue to implement the National Early Warning Score (NEWS) system across all acute hospitals.
- Continue to implement the Irish Maternity Early Warning Score (IMEWS) process.
- Using the *National Standards for Safer Better Healthcare*, ensure hospitals undertake and review output of self-assessments.
- Continue to implement the HSE and HIQA Report into the maternal death in Galway University Hospital 2013.
- Continue to implement the *Report of the Chief Medical Officer into HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006 to date), 2014.*
- Improve influenza vaccine uptake rates amongst staff in frontline acute settings.
- Organ Donation and Transplant Ireland will continue to implement the new national structures to enhance the provision of organ donation and transplantation in Ireland.
- Enable optimum standards in the management of HCAI

Access to services

- Improve access to services in relation to waiting times for scheduled care, and emergency or unscheduled care in public hospitals, including outpatient and diagnostic services.
- Reduce waiting times for scheduled and unscheduled care with priority for those waiting the longest.
- Adhere to the NTPF guidelines in relation to the scheduling of patients for surgery.
- Develop a system wide approach, in conjunction with National Clinical Programmes, to discharge pathways for those patients that require access to long-term care and to primary care services (with the assistance of Community Intervention Teams) in order to reduce the number of delayed discharges in hospitals.
- Ambulance Services access to ED and clinical handover of patients on arrival in ED in line with targets set to ensure that ambulances are available to respond to and adhere to set response times.
- The HSE is committed to publishing waiting lists at consultant and specialty level. A pilot exercise is underway in one of the major teaching hospitals whereby waiting list data is being shared between consultants. The findings from the pilot exercise will be evaluated and inform the requirements for national implementation in early 2015.
- Continue to develop the national cochlear service and to provide bilateral implants for adults and children.

Continue to implement the acute hospital reform programme and enhance service developments

Maternity Services

- Undertake national maternity service improvements including the appointment of additional staffing in line with HIQA Galway Report recommendations, implementation of a national model of care for maternity services and the establishment of a national maternity office in the Acute Hospital Division.
- Undertake a review and evaluation of maternity services nationally.

Hospital Groups

- Fully implement the seven Hospital Group constructs.
- Management Teams for each group in place with responsibility for performance, outcomes, operating within budget and employment limits, with quality and patient safety at the core of business.
- Hospital Groups develop and submit strategic plans by end of 2015 to set out how the Groups will provide high quality, safe, integrated patient care in a cost efficient manner.
- Hospital Groups develop and commence implementation of *Healthy Ireland* implementation plans.
- Finalise implementation of the Smaller Hospitals Framework to ensure that all hospitals irrespective of size work together in an integrated way to meet the needs of patients and staff with an increased focus on small hospitals managing routine or planned care locally and more complex care managed in the larger hub hospitals.

Strengthening financial accountability, HR planning and overall performance

- Commence implementation of hospital budgets based on the activity based funding (Money Follows the Patient) model and block funding for a number of acute hospitals.
- Hospital Groups to review and strengthen budgetary management systems and income collection.
- Address medical and nursing and midwifery recruitment and retention to vacant posts.
- Ensure compliance with European Working Time Directive through skill mix, rostering and reorganisation with a particular focus on further improvement to comply with the 48 hour week.
- Improve performance across the balanced scorecard in acute hospitals through:
  - Encouraging innovation proposals from clinicians which generate new cost saving strategies.
  - Using an applied redesign and improvement methodology that taps into frontline staff and hospital management's local knowledge and commitment to improvement.

The programme will be designed to support the service delivering significant and crucially sustainable change to reduce waiting lists and delays across the total patient journey in the improvement in core process flows consolidating the work of the Special Delivery Unit to date.

Service development

- Implement the review of laboratory services including microbiology reference laboratories.
- Organ Donor and Transplant Ireland will promote improvement in current levels of activity through the new structures, education of staff and public awareness initiatives.
- Further enhance spinal surgery through the provision of degenerative spinal surgery service in Tallaght Hospital to meet service demands; increase in provision of scoliosis surgery for children to meet demand and ensuring emergency trauma theatre availability 24/7 in Mater Misericordiae University Hospital.
- Continue to contribute to the work underway on the development of the new children's hospital with a particular focus on the integration of paediatric services across the three children's hospitals.
- Improve services for paediatric spina bifida in the Children's University Hospital.
- Develop a responsive, structured and organised service for child sexual assault (Acute Forensic Service) for Dublin East and Dublin Mid Leinster regions.
- Address the issue of consultant staff deficits for key services and facilitate service reorganisation by increasing Model 3 and 4 hospital capacity in key clinical services to include Acute Medicine, EDs and Orthopaedics (in conjunction with the Clinical Strategy and Programmes).
- ICT project revenue support for IPMS, RADQA, MedLis, MS-CNS (maternity neonatal electronic record), Electronic Blood Track System, QA Radiology, endoscopy, histopathology.

National Clinical Strategy and Programmes

National Clinical Strategy and Programmes will commence the development of Integrated Care Programmes that are a framework for the management and delivery of health services which ensure that patients and clients receive a continuum of diagnostic, care and support services, according to their needs over time and across different parts of the health system. The ICPs are core to operational delivery and reform with a particular focus on patient flow for the frail elderly.

National clinical models of care will be further implemented to improve quality, optimise patient flow, integrate chronic disease prevention and management and address demographic pressures through development of national clinical programmes:

- Diabetes
  - Provide podiatry services for diabetics presenting with urgent foot problems (Letterkenny, Limerick, Mayo, Navan, Drogheda, Tullamore, Roscommon, Kerry).
  - Implement Phase 2 of the provision of insulin pump therapy to children under five years with type 1 diabetes.
- Renal Dialysis
  - Increase the total number of patients accessing dialysis.
  - Appoint Additional Consultant Nephrologist for Tallaght, Children's University Hospital and Mater University Hospital.
- Acute Medicine Programme
  - Increase opening hours of Acute Medical Assessment Units (AMAUs) to seven days per week in selected hospitals.
- Urgent and Emergency Care
  - Implement an ICP for patient flow and prioritise work streams to enable the health system to see patients in the right place by the right service in a timely manner.

- Transport Medicine Programme
  - Continue implementation of paediatric retrieval on a Monday – Friday daytime basis.
  - Commence adult service on a phased basis in Galway, Cork and Dublin.
  - Implement a national transport medicine education programme.
- National Sepsis Workstream
  - Support hospital groups to create awareness and support the implementation of the national clinical guideline on recognition and management of sepsis.
- Neonatology
  - Target hip ultrasound screening of infants at increased risk of developmental dysplasia of hip (DDH).
- Stroke Clinical Programme (national roll-out of TRASNA)
  - Five hub hospitals to provide telemedicine support to 17 model 2 and 3 hospitals.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015
Activity	
Expected no. of inpatient discharges	643,748
Expected no. of day case discharges	824,317
Emergency Care	
- New ED attendances	1,104,131
- Return ED attendances	84,042
- Other presentations	89,276
Expected no. of emergency admissions	451,157
Elective Inpatient Admissions	99,973
Outpatient Attendances	3,189,749
New: Return Ratio	1:2
Expected no. of births	66,705
Inpatient and Day Case Waiting Times	
% of adults waiting < 8 months for an elective procedure (inpatient)	100%
% of adults waiting < 8 months for an elective procedure (day case)	100%
% of children waiting < 20 weeks for an elective procedure (inpatient)	100%
% of children waiting < 20 weeks for an elective procedure (day case)	100%
Outpatients (OPD)	
% of people waiting < 52 weeks for first access to OPD services	100%
Colonoscopy / Gastrointestinal Service	
% of people waiting < 4 weeks for an urgent colonoscopy	100%
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	100%

Performance Indicator	Expected Activity / Target 2015
ALOS	
Medical patient average length of stay	5.8
Surgical patient average length of stay	5.1
ALOS for all inpatients	5.0
ALOS for all inpatient discharges excluding LOS over 30 days	4.3
Stroke Care	
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	66%
Acute Coronary Syndrome	
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	85%
Surgery	
% of elective surgical inpatients who had principal procedure conducted on day of admission	70%
% day case rate for Elective Laparoscopic Cholecystectomy	> 60%
% of bed day utilisation by acute surgical admissions that do not have a surgical primary procedure	5% reduction
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	To be reported

Performance Indicator	Expected Activity / Target 2015
Emergency Care and Patient Experience Time % 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 % of patients who leave the ED without completing their treatment % of all attendees at ED who are in ED > 24 Hours	95% 100% < 5% 0%
Acute Medical Patient Processing % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	95%
Ambulance Turnaround Times % of ambulances that have a time interval of <30 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available).	New PI 2015
Healthcare Associated Infections Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	< 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%
Adverse Events Postoperative Wound Dehiscence – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015
In Hospital Fractures – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015
Foreign Body Left During Procedure – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015
% of claims received by State Claims Agency that should have been reported previously as an incident	New PI 2015
Activity Based Funding (MFTP) Model HIPE Completeness – Prior month: % of cases entered into HIPE	> 95%

Performance Indicator	Expected Activity / Target 2015
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 Safety % of medication errors reported (as measured through the State Claims Agency)	New PI 2015
Patient Experience % of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	100%
Delayed Discharges % reduction in bed days lost through delayed discharges	10% reduction
% reduction of people subject to delayed discharges	15% reduction
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	100%
% of all clinical staff who have been trained in the COMPASS programme	> 95%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	100%
% of hospitals with implementation of IMEWS for pregnant patients	100%
National Standards % of hospitals who have commenced first assessment against the NSSBH	95%
% of hospitals who have completed first assessment against the NSSBH	95%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

National Cancer Control Programme

2015 Budget €m	
NCCP	15.1

Full details of the 2015 budget are available in Table 5 page 65

Since its establishment in 2007, the National Cancer Control Programme (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. Accountability for service delivery and expenditure has continued to rest with the designated cancer centres. The NCCP will continue to implement the strategy for cancer control in Ireland and to plan, support and monitor the delivery of cancer services nationally.

Key Priorities with Actions to Deliver in 2015

- Continue the implementation of the National Medical and Haemato-Oncology Programmes.
- Progress multidisciplinary HR planning, development of evidence based national guidelines, treatment protocols, quality and safety policies for safe drug delivery, technology review processes for oncology drugs and the introduction of a nationally funded oncology drug and molecular tests budget.
- Enhance Medical Oncology services.
  - Recruit additional consultant medical oncologists and specialist nursing staff to address the growing volume of new patients and increased treatment options available for patients presenting with cancer.
- Enhance Surgical Oncology services.
  - Centralise oncology surgical services to the eight designated Cancer Centres to maintain continued improvements in diagnosis, surgery and multi-disciplinary care.
  - Recruit additional consultant urologist in South / South West Hospitals Group.
- Expand Radiation Oncology services (radiotherapy resources to accommodate demand).
  - Commission additional linear accelerator capacity in St. Luke's Hospital and progress expansion plans for longer term capacity in the Eastern Region.
  - Recruit paediatric radiation oncologist for St. Luke's Radiation Oncology Network and Our Lady's Children's Hospital, Crumlin.
- Develop Community Oncology services.
  - Support and deliver cancer education and training programmes in the community.
  - Pilot and implement a Survivorship Patient Treatment Summary and Long-Term Care Plan.
- Progress Quality initiatives.
  - Complete the development and implementation of an audit plan of national guidelines for breast, lung, prostate, colorectal, hepatobilary and gynaecology cancers.
- Enhance Hereditary Cancer services.
  - Establish a national hereditary cancer service and support access to identification of genetic risk and surveillance in well population at risk.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Symptomatic Breast Cancer Services No. of patients triaged as urgent presenting to Symptomatic Breast Clinics	16,000	Prostate Cancers No. of patients attending the rapid access clinic in the cancer centres	2,500
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals	95%	% of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	90%
Clinic cancer detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer	> 6%	Clinic cancer detection rate: % of new attendances to clinic that have a subsequent diagnosis of prostate cancer	> 30%
Lung Cancers No. of patients attending the rapid access clinic in designated cancer centres	3,000	Radiotherapy No. 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)	4,700
% of patients attending lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	95%	% 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%
Clinic cancer detection rate:% of new attendances to clinic that have a subsequent diagnosis of lung cancer	> 25%	Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

National Ambulance Service

Introduction

2015 Budget €m	
NAS	144.0

Full details of the 2015 budget are available in Table 5 page 65

The National Ambulance Service (NAS) is the statutory pre-hospital emergency care provider for the State. The service delivers pre-hospital care right across the country. In the Dublin metropolitan area, Ambulance Services which are funded by the HSE are provided by both the NAS and Dublin Fire Brigade.

The NAS mission is to serve the needs of patients and the public as part of an integrated health system, through the provision of high quality, safe and patient centred services. This care begins immediately at the time that the emergency call is received, continues through to the safe treatment, transportation and handover of the patient to the clinical team at the receiving hospital or emergency department.

Serving a population of almost 4.6 million people, the service responds to over 300,000 ambulance calls each year. The NAS employs over 1,600 staff across 100 locations and has a fleet of approximately 500 vehicles.

In recent years, the NAS has embarked on a strategic investment programme to develop a modern, quality service that is safe, responsive and fit for purpose. The service is implementing a significant reform agenda which mirrors many of the strategic changes underway in ambulance services internationally as they strive for high performance, efficiency and cope with a continuously increasing demand on services.

Priorities in 2015 include the completion of the major National Control Centre Project, the elimination of on call in the West, the procurement of an electronic patient care record system and service costs associated with mechanical cardiopulmonary resuscitation (CPR) and defibrillator devices. As well as infrastructural developments, the NAS will ensure that clinical and managerial professionalism and excellence is enhanced and embedded in the service.

Major reviews of the service were undertaken or commissioned during 2014. Three of these reports remain to be completed in 2015. The outputs of these important reviews, namely: HIQA Report (2014), the National Ambulance Service Capacity Review (2014), the Provision of Emergency Ambulance Service in Dublin City and County (2015), Management Structural Review (2015), and Fleet Management (2015) will inform the strategic planning process which will shape the development of ambulance services in the coming years. The development of a modern, fit-for-purpose and sustainable ambulance service will necessitate consideration of alternative service models and approaches to the delivery of pre-hospital care (for example, it may prove not to be necessary to transport all patients to an emergency department or an acute hospital and the skills and expertise of highly trained ambulance staff may be used differently).

Quality and Patient Safety

Quality of service and patient safety are core service principles and the *National Standards for Safer Better Healthcare* provides the focus for improving quality services and ensuring patient safety.

Staff across all levels and disciplines aim to be professional, accountable and progressive. The NAS will continuously monitor a range of activities, performance indicators and clinical outcomes, and will remain open to learning and change in the light of performance outcomes. The introduction of an electronic patient record to support more effective clinical audit has been prioritised for 2015.

The service and other stakeholders such as acute hospitals will work together on the implementation of clinical handover protocols and the monitoring of performance indicators related to the ambulance turnaround framework.

The NAS has invested in a single national control and command system with the most up to date technology enabling an efficient national service and effective deployment of all resources. These systems are due to go live in 2015. This infrastructural development will be accompanied by changes in processes to move the service to best practice.

Key Priorities with Actions to Deliver in 2015

The recommendations contained within the major reviews, yet unpublished: HIQA Report (2014), the National Ambulance Service Capacity Review (2014), the Review of the provision of emergency ambulance service in Dublin City and County (2015), the Review of NAS Management Structures (2015) and Fleet Management (2015) will be dealt with by the NAS in a holistic and coherent way and will guide and inform future service improvements.

Finalise the Control Centre Reconfiguration Project.

- Migrate Townsend Street Control Centre and complete the establishment of a modern Single National Control Centre across two sites (Tallaght and Ballyshannon) in line with international best practice.
- Implement a single Computer Aided Dispatch (CAD) system transforming the way in which the ambulance service is operated and emergency vehicles are deployed.

Drive clinical excellence.

- Commence a procurement process to deliver an electronic patient care record solution to improve patient care record keeping and facilitate clinical audit.
- Expand the clinical audit programme.
- Eliminate on call in the West.
- Staff additional ambulance stations in the West.
- Continue to support the National Transport Medicine Programme.

Foster a culture of strong performance management.

- Research and develop a National Performance and Quality Dashboard.
- Complete a Performance Improvement Framework.
- Ensure, in 2015, that a uniform level of appropriate oversight is in place by seeking to implement changes in governance structures with the Dublin Fire Brigade.
- Consider alternate service models as a means of improving performance.

Deploy the most appropriate clinical resources safely, quickly and efficiently.

- Continue the expansion of the Community First Responder schemes.
- Formalise an engagement process with the hospital groups to ensure alignment of ambulance services resulting from a reconfiguration of acute hospital services.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015		Performance Indicator	Expected Activity / Target 2015
Intermediate Care Services % of all transfers which were provided through the Intermediate Care Vehicle (ICV) service (Volume 3,100 represents 70% of total transfers by ICV and Emergency Ambulances)	≥ 70%		% of Clinical Status 1 DELTA (life threatening illness or injury other than cardiac or respiratory arrest) incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	80%

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Clinical Outcome Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using the Utstein comparator group calculation *(Q in arrears)*	40%	Audit % of control centres that carry out Advanced Quality Assurance Audit (AQuA) Audit	100%
Emergency Response Times* % of Clinical Status 1 ECHO (life threatening cardiac or respiratory arrest) incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	80%	Ambulance Turnaround From Acute Hospitals** % delay escalated where ambulance crews were not cleared nationally in 60 minutes (from ambulance arrival time through clinical handover in ED or specialist unit to when the ambulance crew declares readiness of the ambulance to accept another call) in line with the process / flow path in the ambulance turnaround framework	100%
		Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

** The NAS has invested in personnel, systems and infrastructure to deliver improved response times over a number of years. The NAS will review response time targets in the light of the findings of the Capacity Report commissioned by the HSE in 2014.*

*** The acute hospitals PIs include a 'turnaround time' metric for ambulances. Both the acute hospital division and National Ambulance Service have a mutual interest in ensuring full compliance with this PI.*

Palliative Care Services

Introduction

Palliative care is an approach that improves the quality of life of patients, and their families, facing the challenges associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment and management of pain and other physical, psychosocial and spiritual problems. In recent years, the scope of palliative care has broadened and includes not only cancer related diseases but supporting people through non-malignant and chronic illness also.

2015 Budget €m	
Palliative Care	71.9

Full details of the 2015 budget are available in Table 5 page 65

The HSE will continue to work towards the implementation of the recommendations contained in national policy and strategic documents. In 2015 engagement will continue with the voluntary providers and the Irish Hospice Foundation to address the gaps identified in service provision.

The Integrated Care Programmes (ICPs) are core to operational delivery and reform. Palliative Care recognises the potential for the ICPs to improve integration of services, access and outcomes, and commits to actively supporting the development and implementation of the priority workstreams of the five ICPs in 2015.

The vision for the future is that palliative care will be a gradual and natural increasing component of care from diagnosis to death. The goal is to 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.

Quality and Patient Safety

The areas of focus for quality and patient safety will be:

Adult Services

- Model of Care for Specialist Palliative Services
- Palliative care support beds
- Quality assurance and improvement process
- Staff competence
- Medication management
- Healthcare Associated Infections (HCAI)
- National Patient Charter
- Measurement of patient experience
- Serious Reportable Events (SREs)

Children's Services

- Standardised documentation for the appropriate transfer of children.
- Implement the Parent Held Record 'Our Story'.
- Staff Education
- Serious Reportable Events (SREs)

Key Priorities with Actions to Deliver in 2015

Ensure effective and timely access for adult palliative care.

- Meet the identified deficit in palliative care beds in West and North Dublin.
- Meet the deficit in national policy recommendations in palliative medicine in the Midlands through the provision of a Consultant post.
- Ensure patients with non-malignant conditions have equal access to services.

- Provide a pain intervention clinic in Marymount Hospice, Cork for palliative patients with complex or severe pain.

Ensure integrated palliative care structures are in place.

- Establish a national network for specialist palliative care providers.
- Progress the integration of children's palliative care within the development of the new children's hospital.
- Establish effective linkages with developing Hospital Groups.

Ensure quality improvement in palliative care services.

- Adult palliative care services:
  - Ensure compliance with HIQA recommendations on management of HCAI.
  - Ensure local robust management systems are in place to address medication errors.
  - Implement the model of care for specialist palliative care.
  - Implement the recommendations from the first *National Palliative Care Support Beds Review*.
  - Implement the Palliative Care Competence Framework.
  - Establish the Quality and Patient Safety Collaborative Committee and implement the *Quality Assurance and Improvement Workbooks for Specialist Palliative Care (National Standards for Better Safer Healthcare).*
  - Develop a national Patient Charter for specialist palliative care.
  - Identify a suite of performance indicator outcome measures with an associated monitoring system.
  - Continue to work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme and in implementing *Palliative Care for All*.
  - Ensure timely reporting of SREs with subsequent analysis and investigation.
- Children's palliative care services
  - Maintain service provided by Children's Outreach Nurses.
  - Work with National Ambulance Services to implement agreed standardised documentation on the transfer of children.
  - Implement the Parent Held Record 'Our Story'.
  - Provide an education programme that will support staff to meet the needs of children with life-limiting conditions and their families.
  - Ensure timely reporting of SREs with subsequent analysis and investigation.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Inpatient Units - Waiting Times Specialist palliative care inpatient bed provided within 7 days	98%	**Day Care** No. of patients in receipt of specialist palliative day care services per month	349
Community Home Care - Waiting Times i). No. of patients in receipt of specialist palliative care in the community	3,248	**Paediatric Services** Total number of children in the care of the Children's Outreach Nursing service	320
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)	95%	**Serious Reportable Events** % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Note: New indicators will be developed in 2015 on care planning, measurement of patient outcomes and medication management

Mental Health Services

Introduction

The vision for mental health services is to support the population to achieve their optimal mental health through the following key priorities:

2015 Budget €m	
Mental Health	756.8
Additional funding held by DOH	35.0

Full details of the 2015 budget are available in Table 5 page 65

- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.
- Design integrated, evidence based and recovery focused Mental Health Services.
- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.
- Promote the mental health of the population in collaboration with other services and agencies including reducing loss of life by suicide.
- Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

The modern mental health service, integrated with other areas of the wider health service, extends from promoting positive mental health and suicide prevention through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness.

The *Report of the Expert Group on Mental Health Policy - A Vision for Change* (2006) is a progressive, evidence based document which proposed a new model of service delivery which would be patient-centred, flexible and community based. *A Vision for Change* remains the current roadmap, charting the way forward for the mental health service. Work will be undertaken during 2015 to prioritise outstanding actions within this final year of the 10 year policy document informing the identification of any gaps in service. At approximately 9,000 WTEs, mental health staffing levels are at circa 75% of what is recommended by the official policy *Vision for Change* i.e. 12,240 WTE (this is the *Vision for Change* number of 10,657 adjusted for population growth).

The net opening budget allocation for 2015 of €756.8m, along with the additional Programme for Government funding of €35m, represents an increase of €37.6m or 5% compared to the equivalent net closing budget figure in 2014. The provision in Budgets 2012 to 2015 of ring-fenced investment of €125m continues to develop and modernise mental health services in line with the recommendations of *A Vision for Change*. *Programme for Government funding of €35m in 2015* will be directed towards the continued prioritised development and reconfiguration of general adult teams, including psychiatry of later life, and also child and adolescent community mental health services. This will be delivered through further recruitment and investment in agencies and services in order to achieve a consistent service provision across all areas. In addition, the funding will also permit urgent specialist needs to be addressed, including forensic mental health, services for those with mental illness and an intellectual disability, psychiatric liaison services as well as addressing the current service gap for low secure acute care and rehabilitation services for service users with complex needs. The Clinical and Integrated Care Programmes (ICPs) are core to operational delivery and reform. Mental health recognises the potential for these programmes to improve integration of services, access and outcomes and commits to actively supporting the development and implementation of the priority work streams of the programmes in 2015.

Quality and Service User Safety

In 2015, the focus of the Quality and Service User Safety function is to support the Division in providing high quality and safe services for service users and staff. Robust clinical governance arrangements incorporating effective systems and processes to enable quality and risk management are key requirements. Building on the

establishment of the Mental Health Division National Incident Support and Learning Team, other related actions include further capacity building to ensure a standardised response to serious incidents, targeted interventions and practical strategies to help reduce loss of life by suicide, and supporting staff training in management of violence and aggression. This commitment to the development and measuring of quality services will also be delivered through a range of service improvement initiatives, increasing participation by service users and carers, and the further development and enhancement of specialist services and quality indicators. Performance indicators relating to quality and service user safety will be examined and developed during 2015 as part of the development of the mental health quality profile. These will cover reporting and management of serious incidents including serious reportable incident compliance, care planning audits etc. The division will also work with the national HCAI group towards the development of suitable mental health indicators and driving the use of appropriate antimicrobials.

Key Priorities with Actions to Deliver in 2015

Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.

- Build capacity of service users, families and carers to influence the design and delivery of mental health services by identification and delivery of the required training interventions.
- Develop mechanisms for the participation of service users, families and carers in the decision making processes of mental health services at local and national levels by full establishment of the Office of Service User Engagement as an integral component of the Mental Health Division and the appointment of a service user member on each area mental health management team.

Design integrated, evidence based and recovery focused mental health services.

- Identify and prioritise models of care, including required Standard Operating Procedures, arising from the agreed Integrated Care Pathways developed at the end of 2014.
- Establish the three existing Clinical Programmes through appointment of clinical leads and implementation of an agreed monitoring framework.
- Design and establish two additional Clinical Programmes informed by emerging models of care.
- Develop initiatives across health and wellbeing services, primary care services and the Irish College of General Practitioners (ICGP) to address the physical health needs of those with severe and enduring mental illness.
- Develop more secure therapeutic environments for those who meet the criteria for section 21.2 of the *Mental Health Act.*
- Improve responses to service users with complex needs currently managed through external placements.
- Develop and agree processes for integrated working within the mental health service sub-specialities, and with the other Divisions and Tusla.
- Implement, in partnership with Genio, a project to improve integration in four Areas between community mental health teams and supported employment services at local level in order to support identified individuals with severe mental health difficulties to return to paid employment.

Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.

- Fully implement a comprehensive incident management system which is capable of sharing organisational learning.
- Agree and implement guidelines for the management of aggression and violence in the mental health services and linked to performance assurance.
- Complete the reconfiguration of General Adult Community Mental Health Teams (CMHTs) to circa 50,000 population (range 45,000 and 60,000) aligned to Primary Care Networks and co-terminus with the Community Healthcare Organisation structure.

- Assign team co-ordinator responsibilities effectively within each CMHT commencing with General Adult teams, providing the required training.
- Improve performance of Child and Adolescent Mental Health Services (CAMHs), guided by the current CAMHs service improvement project.
- Implement detailed reporting and monitoring processes in relation to performance against targets set for the elimination of admissions of Under 16s and the reductions in numbers of admissions of 17 year olds to Adult Units, informing the required response to governance and capacity of services.
- Provide additional 12 bed capacity for response to eating disorders and other secondary care acute needs in CAMHs.
- Develop a seed CAMHs community based forensic mental health team.
- Continue JIGSAW services nationally within available resources.
- Review and improve access to psychotherapy and psychotherapeutic interventions in conjunction with the Primary Care Division.
- Further implement, following evaluation, the Advancing Recovery in Ireland Project.
- Continue to build on the investment in community based mental health services in MHID (Mental Health in Intellectual Disabilities) and services for the homeless mentally ill.
- Build on the investment in mental health services for General Adult, CAMHs, Psychiatry of Old Age, Liaison, and Rehabilitation and Recovery including appropriate capacity for 24/7 contact and response.

Promote the mental health of the population in collaboration with other services and agencies including reducing loss of life by suicide.

- Develop integrated health promotion teams and programmes based on existing resources at area level in collaboration with Health and Wellbeing and voluntary partners in the context of *Healthy Ireland*.
- Implement Tobacco Free Campus Policy in all mental health approved centres and implement in 25% of community residences.
- Progress mental health actions in partnership with social inclusion arising from the *All Ireland Traveller Health Study* and the *Substance Misuse Strategy*.
- Progress the 'Little Things' mental health promotion media campaign.
- Implement new Strategic Framework for Suicide Prevention recommendations specific to mental health services including introduction of practical strategies aimed at reducing loss of life by suicide among service users and mental health promotion initiatives.

Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

- Devise a funded Workforce Plan and Workforce Development Strategy to ensure an adequate level of trained and skilled staff.
- Develop and implement a process to maximise the allocation of resources on an equitable basis aligned to population and deprivation.
- Address the infrastructure and support deficits for staff to work effectively within their professions.
- Progress the development of systems and infrastructure to support service delivery, performance management and decision making:
  - Address core ICT infrastructure deficits.
  - Develop a phased implementation plan for the national roll out of the Interim National Data Solution Project and implement the national roll out.
  - Implement year two of the e-rostering system for Mental Health.
  - Progress the multi-annual National Mental Health Information System Project.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Adult Mental Health Services % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Teams	> 90%	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.	95%
% 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 within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	> 78%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	> 99%	% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	> 72%
% 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%	Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Social Care Services

Introduction

Social care services are focused on:

- Enabling people with disabilities to achieve their full potential including living as independently as possible, while ensuring that people are heard and involved in all stages of the process to plan and improve services.
- Maximising the potential of older people, their families and local communities to maintain people in their own homes and communities, within existing resources.

2015 Budget €m	
Disability Services	1,459.3
Services for Older People	655.1
NHSS (948.8 gross)	873.9
TOTAL:	2,988.3

Full details of the 2015 budget are available in Table 5 page 65

Social care services support the ongoing service requirements of older people and people with disabilities, with the design and implementation of models of care and services across both of 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 should 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. The over-65 population is growing by approximately 20,000 each year, while the over-85 years population, which places the largest pressure on services is growing by some 4% annually. A greater move towards primary and community services, as the principal means to meet people's home support and continuing care needs is required to address this growing demand and support acute hospital services.

People with disabilities should have access to the supports they require to achieve optimal independence and control of their lives and to pursue activities and living arrangements of their choice. It is estimated that 4% of children have a disability, with adults having a higher prevalence level. As the overall population grows, so does demand for services, particularly in the 0-18 age group. At present 44% of individuals with an Intellectual disability are aged over 35 years placing greater demand on services to meet the changing needs of these people.

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. The design and implementation of these models of care and services, along with how these services are funded, is part of an overall Social Care strategic reform and change agenda which commenced in 2014 and will be further advanced in 2015. This change agenda is supported by a strong performance monitoring and management process, and building on the momentum that has developed in 2014, the rate of change in 2015 will be accelerated in a number of the key priority areas. A Social Care Operating Model within the Community Healthcare Organisations (CHOs) framework is being developed to support the implementation of the change agenda.

Quality and Patient Safety

Social care services are focused on delivering services and supports for older people and people with disabilities in a manner that ensures that the quality and safety of those services is a fundamental priority. Within the overall regulatory framework through HIQA, appropriate governance arrangements and assurance processes for quality and safety are being developed in conjunction with the Quality Improvement Division. This will assist in ensuring that there is clear oversight of service providers and wider system in relation to the quality and safety of services provided and will facilitate the implementation of improvements.

To support effective governance there will be an emphasis on the gathering and analysis of quality and safety information to provide assurance or identify areas where programmes of improvement are required; these will be developed in conjunction with the Quality Improvement Division. This approach will take account of the findings of regulatory inspections and internal systems and promote the achievement of high performance and compliance with regulatory standards in both older persons and disability services. In 2015, the *Vulnerable Adults Policy*, focused on providing appropriate guidance for supporting vulnerable adults, will be introduced on a phased basis.

The suite of KPIs for quality and patient safety will continue to be developed and strengthened over 2015 to include specific measurable KPIs that clearly demonstrate progress in achieving better outcomes and against which progress can be measured on a monthly basis. Particular attention will be paid to the areas of nutrition and hydration, falls prevention, medication management and the use of antibiotics in long stay residential facilities as well as broader issues in terms of response and use of complaints, management of serious reportable events etc.

Disability Services

2015 Budget €m	
Disability Services	1,459.3

Full details of the 2015 budget are available in Table 5 page 65

In 2015, the focus will be on supporting people with disabilities in line with the vision outlined in the *Value for Money and Policy Review of Disability Services* in Ireland '*to contribute to the realisation of a society where people with disabilities are supported, as far as possible, to participate to their full potential in economic and social life, and have access to a range of quality personal social supports and services to enhance their quality of life and well-being'.* This vision sets the scene for a fundamental change in the way services to people with a disability are currently provided. The new models of service delivery will ensure that individual's strengths and personal goals and ambitions will inform the development of their care plans and that individual's will be enabled to live their lives as full citizens within their community. The sector will work closely with local communities and social networks to develop the natural supports necessary to enable people with disabilities to fully participate in a meaningful way within their own communities. It is acknowledged that this will take time to fully implement, however the pace of change is increasing and this will be reflected in the 2015 Social Care Division Operational Plan. To give effect to these new models of care and the transition to them, associated sustainable funding models are being developed, and will include unit costing, zero budgeting and a proportion of payment based on performance against agreed targets.

2015 will see progress continued to be made on the implementation of the recommendations of the *Value for Money and Policy Review of the Disability Services Programme,* these changes centre on: person-centred model of services and supports, strategic planning, implementation, oversight and support, people with disabilities and community involvement, quality and standards, management and information systems and governance and service arrangements. To support the reform programme an expanded range of activity measures will be included in the Operational Plan.

Key Priorities with Actions to Deliver in 2015

New Directions – reconfiguring day services including school leavers and rehabilitative training

- Expand the implementation of New Directions which will embed an approach of individualised supports for all current users of HSE funded adult day services.
- Provide additional day services to benefit approximately 1,400 young people who are due to leave school and Rehabilitative Training Programmes in 2015. Ensure that this service responds in line with the principles of New Directions. *(€12m full year cost and 100WTEs with €6m in 2015)*

Progressing Disability Services for Children and Young People (0-18s) Programme

- Complete the roll out of the Local Implementation Group process, with further service enhancement driving implementation of the programme, through new staff appointments to reconfigured multidisciplinary geographic –based teams and through using innovative approaches, involving public, voluntary and private providers, to achieve targeted reductions of waiting lists for therapies. *(€6m full year cost and 120WTEs with €4m in 2015)*

Congregated Settings

- Work towards the transition of up to 150 people to homes in the community in line with *Time to Move on from Congregated Settings*

Emergency Places

- Planning of service provision in respect of emergency places and changing needs will be enhanced.

Value for Money and Policy Review of Disability Services in Ireland - Implementation Framework Priorities

- *Person-centred Model of Services and Supports*
  - *Strategic Planning:* Establish process to identify and assess the health and social needs of people with disability over the next 5-10 years and determine the capacity of existing and reconfigured services to respond to these needs. The process will evaluate demonstration projects, service models and evaluate and report on good practice which will give effect to the implementation of the future model of person centred care on a sustainable basis.
  - *Implementation, Oversight and Support:* Oversee the national implementation of *Time to Move on from Congregated Settings, New Directions and Progressing Disability Services for Children and Young People (0-18s). Provide* support and guidance to the delivery system with the associated significant change management requirements
- *People with Disabilities and Community Involvement:* Build on existing national and local consultative processes to develop a Participation Framework which meets the changing needs of service users and has the intent of enabling persons with disabilities, carers, families and the wider community to have a meaningful role and voice in service design and delivery.
- *Quality and Standards:* Enhance the quality and safety of services for people with a disability and improve their service experience by putting in place a Quality Framework and Outcomes Measurement Framework.
- *Management and Information Systems:* Determine business and information requirements to be enabled by IT systems, including the development of a web based system which will act as a single point of information and advice on disability services for service users, their families and the community. The process will also develop proposals on the use of performance indicators.
- *Governance and Service Arrangements:* Support maximisation of efficiencies and further development of enhanced governance and accountability throughout disability services, using service arrangements to embed implementation of the change programme linked to funding provided.

Service Improvements Teams (SIT) Process

- Build national capability to support evidence based decision making linking funding provided to activity and outputs, cost, quality and outcomes.
- Work with providers to ensure that resources are used to the best effect within services and that sustainable models of services are implemented to meet the changing and emerging needs of people with a disability in line with the VFM and policy review.

Efficiency Measures

- The social care division will implement efficiency measures in 2015, focused on :

- Pay costs – integrated managed reductions in cost and whole time equivalents associated with direct, agency and overtime
- Non Pay costs – through delivering procurement savings and reductions in back office overhead and other efficiency measures.

Healthy Ireland

- Work with providers to ensure that models of care and service delivery incorporates the strategic priorities set out in *Healthy Ireland*.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
0-18s Programme Proportion of Local Implementation Groups which have local implementation plans for progressing disability services for children and young people	100% (24 of 24)	Quality In respect of agencies in receipt of €3m or more of public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL, CARF or PQASSO.	100%
Disability Act % of assessments completed within the timelines as provided for in the regulations	100%	Respite Services* No. of overnights (with or without day respite) accessed by people with a disability	190,000
Personal Assistant (PA) 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	150
Home Support Hours No. of Home Support hours delivered to people with a disability	2.6m	Day Services % of school leavers and RT graduates who have received a placement which meets their needs	100%
		Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

** The 2015 Social Care Operational Plan will include an expanded range of KPIs which include non-overnight respite and no. of people in receipt of more than 30 overnights continuous respite. It is anticipated that there will be a reduction in overnight respite as services more in line with person centred models are delivered. Data validation will be carried out as transition is made to the new KPIs.*

Services for Older People

During 2015, services for older people will continue to provide a flexible and responsive range of services for clients whilst meeting the challenge of the ongoing needs of an increasing ageing population. The over-65 years population is growing by approximately 20,000 each year, while the over-85 years population, which places the largest pressure on services is growing by some 4% annually. A greater move towards primary and community services, as the principal means to meet people's home support and continuing care needs is required to address this growing demand and support acute hospital services.

2015 Budget €m	
Services for Older People	655.1
NHSS (948.8 gross)	873.9
TOTAL:	1,529.0

Full details of the 2015 budget are available in Table 5 page 65

To respond to this challenge services for older people will continue to progress the strategic realignment of services to provide home care and other community support services in

order to maximise the potential of older people in their own homes close to their families and within their own local communities. In addition to supporting clients in their own homes, services will continue to be provided in order to avoid hospital admission and support early discharge through step-down, transitional care and rehabilitation beds while maximising access to appropriate quality long-term residential care when it becomes necessary. This requires an integrated and innovative approach to the model of care with shared responsibility across Divisions, a multiplicity of professionals, agencies and society as a whole using a model based on the principles of 'Money Follows the Patient'.

Nursing Home Support Scheme (A Fair Deal) – NHSS

2014	€m	2015	€m
Gross budget	938.8	Gross budget*	948.8
Income	74.9	Income	74.9
Net	863.9**	Net	873.9
		*Includes additional funding 2015	10.0

To assist with comparison between the 2014 and 2015 figures, the Gross budget for NHSS in 2014 and 2015 is as follows:

- *2014 - €938.8m (see National Service Plan 2014, page 19, table 8)*
- *2015 - €948.8m – this is €10m higher than the comparable figure in 2014*

*The effective Net budget for 2014 is €836.9m which is made up of the 2014 Gross budget of €938.8m less the 2014 income target of €74.9m (€938.8 - €74.9 = €863.9). **This net budget is after adjusting for the excess asset disregard target of €7m.*

The Net budget for 2015 is €873.9m which is made up of the 2015 Gross budget of €948.8m less the 2015 income target of €74.9m (€948.8 - €74.9 = €873.9m) – this is €10m higher than the comparable figure in 2014.

It is expected that approximately 300 extra long term care places can be purchased in 2015 compared to 2014 based on this additional €10m which has been provided as part of the €25m in respect of delayed discharges within the programme for government funding for 2015.

Key Priorities with Actions to Deliver in 2015

Nursing Homes Support Scheme – A Fair Deal (NHSS)

- Provide quality long-term residential care services for older people who require it through the NHSS.
- Support 22,361 older people under the NHSS, 300 additional places supported for a full year in 2015. (*Programme for Government – Delayed Discharge Funding* €10m)

Public Residential Care Services

- Continue to implement Action Plan to provide the required modern facilities across Public Residential Care Service

Home Care and Community Support Services, including Intermediate and Rehabilitation Services

- Ensure Model of Service provision becomes less reliant on residential care.
- Provide comprehensive home care and community support services, including home care packages to an additional 600 older people, to enable them to live independently, in their own homes, for as long as possible. *(Programme for Government – Delayed Discharge Funding €5m)*
- Implement the recommendations arising from the review of home care which will be finalised in Q1 2015.
- Establish a service improvement programme to define and implement a standardised process in the delivery of home help and HCPs.

- Conclude tender process for the contracting of HCPs to support the implementation of the service delivery model including pilot initiatives in relation to intensive HCPs.
- Provide an additional 115 short stay beds, (including the opening of Mount Carmel, with 65 beds on a phased basis from March 2015) to support older people in the most appropriate care setting in order to avoid admission to acute hospitals, support early discharge from acute hospitals, reduce delayed discharges and, where appropriate, provide rehabilitation services to support the older person in returning to their home. *(Programme for Government – Delayed Discharge Funding €8m)*

Delayed Discharges and Related Issues

- Work with hospitals, primary care and clinical programmes to implement a joint approach to the management of Delayed Discharges in acute hospitals for those patients that require access to long-term care and to primary care services, funded on a named patient basis.

Dementia Strategy

- Work in collaboration with DoH and Atlantic Philanthropies in the roll out of the dementia strategy and co-ordinate the implementation plan with Priory Care, Health and Wellbeing and the support of Genio.

National Positive Ageing Strategy

- Work with Health and Wellbeing Division and the DoH in implementing the *National Positive Ageing Strategy*.

Integrated Care Programme for Older People

- Develop a single Integrated Model of Care for Older People across hospital and community services. This cross divisional programme will be led collaboratively by the Social Care Division and Clinical Strategy and Programmes, supported by the System Reform Group. The model is defining appropriate care pathways both from a clinical and social perspective to support older people to live in their own homes and communities.

Service Improvement Teams (SIT) Process

- Work across residential and home care services providing guidance and support to the delivery system in relation to the provision of such services in a safe and equitable manner as economically as possible.

Service User Engagement

- Increase 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.

Single Assessment Tool (SAT)

- New entries to the NHSS, HCPs and home help schemes assessed by the SAT in targeted areas by end of 2015.

Funding Model for Public, Short Stay and Intermediate Care

- Implement a funding and commissioning type payment model for ‘short stay beds’ based on the ‘Money Follows the Patient’ approach already applied to the NHSS.

Healthy Ireland

- Work with service providers to ensure that models of care and service delivery incorporates the strategic priorities set out in *Healthy Ireland*.

Indicators of Quality Performance

Performance Indicator	Expected Activity / Target 2015	Performance Indicator	Expected Activity / Target 2015
Home Care Packages Total no. of persons in receipt of a HCP	13,800	Nursing Homes Support Scheme (NHSS) No. of persons funded under NHSS in long-term residential care during the reporting month	22,361
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	5,287
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	90%
Immunisations and Vaccines % uptake of flu vaccine for > 65s	75%	Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	See targets on page 69

Supporting Service Delivery

Health Business Services (HBS)

The development of a shared services organisation to support the emerging health environment is a key component of the current Health Reform Programme. It is also reflective of Government policy in the wider public services. In February 2014, the *Health Business Services Strategy* was approved by the HSE Directorate and HBS was established as the shared services division of the HSE. Since then the focus has shifted from strategy formulation to implementation.

2015 Budget €m	
HBS	134.2

Full details of the 2015 budget are available in Table 5 page 65

The HBS Strategy reflects the ambition of the Health Reform Programme to ensure that in line with modern business practices, the operational health and social services including those in Tusla have access to a range of common support business services on a shared basis. This allows 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.

The HBS strategy has 43 actions which will be implemented over a three year timeframe. 2015 will be the first full year of HBS but much progress was made during 2014 on a range of actions. A number of development posts will be recruited to support delivery of 2015 key priorities and actions.

A key development in 2015 will be the transition of ICT to the Office of the Chief Information Officer, who upon appointment in December 2014, will assume full delegated authority for the entire ICT function and its resources.

Key Priorities with Actions to Deliver in 2015

2015 will prioritise the implementation of the next actions in the HBS Strategy implementation plan. This will include focusing on people, portfolios, individual programmes and business cases to ensure that holistic and balanced implementation takes place. The establishment of the customer relationship management (CRM) function with business relationship managers is a critical component for the successful implementation of the HBS business model.

- Continue the development of a service culture, focusing on organisation and client needs, through the recruitment of Business Relationship Managers and the further development of a customer relationship function including service catalogues and Business Partnership Agreements with customers.
- Plan for and implement critical enabling technologies to support common business platforms for HBS. This includes a single finance system, payroll, electronic invoice capture, recruitment, procurement and pensions systems.
- Continue to contribute and actively support the Finance Reform Programme.
- Complete the implementation of the recommendations of the review of recruitment services and increase the capacity of the National Recruitment Service.
- Recruit additional staff to assist in the implementation of the recommendations of the soon to be completed review of pensions services.
- Commence implementation of the HR Enterprise Resource Planning (ERP) system in the South and complete implementation in Tallaght Hospital.
- Complete the reform of the procurement function with the implementation of the vision contained in the HSE's procurement model *One Voice for Procurement* including the transfer of some functions to the

Office for Government Procurement (OGP), the transfer of procurement personnel from the Hospital Procurement Services Group (HPSG) and the further roll out of the national logistics plan subject to required investment.

- Manage the delivery of the HSE Capital Plan and ensure that it strategically supports this service plan and longer term sectoral strategic plans.
- Support the establishment of the Chief Information Officer (CIO) office and ensure a smooth transition of ICT services to that office.
- Manage the ICT plan in line with HSE priorities.
- Support the delivery of HBS services to Tusla.
- Continue the work of the sustainability office collaboratively across the public health sector to support compliance with national goals, targets and regulations and to effect savings through implementation of sustainability measures.

HSE Wide Procurement Savings Targets in 2015

Since 2010, significant savings in relation to procurement have been achieved (€307m). The HSE has been given a €30m procurement savings target in 2015. In light of recent changes in public sector procurement the HSE and OGP will work collectively to achieve this target. The procurement function will continue to work with operational services to assist the services in saving money. It is however dependent upon the on-going availability of clinical and frontline service personnel to focus on improved buying to achieve the targets set, and compliance with contracts once they are in place. It is also dependent on the ready availability of robust data. A system to support this will be implemented in 2015.

Portfolios of goods / services targeted for savings in 2015	€m
Carry forward savings from 2014	13
Dialysis	4
Logistics net savings*	2
2015 savings plan (including voluntaries)**	11
Total:	30.0

**Gross saving of €4m is contingent on investment in 2015 of €2m giving a net saving of €2m*

*** The saving of €11m is contingent upon an investment of up to €1m in data sourcing.*

Estates and Capital Programmes

The Capital Plan for the multi-annual period 2015-2019 supports the Government's priorities as set out in the *Programme for Government* and *Future Health*. A 2015 capital allocation of €366m has been received including an ICT amount of €55m (an increase of €15m on previous years for ICT and reduction of €15m in other capital). It is anticipated that an additional €1m will be transferred to the HSE from the Department of Health capital allocation. The main priority in 2015 will be the prudent management of the capital allocation, the maintenance of the HSE's property portfolio and compliance with all regulatory and statutory requirements including fire safety. In line with *Healthy Ireland,* capital projects should take account of and support strategies to improve health and wellbeing for employees and for service users.

For 2015, the Capital Plan 2015-2019 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. ICT support a wide number of key Health Reform projects in every part of the HSE. A number of key priority projects have been identified by the HSE Directorate. ICT will work with the individual service area to deliver these strategically important projects which enable the HSE deliver a safer service which embeds quality improvements and improves efficiency.

In 2015 ICT are supporting the delivery and funding of a number of strategic projects including:

Health and Wellbeing

- Supporting the approvals process and procurement of the National Immunisation Solution.
- Supporting the planning and delivery of the business case for National Immunisation System.

Primary Care

- Planning for a range of ICT systems including Medical Oncology, Audiology and Unscheduled Care.

Acute Hospitals

- Further roll-out of the Patient Administration System in the University of Limerick Hospital Group.
- Deployment of the national build of the National Maternal and New Born Clinical Management System and rollout of initial site, Cork University Hospital.
- Roll out of the National Electronic Blood Tracking System (phase 3) which will record all patient related events at the patient's bedside from transfusion sample to fate of unit.
- Finalisation of the national contract and national build of the National Laboratory Information System (MedLIS) and deployment of initial sites.
- Continued rollout of the Radiology Quality Assurance system.
- Initial deployment of the e-rostering solution in the Saolta University Health Care Group, Letterkenny site.
- Supporting the continued roll out of the Radiology PACS system (NIMIS).

National Ambulance Service

- Initial build and roll out of the national solution for the Ambulance Computer Aided Dispatch.
- Continued support to centralise ambulance control rooms in two locations.

Mental Health Services

- Deployment of a proof of concept solution for Mental Health Services.

Social Care

- Delivery of the initial sites for the National Single Assessment Tool.

System Wide Support and Finance

- Supporting the approvals process and procurement of the National Financial and Procurement System (in collaboration with Finance Directorate).
- Supporting the national roll out of the Patient Level Costing solution.
- Provision of services to support the delivery of the ICT and e-health components of the system reform programme; supporting the vendor engagement process and the planning and procurement processes.
- Continuing to replace Microsoft XP and associated software.
- Supporting the implementation of National Health Identifiers recently passed into legislation.
- Roll out of secure mail service (HealthMail.ie) across the Irish health service.

In addition there are approximately 40 significant service supporting projects which will be advanced in 2015. Each project has an associated planning, infrastructure and support element to its delivery. The day-to-day support consumes over 65% of the ICT resources; this includes keeping all the existing systems and infrastructure functioning as well as providing helpdesk support to all HSE staff.

In 2015, the HSE's allocated ICT capital allocation amounts to €55m which is an increase from €40m in 2014. 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 Hospital Group and Community Healthcare Organisation reforms. The HSE requires significant additional investment in information technology to meet the information needs of a modern health service.

Appendix 1: Financial Tables

Table 1: ELS Funding

	€m
Acute hospital services (posts and other running costs)	23.9
Pensions	10.8
Home care packages / Residential care – older people	9.9
Disability services – full year cost of existing emergency places	7.2
Health and Wellbeing	7.4
Other Social Care	2.2
Palliative Care (St. Francis Hospice)	2.4
Primary Care leases	1.5
EU cross border directive	1.0
Energy	0.3
Total:	66.6

Table 2: Funded Cost Pressures

Initiative	Assigned 2015 €m
Renal Dialysis	2.55
Spina Bifida	0.35
New Cancer Drugs; Support growth	7.00
Maternity Services	2.00
Hip Screening	0.30
Diabetes Clinical Programme – Podiatry	0.40
Disability – School leavers*	6.00
Disability – Therapies**	4.00
Disability – Sleepover	6.50
Disability – General cost pressures	3.50
Total:	€32.6

* Full year cost €12m

** Full year cost €6m

Table 3: Programme for Government Funding 2015

Initiative	Funding €m
Mental Health Services	
Balance of recurring investment from 2013 and 2014, enabling the continued strengthening of community services, increased suicide prevention resources, advancing clinical programmes and development of other specialist services such as Forensics, Liaison Psychiatry etc. (includes all 2013-2014 posts)	23.0
Primary Care / PCRS	
Provide improved and additional primary care services at PCT and network level	14.0
GP service, without fees, for children aged under 6 years	25.0
GP service, without fees, for older people over 70 years	12.0
Delayed Discharges: Social Care Services / Acute Services / Primary Care Services*	
Develop a discharge pathway for those patients that require access to long-term care and to primary care services in order to reduce the number of delayed discharges in hospitals (see detail below)	25.0
Health and Wellbeing	
Extension of BreastCheck screening programme to women aged 65 – 69 years of age	0.1
Sub-total:	€99.1
Mental Health Services	
Continued prioritised development and reconfiguration of General Adult teams, including Psychiatry of Later Life as well as Child and Adolescent Community Mental Health services towards consistent service provision across all areas. Additionally, this funding will permit the development of sub specialists to address current gaps in service provision.	35.0**
Sub-total:	€35.0

**See detail on page 13*

*** This funding is held by the DoH and will be made available to the HSE as costs come on stream in 2015*

	Funding €m
TOTAL:	€134.1

Table 4: HSE Prioritised Initiatives

	2015 Funding €m
Quality and Patient Safety	
Information Unit	0.104
Advocacy	0.223
National QA Programme	0.481
Office of Clinical Audit	0.172
Governance (Hospital Groups and CHOs - Quality)	0.642
Health and Wellbeing	
BreastCheck	0.073
Critical Service Posts – Inspection, Enforcement and Surveillance	0.500
National Immunisation and Child Health Information System	0.375
Primary Care	
Chronic Disease – Clinical Nurse Specialists	0.415
National PCT Patient Management System	0.300
Unique Patient Identifier	0.300
Diagnostic Radiology Primary Care (Ultrasound Access Initiative – joint funded through Programme for Government and Prioritised Initiatives)	0.263

	2015 Funding €m
Acute Services (Acute Hospitals)	
Activity Based Funding (MFTP - HPO and Hospitals including costing capacity)	0.596
Activity Based Funding (MFTP - HPO and Hospitals including coding and audit capacity)	0.625
Medical Workforce Oversight Group	0.200
Redesign and Improvement Initiatives	1.603
Acute Services – (National Cancer Control Programme)	
New Drugs and support growth	0.098
Paediatric Radiation Oncologist	0.031
Hereditary Cancer Surveillance	0.095
Urology Consultant	0.031
CNS /ANP medical oncology	0.119
Acute Services – (Clinical Strategy and Programmes)	
Integrated programmes - Government / change management	0.667
Self Management Support Initiatives	1.125
National Sepsis Workstream	0.308
National Ambulance Service	
National Control Centre	0.784
NAS Reviews	0.333
Tuam and Mulranny 24/7	0.696
Electronic Patient Care Record System	0.360
Clinical Audit and Competence Assurance	0.450
ELS - Relief / Emergency Aero Medical	2.750
Palliative Care	
Midlands - Consultant	0.031
Children's outreach nurses	0.089
Specialist Palliative Care Community	0.307
Health Business Service	
Estates - Management Capital programme	0.180
HR - Pensions	0.120
Finance - Invoice capture project	0.090
ERPS – HR / Payroll (South)	0.300
Customer Relationship Management	0.457
ICT - Application Support	0.350
Procurement - Automation	0.030
NRS - Recruitment and retention - expand capacity	0.400
Finance	
Finance Operating Model including new system	1.933
Communications	
Digital and Info hub	0.127
Internal Audit	
Additional Internal Audit Staff	0.733
System Reform Group	
Paediatric Hospital	1.400
Hospital groups	0.942
Community Health Care Organisation	0.470
Totals:	€22.7

Table 5: Financial Position

Income and Expenditure 2015 Allocation	Pay** €m	Non-Pay** €m	Gross Budget €m	Income** €m	Net Budget €m
Acute Services	3,377.2	1,503.1	4,880.3	-880.4	3,999.9
National Cancer Control Programme	1.8	13.2	15.1	0.0	15.1
Palliative Care	40.5	41.9	82.4	-10.6	71.9
Primary Care	509.7	246.9	756.6	-30.5	726.0
Social Inclusion	39.0	87.4	126.5	-0.8	125.7
PCRS including Local Schemes	13.0	2,600.1	2,613.1	-127.3	2,485.8
Drugs Task Force Initiative	0.0	21.6	21.6	0.0	21.6
Primary Care	561.7	2,956.0	3,517.7	-158.6	3,359.1
Older People's Services	646.7	395.0	1,041.7	-386.6	655.1
NHSS	0.0	873.9	873.9	0.0	873.9
Disability Services	600.0	963.3	1,563.3	-104.0	1,459.3
Social Care	1,246.7	2,232.1	3,478.9	-490.6	2,988.3
Mental Health	616.9	163.6	780.5	-23.7	756.8
Health and Wellbeing	93.4	119.7	213.1	-11.9	201.2
National Ambulance Service	103.9	40.4	144.3	-0.3	144.0
Total Direct Services	6,042.2	7,070.2	13,112.4	-1,576.1	11,536.3
Quality and Patient Safety	2.3	5.7	8.0	-0.2	7.8
Clinical Strategy and Programmes	9.1	21.3	30.4	-0.2	30.1
National Services*	136.4	260.6	397.0	-274.6	122.3
Statutory Pensions	610.4	0.1	610.5	-176.0	434.5
Totals:	6,800.3	7,357.9	14,158.2	-2,027.2	12,131.0

** National Services includes the Clinical Indemnity Scheme, Health Repayment Scheme and Corporate. Primary Care Leases are also included within National Services but will be moved to Primary Care Division in 2015 with budget and cost.*

*** Pay, Non-Pay and Income figures are preliminary and will be finalised as part of the Operational Planning Process.*

Table 6: 2015 Financial Allocation by Division

Division	Budget 2014 €m	Projected 2014 Deficit €m	2014 Projected Spend / Opening Base 2015 €m	Programme for Govt. Funding €m	Existing Level of Service Funding €m	Funded Cost Pressures €m	Funding for Other Priorities - Hep C €m	HSE Prioritised Initiatives €m	Zero Basing Budget €m	Savings Measures €m	2015 Budget €m	% Change vs 2014 Budget	% Change vs 2014 Projected Spend
Acute Services	3,766.0	267.9	4,033.9	0.0	23.9	5.2	0.0	3.0	-10.0	-56.1	3,999.9	6.2%	-0.8%
NCCP	7.7	0.0	7.7	0.0	0.0	7.0	0.0	0.4	0.0	0.0	15.1	95.8%	95.8%
Palliative Care	68.5	0.6	69.1	0.0	2.4	0.0	0.0	0.4	0.0	0.0	71.9	5.0%	4.1%
Primary Care	704.1	9.9	714.0	16.0	0.0	0.4	0.0	1.3	0.0	-5.7	726.0	3.1%	1.7%
Social Inclusion	125.7	0.0	125.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	125.7	0.0%	0.0%
PCRS including Local Schemes	2,408.7	94.9	2,503.6	37.0	0.0	0.0	30.0	0.0	-19.8	-65.0	2,485.8	3.2%	-0.7%
Drugs Task Force Initiative	21.6	0.0	21.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.6	0.0%	0.0%
Primary Care	3,260.1	104.8	3,364.9	53.0	0.0	0.4	30.0	1.3	-19.8	-70.7	3,359.1	3.0%	-0.2%
Older People's Services	610.2	24.9	635.0	13.0	12.1	0.0	0.0	0.0	-3.4	-1.6	655.1	7.4%	3.2%
NHSS	856.9	7.0	863.9	10.0	0.0	0.0	0.0	0.0	0.0	0.0	873.9	2.0%	1.2%
Disability Services	1,428.9	8.0	1,436.9	0.0	7.2	20.0	0.0	0.0	0.0	-4.8	1,459.3	2.1%	1.6%
Social Care	2,895.9	39.9	2,935.8	23.0	19.3	20.0	0.0	0.0	-3.4	-6.4	2,988.3	3.2%	1.8%
Mental Health	754.2	-15.7	738.5	23.0	0.0	0.0	0.0	0.0	0.0	-4.7	756.8	0.3%	2.5%
Health and Wellbeing	213.7	-20.1	193.6	0.1	7.4	0.0	0.0	0.9	0.0	-0.9	201.2	-5.9%	3.9%
National Ambulance Service	137.7	1.0	138.7	0.0	0.0	0.0	0.0	5.4	0.0	0.0	144.0	4.6%	3.9%
Total Direct Services	11,103.8	378.4	11,482.2	99.1	53.0	32.6	30.0	11.4	-33.2	-138.8	11,536.3	3.9%	0.5%
Quality and Patient Safety	6.2	0.0	6.2	0.0	0.0	0.0	0.0	1.6	0.0	0.0	7.8	25.8%	25.8%
Clinical Strategy and Programmes	28.0	0.0	28.0	0.0	0.0	0.0	0.0	2.1	0.0	0.0	30.1	7.5%	7.5%
National Services	120.3	-9.4	110.9	0.0	2.8	0.0	0.0	7.5	2.3	-1.2	122.3	1.7%	10.3%
Statutory Pensions	393.7	30.0	423.7	0.0	10.8	0.0	0.0	0.0	0.0	0.0	434.5	10.4%	2.5%
Unspecified Pay Savings	-111.1	111.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-100.0%	0.0%
Totals:	11,540.9	510.1	12,051.0	99.1	66.6	32.6	30.0	22.7	-30.9	-140.0	12,131.0	5.1%	0.7%

Notes:

1. *In NSP2014 the key budget figures per division were presented on a gross (Pay and Non pay - vote) basis. The HSE vote is being disestablished from the 1st January 2015 and being amalgamated with the vote of the Department of Health. Accordingly for 2015 and future years the HSE will receive a letter of net non-capital expenditure. In this plan the budget figures are presented on a net basis (Pay and Non Pay less Income – accruals based expenditure). The budget 2014 column in this table is the net figure and is therefore directly comparable to Budget 2015 column.*

(Notes continued overleaf)

2. *National Services includes the Clinical Indemnity Scheme, Health Repayment Scheme and Corporate. Primary Care Leases are also included within National Services but will be moved to Primary Care Division in 2015 with budget and cost.*
3. *See NSP2014, page 15, table 1. (Gross current estimate €13,120.4 - €536.8m (Children and Families) = €12,583.6m - €1,042.7m HSE Own Income = €11,540.9m)*
4. *2014 projected deficit is based on accruals accounting principles*
5. *Budget is stated after utilisation of Pandemic Vaccines and Emergency Management budgets. In the event that costs are incurred that typically would have been addressed via these contingency funds then this will fall to be addressed in discussion with the Department of Health. This plan has been prepared on the basis that such discussions will take account of the fact that costs of this type will generally be urgent in nature and cannot impact on the level of funds available for the services to be provided under this plan.*
6. *The allocation between divisions of the €30m procurement savings for 2015 is preliminary and will be finalised as part of the operational planning process.*

Table 7: Nursing Homes Support Scheme – A Fair Deal (NHSS)

2014		2015	
	€m		€m
Gross budget	938.8	Gross budget*	948.8
Income	74.9	Income	74.9
Net	863.9**	Net	873.9
		*Includes additional funding 2015	*10.0*

To assist with comparison between the 2014 and 2015 figures, the Gross budget for NHSS in 2014 and 2015 is as follows:

- *2014 - €938.8m (see National Service Plan 2014, page 19, table 8)*
- *2015 - €948.8m – this is €10m higher than the comparable figure in 2014*

*The effective Net budget for 2014 is €836.9m which is made up of the 2014 Gross budget of €938.8m less the 2014 income target of €74.9m (€938.8 - €74.9 = €863.9). **This net budget is after adjusting for the excess asset disregard target of €7m.*

The Net budget for 2015 is €873.9m which is made up of the 2015 Gross budget of €948.8m less the 2015 income target of €74.9m (€948.8 - €74.9 = €873.9m) – this is €10m higher than the comparable figure in 2014.

It is expected that approximately 300 extra long term care places can be purchased in 2015 compared to 2014 based on this additional €10m which has been provided as part of the €25m in respect of delayed discharges within the programme for government funding for 2015.

Appendix 2: HR Information

All information in tables has been rounded to nearest WTE

Section 38 Agencies[1]

Service	WTE Dec. 2013	WTE Sept. 2014	Projected Outturn Dec. 2014	End 2014 Employment Ceiling[3]
HSE	61,458	61,568	61,512	59,742
Voluntary Hospitals	21,618	22,096	22,076	21,441
Voluntary Agencies (Non-Acute)	13,417	13,424	13,412	13,026
Section 38 Agencies	35,036	35,520	35,488	34,467
Total[2]	96,494	97,088	97,000	94,209

Note 1: Source – Health Services Personnel Census

Note 2: All figures are expressed on a 2014 Employment Control Framework (ECF) basis as wholetime equivalents

Note 3: Ceilings are indicative and are shown for guidance only

Divisional breakdown

Employment Control Framework 2014 basis[1]					Inclusive of home helps, graduate nurses and intern posts	
Service	WTE Dec. 2013	WTE Sept. 2014	Projected Outturn Dec. 2014	End 2014 Employment Ceiling[2]	WTE Dec. 2013	Projected Outturn Dec. 2014
Acute Services	48,270	49,176	48,978	45,818	48,545	49,667
Mental Health	8,906	8,996	9,186	9,540	9,064	9,405
Primary Care	9,443	9,323	9,311	9,435	10,538	9,654
Social Care	24,391	24,165	24,106	24,037	26,968	27,899
Health and Wellbeing	1,250	1,244	1,222	1,203	1,266	1,225
Ambulance Services	1,615	1,611	1,625	1,633	1,615	1,625
Corporate and HBS	2,619	2,573	2,572	2,543	2,619	2,571
Total	96,494	97,088	97,000	94,209	100,614	102,046

Note 1: WTE expressed on an ECF basis exclude specified grades (circa 5% of WTE), agency and overtime (circa 8% combined)

Note 2: Ceilings are indicative and are shown for guidance only

Divisional breakdown by staff category (as of September 2014)[1]

Service	Medical / Dental	Nursing and Midwifery	Health and Social Care Professionals	Management / Admin.	General Support Staff	Other Patient and Client Care	Total[2]	Projected Outturn Dec. 2014
Acute Services	6,727	19,745	6,175	7,398	5,602	3,528	49,176	48,978
Mental Health	712	4,495	1,142	752	930	964	8,996	9,186
Primary Care	905	2,315	2,286	2,669	333	815	9,323	9,311
Social Care	196	7,290	3,195	1,669	2,134	9,681	24,165	24,106
Health and Wellbeing	147	34	598	394	16	55	1,244	1,222
Ambulance Services	1			47	18	1,546	1,611	1,625
Corporate and HBS	26	112	20	2,058	344	13	2,573	2,572
Total	8,713	33,992	13,417	14,987	9,376	16,602	97,088	97,000

Note 1: Source – Health Services Personnel Census

Note 2: All figures are expressed on a 2014 ECF basis as wholetime equivalents

Appendix 3: Performance Indicator Suite

System-Wide

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Finance (Monthly)			
Variance against Budget: Income and Expenditure	≤ 0%	To be reported in Annual Financial Statements 2014	≤ 0%
Variance against Budget: Income collection / Pay / Non Pay / Revenue and Capital Vote	≤ 0%		≤ 0%
Service Arrangements / Annual Compliance Statement			
% and amount of the monetary value of Service Arrangements signed	New PI 2015	New PI 2015	100%
% and number of Service Arrangements signed	New PI 2015	New PI 2015	100%
% and number of Annual Compliance Statements signed	New PI 2015	New PI 2015	100%
HR (Monthly)			
Rates of absence	3.5%	4.45%	3.5%
Variance from HSE Workforce ceiling*	≤ 0%	2.95% 2,780	≤ 0%
Complaints			
% of complaints investigated within 30 working days of being acknowledged by the complaints officer	75%	69%	75%
Serious Reportable Events			
% of Serious Reportable Events being notified within 24 hours to designated officer	New PI 2015	New PI 2015	99%
% of mandatory investigations commenced within 48 hours of event occurrence	New PI 2015	New PI 2015	90%
% of mandatory investigations completed within 4 months of notification of event occurrence	New PI 2015	New PI 2015	90%
Reportable Events			
% of events being reported within 30 days of occurrence to designated officer	New PI 2015	New PI 2015	95%
Immunisations and Vaccines			
% of health care workers who have received one dose of seasonal Flu vaccine in the 2014-2015 influenza season (acute hospitals and long-term care facilities in the community)	40%	Acute care 24% Long-term care 23%	40%
Pressure Ulcer Incidence			
The Nursing and Midwifery Division will lead, in partnership with the Quality Improvement Division, the development of a performance indicator on 'pressure ulcer incidence' with the aim of reporting by Quarter 3 2015.			
Falls Prevention			
The Quality Improvement Division will lead, in partnership with the Nursing and Midwifery Division, the development of a performance indicator on 'falls prevention with the aim of reporting by Quarter 3 2015.			

* 'Workforce Ceiling' will be determined jointly between Finance and HR based on the initial pay allocations for 2015. The ceiling may therefore be restated during 2015.

Health and Wellbeing

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Immunisations and Vaccines			
% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	95%	93%	95%
% children aged 12 months who have received 3 doses Diphtheria (D3), Pertussis (P3), Tetanus (T3) vaccine Haemophilus influenzae type b (Hib3) Polio (Polio3) hepatitis B (HepB3) (6 in 1)	95%	92%	95%
% children aged 24 months who have received 3 doses Meningococcal C (MenC3) vaccine	95%	88%	95%

Health and Wellbeing

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
% of first year girls who have received third dose of HPV Vaccine	80%	84%	80%
% of health care workers who have received one dose of seasonal Flu vaccine in the 2014-2015 influenza season (acute hospitals and long-term care facilities in the community)	40%	Acute care 24% Long-term care 23%	40%
% uptake in Flu vaccine for > 65s	New PI 2015	New PI 2015	75%
Child Health % newborn babies visited by a PHN within 72 hours of hospital discharge	100%	97%	97%
% of children reaching 10 months within the reporting period who have had their child development health screening on time before reaching 10 months of age	95%	92%	95%
% of babies breastfed (exclusively and not exclusively) at first and 3 month PHN visits	New PI 2015	New PI 2015	56% (first PHN visit) 38% (3 month visit)
BreastCheck No. of women screened (no. of women aged 50-64 who have had a mammogram)	140,000	140,000	140,000
CervicalCheck No. of women screened (no. of unique women who have had one or more smear tests in a primary care setting)	New PI 2015	New PI 2015	271,000
BowelScreen No. of clients invited (no. of first invitations sent to individuals in the eligible age range 60-69 known to the programme)	New PI 2015	New PI 2015	200,000
Diabetic RetinaScreen No. of clients screened (no. of individuals known to the programme aged 12+ with diabetes who have been screened)	New PI 2015	New PI 2015	78,300
Tobacco No. of smokers who received intensive cessation support from a cessation counsellor	9,000	9,000	9,000
% of new facilities opening smoke free in Primary Care, Mental Health and Social Care	New PI 2015	New PI 2015	100%
No. of sales to minors test purchases carried out	480	480	480
No. of frontline healthcare staff trained in brief intervention smoking cessation	1,350	1,350	1,500
Environmental Health – Food Safety No. of planned, and planned surveillance inspections of food businesses	33,000	33,000	33,000
Environmental Health – Sunbeds No. of inspections of establishments	New PI 2015	New PI 2015	400
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Primary Care

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Community Intervention Teams Activity:			
Admission Avoidance (includes OPAT)	PI amended – not comparable	543	1,165
Hospital Avoidance		8,564	17,728
Early discharge / wards (includes OPAT)		3,147	4,123
Other		2,240	2,910
Total		14,494	25,926
Physiotherapy % of referrals seen for assessment within 12 weeks	New PI 2015	New PI 2015	80%

Primary Care

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Occupational Therapy % of referrals seen for assessment within 12 weeks	New PI 2015	New PI 2015	80%
Orthodontics % of referrals seen for assessment within 6 months	New PI 2015	New PI 2015	75%
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%	5.3%	< 5%
Healthcare Associated Infections: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	< 21.7	22.9	< 21.7
Nursing, Podiatry, Ophthalmology, Audiology, Dietetics and Psychology No. of patient referrals	New PI 2015	New PI 2015	New PI 2015
Existing patients seen in the month	New PI 2014	Baselines to be determined 2015	Baselines to be determined
New patients seen in the month	New PI 2014		
GP Activity No. of contacts with GP Out of Hours	994,936	959,455	959,455
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Primary Care (Social Inclusion)

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Opioid Substitution Treatment No. of clients in receipt of opioid substitution treatment (outside prisons)	9,100	9,321	9,400
No. of clients in receipt of opioid substitution treatment (prisons)	500	490	490
Substance Misuse % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%	100%	100%
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	100%	100%	100%
Traveller Health No. of people who received awareness raising and information on type 2 diabetes and cardiovascular health	New PI 2015	New PI 2015	20% of the population in each Traveller Health Unit
Homeless Services % of 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	85%	80%	85%
Needle Exchange No. of unique individuals attending pharmacy needle exchange	700	1,253	1,200
Health (Amendment) Act – Services to persons with state acquired Hepatitis C No. of patients offered assessment of need	New PI 2015	New PI 2015	1,440
No. of patients to be reviewed	New PI 2015	New PI 2015	820
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Primary Care (Primary Care Reimbursement Service)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Medical Cards / GP Visit Cards			
No. of persons covered by medical cards as at 31st December	1,875,707	1,782,395	1,722,395
No. of persons covered by GP visit cards as at 31st December	402,138	155,000	412,588
% of properly completed medical / GP visit card applications processed within the 15 day turnaround	90%	90%	90%
% medical card / GP visit card applications, assigned for Medical Officer review, processed within 5 days	New PI 2015	New PI 2015	90%

Acute Services (Acute Hospitals and National Clinical Care Programmes)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Discharges Activity			
Inpatient	591,699	644,428	643,748
Day Case	797,328	804,212	824,317
Emergency Care			
- New ED attendances	1,093,187	1,104,131	1,104,131
- Return ED attendances	89,371	84,042	84,042
- Other emergency presentations	108,490	89,276	89,276
Inpatient Admissions			
No. of emergency admissions	402,202	451,157	451,157
Elective Inpatient Admissions	99,973	100,653	99,973
Outpatients			
Total no. of new and return outpatient attendances	2,571,115	3,189,749	3,189,749
Outpatient Attendances - New : Return Ratio	1:2	1:2.6	1:2
Births			
Total no. of births	67,899	66,705	66,705
Inpatient, Day Case and Outpatient Waiting Times			
% of adults waiting < 8 months for an elective procedure (inpatient)	100%	75%	100%
% of adults waiting < 8 months for an elective procedure (day case)	100%	75%	100%
% of children waiting < 20 weeks for an elective procedure (inpatient)	100%	50%	100%
% of children waiting < 20 weeks for an elective procedure (day case)	100%	60%	100%
% of people waiting < 52 weeks for first access to OPD services	New PI 2015	New PI 2015	100%
Colonoscopy / Gastrointestinal Service			
% of people waiting < 4 weeks for an urgent colonoscopy	100%	100%	100%
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	100%	60%	100%
Emergency Care and Patient Experience Time			
% of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	66%	95%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%	80%	100%
% of ED patients who leave before completion of treatment	< 5%	5%	< 5%
% of all attendees at ED who are in ED > 24 hours	New PI 2015	3.5%	0%
Acute Medical Patient Processing			
% of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	95%	61%	95%
Ambulance Turnaround Times			
% of ambulances that have a time interval of < 30 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	New PI 2015	New PI 2015	New PI 2015

Acute Services (Acute Hospitals and National Clinical Care Programmes)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Health Care Associated Infections (HCAI)			
Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used	< 0.057	0.06	< 0.057
Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	< 2.5	1.9	< 2.5
Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital	83	84.4	83
Alcohol Hand Rub consumption (litres per 1,000 bed days used)	25	29.3	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%	86.2%	90%
Adverse Events			
Postoperative Wound Dehiscence – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015	New PI 2015	New PI 2015
In Hospital Fractures – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015	New PI 2015	New PI 2015
Foreign Body Left During Procedure – Rate per 1,000 inpatient cases aged 16 years+	New PI 2015	New PI 2015	New PI 2015
% of claims received by State Claims Agency that should have been reported previously as an incident	New PI 2015	New PI 2015	New PI 2015
Activity Based Funding (MFTP) model			
HIPE Completeness – Prior month: % of cases entered into HIPE	> 95%	90%	> 95%
Average Length of Stay			
Medical patient average length of stay	5.8	6.8	5.8
Surgical patient average length of stay	5.3	5.2	5.1
ALOS for all inpatients	5.6	5.3	5.0
ALOS for all inpatient discharges excluding LOS over 30 days	4.5	4.5	4.3
Stroke			
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%	11.1%	9%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	50%	57.6%	66%
Acute Coronary Syndrome			
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%	85.1%	85%
Surgery			
% of elective surgical inpatients who had principal procedure conducted on day of admission	85%	64%	70%
% day case rate for Elective Laparoscopic Cholecystectomy	New PI 2015	New PI 2015	> 60%
% of bed day utilisation by acute surgical admissions that do not have a surgical primary procedure	New PI 2015	New PI 2015	5% reduction
Time to Surgery			
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%	82%	95%
Hospital Mortality			
Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	-	Not yet reported in 2014	To be reported
Re-admission			
% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	9.6%	11%	9.6%
% of surgical re-admissions to the same hospital within 30 days of discharge	< 3%	2%	< 3%
Medication Safety			
% of medication errors reported (as measured through the State Claims Agency)	New PI 2015	New PI 2015	New PI 2015
Patient Experience			
% of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	100%	Annual PI	100%

Acute Services (Acute Hospitals and National Clinical Care Programmes)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Delayed Discharges % reduction in bed days lost through delayed discharges	10% reduction	1.4% reduction	10% reduction
% reduction of people subject to delayed discharges	10% reduction	24% increase	15% reduction
HR – Compliance with EWTD < 24 hour shift	100%	95%	100%
< 48 hour working week	100%	63%	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%	100%	100%
% of all clinical staff who have been trained in the COMPASS programme	> 95%	45%	> 95%
Irish Maternity Early Warning Score (IMEWS) % of maternity units / hospitals with full implementation of IMEWS	New PI 2015	New PI 2015	100%
% of hospitals with implementation of IMEWS for pregnant patients	New PI 2015	New PI 2015	100%
National Standards % of hospitals who have commenced first assessment against the NSSBH	95%	For reporting end 2014	95%
% of hospitals who have completed first assessment against the NSSBH	95%	For reporting end 2014	95%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Acute Services (National Cancer Control Programme)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Symptomatic Breast Cancer Services No. of patients triaged as urgent presenting to symptomatic breast clinics	13,900	16,555	16,000
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals	95%	95%	95%
Clinic cancer detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of breast cancer	New PI 2015	New PI 2015	> 6%
Lung Cancers No. of patients attending the rapid access lung clinic in designated cancer centres	2,700	3,108	3,000
% of patients attending lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	95%	87%	95%
Clinic cancer detection rate: % of new attendances to clinic that have a subsequent diagnosis of lung cancer	New PI 2015	New PI 2015	> 25%
Prostate Cancers No. of patients attending the rapid access clinic in the cancer centres	2,970	2,535	2,500
% of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	90%	46%	90%
Clinic cancer detection rate: % of new attendances to clinic that have a subsequent diagnosis of prostate cancer	New PI 2015	New PI 2015	> 30%
Radiotherapy No. 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	3,708	4,700

Acute Services (National Cancer Control Programme)

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
% 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%	90%	90%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

National Ambulance Service

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Intermediate Care Services % of all transfers which were provided through the Intermediate Care Vehicle (ICV) service (Volume 3,100 represents 70% of total transfers by ICV and Emergency Ambulances)	New PI 2015	New PI 2015	≥ 70%
Clinical Outcome Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using the Utstein comparator group calculation (Quarterly in arrears)	New PI 2015	New PI 2015	40%
Emergency Response Times % of Clinical Status 1 ECHO (life threatening cardiac or respiratory arrest) incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	80%	75%	80%
% of Clinical Status 1 DELTA (life threatening illness or injury other than cardiac or respiratory arrest) incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less	80%	64%	80%
Audit % of control centres that carry out Advanced Quality Assurance Audit (AQuA) Audit	New PI 2015	New PI 2015	100%
Ambulance Turnaround From Acute Hospitals % delays escalated where ambulance crews were not cleared nationally in 60 minutes (from ambulance arrival time through clinical handover in ED or specialist unit to when the ambulance crew declares readiness of the ambulance to accept another call) in line with the process / flow path in the ambulance turnaround framework	New PI 2015	New PI 2015	100%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Palliative Care Services

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Inpatient Units Waiting Times Specialist palliative care inpatient bed within 7 days (during the reporting month)	94%	96%	98%
Community Home Care Waiting Times No. of patients in receipt of specialist palliative care in the community (monthly cumulative)	3,050	3,248	3,248
Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	82%	88%	95%
Day Care No. of patients in receipt of specialist palliative day care services (during the reporting month)	331	349	349

Palliative Care Services

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Paediatric Services No. of children in the care of the children's outreach nursing service	New PI 2014	321	320
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Mental Health Services

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Adult Mental Health Services % of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by General Adult Community Mental Health Teams	New PI 2015	93%	> 90%
% of accepted referrals / re-referrals offered appointment and seen within 12 weeks / 3 months by General Adult Community Mental Health Teams	≥ 75%	73%	> 75%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Psychiatry of Old Age Community Mental Health Teams	New PI 2015	99%	> 99%
% 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%	96%	> 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.	≥ 75%	67%	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	New PI 2015	76%	> 78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks / 3 months by Child and Adolescent Community Mental Health Teams	≥ 75%	70%	> 72%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

Social Care Services (Disability Services)

Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
0-18s Programme Proportion of Local Implementation Groups which have local implementation plans for progressing disability services for children and young people	100% (25 of 25)	40%	100% (24 of 24)*
Disability Act % of assessments completed within the timelines as provided for in the regulations	100%	40%	100%
Personal Assistant (PA) Hours No. of Personal Assistant (PA) hours delivered to adults with a physical and/or sensory disability	1,279,445	1.3m	1.3m
Home Support Hours No. of Home Support Hours delivered to people with a disability	2,392,312	2.6m	2.6m
Quality In respect of agencies in receipt of €3m or more in public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL, CARF or PQASSO	100%	67%	100%
Respite Services** No. of overnights (with or without day respite) accessed by people with a disability	243,260	182,887	190,000

Social Care Services (Disability Services)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Congregated Settings Facilitate the movement of people from congregated to community settings	150	100	150
Day Services % of school leavers and RT graduates who have received a placement which fully meets their needs	100%	100%	100%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

** 24 Local Implementation Groups in 2015 as two have amalgamated*

*** The 2015 Social Care Operational Plan will include an expanded range of KPIs which include non-overnight respite and no. of people in receipt of more than 30 overnights continuous respite. It is anticipated that there will be a reduction in overnight respite as services more in line with person centred models are delivered. Data validation will be carried out as transition is made to the new KPIs.*

Social Care Services (Older People Services)			
Indicator	NSP 2014 Expected Activity / Target	Projected Outturn 2014	Expected Activity / Target 2015
Home Care Packages Total no. of persons in receipt of a HCP	10,870	13,200	13,800
Intensive HCPs – no. in receipt of an Intensive HCP at a point in time (capacity)	190	30*	190
Home Help Hours No. of home help hours provided for all care groups (excluding provision of hours from HCPs)	10.3m	10.3m	10.3m
Immunisations and Vaccines % uptake of flu vaccine for > 65s	New PI 2015	New PI 2015	75%
Nursing Homes Support Scheme (NHSS) No. of people being funded under NHSS in long-term residential care during the reporting month	22,061	22,061	22,361
Public Beds No. of NHSS Beds in Public Long Stay Units	5,400	5,311	5,287
Elder Abuse % of active cases reviewed within six month timeframe	80%	90%	90%
Serious Reportable Events % compliance with the HSE Safety Incident Management Policy for Serious Reportable Events	New PI 2015	New PI 2015	See targets on page 69

** With the delay in implementing the Home Care Tender, some of this funding was used in 2014 to support transitional care for older people, to facilitate early discharge from hospital*

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that were completed in 2013/2014 but not operational, projects due to be completed and operational in 2015 and also projects due to be completed in 2015 but not operational until 2016

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2015 Implications	
						2015	Total	WTE	Rev Costs €m
PRIMARY CARE DIVISION									
Dublin Mid-Leinster									
Wicklow Town	Primary Care Centre, by lease agreement (includes a mental health primary care centre)	Q4 2014	Q1 2015	0	0	0.00	0.00	0	0
Rathangan / Monasterevin, Co. Kildare	Primary Care Centre, by lease agreement	Q3 2015	Q3 2015	0	0	0.00	0.00	0	0
Tus Nua, Kildare town	Primary Care Centre, by lease agreement	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0
Blessington, Wicklow	Primary Care Centre, by lease agreement	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0
Deansgrange, Dublin	Primary Care Centre, by lease agreement	Q4 2015	Q4 2015	0	0	0.00	0.00	0	0
Meath Hospital, Dublin	Demolition of a number of derelict buildings in the Meath Hospital campus, making safe the remaining structures; refurbishment of a number of buildings (City Lodge and Doctor's Residence) to accommodate services currently in rented accommodation	Q4 2014	Q1 2015	0	0	0.50	4.48	0	0
St. Fintan's Hospital Portlaoise. Co. Laois	St. Fintan's administration accommodation for therapy services (top floor)	Q2 2015	Q4 2015	0	0	3.00	4.00	0	0
Dublin North East									
Corduff, Dublin	Primary Care Centre to be developed on HSE owned site	Q4 2015	Q1 2016	0	0	5.89	7.76	0	0
Kells, Co. Meath	Primary Care Centre by lease agreement	Q3 2015	Q4 2015	0	0	0.00	0.00	0	0
Navan Road, Dublin	Primary Care Centre by lease agreement	Q1 2015	Q2 2015	0	0	0.00	0.00	0	0
South									
Gorey (site 3), Co Wexford	Primary Care Centre by lease agreement	Q4 2015	Q4 2015	0	0	0.00	0.00	0	0
Charleville, Co Cork	Primary Care Centre, by lease agreement (includes a mental health primary care centre)	Q3 2015	Q4 2015	0	0	0.00	0.00	0	0
St. Finbarr's Hospital, Cork	Audiology services – ground floor, block 2	Q4 2015	Q4 2015	0	0	0.80	1.50	0	0
West									
Limerick City - (Market 1 and 2 - Garryowen)	Primary Care Centre, by lease agreement	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0
Ballyshannon, Co. Donegal	Primary Care Centre – refurbishment and upgrade of former convent and school	Q3 2015	Q4 2015	0	0	3.80	7.85	0	0
Borrisokane, Co. Tipperary	Extension of primary care facility	Q4 2015	Q1 2016	0	0	0.38	0.40	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2015 Implications	
						2015	Total	WTE	Rev Costs €m
ACUTE DIVISION									
RCSI Hospital Group, Dublin North East									
Beaumont Hospital, Dublin	Renal transplant unit (phase 2)	Q4 2015	Q1 2016	0	24	2.20	5.00	0	0
	Provision of a second catheterisation laboratory	Q4 2015	Q1 2016	0	0	0.00	1.54	0	0
Connolly Hospital, Blanchardstown, Dublin	Upgrade of existing radiology department (phase 1)	Q4 2015	Q1 2016	0	0	1.50	5.00	0	0
	Expansion of urology unit	Q2 2015	Q4 2015	0	0	0.21	0.95	0	0
Rotunda Hospital, Dublin	Electrical distribution system upgrade and completion of the boundary wall, stabilisation works and mortuary upgrade	Q2 2015	Q2 2015	0	0	0.80	1.45	0	0
Dublin Midlands Hospital Group									
Tallaght Hospital - AMNCH	Reconfiguration and upgrade to the adult and paediatric Emergency Department (ED) to provide additional cubicle space, additional resus accommodation, rapid access and additional triage; also upgrade to endoscopy suite	Q1 2015	Q2 2015	0	0	1.00	4.50	0	0
The Children's Hospital Group									
Children's University Hospital, Temple Street, Dublin	Interim works including an ECG room, admissions unit, cochlear implant / audiology facility, rapid access clinic in ED, endoscopy and radiology upgrade	Phased in 2015	Phased in 2015	0	0	1.00	5.37	0	0
Dublin East Group									
National Maternity Hospital, Holles Street, Dublin	Repair works to roof and relocation of the neo-natal ICU	Q4 2014	Q1 2015	0	25	1.00	5.00	0	0
Wexford General Hospital	Upgrade and replacement of fire detection and alarm systems, emergency lighting and passive fire protection works	Q4 2015	Q4 2015	0	0	0.99	3.90	0	0
Our Lady's Hospital, Navan, Co. Meath	Construction of new ED	Q4 2014	Q1 2015	0	0	0.00	1.00	0	0
St. Luke's Hospital, Kilkenny	Redevelopment phase 1 and 2: Construction of new ED, medical assessment unit (MAU), day service including endoscopy (including medical education unit)	Q1 2015	Q2/Q3 2015	11	14	0.95	20.25	0	0
Cappagh National Orthopaedic Hospital	Provision of a recovery unit to serve the theatre department (co-funded with Cappagh)	Q4 2015	Q4 2015	0	0	0.50	0.50	0	0
South / South West Hospital Group									
Cork University Hospital	MRI and CT project	Q4 2014	Q1 2015	2	0	0.00	3.71	0	0
	Development of an acute MAU (phased development)	Q4 2015	Q4 2015	0	23	1.20	2.99	0	0
Cork University Maternity Hospital	Upgrade of ED	Q2 2015	Q3 2015	0	0	0.10	0.10	0	0
Mercy University Hospital, Cork	Replacement / upgrade of boiler and heating controls	Q2 2015	Q2 2015	0	0	0.28	1.00	0	0
South Infirmary University Hospital, Cork	Ophthalmology outpatient department (OPD) relocation	Q4 2014	Q1 2015	0	0	1.20	2.50	0	0
Kerry General Hospital, Tralee	Blood science project - extension and refurbishment of existing pathology laboratory to facilitate management services tender	Q4 2015	Q4 2015	0	0	0.15	0.70	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2015 Implications	
						2015	Total	WTE	Rev Costs €m
ACUTE DIVISION *contd.*									
South / South West Hospital Group *contd.*									
South Tipperary General Hospital, Clonmel	Extension of radiology department to accommodate a CT and future MRI	Q4 2015	Q4 2015	0	0	0.80	1.48	0	0
Waterford University Hospital	Cystic fibrosis unit	Q2 2015	Q2 2015	0	4	0.08	0.63	0	0
	Upgrade of theatre air handling units (AHUs)	Q2 2015	Q2 2015	0	0	0.20	0.40	0	0
Bantry General Hospital, Co. Cork	MAU to enable reconfiguration of acute hospital services	Q1 2015	Q2 2015	8	0	0.45	1.15	0	0
Saolta University Health Care Group									
Letterkenny General Hospital, Co. Donegal	Restoration and upgrade of the catering department damaged in 2013 flood. Part funded by Insurance.	Q1 2015	Q1 2015	0	0	0.52	1.02	0	0
	Restoration and upgrade of the laboratory department damaged in 2013 flood. Part funded by Insurance.	Q2 2015	Q3 2015	0	0	0.87	1.37	0	0
	Restoration and upgrade of the underground service duct (and services). Funded by insurance only.	Q4 2015	Q4 2015	0	0	0.00	0.00	0	0
	New medical education centre (to be funded by NUIG)	Q4 2015	Q4 2015	0	0	0.00	0.00	0	0
Galway University Hospital	Clinical research centre	Q4 2014	Q1 2015	0	0	0.00	0.41	0	0
	Upgrade of maternity unit	Q1 2015	Q1 2015	0	0	0.20	0.45	0	0
Merlin Park University Hospital, Galway	Upgrade of orthopaedic theatre AHUs and theatre plant (including new plant room)	Q3 2015	Q3 2015	0	0	0.49	0.93	0	0
Mayo General Hospital, Castlebar	Cystic fibrosis outpatient unit	Q4 2014	Q1 2015	0	0	0.00	0.20	0	0
Roscommon County Hospital	Provision of endoscopy unit	Q4 2015	Q4 2015	0	2	2.90	5.48	0	0
Sligo General Hospital	New medical education centre (to be funded by NUIG)	Q3 2015	Q4 2015	0	0	0.00	0.00	0	0
	Upgrade of building fabric (roofs, windows, etc) and fire compartmentation works	Q2 2015	Q2 2015	0	0	0.55	0.91	0	0
	Upgrade of boiler plant and boiler room	Q4 2015	Q4 2015	0	0	0.70	0.95	0	0
	Design and dignity scheme (palliative care / chronic illness)	Q1 2015	Q1 2015	0	0	0.25	1.43	0	0
University of Limerick Hospital Group									
Limerick University Hospital	Final fit out of underground car park	Q1 2015	Q1 2015	0	0	1.20	2.59	0	0
Nenagh Hospital, Co. Tipperary	Provision of 2 new theatres adjacent to the existing theatre department plus the upgrade of existing space	Q4 2014	Q1 2015	2	0	0.13	6.23	0	0
Ennis Hospital, Co. Clare	Local injuries unit	Q3 2015	Q4 2015	0	0	0.50	1.17	0	0
ACUTE DIVISION – NATIONAL CANCER CONTROL PROGRAMME									
University of Limerick Hospital Group									
Limerick University Hospital	Symptomatic breast, dermatology, acute stroke and cystic fibrosis inpatient and outpatient block	Q4 2014	Q2 2015	1	0	0.00	1.39	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2015 Implications	
						2015	Total	WTE	Rev Costs €m
HEALTH AND WELLBEING									
National Cancer Screening Services									
BreastCheck	Upgrade and replacement of equipment	Q4 2014	Phased from 2015	0	0	3.00	9.60	0	0
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 2014	Q1 2015	0	0	0.25	12.96	17	2.112
Swords, Co. Dublin	Ambulance base	Q3 2015	Q4 2015	0	0	0.30	0.50	0	0
SOCIAL CARE DIVISION – Services for Older People									
Dublin North East									
Virginia Healthcare Unit, Co. Cavan	Refurbishment and upgrade (to achieve HIQA compliance)	Q4 2014	Q1 2015	50	0	0.08	3.55	0	0
St. Mary's Hospital, Castleblaney, Co. Monaghan	Refurbishment and upgrade (to achieve HIQA compliance)	Q3 2015	Q4 2015	75	0	1.30	4.45	0	0
St. Oliver Plunkett Hospital, Dundalk, Co. Louth	Refurbishment and upgrade (to achieve HIQA compliance)	Q3 2015	Q4 2015	0	40	2.00	4.21	0	0
St. Joseph's, Trim, Co. Meath	HIQA compliance (phase 3)	Q4 2015	Phased 2016	0	0	1.00	4.34	0	0
Sean Cara, Dublin	HIQA compliance (phase 1)	Q3 2015	Q4 2015	0	0	1.50	3.34	0	0
Cuan Ross, Navan Road, Dublin	HIQA compliance	Q2 2014	Q1 2015	0	0	0.00	2.06	0	0
South									
Our Lady's Hospital, Co. Tipperary	HIQA Compliance	Q3 2015	Q3 2015	0	0	1.00	2.11	0	0
West									
St. John's Community Hospital, Sligo	Campus upgrade (phase 1) to replace / upgrade water mains, foul and surface water systems, etc.	Q4 2015	Q4 2015	0	0	0.42	0.77	0	0
SOCIAL CARE DIVISION – Disability Services									
West									
Letterkenny, Co. Donegal	Refurbishment and upgrade of existing early learning day and outreach facility at Kilmacrennan Road	Q2 2015	Q3 2015	0	0	0.20	0.80	0	0
MENTAL HEALTH DIVISION									
Dublin Mid-Leinster									
Cherry Orchard, Dublin	22-bed child and adolescent residential unit (Linn Dara)	Q3 2015	Q4 2015	16	8	6.89	11.80	0	0
Clonskeagh, Dublin	Development of an acute day hospital in St. Brock's on the Clonskeagh Hospital campus	Q4 2015	Q1 2016	0	0	0.35	0.65	0	0
Crumlin, Dublin	Interim primary care centre and community mental health day hospital	Q1 2015	Q2 2015	0	0	0.52	3.12	0	0

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2015 Implications	
						2015	Total	WTE	Rev Costs €m
MENTAL HEALTH DIVISION *contd.*									
Dublin Mid-Leinster *contd.*									
Bru Chaoimhin, Dublin	Refurbishment of Unit 4 to accommodate adult day mental health services	Q3 2015	Q4 2015	0	0	0.50	0.85	0	0
St. Fintan's, Portlaoise, Co. Laois	Alvernia House refurbishment to accommodate Child and Adolescent Mental Health unit, primary care centre expansion, Irish Wheelchair Association and other disability service facilities	Q2 2015	Phased in 2015	0	0	3.00	4.00	0	0
Dublin North East									
Our Lady of Lourdes Hospital, Drogheda, Co. Louth	New acute mental health unit	Q1 2015	Q2 2015	0	45	1.49	12.60	0	0
St. Ita's Hospital, Portrane, Co. Dublin	Stabilisation work to listed building, including repairs to roofs, windows, parapet walls and heating systems (*will not impact on operational status)	Q4 2015	*N/A	0	0	0.10	1.15	0	0
South									
Cork University Hospital	50 bed acute inpatient unit	Q4 2014	Q1 2015	0	50	0.30	15.39	10	0.6
Kerry General Hospital, Tralee, Co. Kerry	Upgrade and extension to the acute mental health unit to include a 4 bed closed observation unit	Q4 2014	Q1 2015	0	4	0.00	2.00	0	0
Killarney, Co. Kerry	Provision of a new 40 bed unit	Q3 2015	Q4 2015	0	40	8.35	13.00	0	0
West									
Community Mental Health Unit, Donegal	Refurbishment of Rowanfield House to provide a community mental health unit for the area	Q4 2014	Q1 2015	0	0	0.12	1.98	0	0
Limerick University Hospital	Completion of refurbishment works in Unit 5B, mental health acute inpatient unit	Q4 2014	Q1 2015	0	0	1.09	8.70	0	0
Loughrea, Co. Galway	Refurbishment of a section of a recently vacated St. Brendan's Community Hospital to provide accommodation for the community mental health team	Q4 2015	Q4 2015	0	0	0.45	0.50	0	0
Ballinasloe, Co. Galway	Reconfiguration of ground floor of the admissions building (POL project)	Q3 2015	Q4 2015	0	16	0.90	1.25	0	0
Ballinasloe, Co. Galway	Provision of a high support hostel accommodation	Q4 2015	Q4 2015	0	8	0.45	0.50	0	0
Gort Glas, Ennis, Co. Clare	Refurbishment of Gort Glas to provide a mental health day centre	Q2 2015	Q3 2015	0	0	0.75	0.80	0	0
Nazareth House, Sligo	Nazareth House refurbishment to accommodate Child and Adolescent Unit/team (phase 1)	Q1 2015	Q1 2015	0	0	0.90	0.90	0	0

Schedule 1: Performance Accountability Framework

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Accountability Framework

Performance Accountability Framework
for the Health Services

2015

CONTENTS

The Accountability Framework: What will be different in 2015?

The HSE's Accountability Framework to be introduced in 2015 is described in this document. It sets out the means by which the HSE and in particular the National Divisions, Hospital Groups and Community Healthcare Organisations (CHOs), will be held to account for their performance in relation to Access to services, the Quality and safety of those Services, doing this within the Financial resources available and by effectively harnessing the efforts of its overall Workforce.

The introduction of an Accountability Framework as part of the HSE's overall governance arrangements is an important development and one which will support the implementation of the new health service structures. Many of the accountability processes are already in place and have operated over a number of years. The main changes in 2015 will be:

- Strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group CEOs and the CHO Chief Officers.
- The introduction of formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers.
- The introduction of a formal escalation, support and intervention process for underperforming services which will include a range of sanctions for significant or persistent underperformance.
- New national level management arrangements for the new CHO Chief Officers.
- The establishment of a new National Performance Oversight Group which will replace the current National Planning, Performance and Assurance Group (NPPAG).
- Accountability arrangements will also be put in place between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc.) in respect of delivery against their Divisional Operational Plans.

All of the above changes, together with the other arrangements that are in place, are described in this document.

Introduction and Executive Summary

Overview

The HSE is the statutory body with responsibility for the delivery of health and personal social services within the resources allocated to it by the Minister. In discharging its public accountabilities, the HSE has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it also has a range of other accountability obligations to the Oireachtas, Oireachtas Committees and to its Regulators.

The HSE regularly reviews its Governance arrangements and in the context of the new health service structures currently being implemented through the establishment of 7 Hospital Groups and 9 Community Healthcare Organisations (CHOs), the HSE is strengthening its Accountability Framework to bring greater clarity in relation to accountability obligations at each level of the organisation.

Accountability and the National Service Plan 2015

The HSE recognises that continually strengthening accountability and good governance within the HSE is of critical importance. In this context, the Minister has requested that the HSE develop and implement a robust Accountability Framework for 2015. In particular the Framework is required to make *'explicit the responsibilities of managers and which describes in detail the means by which the health service, and in particular hospital groups and community healthcare organisations, will be held to account in 2015 for their efficiency and control in relation to service provision, patient safety, finance and HR'*. In addition, it requires the National Service Plan to '*include specific targets (across the balanced scorecard of quality, access, finance and HR), timelines for achievement, escalation processes and actions to be taken on foot of underperformance'*.

An effective regime of scrutiny and accountability must therefore provide clarity about a single line of accountability through the organisation, be accompanied by a clear set of rules, standards, measures and measurement systems and be underpinned by values and behaviours that will support and not undermine individual and organisational accountability.

Introduction to the Accountability Arrangements

The Accountability Framework to be introduced in 2015 is described in this document. It sets out the means by which the HSE and in particular the National Divisions, Hospital Groups, CHOs and the National Ambulance Service, will be held to account for their performance in relation to Access to services, the Quality and safety of those Services, doing this within the Financial resources available and by effectively harnessing the commitment and expertise of its overall Workforce.

The key components of the Accountability Framework set out in this document are the:

Section 1: Accountability levels

Section 2: Accountability Suite (Plans, Agreements and Reports)

Section 3: Accountability processes

Section 4: Escalation, supports, interventions and sanctions

Section 1: Accountability levels

There are five main levels covered by this Accountability Framework. These are the accountability of the:

- HSE through the Directorate to the Minister
- Director General to the Directorate
- National Directors to the Director General, (including National Directors for Support functions, Finance, HR and Health Business Services).
- Hospital Group CEOs and CHO Chief Officers to the relevant National Directors.
- Service Managers and the CEOs of Section 38 and Section 39 agencies to Hospital Group CEOs and CHO Chief Officers.

Section 2: Accountability Suite (Plans, Agreements and Reports)

The National Service Plan is the contract between the HSE and the Minister, against which the HSE's performance is measured. A National Performance Assurance Report is produced on a monthly basis which is provided to the Minister for Health and subsequently published. An Annual Report is also produced.

A key feature of the Accountability Framework in 2015 will be the introduction of formal Performance Agreements. These Agreements will be put in place at two levels.

- The first level will be the National Director Performance Agreement between the Director General and each National Director (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service).
- The second level will be the Hospital Group CEO Performance Agreement and CHO Chief Officer Performance Agreement which will be with the National Director Acute Hospitals and relevant National Directors for community services respectively.

National Directors will be accountable for the delivery of their Divisional component of the National Service Plan. This will be reflected in the Performance Agreement. The Performance Agreement will in addition focus on a number of key priorities contained in the Service Plan or Divisional Plan. These priorities will be captured in a Balanced Score Card which will ensure accountability for the four dimensions of Access to services, the Quality and safety of those Services, doing this within the Financial resources available and by effectively harnessing the commitment and expertise of its overall Workforce. The Balanced Score Card will set out both quantitative and qualitative measures.

The Agreement will also set out the core performance expectations, accountability arrangements and escalation and intervention measures that will be put in place. A consistent approach to these new arrangements will be required at each accountability level.

Accountability arrangements will also be put in place between the Director General and the relevant National Directors for support functions (e.g. Finance/ HR/ Health Business Services etc) in respect of delivery against their Divisional Operational Plans.

Section 3: Accountability processes

A number of Corporate and Divisional level performance management processes are already in place. One of the key features of this Accountability Framework will be the establishment of a new National Performance Oversight Group which will replace the current National Planning, Performance and Assurance Group (NPPAG). The role, functions and membership of the National Performance Oversight Group will be different to the NPPAG. It will have a new remit in relation to the HSE's overall Accountability Framework and it will be the principal planning and performance assurance group in the HSE. The arrangements for the new Oversight Group are set out in Section 3. The main outputs from this Group will be the:

- Monthly National Performance Assurance Report for submission by the Directorate to the Minister.
- Formal escalation of performance issues to the Director General by the Deputy Director General (Chair of the National Performance Oversight Group).

The monthly Performance Management processes between the Director General and National Directors and between National Directors and Hospital Group CEOs and CHO Chief Officers will be further strengthened in 2015 to give effect to the new Performance Agreements.

Section 4: Escalation, interventions and sanctions

One of the most important elements of the HSE's strengthened accountability arrangements will be a requirement that Managers at each level ensure that any issues of underperformance are identified and addressed at the level where they occur. Where there are however issues of persistent underperformance in any of the quadrants of the Balanced Score Card, the HSE will implement a formal Performance Escalation, Support and Intervention process as part of its Accountability Framework. The process will include the:

- Responsibilities at each level for performance and escalation.
- The thresholds and tolerances for underperforming services at each level.
- The type of supports and interventions to be taken at each level of escalation.

Each National Director as part of their Performance Agreement with the Director General, will be required to specify and agree the escalation thresholds and intervention measures for the targets set out in the Balanced Score Card

Summary: What will be different in 2015?

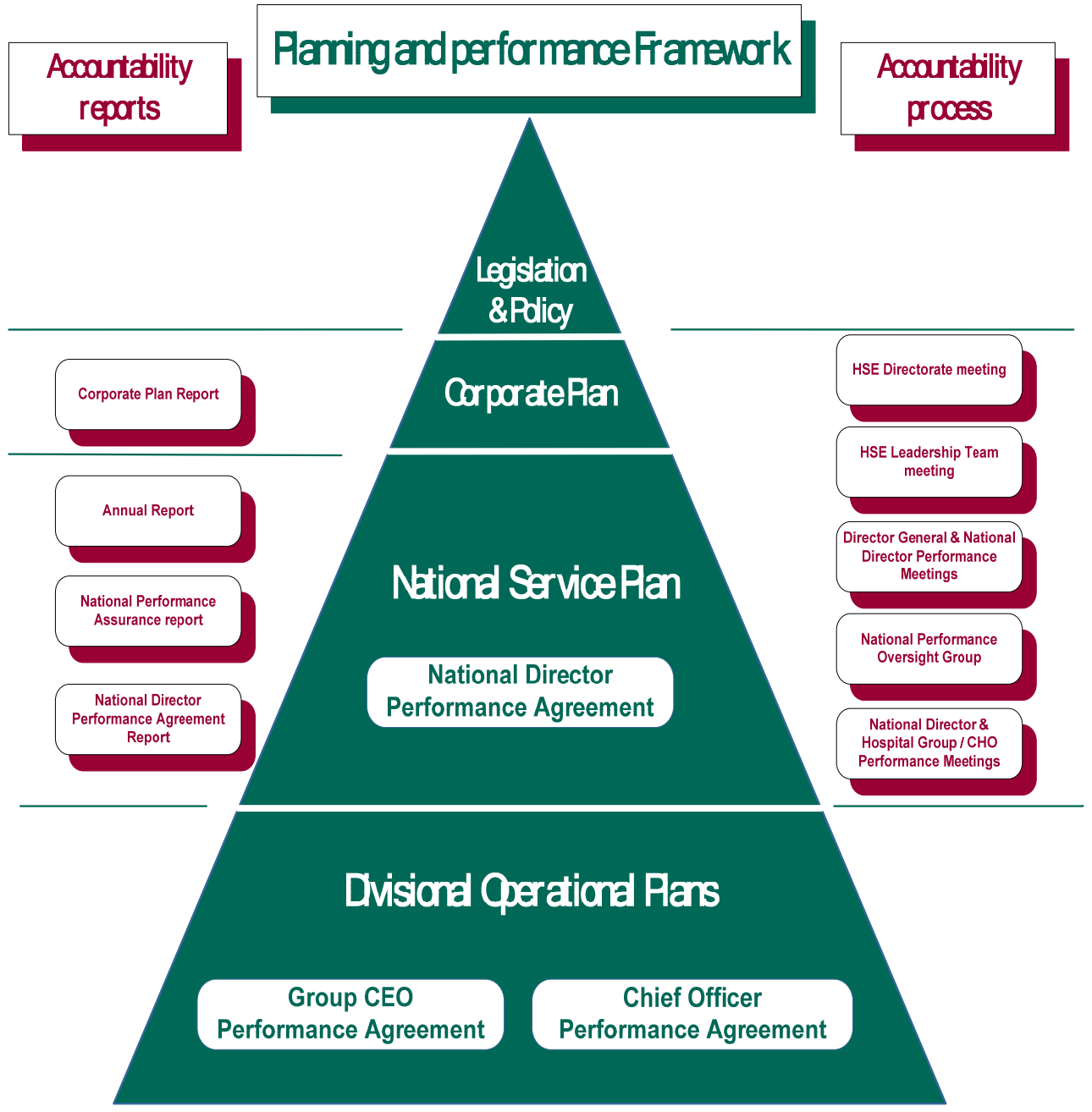
The introduction of an Accountability Framework as part of the HSE's overall governance arrangements is an important development and one which will support the implementation of the new health service structures. Many of the accountability processes are already in place and have operated over a number of years. The main developments in 2015 are:

- Strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group CEOs and the CHO Chief Officers.
- The introduction of formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital Group CEOs and the CHO Chief Officers.

- The introduction of a formal escalation and intervention process for underperforming services which will include a range of sanctions for significant or persistent underperformance.
- New national level management arrangements for the new CHO Chief Officers.
- The establishment of a new National Performance Oversight Group which will replace the current National Planning, Performance and Assurance Group (NPPAG).

All of the above changes, together with the other arrangements that are in place, are described in this document.

HSE Accountability Framework 2015



Section 1. Accountability levels

The five levels of accountability (i.e. who is calling who to account) set out in the Framework are described below.

Level 1 Accountability:	■ The HSE's accountability through the Directorate[2] to the Minister for Health
Level 2 Accountability:	■ The Director General's accountability to the Directorate
Level 3 Accountability:	■ National Directors accountability to the Director General
Level 4 Accountability:	■ Hospital Group CEOs accountability to National Director Acute Hospitals. ■ CHO Chief Officers accountability to National Directors for Community Services
Level 5 Accountability:	■ Service Managers accountability to the relevant Hospital Group CEO or CHO Chief Officer. ■ Section 38 and Section 39 funded agencies accountability to the relevant Hospital Group CEO or CHO Chief Officer.

Section 2. Accountability suite (Plans, Agreements and Reports)

2.1 Overview

Plans

There are a number of documents that form the basis of the Accountability Framework.

- The Corporate Plan is the 3 year strategic Plan for the Health Service.
- The National Service Plan sets out prospectively the performance commitments of the HSE. It describes the type and volume of services which will be provided within the funding provided by Government. This Plan serves as the Contract between the HSE and the Minister for Health, against which the performance of the HSE is measured.
- Divisional Plans are prepared for each of the HSE's service Divisions. These detailed Plans, together with the divisional component of the National Service Plan are the basis against which the performance of each National Director and their Division are measured and reported.

Performance Agreements

From 2015 the monitoring and management of these plans will be strengthened through the introduction of formal Performance Agreements which will explicitly link accountability for the delivery of the HSE's Plans to managers at each level of the organisation.

- The National Director Performance Agreement will be between the Director General and National Directors. (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service).The form of this agreement is currently being developed.

---

[2] Section 7 of the Health Service Executive (Governance) Act 2013 establishes the Directorate as the governing body of the HSE. The Directorate is accountable to the Minister for the performance of its functions and those of the HSE and the Director General accounts to the Minister on behalf of the Directorate through the Secretary General of the Department of Health. The current members of the Directorate are the Director General, the Deputy Director General, the Chief Financial Officer and the National Directors for Acute Hospitals, Primary Care, Social Care, Mental Health and Health and Wellbeing services.

- The Hospital Group CEO Performance Agreement will be between the National Director Acute Hospitals and each Hospital Group CEO.
- A single CHO Chief Officer Performance Agreement (covering all community services Divisions) will be put in place between the four National Directors for Primary Care, Social Care, Mental Health and Health and Wellbeing and each of the CHO Chief Officers.
- *Performance Agreements at each level, while linked to specific Divisions and service organisations, will also set out expectations in relation to integration priorities and cross boundary working.*

An Executive Management Committee for Community Services, comprising the four National Directors (i.e. Primary Care, Social Care, Mental Health, Health and Wellbeing) will be established in 2015. One of the four Directors will be appointed by the Director General to Chair the Committee.

It will be in this Forum that each CHO Chief Officer will be held to account and the Committee will be expected to oversee community services performance in a coordinated way. Individual National Directors and their Teams will have ongoing interactions with the CHO Chief Officers and their teams in the normal course of the business of each Division. In this context National Directors will continue to hold their Divisional meetings with each CHO in discharging their delegated accountability.

CHO Chief Officers will have a single reporting relationship and this will be to the Chair of the Executive Committee who will be their Line Manager and to whom they will be accountable.

Performance reports

The HSE will also continue to retrospectively account for delivery of its services through the National Performance Assurance Report (NPAR). This Report is produced on a monthly basis by the HSE and submitted to the Department of Health. The NPAR sets out the HSE's performance against its National Service Plan commitments.

The HSE also prepares an Annual Report which having been submitted to the Minister for Health is laid before the Houses of the Oireachtas.

2.2 Accountability Arrangements at each level

National Directors accountability to the Director General

As set out above, delivery of the National Service Plan will be measured, monitored and performance managed in 2015 through a formal Performance Agreement to be put in place between the Director General and each National Director.

National Directors will be accountable for the delivery of their Divisional component of the National Service Plan. This will be reflected in the Performance Agreement. The Performance Agreement will in addition focus on a number of key priorities contained in the Service Plan or Divisional Plan. These priorities will be captured in a Balanced Score Card which will ensure accountability for the four dimensions of Access to services, the Quality and safety of those Services, doing this within the Financial resources available and by effectively harnessing the efforts of its overall Workforce.

The Performance Agreement will also set out the core performance expectations, accountability arrangements and escalation, support and intervention measures that will be put in place.

The Balanced Score Card will be the basis for the Performance Agreements and Performance Management Reports to the Director General. *Two sample Balanced Score Cards (BSC) are set out below for illustrative purposes only. The measures listed are not necessarily those which will appear on the 2015 Balanced Score Card.*

Balanced Score Card 2015 Acute Hospitals

1. Quality and Safety	3. Access
▪ Client experience and complaints ▪ Serious Reportable Events compliance ▪ Pressure Ulcer Incidence ▪ Stroke services ▪ Acute Coronary Syndrome services ▪ Re-admission rates ▪ Hospital Mortality rates ▪ National Early Warning Score (NEWS) implementation	▪ Discharges Activity ▪ Inpatient Admissions ▪ Inpatient waiting times ▪ Emergency Care and Patient Experience Time ▪ Colonoscopy / Gastrointestinal Service waiting times ▪ Delayed Discharges reduction ▪ Ambulance Turnaround Times at emergency departments ▪ Average Length of Stay (ALOS) for all inpatients
2. Finance	**4. Human Resources**
▪ Variance against Budget: Income and Expenditure ▪ Variance against Budget: Income collection / Pay / Non Pay / Revenue and Capital Vote ▪ Service Arrangements in place ▪ Annual Compliance Statements signed	▪ Absence rates ▪ Staffing levels Variance from approved funding level ▪ Levels of agency spend and conversion of agency spend ▪ Compliance with European Working Time Directive (EWTD) ▪ Workforce development and training

Balanced Score Card 2015 Disability Services

1. Quality and Safety	3. Access
■ Client experience and complaints ■ Serious Reportable Events compliance ■ Disability Act assessments ■ Quality improvement methodologies in place	■ 0-18s Programme implementation plans ■ Personal Assistant (PA) Hours provided ■ Home Support Hours provided ■ Rehabilitation Training graduate placements ■ Overnight respite Services ■ Moving from congregated Settings
2. Finance	**4. Human Resources**
■ Variance against Budget: Income and Expenditure ■ Variance against Budget: Pay / Non Pay / Revenue and Capital Vote ■ Service Arrangements in place ■ Annual Compliance Statements signed	■ Absence rates ■ Staffing levels and variance from approved funding ■ Levels of agency spend and conversion of agency spend ■ Workforce development and training

Hospital Group CEOs/ CHO Chief Officers accountability to National Directors

The Divisional Plans for each Hospital Group and CHO are the basis against which the performance of these service delivery organisations will be measured and reported.

Mirroring the accountability arrangements in place between the Director General and each National Director, delivery of the Hospital Group and CHO Plans will be measured, monitored and performance managed in 2015 through a formal Performance Agreement to be put in place between the relevant National Directors and each Hospital Group CEO and CHO Chief Officer. This Performance Agreement will focus on a number of key priorities set out in the Hospital Group/ CHO Plans. The Agreement will also set out the core performance expectations and accountability arrangements that will be put in place between the National Directors and the Hospital Group CEOs/ CHO Chief Officers.

Performance Agreements for each Hospital Group CEO and CHO Chief Officer will also be required to set out the integration arrangements that will be put in place between hospital and community services.

In the case of acute hospitals, a Memorandum of Understanding (MOU) is being developed to regulate and give context to the relationship between the HSE as the relevant legal entity and the non statutory Board in place for each hospital group. The MOU ***will not*** *be an accountability mechanism between the HSE and a hospital group and / or Group CEO.*

Service Managers accountability to Hospital Group CEOs/ CHO Chief Officers

Hospital Group and CHO Plans will be the basis against which the performance of each individual service is measured and reported on by the relevant Hospital Group CEO or CHO Chief Officer.

Service Arrangements and Grant Aid Agreements will continue to be the contractual mechanism governing the relationship between the HSE and each Section 38 and Section 39 Agency. Work will be undertaken during 2015 to streamline the Service Arrangement and Grant Agreement process with a particular focus on reducing the requirement for multiple Agreements for single national agencies.

Section 3. Accountability processes

The HSE's Accountability Processes for 2015 are described below.

HSE corporate accountability to the Minister

National Performance Oversight Group

The National Planning and Performance and Assurance Group as a sub Group of the Directorate is currently the principal planning and performance assurance group in the HSE. Until the third quarter of 2014, its assurance role was supported by the regional assurance processes undertaken by the Regional Directors of Performance and Integration.

As part of the strengthened accountability arrangements for 2015 the following arrangements will be put in place.

- National Directors will continue to be directly accountable to the Director General for their performance and that of their Divisions.
- A new National Performance Oversight Group will be established and will replace the current National Planning, Performance and Assurance Group (NPPAG).
- This Group will have formal delegated authority from the Director General to serve as a key accountability mechanism for the health service and to support him and the Directorate in fulfilling their accountability responsibilities.
- It will be the responsibility of the newly constituted National Performance Oversight Group as a part of the overall accountability process to hold each National Director as the head of their Division to account for performance against the National Service Plan, under the four Balanced Score Card quadrants of Quality and Safety, Finance, Access and Workforce.
- The standing membership of the Group will be the:
  - Deputy Director General (Chair)
  - Chief Financial Officer
  - National Director Quality Assurance and Verification
  - National Director Human Resources.
- The National Performance Oversight Group will meet with each National Director for services (i.e. Acute Hospitals, Primary Care, Social Care, Mental Health, Health and Wellbeing and the National Ambulance Service) on a monthly basis to review the performance of their Division against the National Service Plan. (The format for these meetings will

be different to the current NPPAG as they will involve individual meetings with each National Director, rather than a round table with all Directors).

- The Leadership Team will then be the primary round table meeting to discuss the National Performance Assurance Report.
- The National Directors for Clinical Strategy and Programmes and Quality Improvement may be requested to attend the meetings of the NPOG where required.
- Other National Directors, personnel may attend as required to deal with specific performance related issues.

The main outputs from this Group will be:

- The Monthly National Performance Assurance Report for submission to the Director General
- Where required a formal Escalation Report in relation to serious performance issues to the Director General by the Deputy Director General (Chair of the Oversight Group).

The Director General will on the basis of the National Performance Assurance Report, report on overall health service performance to the Directorate. The Directorate will then formally consider the National Performance Assurance Report before its approval and submission to the Minister.

A post National Performance Oversight Group escalation meeting with the Director General may be requested by the Deputy DG as Chair of the Group. Depending on the performance issue being escalated, the Chair may be accompanied at this meeting by the Chief Financial Officer, the National Director for Quality Assurance and Verification and other National Directors as required.

There will be a full annual comprehensive review of Performance by the National Performance Oversight Group undertaken once a year. This meeting will be attended by the Director General.

National Directors accountability to the Director General

The Director General will formally review the delivery of the National Director Performance Agreement at monthly Performance Review Meetings with individual National Directors. The Director General may also convene an Exceptional Performance Review meeting to address any major issues of underperformance and in particular any issues escalated by the Chair of the NPOG.

A Performance Agreement Report to support the Performance Review will be produced monthly. The elements of the report will include:

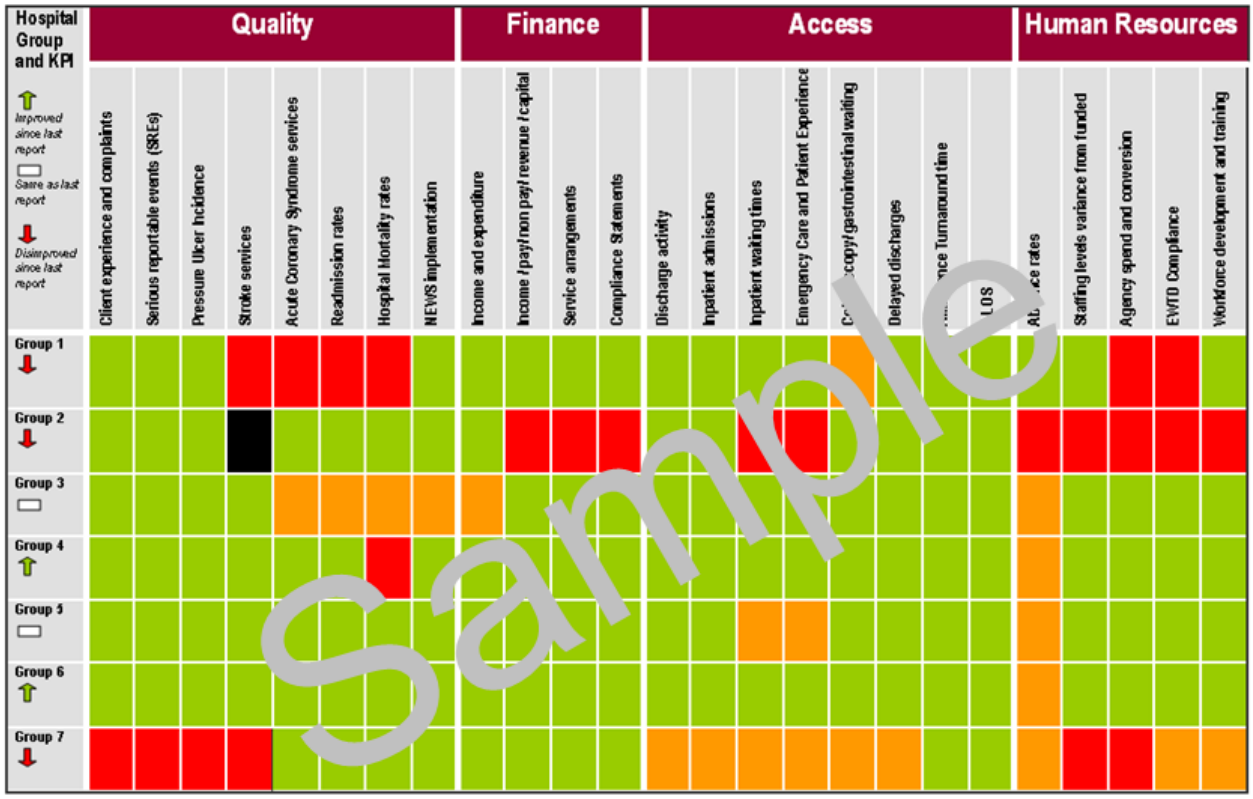
- Divisional component of the National Performance Assurance Report based on the Balanced Score Card (BSC). A sample *Heat Map* report is set out below and larger copy in the final section of this document)
- Any Escalation Report.
- A report on any formal Action Plans agreed at the previous review meeting may also be considered.

If any exceptional issues are to be addressed the Director General may request the attendance of the Deputy Director General, Chief Financial Officer, National Director HR, National Director for Quality Assurance and Verification or other National Directors.

The metrics in this Heat Map are for illustrative purposes only and are not necessarily those which will appear on the 2015 Balanced Score Card.

Acute Hospitals Division *Sample*

Performance: Summary Heat Map



Hospital Group CEOs and CHO Chief Officers accountability to National Directors

The National Directors for Acute Hospitals and Community Services will hold formal monthly Performance Management meetings with Hospital Group CEOs/ CHO Chief Officers. These will take the form of;

Acute Hospitals

The National Director for Acute Hospital Services will formally review the delivery of the **Hospital Group CEO Performance Agreement** at monthly **Performance Review Meetings** with each individual Hospital Group CEO and members of their core teams. These will be the principal accountability meetings at which progress against the **Hospital Group CEO Performance Agreement** and the **Divisional Service Plan** with each Group CEO will be reviewed.

The National Director Acute Hospitals will be required to set out in writing the formal **Performance Management Arrangements** for his Division and agree these with the Director General, together with his Performance Agreement.

Community Services

The Community Services Executive Management Committee will formally review the delivery of the CHO Chief Officer Performance Agreement at monthly Performance Review Meetings with each CHO Chief Officer and members of their core teams. These will be the principal accountability meetings at which progress against the CHO Chief Officer Performance Agreement and the Divisional Service Plans will be reviewed.

The output of these meetings will form part of the Divisional Component of the National Performance Assurance Report.

National Directors and their Divisions will continue to have ongoing interactions with the CHO Chief Officers and their teams in the normal course of the CHOs' business.

Each of the National Directors for Community Services will be required to set out in writing the formal Performance Management Arrangements in place for their Division and in relation to their interactions with the CHOs. These will have to be coordinated by the Chair of the Community Services Executive Committee and agreed with the Director General, together with their Performance Agreements.

National Ambulance Service

The National Director with responsibility for the National Ambulance Service will formally review the delivery of Ambulance Services at monthly Performance Review Meetings with the Director of the National Ambulance Service and members of his core team. This will be the principal accountability meeting at which progress against the National Ambulance Service Operational Plan will be reviewed.

The National Director with responsibility for the National Ambulance Service will be required to set out in writing the formal Performance Management Arrangements for the National Ambulance Service and agree these with the Director General, together with his Performance Agreement.

Service Managers accountability to Hospital Group CEOs/ CHO Chief Officers

Each Hospital Group CEO and CHO Chief Officer will be required to establish a formal monthly performance management process with their next line of managers. It is expected that any deviations from planned performance will be addressed at this level in advance of the Hospital Group or CHO Performance Management meetings with the National Directors.

Section 38 and 39 Agencies accountability to Hospital Group CEOs/ CHO Chief Officers

The HSE provides funding of more than €3 Billion annually to the non statutory sector to provide a range of health and personal social services. The Service Arrangement or Grant Aid Agreement will continue to be the principal accountability agreement between the Hospital Group CEOs and CHO Chief Officers and Section 38 and 39 funded Agencies. There will be a named manager responsible for managing the contractual relationship with each individual agency. The level of seniority will reflect the level of funding provided. This person will be responsible for overseeing the negotiation of the Service Arrangements or Grant Aid Agreements including specific service specification, financial and

quality schedules etc. They are also responsible for monitoring the performance and financial management of the specified agreement.

The HSE has appointed a Head of Compliance. Further direction in relation to how accountability arrangements between the HSE and its funded agencies can be strengthened will be set out in the final quarter of 2014.

Section 4. Escalation and intervention framework

4.1 Performance

One of the most important elements of the HSE's strengthened accountability arrangements will be a requirement that Managers at each level ensure that any issues of underperformance are identified and addressed at the level where they occur.

Underperformance in this context includes performance that:

- Places patients or service users at risk;
- Fails to meet accepted and required standards for that service.
- Departs from what is considered normal practice.

As described in this document, performance will be measured against the four Balanced Score Card quadrants of Quality and Safety, Finance, Access and Workforce. Where the measures and targets set out in these areas are not being achieved, this will be considered to be '*underperformance*'. It is recognised however that underperformance may be minor to severe and may be temporary or persistent. Any formal designation of service underperformance will have to recognise these conditions. Each National Director will be required therefore as part of the new Accountability Framework to agree an overall set of thresholds and 'tolerance levels' against which underperformance issues will need to be escalated to Group CEOs/ CHO Chief Officers, National Directors, the Chief Financial Officer, the National Director Quality Assurance and Verification, the Deputy Director General or indeed the Director General.

Where escalation occurs, the accountability arrangements in place will require the relevant senior manager to ensure that appropriate interventions are commissioned and implemented.

4.2 Escalation levels

The HSE is currently developing a formal performance escalation process as part of its Accountability Framework. The process will describe the:

- Responsibilities at each level of performance and escalation.
- The thresholds and tolerances for underperforming services at each level.
- The type of interventions to be taken at each escalation level.

It is recognised that formal escalation processes will be new to many parts of the health service. As such it is intended that escalation arrangements for 2015 will be practical and implementable and will form the basis for more sophisticated systems in subsequent years.

Sample escalation levels are set out below and each National Director as part of their Performance Agreement with the Director General will be required to specify and agree the escalation thresholds and intervention measures for the targets set out in the Balanced Score Card

Responsible person	Escalation level	Description
Service Manager	Level 0	Normal operating No issues
Service Manager	Level 1	Green Step-up level 1 Early signs of difficulty requiring some extra management support or intervention at service level
Hospital Group CEO CHO Chief Officer	Level 2	Amber Escalation level 2 Persistent performance issues requiring significant additional management action at Hospital Group/ CHO level
National Director Deputy Director General CFO	Level 3	Red Escalation level 3 Severe and/or prolonged performance issues requiring significant additional senior management action and intervention
Director General	Level 4	Black Escalation level 4 Critical and/or prolonged performance issues that seriously threaten the quality, delivery or financial sustainability of services that require action to be taken by the Director General or Directorate.

4.3 Performance ratings

In 2015 the HSE will introduce a system of performance ratings for individual services based on the escalation levels set out above. These will be proposed by the National Performance Oversight Group on a monthly basis and agreed with the relevant National Directors before being submitted to the Director General.

4.4 Support, Intervention and Sanctions

Supports

In most cases of underperformance, managers up to and including National Directors will be expected to put in place a programme of supports to assist individual managers and services in addressing any issues of underperformance. This support may take a range of forms including:

- Assistance in analysing the contributory issues leading to underperformance and in designing solutions.
- Additional supports from the relevant business support and / or Clinical Strategy and Programmes Divisions.
- Mentoring for managers and clinicians.
- Advisory support.
- Access to specialist resources, consultancy etc.
- Training and development.

Interventions

In addition to supports being put in place it is anticipated that in most cases, additional monitoring and management focus will be sufficient to address areas of underperformance. There will be times however, either because of the severity of the underperformance issue, or because of its persistent nature, that formal service interventions will be required. These Interventions may take a number of forms depending on the performance issue identified and may include:

- Enhanced monitoring by Hospital Group CEOs, CHO Chief Officers and National Directors.
- Issuing of formal performance notices to National Directors, Hospital Boards, Hospital Group CEOs, CHO Chief Officers and other managers specifying the performance improvement expectation, timeframes, accountability arrangements and consequences where there is insufficient improvement.
- Developing, implementing and monitoring service improvement plans.
- Placing a service formally into a 'Special Measures' category. This could result in:
    - Temporary Removal of some delegated authority from the service while improvement plans are being implemented.
    - Assigning a formal improvement team to support underperforming services.
    - Assignment of a senior manager on an interim basis with specific delegated responsibility for the service concerned and with a primary focus on addressing the areas of underperformance.
    - Sanctions being applied. (see below)
- Compulsory training programmes.
- Public reporting on the performance status of individual services and the programme of interventions in place.

Sanctions regime

The HSE aspires to be a learning organisation and one that supports managers, clinicians and staff to deliver on the objectives and expectations of the organisation. There will however be times where in spite of supports provided or formal interventions taken, performance does not improve. In these cases sanctions may have to be imposed. Sanctions where imposed should be graduated and always aimed at bringing about improvement rather than as punishment. Examples of the type of sanctions that may be imposed by the Director General or National Directors include;

- Financial penalties (e.g. reduction in budget, deficits as first charge on subsequent year, less priority given for development funding etc).
- Invoking the disciplinary process up to and including the removal from post of the National Director, Hospital Group CEO or Chief Officer.

Samples

Sample Balanced Score Cards
Sample Performance Report (Heat Map)

Balanced Score Card 2015 Acute Hospitals

1. Quality and Safety	3. Access
■ Client experience and complaints ■ Serious Reportable Events compliance ■ Pressure Ulcer Incidence ■ Stroke services ■ Acute Coronary Syndrome services ■ Re-admission rates ■ Hospital Mortality rates ■ National Early Warning Score (NEWS) implementation	■ Discharges Activity ■ Inpatient Admissions ■ Inpatient waiting times ■ Emergency Care and Patient Experience Time ■ Colonoscopy / Gastrointestinal Service waiting times ■ Delayed Discharges reduction ■ Ambulance Turnaround Times at emergency departments ■ Average Length of Stay (ALOS) for all inpatients
2. Finance	**4. Human Resources**
■ Variance against Budget: Income and Expenditure ■ Variance against Budget: Income collection / Pay / Non Pay / Revenue and Capital Vote ■ Service Arrangements in place ■ Annual Compliance Statements signed	■ Absence rates ■ Staffing levels Variance from approved funding level ■ Levels of agency spend and conversion of agency spend ■ Compliance with European Working Time Directive (EWTD) ■ Workforce development and training

The metrics in this Balanced Score Card (BSC) are for illustrative purposes only and are not necessarily those which will appear on the 2015 BSC.

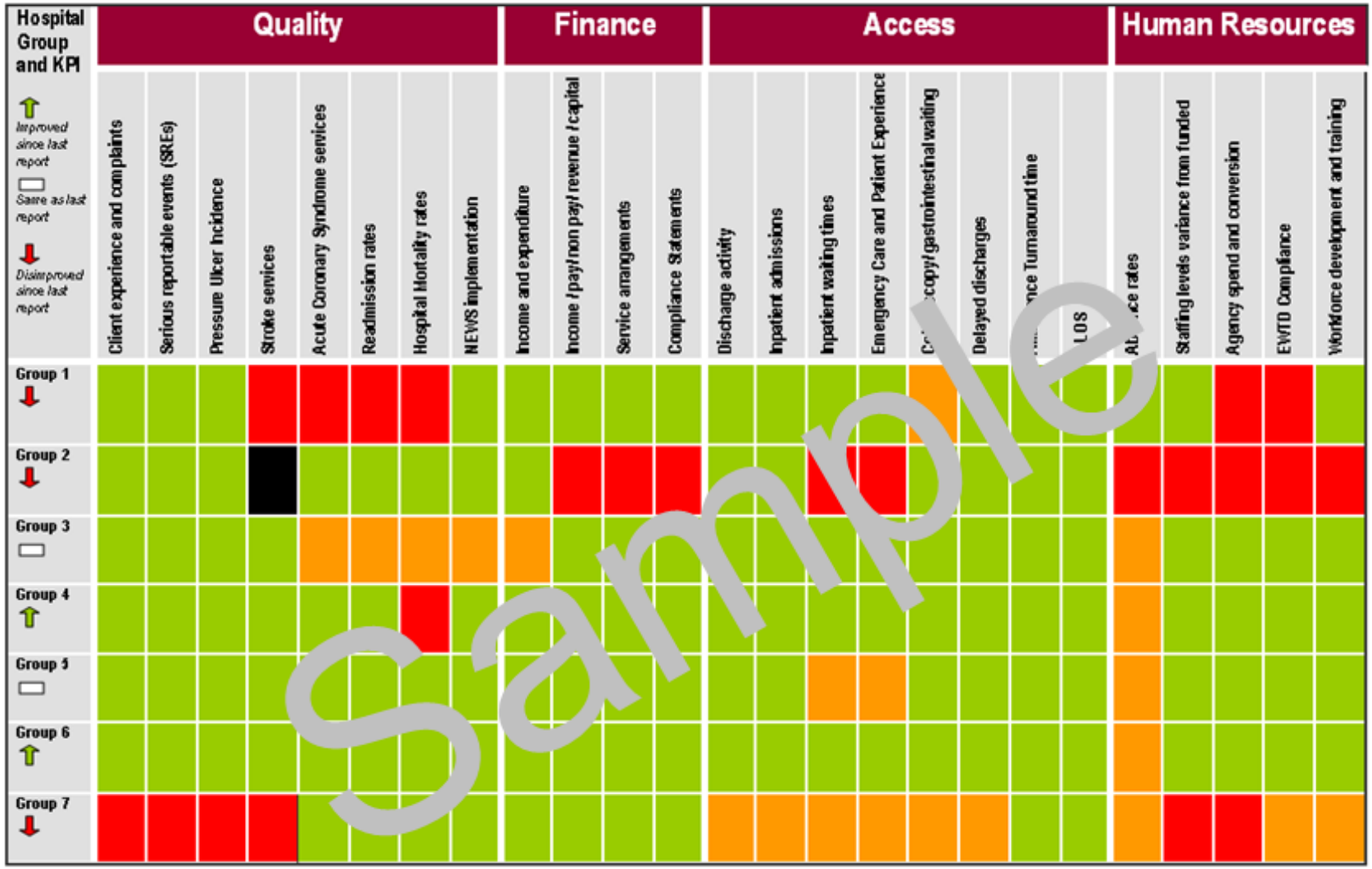
Balanced Score Card 2015 Disability Services

1. Quality and Safety	3. Access
■ Client experience and complaints ■ Serious Reportable Events compliance ■ Disability Act assessments ■ Quality improvement methodologies in place	■ 0-18s Programme implementation plans ■ Personal Assistant (PA) Hours provided ■ Home Support Hours provided ■ Rehabilitation Training graduate placements ■ Overnight respite Services ■ Moving from congregated Settings
2. Finance	**4. Human Resources**
■ Variance against Budget: Income and Expenditure ■ Variance against Budget: Pay / Non Pay / Revenue and Capital Vote ■ Service Arrangements in place ■ Annual Compliance Statements signed	■ Absence rates ■ Staffing levels and variance from approved funding ■ Levels of agency spend and conversion of agency spend ■ Workforce development and training

The metrics in this Balanced Score Card (BSC) are for illustrative purposes only and are not necessarily those which will appear on the 2015 BSC.

Acute Hospitals Division *Sample*

Performance: Summary Heat Map



The metrics in this Heat Map are for illustrative purposes only and are not necessarily those which will appear on the 2015 BSC

Schedule 2: Quality and Patient Safety Enablement Programme

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality and Patient Safety

Quality and Patient Safety Enablement Programme

CONTENTS

Overview: Quality and Patient Safety Enablement

The HSE places a significant emphasis on quality and patient safety and it seeks to ensure this focus remains at the heart of health service delivery, so that people's experience of the health service is not only safe and of high quality, but also caring and compassionate. It is in this context that the HSE wants to put in place the optimum arrangements for Quality Improvement and Patient Safety, which also take account of the HSE's new organisational structures. A review of the current Quality and Patient Safety arrangements was undertaken in 2014. This review took account of International best practice and this paper therefore;

- Sets out the changes that flow from this review.
- Describes the rationale for and key elements of a new Quality and Patient Safety Enablement Programme established by the HSE, that captures the continuum of activities required to effectively deliver on all aspects of quality improvement and patient safety.

To deliver on this Programme, key organisational leadership roles have been assigned to two National Directors. Dr Philip Crowley will be responsible for the Quality Improvement Division (QID) and Mr Ian Carter will be responsible for the Quality Assurance and Verification Division (QAVD).

This paper sets out the arrangements for the new Quality and Patient Safety Enablement Programme and has four key parts. They are;

1. The Quality and Patient Safety Enablement objectives and functions in line with International best practice. *(Sections 1 to 8)*
2. A functional and divisional summary of the Programme's key objectives and elements. *(Appendix 1)*
3. The allocation of the areas of Responsibility between the two newly described Divisions namely the Quality Improvement Division and the Quality Assurance and Verification Division. *(Appendix 2)*
4. Process flow for Serious Reportable Events. *(Appendix 3)*

The objective of the Quality and Patient Safety Enablement Programme is to deliver safer services, quality improvements and a patient safety culture across the health services.

INTRODUCTION

The HSE, like all leading healthcare systems, places patient safety and quality of care at the heart of service provision and delivery. The delivery of high quality, evidence based, safe, effective and person-centred care, is a key objective for the Health Service Executive.

International best practice points to the need for quality and patient safety functions to be robust at corporate level to support staff to embed a culture of quality and safety within their services. In this context, the HSE has redesigned its national Quality and Patient Safety function to give it an enhanced role in relation to both quality improvement and quality assurance, within an environment where patients, service users and staff are involved, their opinions sought and their voice is heard.

Underpinning these new arrangements is the establishment of a Quality and Patient Safety Enablement Programme which will give effect to these changes. This requires a reorganisation of its functions to support, facilitate and build a quality and safety agenda at corporate, divisional and service provider levels.

Enablement in this context refers to an approach that provides the means, opportunity and authority for service users and providers to develop the skills and confidence necessary to improve the quality and safety of services. The overall goal of the HSE's Quality and Patient Safety Enablement Programme is to improve the quality of services with measurable benefits for patients and service users. The four key objectives which underpin the Programme are as follows:

Objective 1:	Services must subscribe to a set of clear quality standards that are based on international best practice.
Objective 2:	Services must be safe and that there must be a robust level of both quality improvement and quality assurance.
Objective 3:	Services must be relevant to the needs of the population.
Objective 4:	Patients must be appropriately empowered to interact with the service delivery system.

To deliver on the key objectives required for the development of an effective and sustainable Quality, Patient Safety and Enablement Programme, a number of interlocking functions are necessary.

The interlocking quality functions comprise 8 key components:

1. A population focused enablement function
2. Enablement of the service delivery model
3. Identification of quality models of care
4. Performance measurement

5. Performance management
6. Assurance and verification
7. Intervention
8. Enforcement

Each of these components is explained below with a summary description of the;

- Core objectives of each relevant function in relation to quality and safety.
- Elements required to ensure successful implementation and long-term sustainability of patient safety and quality improvement activity.

A summary diagram encapsulating all eight components and their constituent parts is set out in Appendix 1 for ease of reference.

1. Population / Service User and Staff Engagement

1.1 Core Objectives

There are two main objectives to this function. The first is to deliver on staff, patient and client engagement by developing a proactive approach for engagement to inform service design and improvement and listening to ensure a responsive and patient centred organisation. This approach should seek to balance the power between service user and service provider by way of a strong patient advocacy focus, with particular attention on the following elements:

- Access to services
- Information
- Choice
- Redress
- Representation

The function must represent, and advocate on behalf of service users and ensure that the above elements are consistently applied to the overall service delivery model. The function would therefore work with services to use the insight gained from listening to patients and staff to influence improvement and innovation.

The second objective of this function is to support the Clinical Strategy and Programmes and Health and Wellbeing Divisions in the development of models of care that maximise the potential for patients and clients to self manage their care particularly in respect of chronic disease management. The support required to enable self-management encompasses the care and encouragement provided to people with chronic conditions and their families to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviours. This

requires a collaborative relationship that supports patients and clients in building the skills and confidence they need to achieve these goals.

1.2 Key elements

In order to ensure the successful implementation of this function the following key elements need to be put into place:

- Appointment of a designated lead officer within the Quality Improvement Division with responsibility for delivering on all objectives
- Development of formal work structures and work streams with each of the Service Divisions as well as Clinical Strategy and Programmes and the National Cancer Control Programme. This includes the need to establish cross functional matrix teams from the various Divisions and from within the service operational system under the leaderships of the designated officer.

2. Service Delivery Model / Quality Improvement

2.1 Core Objectives

The basic tenet of this function is to develop promote and embed a quality enablement service delivery models based on comprehensive engagement with patients, clients and staff. This requires:

- Creation of work structures and streams that allow for the appropriate level of engagement with patients and staff to ensure that their voice and experience is central to improving the services provided.
- Development of structures that enable the HSE to work with patients and staff to generate ideas and drive the spread of successful projects and innovation.
- Provision of appropriate supports to the system to enable compliance with national standards.
- Initiation of focused Quality Improvement Audits to ensure continuous service improvements
- Analysis of quality improvement information and data
- Development of framework for Clinical Governance including National Clinical Directors Programme

2.2 Key elements

In order to ensure the successful implementation of this function the following key elements are required:

- Establishing the National Performance Oversight Group (NPOG) as part of the HSE's new Accountability Framework for 2015. The NPOG will benchmark the performance of the service Divisions against the agreed targets set out in the National Service Plan and associated Divisional

Plans. There is a particular need to ensure focus on management of chronic conditions and Integrated Care Pathways particularly for the elderly population.

- Appointment of a designated lead officer from within the Quality Improvement Division with responsibility for delivering on all objectives.
- Development of formal work structures and streams with each of the 5 Service Divisions as well as Clinical Strategy and Programmes and the National Cancer Control Programme. This includes the need to establish cross functional matrix teams from the various Divisions and from within the operational system under the leadership of the designated officer.
- Authority for the ND QID to 'access all areas' of service provision to identify opportunities for service quality improvement, including the use of focussed quality improvement audits.

3. Identification of Quality Models of Care

3.1 Core Objectives

The international literature points to the need for robust engagement with service providers in order to identify agree and implement models of service delivery. Engaging service providers so that their voice and experience can be heard is central to how collective efforts can be harnessed to improve the services provided.

3.2 Key elements

In order to ensure the successful implementation of this function the following key elements are required:

- Clinical Strategy and Programmes continue to have a central role in designing clinical models of care that are appropriate, efficient and effective in collaboration with the Health and Wellbeing Division
- Service Divisions are responsible for implementing agreed models of care and for the monitoring and management of performance.

4. Performance Measurement

4.1 Core Objectives

Performance measures tell us how well we are doing, if we are meeting our goals and if improvements are necessary. Successful systems rely on the proactive collection and evaluation of both 'hard' and 'soft' intelligence that help us to understand our processes and to ensure that decisions are based on well documented facts and evidence.

The development and use of appropriate performance measures, indicators outcome measures and standards must:

- Be clear and measurable or quantifiable at local, regional and national level. Activity that cannot be measured cannot be controlled. Without dependable measurements, appropriate and optimal decisions cannot be made.
- Can be benchmarked nationally and internationally
- Must clearly define what is acceptable and unacceptable performance
- A successful quality performance measurement regime requires the information architecture that supports the collection of multiple datasets and readily enables the analysis and correlation of data from all sources including directly provided HSE services, voluntary agencies, State Claims Agency, Open Disclosure, Complaints, and Internal Audits etc.
- Arrangements for receiving assurance from service providers that action plans have been implemented remains the responsibility of the Service Divisions.

4.2 Key elements

In order to ensure the successful implementation of this function the following key elements are required:

- Identification of key performance indicators and outcomes and definition of acceptable and unacceptable performance
- Mandatory requirement to identify key risks and likelihood of these risks occurring based on international norms. This will enable agreed definition of acceptable and unacceptable performance
- Mandatory requirement for the timely escalation of alerts in relation to serious incidents and adverse events. The serious incident policy uses a system wide perspective for notification, management and learning from serious incidents. It supports openness, trust and continuous learning and service improvement.
- Service providers are required to notify the National Director Quality Assurance and Verification and HIQA about events that indicate or may indicate risks and adverse incidents.
- The National Director Quality Assurance and Verification has a responsibility to ensure that when a serious incident does happen, there are systematic measures in place for:
    - An auditable process and mechanism for reporting serious incidents to relevant bodies including HSE, HIQA, Mental health Commission etc
    - Agreed processes for reporting Serious Reportable Events to the HSE, with discussion as appropriate
    - Arrangements for ensuring that investigations take place within required timescales and use best practice methodologies such as root cause analysis
    - Ensuring that steps are taken in order to understand why the event occurred
    - Sharing the learning with other service providers

- Developing business intelligence capacity including robust data validation
- Developing ICT capacity to enable consolidation of multiple data and information strands

5. Performance Management

5.1 Core Objectives

Each Service Division is responsible for performance management within their areas and for ensuring that the appropriate controls are in place. Performance management includes activities which ensure that goals are consistently being met in an effective and efficient manner.

6. Assurance and Verification

6.1 Core Objectives

Robust quality assurance gives confidence that services are being provided in line with agreed national standards and are progressing in line with expectations. The international literature outlines the key elements necessary for successful Quality Assurance:

- Is robust and rigorous and gives confidence
- Ensures fairness to all patients, clients, service providers and is open and transparent
- Is fit for purpose and is proportionate
- Promotes capacity building and quality improvement.

The development of an enhanced quality assurance and verification function within the HSE must:

- Be discreet from other quality functions
- Have the authority, responsibility and accountability to undertake reactive and own initiative, indirect assessment, monitoring and inspection of all aspects of the service delivery model
- Independently report on service delivery model in terms of actual performance, causal factors for any unacceptable levels of performance and recommend corrective remedial actions where necessary
- Responsibility for implementation of all corrective and remedial actions remains with the Service Divisions

6.2 Key elements

In order to ensure the successful implementation of this function the following key elements are required:

- The existing National Incident Management Team (NIMT), Consumer Affairs, Quality Assurance and Verification will be incorporated into an enhanced and independent Quality Assurance and

Verification function headed by a Director of Quality Assurance and Verification (new function and position)

- Restructuring of existing staff from within existing departments of NIMT, Quality Assurance and Verification , QPS and Consumer Affairs
- Responsible for the development and maintenance of the Corporate Risk Register and for attendance at the HSE Risk Committee
- Designation of new post of National Director of Quality Assurance and Verification

7. Intervention

7.1 Core Objectives

The corporate control system must have sufficient authority, capacity capability and resolve to successfully intervene and ensure remedial action in instances of unacceptable performance.

In order to ensure the successful implementation of this function the following key elements are required:

- Adopt a zero tolerance regarding persistent poor performance.
- Ensure that the appropriate systems are in place to provide alerts to the HSE, DOH, HIQA and Mental Health Commission as required.
- Responsibility for implementation of necessary remedial action remains the responsibility of the Service Division

7.2 Key elements

- Mandate for the creation and mobilisation of Rapid Response Review Teams following detection of serious risk events that occur, have the potential to occur and in response to key performance diminution.
- The composition of Rapid Review Teams is most likely to be developed from cross divisional matrix teams previously mentioned.
- Authority for the instigation of Rapid Reviews is confined to the Director General, Deputy Director General, Service National Directors and National Director Quality Assurance and Verification
- The National Director of Quality Assurance and Verification has the authority to initiate an immediate review based on concerns or identified risks

8. Enforcement

8.1 Core Objectives

If a service provider is found to be in breach of regulations, standards or persistent poor performance, specific action is taken to improve performance. The action should be proportionate to the impact that the incident or poor performance has on the service and those who use it.

In the first instance, support should be provided to the service provider to enable them to achieve compliance. Compliance actions are therefore often precursors to enforcement action. Enforcement actions are taken where the breach is more serious or where a compliance action has not worked. Enforcement action can:

- Issuing a warning notice
- Impose change or condition in service provision
- Suspend service or relocate to alternative provider and or setting

These criteria include taking into account

- the impact on and outcomes for patients, carers and families, including the degree of risk to which they have been exposed by the non-compliance/ poor performance
- whether we have found non-compliance with the same service provider previously
- the authority to active enforcement process rests with the Director Assurance and Verification and other relevant Service Division National Directors

Summary

The HSE is committed to putting in place a Quality, Patient Safety and Enablement Programme in order to deliver high quality, evidence based, safe, effective and person centred care.

In order to deliver on this Programme responsibility for the key areas has been delegated to the relevant National Directors and is captured in the two key diagrams set out at *Appendix 1* and *Appendix 2*. In addition, a process flow in relation to Serious Reportable Events has also been included for completeness.

Dr Philip Crowley will continue his contribution to improving quality and patient safety in the health service in the post of National Director Quality Improvement as described in this paper. Mr Ian Carter will be assigned to the new role of National Director Quality Assurance and Verification. All of the arrangements and responsibilities set out in this paper are to be effective from November 2014.

Tony O'Brien

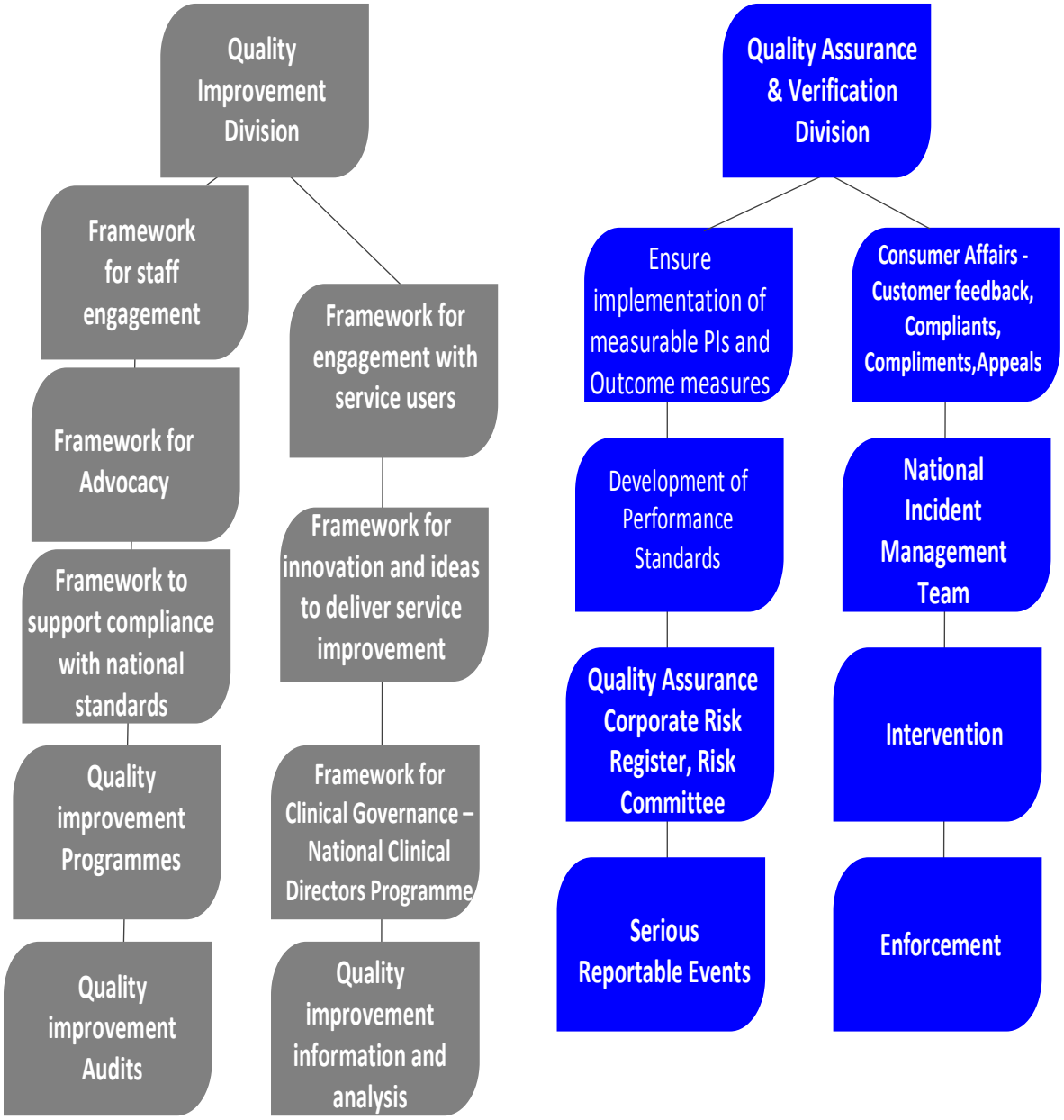
Director General 28th October 2014

Appendix 1: Quality, Patient Safety and Enablement Programme

	(1) Population Function/ Service User & Staff	(2) Service Delivery Model Function/ Quality Improvement	(3) Identification of Quality Models of Care Function	(4) Performance Measurement Function	(5) Performance Management Function	(6) Assurance and Verification Function	(7) Intervention Function	(8) Enforcement Function
CORE OBJECTIVES	**(a)** Proactive approach for client/ staff engagement to inform service design & improvement **(b)** Balance power between service user & provider through strong advocacy focus **(c)** Support CSP and HWB in the development of Models of care that maximise potential for self care (e.g. chronic illness)	**(a)** Framework for staff / patient engagement to ensure their voice & experience is central to improving services **(b)** Work with patients/ staff to build will, generate ideas & share successful projects/ innovation **(c)** Support to enable compliance with national standards **(d)**Quality improvement audits, information and analysis **(e)**Framework for Clinical Governance/ National Clinical Directors Programme	**(a)** Robust engagement with service providers to identify, agree & implement models of care **(b)** Engage with service users and providers to ensure their voice and experience is central to how collective efforts can be used to improve services	**(a)** Appropriate measures that are quantifiable at local, regional & national levels & can be benchmarked nationally and internationally **(b)** Clearly define what is acceptable & unacceptable performance **(c)** Information architecture to support consolidation of data from all sources including complaints, audits, State Claims Agency etc **(d)** Service Divisions responsible for ensuring implementation of actions	**(a)** Service Divisions responsible for performance management & ensuring controls are in place **(b)** Includes activities to ensure goals are consistently being met	**(a)** Is discreet from other quality functions **(b)** Authority„ responsibility & accountability to undertake proactive & reactive, indirect assessment, monitoring & inspection **(c)** Report on causal factors for un-acceptable performance & recommend remedial action	**(a)** Authority, capacity, capability to intervene in instances of unacceptable performance **(b)** Zero tolerance re persistent poor performance **(c)** Appropriate systems to escalate alerts **(d)** Service Divisions responsible for implementing remedial actions	**(a)** Proportionate to impact **(b)** Compliance actions are precursors to enforcement **(c)** Enforcement actions – issue warning notice, impose change or condition in service; suspend or relocate to alternative provider
KEY ELEMENTS	**(a)** Designate lead officer (QID) to deliver objectives **(b)** Develop formal work structures with each Operational Division and Clinical Strategy & Programmes and NCCP **(c)** Creation of cross functional matrix teams led by designated officer	**(a)** Maintain existing NPPAG where performance is benchmarked against agreed targets in NSP. Particular focus on management of chronic conditions and Integrated Care Pathways **(b)** Designated lead officer (QID) to progress all actions **(c)** Formal work streams with the 5 Divisions, CSP, NCCP, including cross functional matrix teams led by designated officer **(d)** Quality improvement audits, information, analysis	**(a)** Clinical Strategy and Programmes continue to have central role in designing clinical models of care/ pathways **(b)** Service Divisions are responsible for implementing agreed models of care and for monitoring & managing performance	**(a)** Identification of key performance indicators and outcomes and defining acceptable and unacceptable performance **(b)** Mandatory requirement to identify key risks & likely occurrence based on international norms **(c)** Mandatory requirement for timely escalation of alerts in relation to serious incidents and adverse events **(d)** ND Assurance & Verification responsible for ensuring systematic measures in place when serious incident occurs **(e)** Develop business intelligence and ICT capacity	Within Operational Divisions	**(a)** Existing NIMT, QAV incorporated into enhanced independent QAV function headed by Dir QAV (new) **(b)** Restructure existing staff from NIMT, QAV, QPS & Consumer Affairs **(c)** Develop and maintain Corporate Risk Register & attendance at Risk Committee **(d)** Designation of new post of Dir Quality Assurance & Verification	**(a)** Mandate for creation and mobilisation of Rapid Response review teams **(b)**Authority for instigation of Rapid reviews confined to DG, DDG, National Directors & Dir QAV **(c)** Dir QAV has authority to initiate an immediate review based on concerns or identified risks	Within Operational Divisions
RESPONSIBLE	**National Director Quality Improvement**	**National Director Quality Improvement** **National Performance Oversight Group (NPOG)**	**Clinical Strategy & Programmes** **Service National Directors**	**National Directors for Clinical Strategy & Programmes/ Services / Quality Improvement ¡ Quality Assurance & Verification/ BU / NPOG /ICT/ Health Intelligence**	**Service National Directors**	**National Director Quality Assurance & Verification**	**National Director Quality Assurance & Verification/ DG/DDG/ Service National Directors**	**National Director Quality Assurance & Verification** **Service National Directors**

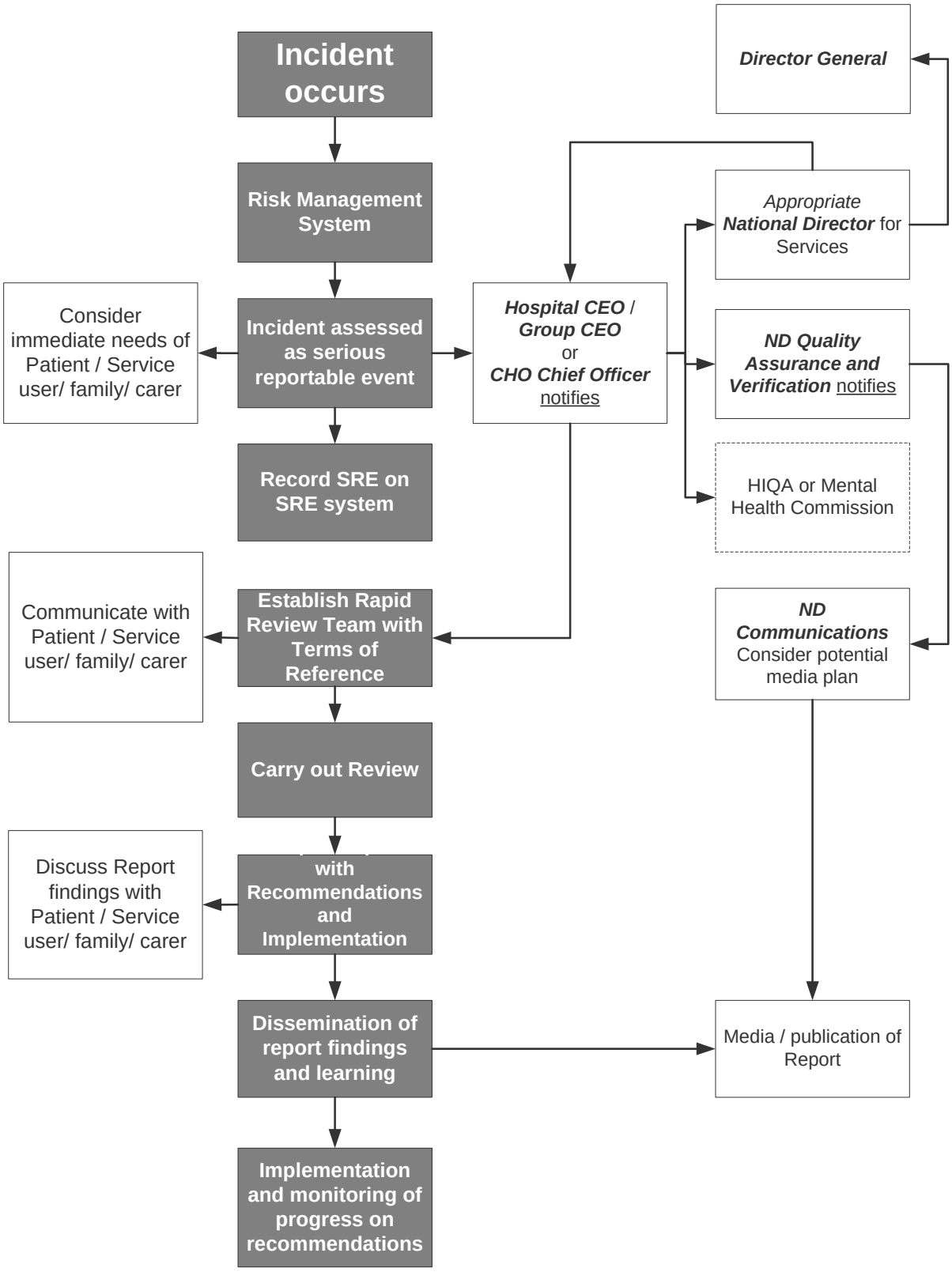
Appendix 2

Areas of responsibility of Quality Improvement Division and Quality Assurance and Verification Division



Appendix 3

Serious Reportable Events



Dr. Steevens' Hospital
Steevens' Lane
Dublin 8

Telephone: 01 6352000
www.hse.ie

November 2014
ISBN 978-1-906218-83-6