Our National Service Plan 2024

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A: Foreword from the Chair of the Board

On behalf of the Board, I am pleased to present the National Service Plan (NSP) for 2024. The plan continues to move the HSE towards the goal of universal healthcare in line with the ambitions of the Government. In doing so, it builds on the growth in funding and in staff we have seen over the past five years, growth which has enabled Ireland to continue to improve the health and life expectancy of the public. Funding has increased by €6,464m to €23,520m over the past five years and the number of Whole Time Equivalent (WTE) staff to 143,892 (in October 2023) from 119,813 (December 2019). However, despite this welcome investment, the cost of running our existing services at current levels over the next twelve months is likely to exceed the 2024 funding allocation.

The latest data shows that Ireland's life expectancy is now 82.4 years, the ninth highest in the EU and more than two years higher than the EU average. Life expectancy in Ireland improved by two years in the preceding decade, outperforming other EU countries. This improvement, as well as the progress across so many other areas of health and care, is down to the skill, hard work and commitment of our own staff, the staff of our colleagues in the Department of Health and the Department of Children, Equality, Disability, Integration and Youth and in our partner organisations. Each of them has the thanks and admiration of the Board.

The NSP for 2024 is a continuation of the work of the preceding year and represents another year of growth. Together, the two years will see staff increase in the region of +9,000 WTE and funding by €3,002m. However, 2024 will also be a year to consolidate the developments of recent years and ensure that the substantial increases in funding deliver the increased activity which justified the investment. This will mean a focus on pathways to ensure our increased number of clinical staff are supported to care for a similarly increasing number of patients and have the enabling environment which maintains the productivity of our services.

We intend to improve disability services for children as defined in the Progressing Disability Services roadmap. This will include seeking to address the pressure on children's disability network teams from staffing issues and the demands of the statutory assessment of need. Similarly, the *Action Plan for Disability Services 2024-2026* sets out our activities to improve residential services and respite care.

In addition to absorbing an unprecedented growth in demand, waiting lists still have seen improvements across a range of wait times for patients, with waiting list removals of 1,592,434* in 2023. A priority for the HSE for 2024 will be to further reduce waiting lists, with a specific focus on maximising an integrated approach to patient care across community and acute settings. Mental health waiting lists, in particular for children and young people, will rightly be a major focus in line with Government priorities.

Urgent and emergency care (UEC) has seen presentation at emergency departments increase to record levels. The UEC operational plan will seek to further improve the flow of patients through the care pathways. The most tangible measure of improvement will be a reduction in the number of patients on trolleys and the time they spend there.

Strengthening our governance and responsiveness to the needs of the population will take a major step forward with the creation of the Health Regions which are tasked with a greater focus on integrated care. In

parallel, we will look at enhancing oversight of clinical governance to support our colleagues to deliver high-quality care as safely as possible.

Improving the infrastructure of the HSE continues to require capital for both the estate portfolio and for technology and eHealth. Recognising it is best to invest where most benefit is achievable, we will work with a prioritisation framework to ensure best value for money.

While much has been progressed in 2023 there is still a lot more to do. Demand for care will continue to rise in 2024 driven by population demographics – most significantly the increase in the number of people over 65 years of age which has risen by 22% over seven years. This will, of course, put pressure on our finances. There have been unprecedented levels of additional Government investment in health in recent years. Despite this very welcome investment, the cost of running our existing services at current levels over the next twelve months will be a significant challenge in the context of the total funding available to the health service in 2024. This will likely require supplementary funding support, including in relation to the first charge (2024 first charge is the excess of 2023 costs over the final 2023 funding). It is not intended to cut services in 2024 so in financial management terms we will seek to minimise any deficit that might arise should financial risks materialise. This financial risk will be managed by a combination of judicious management to maximise productivity, the ongoing reform agenda, and collaboration with our colleagues in both Government departments.

Public health interventions are a long-term investment in our collective health. Working with partners to promote a Healthy Ireland is critical to the long-term sustainability of our health system. It is the collective endeavour of colleagues and partners which has driven the successes of recent years and will no doubt do so again in 2024. We look forward to playing our part.

**Year end waiting list not available until year end; figure represents outpatients, inpatients, day cases and gastrointestinal (GI) scopes.*

Ciarán Devane

Chairperson

26 January 2024

B: Introduction from the Chief Executive Officer

I am pleased to introduce the 2024 National Service Plan for the HSE. The plan sets out the provision of health and social care services to be provided to the people of Ireland within the allocated budget of €23.5bn. This is the first year of a plan with two separate Government departments combined, following the transfer of functions to the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) in respect of disability services.

The plan is also my first full year roadmap in my tenure as CEO, a post I was privileged to take up on 6 March 2023. 2024 is also the final year of our current Corporate Plan, the objectives and enablers of which have guided our decision-making for the coming year.

We are also guided by:

- The Programme for Government
- Priorities set by the Minister for Health and Minister for Children, Equality, Disability, Integration and Youth
- The policy framework, *Sláintecare*.

Ultimately, all of those guiding documents require us to deliver health and social care services that manage the requirements for safety, quality of outcome, access and effective use of available resources. In a post-pandemic environment of unprecedented demand for services, a cumulative increase to highest ever levels of investment and a volatile cost environment, these requirements must always be considered carefully.

The HSE's budget for 2024 and the increases in funding over recent years represent a significant investment by the State which has resulted in many improved outcomes for the population we serve. This investment in our services is welcomed and has allowed the HSE to respond to sustained pressures, but not yet to overcome all of them. In 2023, we have improved access in both scheduled and unscheduled care but, with many challenges remaining, these must be our priorities again in 2024.

Medical inflation remains high and this is compounded by a significant acceleration in the cost of delivering healthcare, notably energy and staffing costs. In the finance section, I set out the conditions that will ultimately dictate the level of dependency we will have on supplementary support from Government in 2024. Our starting position must be to demonstrate the best use of the significant resources we have and then to work with Government throughout the year to accurately project the position ahead of the summer economic statement and the estimates process that will follow.

In addition, our ageing population continues to grow with the number of those aged 65 years and older expected to double and the population aged over 80 to increase almost threefold in the next two decades. We must embrace this success in life expectancy improvement by ensuring we care for and respond to our older people, many of whom can experience frailty and vulnerability, linked to chronic disease.

Limitations in our infrastructure and especially bed capacity across our community and hospital systems further impact how we manage, organise and deliver care in the context of rising demand and complexity of care. The additionality of acute and community bed infrastructure in recent years has been most welcome and further will be required in the years ahead.

We will have a significant focus in 2024 on productivity. I am conscious that the traditional use of this concept might be in the negative and I want to be clear that our mandate from the Minister is to use it in the positive and not to cut services. By that, I mean delivering additional activity from better use of the resources we have, to further meet the needs of the people we are privileged to serve. We know that with the highest ever workforce in the history of the HSE, modern methods of care and the use of technology, that productivity can be a constant and positive improvement.

Our staff are undeniably our greatest asset with their dedication, expertise and passion delivering exceptional service for our patients and service users. Our various colleagues bring diverse skills and perspectives, adaptability and innovation which will help us to drive productivity and help us all to reach our goals. We intend to use to the full the significant investments made in previous years and aim to enable many sites to leave the pandemic behind.

While the primary purpose of this plan is to set out the type and volume of services to be provided in 2024 within the available resources, the focus of NSP 2024 is on the public need as it relates to:

1. Delivering **urgent and emergency care**

While our urgent care services are delivering more care to more patients each year, this has resulted in services being under pressure almost all year round. The HSE Board is overseeing a multiannual Urgent and Emergency Care (UEC) Plan (2024-2026) as part of a new UEC Programme that is focusing on what is working well. In 2023, we started with the introduction of a plan to see through the second half of the year and the start of 2024. We will continue to focus on the core tasks that we know reduce the difficulties for the public and staff, as is often evident in our emergency departments. Having left behind the concept of winter planning we will, in 2024, improve access to urgent and emergency care by implementing the year one commitments of the new multiannual UEC Plan related to the four pillars of priority focus: hospital avoidance, emergency operations, in-hospital operations and discharge operations.

In parallel, longer-term enabling programmes will add much needed capacity, an increased number of GPs delivering care to our population and key digital requirements for integrated care.

2. Addressing **waiting lists** and times to deliver equitable, timely and transparent access

The multiannual Waiting List Action Plan will reduce and reform waiting lists, spanning acute and community settings beyond urgent and emergency care. In 2023, we are relatively unique as a jurisdiction in the improvement on key measures. We responded to more than 100,000 people above what had been targeted. We reduced the time people are waiting to levels not experienced in many years. The reduction in those waiting longest was particularly beneficial. 2024 will see a repeat of a targeted plan.

Our vision remains the delivery of a modern, world-class, public health service for all, in which everyone has equitable, timely and transparent access to high-quality scheduled care, where and when they need it. Enabling the advancement of modernised care pathways is only one example of how our teams are working in innovative ways to ensure delivery on this vision.

3. Managing **our workforce** who are fundamental to delivering care across our country

Our staff and teams are at the heart of our health and social care services.

It is my intention for 2024 that budget-holding areas will have a full Pay and Numbers Strategy and allocation within which to work and within which the targets will be very clear. An improved control environment will allow for these targets to be met and maintained, but not exceeded. This will require a particular co-ordinated focus on existing staff (noting that there are certain staff disciplines where

recruitment and retention remain a challenge), the management of new posts, the management of the use of agency and overtime, and conversion from agency staff to direct employment, where appropriate and possible.

It is important to state that these controls do not mean there will be no recruitment in 2024. Notwithstanding the challenges outlined above, improved access to care will continue to be prioritised with ongoing investments in planned multiannual improvements to urgent and emergency care and waiting list performance. More than 2,200 additional staff are provided for in 2024. However, it is fair to say that 2024 will be a year of consolidation, smaller growth and better control. The impact of recruitment in 2023 above available funding will require careful management as we move to a fully understood and compliant Pay and Numbers Strategy. We will work with our Government departments to achieve this without impact on service delivery.

4. Ensuring value for money in the provision of high-quality **healthcare infrastructure**

In 2024, the capital vote allocation funding available for healthcare infrastructure, equipping and furnishing is €1,056.28m from the Department of Health (DoH) and €23.72m from DCEDIY. This funding will be managed to achieve value for money in accordance with the requirements of the revised Public Spending Code and the Capital Projects Manual and Approvals Protocol of the HSE. Our goal is to ensure that safe, secure and high-quality infrastructure is provided to support current and future needs, playing a key role in improving the experience and outcomes of patients, service users, their families and staff who access and work in healthcare facilities. Separately, there is an allocation for eHealth requirements of €155m capital funding and €314m operational budget. The funding is expected to cover our ICT capital projects, the Cyber Transformation Plan, and the operational budget to fund pay costs for the largest technology landscape in the State, as well as some revenue funded initiatives such as the O365 programme. The introduction of App technology for the public in 2024 will be a milestone in transformation.

5. Enhancing **mental health** and **disability** services

In 2024, we are also committed to promoting our population's mental health. Our focus is on prioritising child and adolescent early intervention, enhancing early interventions for adult mental health services and improving access to person-centred mental health services. In order to ensure integrated care, service continuity and the best possible outcomes for those experiencing mental health difficulties, mental health services are provided within a stepped care model where each person can access a range of options of varying intensity to match their needs, with the ultimate aim of reducing the requirement for specialist, acute and inpatient services. Of particular recent concern are the findings from the *Report on the Look-Back Review into Child and Adolescent Mental Health Services County MHS Area A (Maskey Report) 2022*, and we will continue to prioritise the implementation of the report's recommendations.

Specialist Community-Based Disability Services transferred to the DCEDIY in March 2023. DCEDIY finalised and secured Government approval for the *Action Plan for Disability Services 2024-2026* in July 2023 which, along with the Roadmap for Service Improvement 2023-2026, Disability Services for Children and Young People, is reflected in this service plan. The Action Plan underpins the delivery of service developments identified as being required in the *Disability Capacity Review to 2032 – A Review of Disability Social Care Demand and Capacity Requirements to 2032*. The principle of 'mainstream first' requires that HSE-led services are developed in the context of supporting actions by Government departments in the areas of housing, transport, education, including higher education, employment and social protection. The developments planned for 2024 within the available funding will improve services for

some, but the scale of need identified in the Capacity Review report will require continued investment and reform over the coming years.

Partnership, collaboration and integrated working has to become our default, given the interdependence between different actors to deliver quality, people-centred care. Voluntary organisations, including Section 38 and Section 39 agencies, play an integral role in health and social care service delivery and improved collaboration is an important enabler in health sector reform. Partnership also includes close collaboration with patients and service users to ensure we continue to build resilient, responsive health and social care services that deliver for patients and service users.

Of particular significance for 2024 is the establishment of the six new HSE Health Regions and the change in size, purpose and function of the HSE at national level. Designed to bring about integrated care, effective decision-making and local focus, these new structures will mark a significant departure from the organisation that was over the past 18 years.

Changing a structure has to be matched with a continuous effort to improve culture and care. We must focus on ensuring that care is available and delivered to people who need it at the right time, in the right place and as close to home as possible.

I want to thank staff across all health and social care services for their continued work and dedication to ensure we deliver a responsive and caring healthcare system to the people we are privileged to serve every day. As we face the challenges and opportunities of the year ahead, it is through the efforts, expertise and professionalism of our staff and of our partners that we will deliver this plan towards the reformed HSE that we all want.

Bernard Gloster

Chief Executive Officer

26 January 2024

C: Setting the Context: National Service Plan 2024

This section of the Plan outlines the strategic context in which the National Service Plan (NSP) 2024 has been prepared, reflecting public need, and the broader trends and environmental factors that influence its delivery. It also reflects the alignment with the Health Service Executive (HSE) *Corporate Plan 2021-2024* priorities, the *Organisational Reform HSE Health Regions Implementation Plan*, the *Programme for Government: Our Shared Future, Partnership Principles* and *Sláintecare*. The content of this Plan is informed by a rapid evidence synthesis of population health and social and environmental trends (June 2023). This section concludes by highlighting the importance of ensuring transparent and effective arrangements are in place to track progress in both service delivery and population health.

1. NSP 2024 is guided by the needs of the people we serve and the people who serve them

'A healthier Ireland, with the right care, at the right time and in the right place' – for each of us, this fundamental tenet underlying the goal of universal healthcare will mean something different. All of us want to see a health service that puts patients and service users at the centre, is managed well and which makes the best use of public resources, including support for intensive change processes anticipated. To do this requires an evidence-informed, population-based approach to health improvement, as reflected by the objectives set out in the *HSE Corporate Plan 2021-2024* and translated as our performance delivery commitment to the people of Ireland in NSP 2024.

In addition to the HSE's Corporate Plan, our agenda for positive change and translating aims into reality is guided by the *Programme for Government: Our Shared Future*, *Sláintecare*, the *Partnership Principles* (April 2023) and the *Health Regions Implementation Plan* (July 2023).

The time to embrace new and improved ways of working is now. Health service capacity constraints and variation in operational performance mean that significant issues with access to healthcare persist. Population ageing and the increasing burden of chronic disease are set to increase demand for healthcare to levels which will challenge our system's sustainability. While we are innovating our models of care, we need to continue to shift the emphasis in our healthcare response from acute hospitals to community, home-based care and the promotion of health and well-being which is truly integrated. We can expect further challenges from emerging infectious diseases, and the climate emergency is certain to impact future health. The public and political support for our people and our services was well-earned through COVID-19, and we need to continue building their trust and confidence in our services for the future. Continuing to attract, retain and fully enable our health workforce and leadership will be key to our success.

Source: *HSE Corporate Plan 2021-2024*

A key consideration underlying NSP 2024 is the implementation of new integrated healthcare structures, called Health Regions. These are set out in the *Health Regions Implementation Plan* published by Government in July 2023. Health Regions will deliver integrated hospital and community care to six defined geographies, ensuring effective governance is in place to better respond to local community and population needs.

Restructuring the HSE into six operational regions, supported by enabling functions at the centre, will support the delivery of more efficient, streamlined and productive services. Its aim is to improve the health service's ability to deliver timely integrated care to patients and service users that is planned and funded in line with the population needs at regional and local level, while ensuring national models are co-developed with regions. Strong national standards and frameworks will be balanced with increased local autonomy and accountability to maintain consistent quality of care across the country.

A new integrated service delivery model will be introduced in the provision of patient / service user care closer to home. In 2024, the Health Regions Programme Team will finalise the detailed design and progress the implementation of the integrated service delivery model structures that will support the universal healthcare objective of patient / service user care closer to home. Building on the community healthcare network (CHN) structure, Integrated Healthcare Areas will be introduced within each Health Region which will see both acute and community services being geographically aligned under a single management structure to serve the local population. It is accepted that structures alone will not deliver integrated care, therefore standardised models of care (such as the Integrated Care Programme for Older Persons and Chronic Disease Programmes) and new ways of working will be required within and across all teams both regionally and nationally as part of the reform process.

The implementation of Health Regions is a major and complex change programme which will involve changes in structures, but this alone will not deliver the goal of universal healthcare. There will also be a

requirement for new ways of working together across all health and social care services, both within the HSE and across non-HSE healthcare providers, as well as local authorities.

The transition to the new structures will begin in 2024 with the appointment of six Regional Executive Officers and the Health Regions stood up in early 2024. Transition will continue throughout 2024 to merge the governance, management and funding streams for acute and community services. The aim is to stand down Hospital Groups and Community Healthcare Organisations by Q4 2024, once the regional management teams are in place. This approach is in line with the Government's commitment to universal healthcare as well as recommendations made in the *Oireachtas Committee on the Future of Healthcare Sláintecare Report*.

The transition to Health Regions and reform of the HSE centre is reflected throughout NSP 2024 and greater detail will be provided in NSP 2025 as the transition is further progressed and becomes embedded. A revised process for drafting NSP 2025 and the new Corporate Plan, in the context of the Health Regions, will be developed in consultation with the Department of Health (DoH) and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).

2. Sustainable impact through partnership is at the core of National Service Plan 2024

Over recent decades, Ireland has made significant improvements in terms of gains in life expectancy (now outranking other European countries) and reductions in mortality rates (including mortality for cardiovascular disease, respiratory disease and cancer). These are important markers of the improvement in population health and underline the importance of the services that are in place to promote and protect people's wellbeing, as well as the services that treat people when they are ill.

Gains in life expectancy have been driven by sharp reductions in mortality from major diseases. Better standards of living in Ireland mean that more people have access to the basic building blocks of good health. Healthcare, including care that prevents disease and promotes good health, as well as care for when people get sick, also plays a key role. For more details on this, please see Section 1 of this NSP. Preventable deaths (i.e. causes of death that can be mainly avoided through effective public health and primary prevention interventions before the onset of illness) for men and women in Ireland are lower than the European Union (EU) average, as are treatable deaths (i.e. causes of death that can be avoided through optimal quality healthcare).

A challenge now facing us is to ensure such positive trends for people's health persist while working collectively to address known service capacity deficits impacting access to services and quality of care.

In delivering the reform required to achieve universal healthcare, demographic pressures, financial challenges, issues relating to recruitment, training and retaining qualified staff, the need for more investment in technology, and the legacy issues associated with COVID-19 are some of the challenges that persist. Ultimately, such challenges can only be resolved by involving all who are impacted (both staff and patients / service users) to be part of the solution – both in design and implementation of care.

Partnership, collaboration and integrated working has to become 'the way we do our business' in the health and social care sector given the interdependence between different actors to deliver quality, person-centred care. This includes voluntary, academic and research institutions and the development of new networks. In particular, voluntary organisations, including Section 38 and Section 39 organisations, play an integral role in

service delivery in the Irish health and social care system. An important enabler in health sector reform is improved collaboration between the State and voluntary organisations, with the shared objective of strengthening relationships for the benefit of patients and service users. The HSE is committed to embedding the *Partnership Principles* as the foundation for the relationship between voluntary organisations and the HSE at all levels, and will continue our bilateral engagement on the design and implementation of the Health Regions, review of the Service Arrangement and Grant Aid Agreement, and our support and active participation in the work of the Dialogue Forum.

Partnership, most importantly, includes close collaboration with patients, service users and community organisations to ensure we continue to build resilient, responsive health and social care services that deliver for patients and service users. For more detail on this please see Section 4 of this NSP.

An overarching reality facing health and social care services globally is the increasing and evolving demand that exceeds available resources. COVID-19 compounded this reality but also showed us that we are able to develop efficient and effective ways of working together to optimise processes, technology and roles while innovating at the same time. Investing in health is an investment in continuing economic and social progress.

Our planning recognises and seeks to respond effectively to significant, long-standing challenges that exist within our health service, especially service access, by working smarter together and making the best use of investments already within our system. Of particular focus will be our multiannual, whole of system approach to tackling long waiting lists for scheduled care in hospitals and community-based services and long waits in emergency departments, particularly for older people, those with more complex needs, and people with lower incomes. For more detail on this please see Section 1 of this NSP. Though NSP 2024 is the HSE's one-year plan that sets out service delivery priorities and activities to be taken forward in 2024, it is part of a longer range, strategic outlook that will take into account feasibility, affordability and sustainability of high-quality services.

3. Preparing for the future: keeping pace with potential solutions to persistent challenges

Preventing and managing chronic diseases

In common with other developed countries, chronic diseases are becoming more common in Ireland, as the population ages and grows. The prevalence of long-standing illness in Ireland is 25.7% for men and women; this is, however, less than the EU-27 average (33.8% and 37.7% for men and women in EU-27). The HSE has been leading a multiannual programme of work with services to a) reorient service delivery towards prevention, early detection and better management of chronic disease; and b) work with an array of partners to address the wider determinants of health. We know preventative care represents 1% of our total healthcare expenditure, yet we also know that any investment in prevention can yield two to four times the economic benefit.

While there is progress in reducing the prevalence of health behaviours that negatively affect health in Ireland and lead to chronic disease, we can – and must – do more to reduce cigarette and alcohol consumption per capita and the rapid emergence of excess weight and obesity, especially among children.

Investing in staffing and the 'right' workforce

Recruitment and retention of people in our health and social care system is a key challenge, not only faced in Ireland but globally. Our staff and teams are at the core of our national health service. Their wellbeing is

critical, especially as we continue to emerge from the pandemic with a workforce that has experienced increasing levels of stress and burnout, leading to loss of staff and morale concerns. In certain geographies, sectors and specialties, the impact of the recruitment and retention challenge is particularly significant. A notable area of concern is that, despite the intention to strengthen community services, by August 2021, the staffing gap between community and acute services had tripled a reverse of the 2008 situation when the numbers were weighted in favour of community settings.

For 2024, part-year funding will be provided to recruit an additional 2,268 Whole Time Equivalents (in addition to those recruited for disability services) to augment specified existing services and progress specified new developments, aligned to the Minister's priorities. We will have a strong focus on consolidating services and service developments funded in prior years with the intent of having maximum impact for patient services and outcomes. Our highly skilled workforce is our most valuable asset. In addition to growing our workforce in 2024, we will equally focus on retaining our existing staff, supporting them at every stage of their working lives. Regional reforms will also work to create conditions where staff feel enabled to lead and shape services to deliver more integrated care at local community level.

Modernising our digital infrastructure to enable greater integration

It has long been recognised that digital health is a crucial enabler in delivering better, smarter healthcare, providing innovations and solutions that can improve access, efficiency, and quality of care. A comprehensive digital health investment programme is imperative in enabling integrated care to address current healthcare challenges faced by the Irish health system and the patients that use it, such as rising costs, siloed systems and increasing demand for services. Leveraging digital technologies will change healthcare delivery, optimise resource allocation, and empower patients to actively participate in their own care. As we look to the future, alignment with national and international objectives will be critical, such as the DoH Digital Health Strategic Framework, the Health Information Bill (in development), *Sláintecare*, the European Health Data Space, and the World Health Organisation's (WHO) *Global strategy on digital health 2020-2025*. For more detail on this please see Section 3, chapter 3 of this NSP.

4. Optimising the productivity of our services to meet rising, more complex needs

There have been unprecedented levels of additional Government investment in health in recent years, particularly 2021-2022. Staffing levels have increased by 20% since the end of 2019, the equivalent of around 24,000 extra full-time staff. The level of associated recruitment over the last three years has represented the biggest annual increases in workforce since before the economic crash of 2008. Additional staff were recruited for circa 170 priority service developments over the last three years. While this is very welcome, the challenge remains of demand significantly outpacing supply. Different and improved ways of working are required for us to rise to this challenge, so that we can meet the service needs of our population.

The level of recruitment in prior years better positions services to meet increasing demand and to expand services. Examples of the impact are reflected in the expansion of services to respond to increasing need, across all service settings (hospital, maternity, paediatrics, community services, including mental health and disability services) and all age ranges (from older patients to babies and children). Many specialist staff were also recruited to deliver on initiatives designed to increase safety for staff and service users. For example, investments were made in increasing nursing levels on hospital wards, introducing multidisciplinary teams, putting in place staffing to prevent and manage the spread of hospital and

community acquired infections, and increasing IT staffing levels to address cyber risks and implement eHealth service solutions.

Substantial Government investments, particularly over the past three years, are very welcomed and have supported our services to respond to sustained pressures (including a global pandemic) and deliver higher volumes of service. However, it needs to be recognised that many services have continued to operate at challenging levels (e.g. hospital occupancy rates) for many years, as demand outstrips this increased capacity to respond to patient need. Despite delivering more care to more patients each year, our services are under pressure almost all year round and are operating in challenging environments. For example, over the period 2017 to 2022, unscheduled care presentations increased from 1.25 million to 1.59 million, an increase of 27%. The continued growth in patient demand presents ongoing challenges, both in terms of staffing and delivery of healthcare in this setting, and in the financing of this growing level of activity. In 2024, staff will continue to experience and respond to the predicted increases in presentations and higher volumes of complex care, specifically associated with the number of older patients and service users which is projected to increase almost threefold in the next two decades (2022-2042). In parallel, the prevalence of many key health conditions is set to increase.

The cost of running our existing services at current levels over the next twelve months will exceed the total funding available to the health service in 2024. Therefore, in addition to developing more effective service delivery approaches to enable greater activity to meet rising demand, we will also seek other opportunities to minimise the level of financial deficit that will arise. The organisational financial management approach to this is set out in Section 3, chapter 2.

Opportunities remain to innovate and accelerate the spread and scale of best practices, different models of care and evolving technology already in use in our system. In 2024, with the establishment of the Health Regions, our focus will be on fully embedding integrated service models that we know will deliver the greatest impact for patients and for services, and will offset predictable increases in service demands. Improved access to care will continue to be prioritised with ongoing investments in planned multiannual improvements to urgent and emergency care and waiting list performance. The implementation of modernised care pathways, transforming scheduled care services, will achieve improved timeframes to access services, improved quality of services, and care delivery in the best location for the patient. Implementation of the *HSE Patient Safety Strategy 2019-2024* will also continue to be prioritised, including improvement programmes to address the common causes of harm. In addition, development will continue of the systems and supports necessary to deliver on the HSE's commitment to provide an enhanced feedback process for service users. Collectively, even within resource constraints, strides will be made through improved and re-designed ways of working at every level, leading to enhanced efficiency and better value.

Our NSP sets out what is within our control to better respond to service user demand and improve service quality in 2024. It sets out actions that will optimise our current resources through effective implementation of integrated service models and service user pathways. This work, undertaken across all service provider settings, is focused on improving service user experience and outcomes and providing more efficient and effective service delivery.

This challenge provides an opportunity to work smarter and differently to deliver additional activity for patients, using prior years' investment, noting the underlying demand / capacity challenges across services and regions.

5. Tracking delivery

Implementation of our commitments requires concrete and well-defined steps to be taken, over time, that are also measurable. As we look to the future, we must improve how we measure ourselves against our ambition. To that end, a comprehensive Health System Performance Assessment (HSPA) framework has been developed by the DoH, working with the HSE, guided by an international advisory expert panel which includes people from the Organisation for Economic Co-operation and Development and the WHO.

A Productivity Task Force is being established by the Minister for Health, which will be dedicated to ensuring that the quantum of health service provided remains commensurate with the increasing resources invested over recent years. This will help to ensure that improved productivity is actively managed and supported. Further detail is set out in Section 3, chapter 2.

NSP 2024 outlines the broad results each service area is committed to and, as applicable, is accompanied by key performance indicators and targets already reflective of the HSPA framework's main elements. In addition, programmes like the Health Performance Visualisation Platform Programme have been introduced by the HSE to address gaps in the centralised information available to support operational performance monitoring and decision-making at strategic and operational level to facilitate improvement planning and delivery. Data for all Phase 1 sites will be fully published by end Q2 2024 and all other sites will follow with publication once Phase 2 is rolled out.

To support oversight and decision-making, the Board Strategic Scorecard (BSS) report provides the HSE Board with a monthly update on progress against key strategic programmes / priorities for the calendar year, aligned to the objectives and goals of our NSP and Corporate Plan. Following consideration by the Board, the BSS report is submitted to the DoH and DCEDIY on a monthly basis and is also published on our HSE website. The BSS is a key reporting and assurance tool for the HSE's Executive Management Team, Board and wider stakeholders. Please see Appendices for the National Performance Indicator Suite and Activity 2024.

The BSS and all developments in reporting mentioned above, are supporting an ambition to make health service activity and performance data available to the public. We are committed to making more progress in 2024, to publish more information on our website and to facilitate public access to healthcare information. As stewards of public resources, we recognise that part of our social accountability to the people of Ireland is to transparently demonstrate where strides are being made as well as continued opportunities for improvement.

Section 1
Improving Access to Care and Performance

1. Whole of system approach to improving access to care
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1. Whole of system approach to improving access to care

Our first focus is to ensure that care is available and delivered to patients who need it at the right time, in the right place and as close to home as possible. To do this, we must deliver services that are more integrated and co-ordinated including continuity of care for people with complex urgent and emergency needs across the whole healthcare system.

1.1. Urgent and Emergency Care

Responding to the challenges in urgent and emergency care (UEC) is a top priority for the HSE. Our urgent and emergency care teams provide high-quality and life-saving expert care in emergency departments (EDs), responding to approximately 1.5 million attendances annually. While the number of patients on ED trolleys fell by 8% in 2023, compared to 2022, and there was further improved performance in the second six months of 2023 with the number of patients on trolleys down by 22% between July and December of 2023 compared to the same six months in 2022, there will be, in 2024, a continued focus on improving the experience for patients and their families in urgent and emergency care. Performance in EDs is a barometer of access and performance throughout other parts of our system and not only within the acute sector where EDs are located. Extensive consultation with key partners and stakeholders, including service users, has now led to the development of a three-year multiannual Urgent and Emergency Care Plan (2024-2026) to improve performance on an incremental and sustained basis. As has been the experience in other countries, ED attendance rates in Ireland have increased significantly in recent years driven by various factors including demographic growth, population ageing and chronic disease. This growth in numbers is most notable in the over 75 years age group. Our EDs are delivering more care to more patients year on year and this growth in demand, combined with other health system capacity challenges, is culminating in sustained and record pressures on our services. The associated overcrowding in EDs is linked to an increased risk of harm to patients, inefficient use of resources and creates a difficult work environment for staff.

The HSE is committed to the development and implementation of a three-year Urgent and Emergency Care Plan (2024-2026) to continue the approach set out in the 2023 Urgent and Emergency Care Operational Plan. This plan, once approved by the HSE Board and the Minister for Health, will build on key service developments enabled in recent years by significant investments in urgent and emergency care. As per the 2023 UEC Operational Plan, the three-year plan will support the delivery of continued service improvement across four pillars of actions: hospital avoidance, ED operations, in-hospital care delivery and discharge management. The UEC Plan has a particular focus on improving the experience of older adults.

While good practices have been firmly established in many of our services, there is still more to do. The focus in 2024 at local, regional and national level will be to fully embed integrated service models, service efficiency and productivity measures that we know will deliver the greatest impact for patients / service users and services, and will offset predictable increases in service demands.

1. Hospital avoidance: in 2024, the focus will be on supporting patients / service users to access care close to home and at the lowest level of complexity. We will:

- Increase the productivity and impact of existing service models in place across community, ambulance and acute services to deliver care to patients close to their homes: (community intervention teams (CITs) and community specialist teams (CSTs) for older persons and chronic diseases integrated with local general practitioner (GP) response, National Ambulance Service (NAS) alternative care pathways and hospital-led outreach programmes)
- Extend enhanced community care services into public and private long stay residential care facilities to enable residents to receive appropriate care where they live and avoid hospital attendance or admission
- Increase GP training places and progress the non-EU GP scheme to ensure we are increasing GP capacity over time
- Expand the Emergency Department in the Home (EDITH) frailty response service in St. Vincent's University Hospital and establish the EDITH service in University Hospital Limerick
- Augment information and communications to patients and the public locally on all care options available, including signposting to self-care, through our website and multi-media
- Provide more patients with consistent access to alternative care options by standardising the opening hours of injury units across the country to provide a service seven days per week from 8am to 8pm
- Expand virtual care services in Ireland by establishing an acute virtual ward in two Health Regions to provide care to people in their home who would otherwise need to be admitted to hospital
- Improve uptake levels for vaccination programmes and for smoking cessation services

2. ED operations: in 2024, the focus will be on actions that ensure our most vulnerable patients receive safe, timely and high-quality care in our EDs, as follows:
   - Complete initial Safe Staffing implementation Phase 2 for EDs
   - All EDs to screen patients over 75 years for delirium and frailty at the point of triage and provide early access to emergency and specialist gerontology care
   - Prioritise care and compassion for older adults identified as at risk in our EDs by always assigning a designated person to keep them informed and assist them as needed
   - Establish local integrated clinical and operational groups for older adults to plan for and commence implementation of UEC older adults pathways across community and hospital settings
3. In-hospital care delivery: in 2024, the focus will be on improving and standardising processes to reduce variation in care, improve flow across our hospitals and free up bed capacity:
   - Hospitals will work to consistently implement the SAFER standard operating policy to improve patient flow
     - Senior review before midday by a clinician able to make management and discharge decisions
     - Flow of patients will commence at the earliest clinically appropriate opportunity from assessment units to inpatient wards
     - Review: a systematic multi-disciplinary team review for those with extended length of stay (LOS) (> 6 days) with a clear 'home first' approach
   - Hospitals will implement protocols for inpatients with LOS over 14 days transitioning to over seven days

- Patients will be cohorted to specialty or dedicated wards to optimise patient flow and multidisciplinary care to support differentiated care requirements
- Each hospital / community will establish a centralised operational hub or equivalent that provides a shared view of real time capacity for all teams to support better operational processes

4. Discharge management: in 2024, the focus will be to build on integrated actions undertaken at local and regional service level to facilitate faster discharge to home or community care as soon as patient acute hospital treatment is complete:
   - Adopt a 'Home First' policy so that integrated discharge planning starts early and is defined by a person's needs, will and preferences
   - All inpatients will have a predicted date of discharge which is communicated to relevant community services to enable an integrated discharge approach
   - Work as fully integrated teams across community and acute services guided by a patient-first principle to reduce unwarranted variation in discharge rates.

A strengthened and integrated system of governance and accountability will underpin the monitoring, performance oversight and delivery of UEC services and service improvements in 2024 and beyond. This will be aligned to the six new Health Regions and the redefined national centre.

Greater regional support for local UEC service improvements will be enabled by reconfiguring teams to deliver a programmatic approach to service delivery and plan implementation, with a particular focus on improving local analysis and insights to better inform decision-making, resource allocation and improvement trajectories at service level.

In parallel, we will continue to deliver planned additional acute bed and diagnostic capacity to improve access for patients while working with Department of Health (DoH) to progress an updated Health Services Capacity Review which will project health and social care capacity needs out to 2040.

Work will also progress in 2024 on plans to extend services (acute and community) over weekend days to ensure equitable and timely access for our patients, regardless of the day of the week that they present to hospital.

1.1 (a) Critical Care

In 2024, we will:

1. Deliver an additional 22 beds to bring total critical care capacity to 352 beds
2. Enhance the quality of our critical care service by embedding the investment in the Critical Care Outreach service, progressing the implementation of the critical care clinical information system, and consolidating the investment in critical care retrieval services.

1.1 (b) Trauma Services

The National Trauma Strategy recommends the establishment of an inclusive Trauma System for Ireland. Over a number of years, the Trauma System will be organised into two Trauma Networks, Central and South. Both will operate a hub-and-spoke model, each with a Major Trauma Centre as the hub and a number of supporting Trauma Units.

Major Trauma Centres will provide the highest level of specialist trauma care to the most severely injured patients on a single hospital site and will act as the highest point of escalation for trauma services within their respective Trauma Network. Trauma Units will deliver trauma care to patients who do not need the specialist expertise of a Major Trauma Centre. The National Trauma Strategy also recommends the development of University Hospital Galway as a Trauma Unit with Specialist Services, given the breadth and depth of services currently provided, and travel distance from the nearest Major Trauma Centre.

In 2024, we will:

1. Complete Phase 1 of the development of Major Trauma Centres at the Mater Misericordiae University Hospital (MMUH) and Cork University Hospital (CUH):
    - MMUH will receive major trauma patients as secondary transfers from hospitals within the Central Trauma Network
    - CUH will receive major trauma patients injured within a 45-minute travel time of the hospital and direct trauma specialist referrals from hospitals in the region
    - Additionally, CUH will complete the establishment of the Planned Trauma Care Service, in line with the development of the surgical hub
2. Progress the capital projects associated with the National Trauma Programme at MMUH and CUH
3. Continue to plan for the development of the Trauma Unit with Specialist Services at University Hospital Galway, including a Planned Trauma Care Service at Merlin Park University Hospital in the future
4. Complete the operationalisation of the pre-hospital trauma triage tool to support the development of bypass protocols and education for pre-hospital care providers. This will ensure that, in the future, trauma patients will be brought directly to an appropriate trauma-receiving hospital
5. Complete the operationalisation of the dedicated inter-hospital transfer referral service ‘1800-Trauma’ operated by the National Emergency Operations Centre to facilitate inter-hospital transfers from Model 3 and 4 hospitals to the Major Trauma Centres when required.

1.1 (c) National Ambulance Service

The National Ambulance Service (NAS) serves 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. NAS provides a range of services that includes the provision of unscheduled care in response to 112 / 999 emergency calls and critical care retrieval services. Care begins immediately at the time an emergency call is received and continues through to the safe treatment, referral, discharge or transportation and handover of the patient at an ED or hospital.

In 2024, we will:

1. Continue to work with system partners to contribute to the delivery of integrated urgent and emergency patient care
2. Continue to effectively deploy existing resources to deliver the best possible care including the use of available alternative care pathways.

1.2. Scheduled Care Reform and Waiting List Action Plan

Building on the success in reducing waiting lists in 2022, the number of patients who were seen in 2023 exceeded 2022 levels across all areas and exceeded the planned 2023 National Service Plan (NSP) targeted levels of activity. 2023 was the second year in a row that waiting lists reduced and the aim is for 2024 to be the third. This activity was supported by the additional funding provided in the *2023 Waiting List Action Plan*.

In 2023, our acute hospitals provided access to circa 3,579,180 consultant-led outpatient consultations, circa 1,160,283 day cases and circa 82,785 elective inpatient episodes of care.

There have been significant improvements in relation to key NSP access performance indicators, in particular, the timeframes that patients have waited in 2023. Key areas include:

- 84% of people waiting <15 months for first access to outpatient services in 2023
- 80% of adults waiting <9 months for an elective procedure in 2023
- 93% of people waiting <9 months for an elective procedure gastrointestinal (GI) scope in 2023.

This improvement has happened in the context of an unprecedented rising demand for outpatient services, with a 16% increase year to date 2023.

The *2023 Waiting List Action Plan* has been a key enabler for the improvements outlined above, as waiting lists for scheduled care in our hospitals increased by nearly 60% between 2015 and 2021, creating large backlogs and necessitating the multiannual action plan approach to address this backlog. The plan has also enabled the progression of seven modernised care pathways in 2023 across both acute and community settings.

By continuing this approach into 2024, reducing waiting lists and times, our vision remains the delivery of a modern world class public health service for all, in which everyone has equitable, timely and transparent access to high-quality scheduled care, where and when they need it. Successful implementation of the Waiting List Action Plan (WLAP) remains susceptible to a number of risks, including repeated COVID-19 / flu / respiratory surges and associated pressures on EDs, as well as the continuation of the high volume of referrals, which has largely been related to meeting suppressed demand arising from the pandemic. This reflects experience in the United Kingdom (UK) and internationally. This high volume of referrals is expected to continue into 2024. To support management of this increase in demand for outpatient services, work will take place in collaboration with GPs to develop and utilise alternative pathways for their patients to access timely care directly in the community.

Scheduled care activity is vulnerable when acute hospitals and healthcare staff are under significant pressure due to surges in demand for unscheduled care. Increased ED attendances can result in cancellations of elective procedures, and it is recognised the impact this has on patients. Additionally, persistent recruitment challenges may impede the ability to fully implement the proposed waiting list initiatives and reforms.

Achieving 2024 NSP targets will be progressed in line with the goal of universal healthcare as part of a phased multi-year approach towards achieving *Sláintecare* maximum wait times of no more than 12 weeks for an inpatient / day case (IPDC) procedure or GI scope and 10 weeks for a new outpatient appointment. This will result in implementation of national strategies and services in collaboration with community services. Targets in outpatient, IPDC, GI scope are set at 5% above the 2023 outturn, to be delivered by increasing core activity by 2.5% and by a further 2.5% as part of the WLAP, and targets in relation to the

Sláintecare maximum wait times will be set out as part of the WLAP. We will aim to further increase activity including through recruitment of new consultant posts and implementation of the consultant contract.

In 2024, in line with the Waiting List Action Plan, we will:

1. Embed the existing proven waiting list initiatives to support more timely access to scheduled care with a focus on development of sustainable care models and enhanced capacity, including specialty-based programmes and reform initiatives (Patient Initiated Review, central referral office, advanced clinical prioritisation)
2. Continue to focus on patient treatment across identified priority areas (obesity, spina bifida / scoliosis and gynaecology) and, within existing capacity, identify areas where there is an evidenced capacity and demand imbalance, in particular otolaryngology (ENT), ophthalmology and dermatology where capacity allows
3. Continue to support the sustainable reduction in waiting times through the implementation of improved operational processes and ongoing development of evidence-based models of care
4. Embed the implementation of the modernised care pathways
5. Continue to take forward our information communications technology (ICT) and analytic capabilities, including Artificial Intelligence (AI), in building quality data and information capability and insights at local, regional and national levels and to build on other eHealth projects critical to enabling the delivery of our elective services in acute hospitals.
6. Surgical hubs are being developed in the following locations: South Dublin, North Dublin, Galway, Cork, Waterford and Limerick with feasibility being progressed for the North West. In 2024, the surgical hubs in South and North Dublin are expected to be fully operationalised and opportunities to open in Galway also being progressed. The remaining hubs are being delivered on an expedited schedule and are expected to be fully operationalised on a phased basis during 2025. In 2024, we expect that the total additional capacity delivered through the two new Dublin surgical hubs will result in 1,400 additional day case procedures, 3,800 additional minor operating procedures, and 12,000 additional outpatient department appointments. This capacity is expected to ramp up to full capacity throughout 2025 as the hubs become fully operational. When fully operational, each hub is expected to deliver circa 4,000 additional day case procedures, circa 5,800 additional minor operations, and circa 18,500 additional outpatient consultations
7. Establish the average number of outpatients seen by consultants in each specialty and assess reasons for potential variance so as to improve activity in line with patient need.

1.3. Cancer Services

The National Cancer Control Programme (NCCP) leads on the implementation of the *National Cancer Strategy 2017-2026*, working collaboratively and engaging with service users, external stakeholders, and acute and community services.

Cancer services are designed and delivered through nine cancer centres, including Children's Health Ireland (CHI) Crumlin for children and young adults, a satellite unit in Letterkenny University Hospital for breast cancer services, and a further 16 public hospitals for systemic anti-cancer therapy (including chemotherapy and immunotherapy). Radiotherapy is provided through five public centres and two private centres. Services are designed and managed to ensure timely, equitable access to safe, quality-assured,

person-centred care and enhanced patient experience. NCCP will continue to focus on emerging treatments and technologies, along with supporting community and voluntary services.

In 2024, we will:

1. Provide optimal care: ensuring that patients / service users are provided with the right treatment through continuation of the agreed surgical oncology centralisation project, supporting the National Plan for Radiation Oncology Phase 2 expansion at St. Luke's Radiation Oncology Network, Beaumont Hospital, continuing to work with medical oncology, haematology and systemic anti-cancer therapy (SACT) services to meet demand, and continued implementation of national chimeric antigen receptor T-cell (CAR-T) therapy, peptide receptor radionuclide therapy (PRRT) and stem cell therapy (SCT) specialised services
2. Maximise patient involvement and quality of life: through the development of psycho-oncology, cancer survivorship, child, adolescent and young adult (CAYA) services and the Community Cancer Support Centre network
3. Reduce the cancer burden through prevention and early detection, including progressing the implementation of the national plan for skin cancer prevention and the *Early Diagnosis of Symptomatic Cancer Plan 2022-2025,* and progression of initiatives and research into reducing health inequalities surrounding cancer services
4. Enable and assure change in our services based on best practice, in line with the Health Regions, and continue the roll-out of the National Cancer Information System and multidisciplinary meeting module across the Hospital Groups (and Health Regions when established) and SACT centres in 2024.

2. Strengthening core services including capacity-building in the community

We want to deliver services that help keep people well, including addressing health inequalities with a focus on health promotion. Reducing our dependence on the current hospital-centric model of care and supporting capacity building in the community is key to realising the vision of universal healthcare. With our growing and ageing population and the increasing incidence of chronic disease, timely access to community and primary care, aligned to general practice, and delivering services at home in the community, will not only ease pressure on our hospital system, it will better deliver what people want and need, supporting people to live well, full lives, connected with their community.

2.1. Prevention and Wellbeing

Health and Wellbeing

Promoting health and wellbeing and preventing chronic disease is a critical component of creating a sustainable shift in our national approach to delivering healthcare. In line with *Sláintecare*, the DoH *Healthy Ireland Strategic Action Plan 2021–2025*, and the *Health Services Healthy Ireland Implementation Plan 2023-2027,* the leadership focus will be on driving the whole health and social care system towards a culture that places greater emphasis and value on keeping people well, moving from an illness orientation culture to one with an equal focus on prevention, early intervention and self-management of chronic disease. Existing relationships and work with local communities and organisations will be strengthened to continue promoting healthy behaviours through all stages of life and reduce health inequalities.

In 2024, we will:

1. Develop training programmes, resources, research and guidance to enable all health professionals to take a more holistic approach towards wellbeing in their practices and services, including providing guidance and support for the development of HSE Health Regions Healthy Ireland Implementation Plans and supporting all clinical staff, through the Making Every Contact Count (MECC) Programme, to promote positive lifestyle behaviour change for service users as part of routine consultations
2. Deliver health interventions and services to address key behavioural risk factors including tobacco, alcohol, physical activity and diet; promote sexual health and positive mental health as well as social prescribing and implementing evidence-based models of self-management support including *Living Well – A Programme for Adults with Long-term Health Conditions*; implement activities to improve breastfeeding rates and the uptake of the seasonal influenza vaccination programme amongst healthcare workers as well as promoting uptake amongst at risk vulnerable groups
3. Empower people to increase control over their health through collaborative working with local communities, local authorities, local statutory and voluntary partners; and in places of education and workplaces to improve our population's physical and mental health and wellbeing. Examples of focused, partnership-driven delivery include *Sláintecare* Healthy Communities in high deprivation areas, promotion of physical and mental health in education settings, promotion of healthy ageing

actions and Healthy Cities and Counties programmes, and building capacity for pathways to physical activity outside the HSE in partnership with Sports Ireland.

National Environmental Health Service

The National Environmental Health Service (NEHS) plays a key role in protecting the public from threats to health and wellbeing. The primary role of the NEHS is as a regulatory inspectorate responsible for a broad range of statutory functions enacted to protect and promote human health, including in the areas of food safety, tobacco control, cosmetic products control, sunbed regulation, alcohol control, import and export controls, port health and fluoridation of public water supplies. Potential risks associated with the UK's exit from the European Union (e.g. regulatory divergence), geopolitical impacts and economic factors will be managed through engagement with Government departments and agencies.

In 2024, we will:

1. Continue to implement and inform the development of key environmental / public health legislation including enforcement of the *Public Health (Alcohol) Act 2018* and planning and preparation for the commencement of the proposed Public Health (Tobacco and Nicotine Inhaling Products) Bill 2023
2. Maintain and deliver statutory programmes of inspection, surveillance, sampling and investigation on a risk-assessed basis, in relation to food safety, sunbeds, alcohol, port health, cosmetic products, tobacco, e-cigarettes and import and export controls
3. Further develop collaborative engagement across a variety of multi-sectoral fields, including with DoH, Department of Agriculture, Food and the Marine, Department of Justice, Food Safety Authority of Ireland and the Revenue Commissioners to strengthen the implementation of preventative health policies, legislation and health protection.

National Screening Service

The National Screening Service delivers four national population-based screening programmes for bowel, breast and cervical cancer, and for detecting sight-threatening retinopathy in people with diabetes. These programmes, working with patients, advocacy and wider stakeholder groups, aim to reduce morbidity and mortality in the population through early screen detection of disease, and treatment. Recent evidence (*Breast, cervical and colorectal cancer 1994-2019: National trends for cancers with population-based screening programmes in Ireland*, National Cancer Registry of Ireland, 2022) confirms the positive impact of BreastCheck, CervicalCheck and BowelScreen on cancer detection in Ireland and outlines a noticeable increase in earlier diagnosis, and a demonstrable reduction in mortality rates.

In 2024, we will:

1. Implement *Choose Screening: National Screening Service Strategic Plan 2023-2027* to provide a person-centred and standardised approach to communications, strengthen quality assurance, address screening inequalities over the next five years and work to maximise screening opportunities
2. BowelScreen programme: continue implementation of the programme age range expansion for 59 year olds, commenced in 2023
3. BreastCheck programme: implement the new client and radiology information system, plan for the implementation of surveillance for women with a family history of breast cancer, and implement a real-

time digital patient experience survey to capture and understand women's experiences in the programme and identify opportunities for improvement

4. CervicalCheck programme: continue the multi-year collaboration with the National Immunisation Office, the National Cancer Control Programme (NCCP) and the National Cancer Registry Ireland to progress Ireland's approach towards elimination of cervical cancer. Additionally, continue the development of a new information management system, and continue to plan for the capacity fluctuations across the full cervical screening pathway taking into account the modelling work completed in 2023 and the impact of moving from a three to five-year cycle for women. Continue to collaborate with the Coombe Hospital on building capacity within the National Cervical Screening laboratory
5. Diabetic RetinaScreen programme: roll out nationally the digital surveillance screening pathway following completion of a pilot project.

2.2. Public Health

Public health and prevention are fundamental principles to achieve universal healthcare. Aligned to our legislative responsibilities and international best practice, Public Health works across the domains of health improvement, health service improvement, health intelligence and health protection to protect and promote the health and wellbeing of the population.

Building upon the strategic reform of Public Health, an enhanced and strengthened Area Public Health function, already aligned with the new Health Regions, is well placed to support the delivery of a population-based approach to planning health and social care, with a focus on addressing health inequalities for all members of the public.

In 2024, we will:

1. Build an enhanced and strengthened public health service, providing strong clinical leadership through the establishment of a population-based approach to service planning, delivery, evaluation and resource allocation to serve as a foundation for population health and wellbeing, including developing the framework for population-based needs assessments
2. Continue to deliver on the HSE *Health Protection Strategy 2022-2027* including preparing for and responding to public health threats and major incidents across all hazards, ensuring consistent, high-quality public health approaches to prevention, investigation, surveillance, and response to notifiable infectious diseases in all parts of the country, continuing to enhance our understanding of global health threats, and completing the full transition of COVID-19 Test and Trace to a business as usual operating model embedded in Public Health and advancing the implementation of an Outbreak Case and Incident Management IT System
3. Deliver a high-level of prevention and control of vaccine preventable diseases across population groups through immunisation programmes, including COVID-19, seasonal flu (including working with the DoH to agree and implement a plan to expand the flu vaccination programme to more class years in 2024 in all primary schools in line with the funding provided) and the Primary Childhood Immunisation Schedule (information in relation to the COVID-19 vaccination programme can be found further in this section) and advance the National Immunisation Information System project
4. Provide support to children, parents and child healthcare providers through the Child Health Public Health and the National Healthy Childhood Programme; initiate development of a Child Health Public

Health strategy for the next three to five years; agree with the DoH an implementation plan and schedule for delivery for the expansion of the HSE Newborn Bloodspot Screening Programme, to include severe combined immunodeficiency and spinal muscular atrophy, and to commence implementation of that plan in 2024, and continue measures to support the delivery of the programme.

COVID-19 Vaccination Programme

The COVID-19 Vaccination Programme is responsible for the end-to-end management and distribution of the COVID-19 vaccines, including implementation of Government policy and National Immunisation Advisory Committee guidance, provision of clinical guidance and training for healthcare professionals, communication with stakeholders and with the public, and monitoring and remediation of any risks to the successful delivery of the programme. The efficient provision of safe and effective vaccines to the population reduces the incidence of serious illness and death as a consequence of COVID-19. We will ensure there is timely implementation of surge capacity and / or emergency response plans based on agreed triggers, and continue the development of a sustainable model for future management of the COVID-19 Vaccination Programme or similar programmes in response to threats and outbreaks.

In 2024, we will:

1. Develop and deliver a programme plan for administration of COVID-19 vaccines in line with recommendations.

2.3. Primary Care and Enhanced Community Care Programme

As we move forward with the establishment and evolution of the Health Regions, there will be a natural coalescing of Primary Care Services and the Enhanced Community Care (ECC) Programme into one, noting the clear interdependencies between them. For this NSP, the particular objectives are shown separately to reflect the way in which current teams are organised.

Primary Care

Primary care supports people across the continuum of their lives, close to home, through a community-based approach. Its goal is to provide quality, timely service at the lowest level of complexity. For many people, primary care is the first point of contact that they have with health and social services. Primary care incorporates GP and GP out-of-hours services in addition to a wide range of diagnostics, treatment and supports including community and public health nursing, oral health, audiology, ophthalmology, child psychology and a range of therapy services.

Primary care will continue to deliver:

- CITs who offer an extended service, seven days per week to facilitate care in the community, home or nursing home setting
- Outpatient parenteral antimicrobial therapy which is the delivery of intravenous antibiotics in the patient's home, infusion centre or suitable step down unit

- Paediatric home care packages which are intensive packages of nursing care primarily put in place to support the discharge of seriously ill children from acute hospital services into the care of their families to live and be cared for at home
- Community funded schemes provide an extensive range of aids and appliances, products and services to many service users living with a wide variety of different medical and physical conditions.

In 2024, we will:

1. Work as part of an integrated team to support the implementation of policies and programmes including the National Access Policy, the Assisted Decision Making Policy, the MECC Programme and the National Healthy Childhood Programme
2. To support the National Oral Health Policy *Smile agus Sláinte*, in 2024, the focus will be the development of a comprehensive phased implementation plan for the range of actions identified, including stakeholder engagement and resource identification. The plan, which will be developed in consultation with the DoH and other stakeholders, will include the progression in 2024 of oral health and care packages for children aged from birth to seven years of age and the design of preventative clinical elements for adult medical cardholders as referenced in the policy
3. Improve access to primary and community care through a range of actions and interventions:
    - Maximise activity to manage waiting lists and waiting times (including procuring services from private providers as appropriate) within available resources
    - Continue to develop services and implement waiting list initiatives across orthodontic and psychology services for children and young people
    - Improve access to immunisation programmes
    - Continue to implement the National Access Policy for Children and Young Adults from within available resources
    - Continue to improve integration between primary care and other care groups i.e. disability services, older persons' services and mental health services
    - Continue to work with Community Healthcare Organisations (CHOs) / Health Regions on productivity analysis of service provision within primary care
4. Improve access to person-centred care close to home and within service users' communities through the delivery of a programme of new primary care centres
5. Continue to progress a standardised approach to the collection of data, activity and outcome measurement as part of the enabling drivers for the Integrated Community Case Management System
6. Work with the DoH on the development of a programmatic approach to primary care therapy waiting lists
7. Continue to support all necessary actions relevant to primary care, from within available resources, contained in the Urgent and Emergency Care Plan.

Enhanced Community Care Programme

The Enhanced Community Care (ECC) reform programme will, over time, reorient service delivery towards general practice, primary care and community-based services with community healthcare networks (CHNs) and CSTs working in an integrated way with CITs, the NAS and acute services to deliver end-to-end care, keeping people out of hospital and embracing a 'home first' approach.

The ECC multidisciplinary teams across acute and community services will achieve increased maturity levels in 2024, maximising the impact of their inputs, activity and outputs. As these teams mature, they are working in a more integrated way, delivering increased levels of service closer to people's homes, facilitating early discharge and hospital avoidance, along with delivering modernised care pathways particularly focused on addressing waiting lists. Productivity will be greatly assisted by the filling of the remaining ECC and modernised care pathways consultants and GP leads, whilst ensuring the backfilling of key leadership roles (CHN managers and CST operational leads) that will become vacant in 2024 within the affordable Whole Time Equivalent envelope.

In 2024, we will:

1. Deliver over 141,000 patient contacts through 28 Integrated Care Programme for Older Persons CSTs, and over 228,000 patient contacts through 28 Integrated Care Programme for Chronic Disease CSTs, resulting in a reduction in ED attendance and hospital admission rates, quicker discharge from acute settings and a reduction in hospital waiting lists, with an initial focus on those longest on waiting lists
2. Embed multidisciplinary team working and service delivery in the CHN model, incorporating the services of ALONE and Health Promotion and Improvement Officers. This will include completing the roll-out of Healthlink for all GP referrals to the CHNs and CSTs and ensuring regular clinical team meetings are taking place in each CHN
3. Flex the ECC model to support over 2,800 admissions to nursing homes through inpatient geriatric assessment, CST-led advance care planning and access to CHN services
4. Provide direct access for GPs to community diagnostics by completing up to 240,000 community radiology tests alongside up to 161,000 tests across areas such as echocardiography, spirometry and natriuretic peptide blood tests, totalling over 400,000 tests
5. Implement the interim ICT solution for CHNs and CSTs, in tandem with progressing the necessary work for the longer-term ICT infrastructure, supporting the digital enablement of services
6. Increase general practice capacity with an increase in GP training places to 350, a 23% increase from the intake in 2023 and an increase in the non-EU Doctor Scheme with a planned intake of up to 250 in 2024
7. Complete the Strategic Review of General Practice, examining the following issues:
    - GP training
    - GP capacity
    - Out-of-hours service reform
    - eHealth agenda
    - Financial support model for general practice
8. Target, through the Chronic Disease Management (CDM) Programme, 529,212 patient reviews. The impact of the CDM programme, aligned with the UEC Plan, will continue to result in a reduction in bed days used for patients
9. Complete the roll-out of the Prevention Programme to include all medical card / GP visit card holders with hypertension over 18 years, and all women over 18 years who had gestational diabetes mellitus or pre-eclampsia in a pregnancy since January 2023.

Social Inclusion

Social Inclusion works across a range of statutory services in partnership with the community and voluntary sectors to address health inequalities and improve access to health services for vulnerable and excluded groups, informed by a human rights-based person-centred approach. Key groups experiencing exclusion and inequality include people who are experiencing homelessness; people who use drugs and alcohol in a harmful way; vulnerable migrants, refugees, Beneficiaries of Temporary Protection (BOTPs) and international protection applicants; Traveller and Roma communities; lesbian, gay, bisexual, transgender and intersex (LGBTI+) people; and people who experience domestic, sexual and gender-based violence (DSGBV).

In 2024, we will:

1. Further develop social inclusion health services through implementation of the recommendations of the service user engagement study, establishing an approach to comprehensive pathways of care within and between health and community services to better address the health needs of vulnerable and marginalised populations, and promoting the uptake of the Ethnic Equality Monitoring HSeLanD module to support the roll-out and use of health service data sets to inform access, participation and health outcomes for different ethnic groups
2. Increase access to drug and alcohol services and ensure sustainability in the community, in partnership with key internal and external stakeholders (e.g. DoH, Drug and Alcohol Task Forces, community and voluntary services, mental health services, TUSLA, An Garda Síochána, the Probation Service)
3. Enhance existing adolescent addiction services, in conjunction with the mental health programme for dual diagnosis, and address the substance use needs of young people presenting with first episode psychosis by progressing a case management approach between social inclusion and the mental health early intervention in psychosis clinical programme
4. Progress integrated care pathways and harm-reduction responses, including the establishment of a medically supervised injecting facility (Merchant's Quay Ireland) and an addiction facility for homeless people (Usher's Island), continue initiatives addressing cocaine use, strengthen drug monitoring services, and support the implementation of the Health Diversion Programme
5. Strengthen preparedness for drug overdoses in light of the emergence of new synthetic drugs and increase availability and training in naloxone
6. Continue to support those receiving drug treatment services, children, parents and their families. Progress a tendering process for proposals in relation to building recovery capital in urban and rural areas
7. Review ongoing pilot initiatives for those experiencing difficulties with gambling and gaming, and expand initiatives nationally to additional areas
8. Maintain essential public health measures, consolidate advancements in healthcare delivery (including integrated care and case management) for people experiencing homelessness and provide health supports for 260 new Housing First tenancies. Work towards improving and expanding access to healthcare services for people experiencing homelessness and other social inclusion groups, including Roma communities, survivors of DSGBV, and members of the LGBTI+ community
9. Monitor and improve Traveller health outcomes through implementation of the *National Traveller Health Action Plan, 2022-2027*, and evaluate the impact of primary healthcare projects for Travellers.

Health response for refugees and applicants seeking protection

In 2022 and 2023, the HSE has put in place a service delivery model for refugees and applicants seeking protection. Primary care in-reach teams have supported the case management of complex cases from the significant numbers of new arrivals as well as supporting vulnerabilities that may arise as people become settled. Improvement in health outcomes is achieved by promoting, enabling and advancing an inclusive health service, enabling initiatives in health service design and delivery, and contributing to addressing health inequalities.

Once-off funding of €50m has been allocated to the Ukraine health service response for 2024, primarily across the Primary Care Reimbursement Service (PCRS), primary care, social inclusion and acute hospital services. €28m in funding is provided to primary care and social inclusion to oversee, co-ordinate and implement all Ukraine related health programmes including vaccine catch-up, GP sessional visits, migrant health teams, psychosocial response, infectious disease testing, National Transit Centre, the Health Status Questionnaire, translation and communications. €20m has been allocated to PCRS to fund medical card expenses including GP visits. €2.1m is provided to acute hospitals to support migrant populations and in relation to costs associated with medical evacuations from Ukraine.

In 2024, we will:

1. Continue to provide targeted healthcare services to refugees, international protection applicants, BOTPs and vulnerable migrants:
    - Support the implementation of the Refugee and Applicants seeking Protection Service Delivery Model and the work of the migrant health in-reach teams, GP sessional clinics and psychosocial supports
    - Working with public health, community services and GPs, seek to increase access to in-reach health screening, vaccination and psychosocial supports.

Palliative Care

Palliative care 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 multidisciplinary assessment and treatment of pain and other physical, psychosocial and spiritual problems. Specialist palliative care reduces acute hospital admissions and facilitates earlier discharge from hospitals to the community where care is delivered in hospices and people's homes (including nursing homes) by the palliative care team, in conjunction with primary care services. Our mission is to enable more people to die at home by providing integrated palliative care across primary, acute and social care services in 2024.

Specialist palliative care for children and adults has received significant investment in recent years to meet the increased demand for services. In the average month, care is provided to 3,800 individuals in their own homes, 1,100 patients in acute hospitals, 570 people in palliative care inpatient units (hospices), and 440 families receive bereavement care. In addition, every month, 320 children with life-limiting conditions are supported at home and 60 children receive specialist palliative care in CHI Crumlin and Temple Street.

In 2024, we will:

1. Enhance the provision of palliative care to children by developing the capacity of the CHI specialist palliative care team and establishing a network of regional paediatricians with a special interest in

palliative care to lead the development of tertiary services in line with the model of care. We will continue to develop and implement blended learning programs to support clinicians providing multidisciplinary palliative care to children in the community. In addition, we are supporting Laura Lynn to open a third hub which will increase availability and equity of the Hospice in the Home service throughout the country

2. Provide equal access to palliative care services for people with life-limiting conditions by progressing the development of new specialist palliative care inpatient units in Tullamore, Drogheda and Cavan. We will complete the re-designation of Section 39 hospices to Section 38 status to ensure a sustainable and equitable model of funding for specialist palliative care nationally. We will progress the development of a Clinical Management System to enhance access to patient records and improve the patient journey
3. Improve knowledge and skills of nursing home staff to ensure patients and their families receive compassionate palliative care that enhances quality of life as well as a good death. This will be achieved by implementing the Caru nursing home programme in 2024 across all nine CHOs (and Health Regions when established), in conjunction with the Irish Hospice Foundation and the All Ireland Institute of Hospice and Palliative Care.

2.4. Mental Health Services

We are committed to promoting our population's mental health. Our focus is on prioritising child and adolescent early intervention, including reducing waiting lists; enhancing early interventions for adult mental health services and improving access to person-centred mental health services.

Mental health services aim to promote positive mental health, intervene early when problems develop, prevent suicidal behaviour, and provide accessible, comprehensive and recovery-focused community-based mental health services for those who need them. A person-centred approach is taken, with a focus on enabling and supporting the recovery journey of each individual, based on lived experience, clinical expertise and evidence-based practice. The range of mental health services delivered by, or on behalf of, the HSE covers specialist inpatient services, day hospitals, day services and residential services. It also includes mental health services provided within community settings and in primary care, as well as non-specialist supports and services, many of which are provided in collaboration with our funded partner organisations.

Multidisciplinary community mental health teams for child and adolescent mental health services (CAMHS), the general adult population and older people are a core component of the specialist mental health services. Specialist service provision also includes mental health services for people with an intellectual disability, people with eating disorders, liaison mental health services, perinatal mental health services, counselling for adults who have experienced childhood abuse, peer and family support, rehabilitation and recovery education. The National Forensic Mental Health Service provides inpatient services through the Central Mental Hospital, community-based support services through the Rehabilitation and Recovery teams and prison in-reach services to the Irish Prison Service. The provision of intensive care rehabilitation services is at planning stage for 2024.

In order to ensure integrated care, service continuity and the best possible outcomes for those experiencing mental health difficulties, mental health services are provided within a stepped care model where each person can access a range of options of varying intensity to match their needs. This includes access to digital mental health interventions such as guided online cognitive behavioural therapy as well as the Counselling in Primary Care Service which provides access to talk therapies for adults presenting with mild

to moderate mental health difficulties in primary care. The aim of mental health promotion, early intervention and 'upstream services' is to protect people's mental wellbeing and to reduce, in time, the need for specialist, acute and inpatient services.

Productivity and service provision will be enhanced in 2024 through a concerted effort to focus on staff engagement at all levels so that community teams and inpatient services know that they are being supported and guided in their work. Regular calls and meetings are scheduled and ongoing with regional mental health management teams while the *Sharing the Vision* communications plan will facilitate awareness across the country of priority service improvement plans. In turn, data on service activity and, where feasible, mental health outcomes will be gathered at a local level and reported regularly. Short-term *Sharing the Vision* recommendations are due for implementation by the end of 2024 and will address some of the following key areas: enhanced roll-out of social prescribing, shared care between primary and secondary mental health services, child and youth mental health service improvement and crisis support services. In addition to these key areas, mental health services will work to ensure partnerships with voluntary and community organisations are enhanced and that we continue to scale up digital services. Management of partnerships and digital services will include the monitoring and reporting of outcomes based on agreed measures. Where appropriate, capacity will be enhanced through waiting list initiatives and through early intervention (primary care and digital). Routine reporting of mental health service activity will complement the quarterly online reporting on *Sharing the Vision* implementation.

In 2024, we will:

1. Continue to deliver on *Sharing the Vision – A Mental Health Policy for Everyone* in line with the priorities set out in the current implementation plan (2022-2024) with a particular focus on short-term recommendations. Priorities include those recommendations which facilitate improved access and integration of services, including digital, psychosocial, talk therapies and primary care mental health service improvements. In parallel, the second *Sharing the Vision* implementation plan will be drafted in consultation with all relevant stakeholders
2. Develop clinical and service improvement programmes for children and young people, including early intervention psychosis, eating disorders and dual diagnosis, and support the enhancement and continued implementation of the CAMHS Hub Model of Care within the existing learning sites
3. *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2024*, has been running for eight years and the development of a successor strategy will commence in 2024. The successor strategy will be informed by the evaluation of *Connecting for Life* and the most up-to-date evidence on suicide prevention and data on suicide mortality. In 2024, existing suicide bereavement support services will be enhanced to meet increasing demands and identified needs
4. Deliver timely, clinically effective and standardised safe mental health services in compliance with statutory requirements through an overall long-term Child and Youth Service Improvement Programme into which the new Child and Youth Mental Health Office has consolidated the recommendations from the *Report on the Look-Back Review into Child and Adolescent Mental Health Services County MHS Area A (Maskey Report) 2022*, the Mental Health Commission report on CAMHS provision, CAMHS audits, *Sharing the Vision* recommendations and clinical programmes, directed by *Sharing the Vision*
5. Continue to implement the *Mental Health Engagement and Recovery Office Strategic Plan 2023-2026 Engaged in Recovery* to ensure that the perspective of patient / service user lived experience is central to the design, development and delivery of mental health services through i) the phased roll-out of the Enhancing Engagement Framework; ii) a review of Recovery Education structures; and iii) the completion

of the Framework for Recovery in Mental Health Services and supporting implementation plan

6. Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure through the roll-out of the agreed 2024 Capital Plan, continued support of professional development opportunities for staff, retention initiatives and active recruitment of approved development posts.

While any person might need to avail of any of our health and social care services, certain cohorts have particular needs at particular times that must be addressed as part of our commitment to provide a healthier Ireland, with the right care, at the right time and in the right place. The below sections outline specific commitments to improve the health of children and women and of older persons in particular.

2.5. Children's Health

Protecting and improving the health of children is of fundamental importance so that all children and young people in Ireland will be able to live their best, healthiest life. We will enhance our focus on prevention and early intervention to improve children's health and wellbeing now and into the future through a population health management approach. This includes through access to mental health services and services for children with disabilities, and through the work of Children's Health Ireland (CHI) and acute hospitals nationally. Work will continue with CHI and acute hospitals across the Health Regions to configure clinical networks within existing resources to bring care closer to home for children and families as envisaged in the Paediatric Model of Care.

In 2024, we will:

1. Work to reduce the risk factors for chronic disease, with a clear focus on tackling rising obesity rates and alcohol harm
2. Continue to prioritise the delivery of health and social care professional services to children with disabilities and their families to support them to reach their full potential
3. Enhance early interventions and improve access to person-centred CAMHS teams
4. Prioritise safeguarding of vulnerable children
5. Support national oversight and implementation of a national strategy for integration of children's and young persons' care across the Health Regions including primary, community and acute health and wellbeing services
6. Working with CHI, within existing service resources, prepare for the opening of the National Children's Hospital
7. Consolidate the existing investment in the Paediatric Model of Care across all Health Regions
8. Embed the investment in the multi-agency Barnahus model of child sexual abuse services.

2.6. Women's Health

The National Women and Infants Health Programme (NWIHP) was established to lead on the implementation of: *National Maternity Strategy – Creating a Better Future Together 2016-2026*.

The NWIHP oversees a comprehensive programme of work focused on women and infant health and continues to work closely with the DoH to drive forward and implement the *Women's Health Action Plan 2022-2023*, focusing on the physical, mental and emotional wellbeing needs of women in Ireland. This includes the continued development of perinatal mental health services, obstetrics event support, 'see and treat' gynaecology clinics and specialist endometriosis and menopause services. NWIHP strengthens and quality assures maternity services through collaborative working with internal clinical advisers, operational delivery teams and key external partners.

In 2024, we will:

1. Continue to drive the implementation of the National Maternity Strategy and associated actions with particular focus on audit and research, eHealth, clinical guidelines, pregnancy loss and bereavement care
2. Ensure quality and safety in the provision of maternity care through continued engagement with service users and advocacy groups, monitoring of performance with an enhanced focus on maternity indicators, data collection and analysis and information systems, and through the work of NWIHP's Obstetric Emergency Support Team, focusing on identification and mitigation of clinical risk and the provision of rational and practical support to hospitals when an adverse incident occurs
3. Enhance access to gynaecology services through the expansion of ambulatory gynaecology services, implementation of the framework for endometriosis care, and the continued roll-out of dedicated Women's Health Hubs in the community, facilitating access to high-quality, timely care in an appropriate environment
4. Support sexual and reproductive health through the continued roll-out of the National Framework for Perinatal Genetics, expansion of termination of pregnancy services, and completion of Phase 2 of the roll-out of the Model of Care for Infertility with the development and introduction of publicly funded, publicly provided advanced human reproductive services, incorporating in vitro fertilisation (IVF)
5. Continue to work with the DoH to progress the next steps from the work of the HSE National Vaginal Mesh Oversight Group.

2.7. Older Persons' Services

One third of adults aged over 75 years are living with frailty in Ireland. We must continue to provide support to enable them to remain living at home, in their communities, as independently as possible for as long as is feasible. To facilitate this need, the HSE will provide a wide range of core services for older persons including home support, day care, and other community-based supports in partnership with voluntary groups.

In addition, the HSE will provide community bed-based rehabilitation for older people to support them in maximising their independence, ensuring they can remain in their own homes. Long-term residential care provision will be available to support people who have more complex health and care needs, with this option available only when remaining at home is no longer feasible.

During 2024, the HSE will prioritise support services towards older people most at risk of admission to hospital, and enable them wherever possible to receive appropriate care and support in the community. This includes the provision of complex case packages particularly for older people with dementia. The HSE will continue to implement the new model of care specifically aimed at nursing home residents, which ensures equity of access for the entire population whether they live in their own homes or in residential care. In addition, the HSE will provide aids and appliances to residents in nursing homes as per their assessed need

for equipment to support the delivery of safe care. We will continue to implement the mobile diagnostics care pathway for older people in residential care to reduce any unnecessary travel to EDs (as an example of hospital avoidance activity referenced in Section 1, chapter 1 (1.1) in relation to the multiannual Urgent and Emergency Care Plan).

Services for older people are delivered directly by the HSE and through service arrangements with voluntary, not-for-profit and private providers. Our priority for 2024 is to remain focused on the quality of care we deliver and the quality of the environment in which we deliver those services by increasing and maintaining compliance with statutory regulations that monitor our services. It is necessary that older persons' services maximise productivity; we will continue our work to reduce the cost of care while maintaining and ensuring high-quality service provision. The HSE will continue to strategically commission and procure services that represent value for money and that are effective in driving greater outcomes for older people. In addition, we will continue to integrate our services, ensuring timely access is at the heart of what we do and that our prevention agenda takes centre stage in supporting our older people to remain as independent as possible for as long as possible in their own homes and communities.

In 2024, we will:

1. Continue to provide integrated models of home and community support, enabling increased access to care and supports in the community and egress from acute hospitals, through the delivery of 22 million home support hours to approximately 54,100 people
2. Provide 140,000 personal care hours (Complex Case Home Support Packages) to people discharged from the National Rehabilitation Hospital, to reduce the number of people admitted to long-term care
3. Ensure timely access to dementia care and a reduction in waiting times, including for dementia assessment, diagnostics and post-diagnostic support services, and allocate a minimum of 18% of new home support hours to people living with dementia or a cognitive impairment
4. Maintain and keep operational over 300 day centres
5. Continue to support older people transitioning from acute hospitals through the provision of transitional care funding, with up to 10,681 people on this care pathway in 2024. In addition, the HSE will continue to provide community inpatient rehabilitation to support older people regain physical functioning so they can live as independently as possible, and continue to make available respite provision to benefit both older people and their carers
6. Support an average of 23,280 people through the Nursing Homes Support Scheme (NHSS) while maintaining the average four-week waiting period for funding
7. Continue to prioritise the implementation of International Resident Assessment Instrument (interRAI) care needs assessment across home support services as part of the development of a standardised home support operating model. It is envisioned the HSE can progress the roll-out across older person services in line with our available resources (12,000 home supports assessments are targeted for 2024)
8. Progress the procurement planning for an ICT system for home support services and the NHSS. This ICT system will enable the HSE to futureproof home support service delivery with the anticipated enactment of statutory regulations for home support
9. Continue to fund agencies to deliver over 2.7 million meals on wheels in the year to over 54,000 recipients each week
10. Continue to work collaboratively with the DoH and other key stakeholders in progressing the recommendations of the Strategic Workforce Advisory Group.

Section 2
Improving Access to Care and Performance: *Disability Services*

Disability Services

We are committed to delivering the key health and social support services that are required by people with a disability in keeping with the United Nations Convention on the Rights of Persons with Disabilities. Our focus is on providing a person-centred responsive service model to achieve greater flexibility and choice for all people who need specialist disability services.

The delivery of specialist disability services is through the alignment of the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), the HSE, people with disabilities and their families, disabled persons' organisations, service providers and a wide range of other stakeholders. The HSE will build on existing partnerships, working with all these stakeholders, to develop and improve services, with a particular focus on services to children in recognition of the significant gaps in service currently experienced by children and families.

Addressing deficits in services provided in Children's Disability Network Teams (CDNTs) is a critical task for the HSE and its partners in 2024, recognising the very significant positive impact that early intervention can have on the outcomes for children and their families. An extensive and ambitious programme of work is laid out in the HSE's *Roadmap for Service Improvement 2023-2026 Disability Services for Children and Young People.* The Roadmap contains a robust suite of retention and recruitment actions to make CDNTs an attractive place to work, in order to improve access to timely services for children and their families. The HSE is entirely committed to the delivery of the actions over the lifetime of the plan. Progress towards a resolution of the assessment of need backlog is a critical component of this work. Significant work has been committed to this and to balancing the delivery of assessment and actual access to therapeutic interventions where required.

This reflects the HSE's ambition for, and commitment to, improving access to services for children and families. As agreed in the National Access Policy, disability services, child and adolescent mental health services and primary care services will work closely to improve co-ordination and integration across all services. €3m was ring-fenced in the Budget for targeted services for children, allowing projects in relation to the following to be progressed in line with the HSE approval process:

- Chime
- Erb's Palsy
- Central Remedial Clinic
- Dyspraxia / DCD Ireland
- ChildVision
- Debra Ireland
- Crann Centre
- National Rehabilitation Hospital Clinical Lead Programme.

In addition, tenders are being put forward for two research proposals while, separately, a foetal alcohol project will be undertaken using a multi-care health sector approach (primary care, mental health services etc.)

Following the transfer of functions, capacity and capability is being expanded within the new Disability Division in DCEDIY. Matching capacity and capability is also required in the HSE to address the significant challenges facing the sector. This will be supported by a clear programmatic approach focused on reform

and change delivering momentum around the Action Plan and the Roadmap. National direction with strong governance at regional level will facilitate an inclusive and comprehensive partnership approach to achieve the ambitious goals of the programme. The revised HSE centre and regional structures will include specific enhanced leadership capability for disability services.

The HSE is committed to supporting the implementation of *Sláintecare*, including the transition to Health Regions during 2024. The Health Regions will promote improved, integrated service delivery and access to services (mainstream and specialist) for persons with a disability.

Specialist disability services focus on providing supports to people with more complex disabilities throughout life, and on complementing the mainstream health and social care services provided. The primary goal of disability services is to improve access for children and adults to essential health and social care services that support people to have equity of opportunity to maximise their potential of living a life with choice and control.

Specialist disability services are delivered through the HSE, Section 38, Section 39 and for-profit providers. The range of specialist disability services that are provided to circa 80,000 people with physical, sensory, intellectual disabilities and autism include residential, home support and personal assistant services, health and social care services, neuro-rehabilitation services, respite services, day services and rehabilitative training.

Specialist Community-Based Disability Services transferred to the DCEDIY in March 2023. DCEDIY finalised and secured Government approval for the *Action Plan for Disability Services 2024-2026* in July 2023 which, along with the *Roadmap for Service Improvement 2023-2026*, *Disability Services for Children and Young People* (approved by the HSE Board in July 2023 and launched by the Minister in October 2023), is reflected in this service plan.

These initiatives provide a flexible future-focused template for the further development of disability services and will inform HSE service plan actions over the next three years. They reflect a clear Government commitment to supporting the HSE, providers and families in addressing the significant current deficits in services as well as future needs.

The development of all specialist disability services is underpinned by key principles including:

- Rights-based services aligned with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- Localised services provided in the community where people live
- Early intervention to maximise people's capacities
- Person-centred services supporting people's choice and control
- A strengths-based approach, recognising and supporting the inherent abilities of people with disabilities
- Coherent and integrated services and supports
- Services that are equitable, consistent and sustainable
- Prioritisation on the basis of assessed need
- Services provided by interdisciplinary teams, networked regionally with other teams, and supported by enhanced services and supports where necessary.

The principle of 'mainstream first' requires that HSE-led services are developed in the context of supporting actions by Government departments in the areas of health, housing, transport, education (including higher education), employment, social protection and justice.

In 2024, we will continue to deliver the reform of disability services through the implementation of the Transforming Lives programme and the implementation of learning from the Stability and Sustainability process. The Transforming Lives programme includes the main policies underpinning the development of disability services including New Directions, *Progressing Disability Services for Children and Young People*, *Time to Move on from Congregated Settings – A Strategy for Community Inclusion*, personalised budgets and the Neuro-Rehabilitation Strategy. It also frames the development of important enabling actions including the development of ICT and management information in disability services, the inclusion of disabled people in decision-making and underpins the collaborative working between the HSE and the voluntary sector. We will continue to work collaboratively with Government departments and agencies, and disability services stakeholders, to work towards best practice, supported by the financial and operational sustainability of the sector. We will work with HSE Estates and service providers to develop a multiannual capital strategy to set out the infrastructural needs for disability services. Through our services, we will enable people with disabilities to be active participants in their care and support.

The *Action Plan for Disability Services 2024-2026* underpins the delivery of service developments identified as being required in the *Disability Capacity Review to 2032 – A Review of Disability Social Care Demand and Capacity Requirements to 2032*. The developments planned for 2024 within the available funding will improve services for some, but the scale of need identified in the Capacity Review report will require continued investment and reform over the coming three years as set out in the Action Plan. The HSE is committed to reviewing the information and outcomes from the current sustainability impact assessment processes to identify potential systemic implications and benefit to the sector, to identify learning, and to refine processes. This learning will be applied to other organisations throughout 2024.

The implementation of the service plan is predicated on the effective use of the resources provided, including increased productivity. The HSE will focus on residential service costs in 2024 to implement a programme of work to better manage costs, provide for transition from high-cost placements, where appropriate, to meet the needs of the person, and maximise the use of available funding. The Placement Improvement Programme was established to review high-cost placements (in excess of €250,000) across disability and mental health services, to ensure that the service user and the HSE are getting good quality person-centred services at the most economical cost available. An identified parallel requirement is to address how capacity needs to be developed for onward supports and, ultimately, for minimising the need for these types of placements through enhanced early intervention responses.

Recruitment and retention of staff is essential to the delivery of the plan. This year, as part of the enhanced development and implementation of the HSE Resourcing Strategy, which supports the delivery of *Sláintecare* through Health Regions, there will be a targeted strategic focus on recruitment and retention of the workforce for disability services – further detail is set out in Section 3, chapter 1. The HSE will work with relevant stakeholders to implement a range of initiatives, including expanding the number of health and social care professionals (HSCPs) with targeted recruitment campaigns for therapy professions, including therapy assistants. The HSE desires the introduction of therapy assistants to support CDNTs and Special Schools. This is recognised as a fundamental change for many practitioners. Significant engagement will occur in the first half of 2024 to assess what is possible and required to achieve this line of workforce development.

In recognition of the importance of supports and services for children, we will continue to prioritise the delivery of HSCP services to children with disabilities and their families. While these resources are being expanded, the HSE will continue to explore and expand the level of other supports being made available to children, including the provision of therapy supports for children in Special Schools, sourcing therapy supports wherever available under the governance of HSE.

We will continue to take a life course approach, providing supports as people transition from childhood to adult to older person life stages, developing a range of services.

We will develop residential services in response to the increasing need for those services by adults with disabilities. Our residential services include planned and, where needed, emergency placements and care. Continued development of this resource is essential to addressing both new and existing need and supporting parents and their children in a structured way. This is done through new funding as a result of the Government's commitment to the *Action Plan for Disability Services 2024-2026* and through programmes to examine current services leading to reform and improved use of existing resources.

Respite is a critical service to families. Expansion of respite options will be a key priority in that it provides important supports for families in maintaining their caring role. This is in addition to the allocation of resources towards alternative models of respite to benefit carers and support people with disabilities.

In 2024, we will:

1. Improve the delivery of a range of specialist community-based disability services and increase service capacity for people with a disability throughout life in the areas of day, respite, multidisciplinary, residential, home support, neuro-rehabilitation and personal assistant services using the resources available, including:
    - Provision of circa 100 priority 1 placements for immediate occupation
    - Increasing the occupancy of existing respite capacity, where feasible, and alternative respite provision, including in-home respite support hours and group-based targeted measures such as summer camps and evening provision
    - Delivery of additional personal assistant hours to support persons with a disability in their own communities, within available funding
    - Provision, also, of an Enhanced Pathway to health and social care supports for Irish survivors of thalidomide
2. Progress the delivery of the assessment of need process in line with legislative obligations and the *Roadmap for Service Improvement 2023-2026*, using all available mechanisms to provide these assessments, including the procurement of assessments. Progress made in the latter half of 2023 will be further pursed in 2024
3. Continue to implement the recommendations of the 2018 Autism Report, led by the Service Improvement Programme for the Autistic Community Board
4. Through the Stability and Sustainability Team, continue to focus on service and organisational financial and governance challenges for specific organisations. Develop proposals for more sustainable models of service, extracting high-level learning from its current programme of work to inform future service considerations, including policy where appropriate. The Stability and Sustainability analysis places particular emphasis on maximising the use of available resources according to the principle referenced in the UNCRPD. The aim is to achieve greater efficiency and productivity overall, driving better value in the voluntary sector leading to an overall better service for those supported and in need of supports

5. Continue the transition of people from institutional settings to community-based services in line with *Time to Move on from Congregated Settings* policy and the recommendations of *Wasted Lives: Time for a better future for younger people in nursing homes*, with a specific focus on continuing to support individuals to move into more appropriate community-based settings, in line with their will and preference, within available funding and reasonable options
6. Continue the roll-out of community neuro-rehabilitation teams in line with the Neuro-Rehabilitation Implementation Framework. Teams will be developed as the HSE progresses from Community Healthcare Organisations (CHOs) to regional structures. The size of teams will be developed to reflect the geography of the region and in line with the implementation report. 2024 will see progress in CHO aligned areas 1, 2, 4, 6 and 7
7. Move towards evaluation of the personalised budgets project in 2024
8. Further implement the New Directions day services for adults with disabilities policy through the provision of between 1,250 and 1,400 new day service placements for school leavers and graduates of rehabilitative training
9. Work closely with DCEDIY to develop and embed effective governance and working structures following the transfer of functions of Specialist Community-Based Disability Services from the DoH to the DCEDIY
10. Establish a working group to agree a programme of work to improve disability data coverage and quality, to enable a greater focus on service delivery and performance monitoring across the HSE, voluntary and for-profit service providers, and to inform policy development. Specific areas of focus will be Service Agreement / Grant Aid Agreement signing, including provision of a national view of relevant data, and monitoring of service delivery targets against grants to organisations.

Section 3
Resource Optimisation Delivering Accountable Implementation

1. Workforce Resourcing and Reform
2. Financial Management Framework
3. eHealth
4. Capital Infrastructure
5. National Schemes and Reimbursement
6. Internal Audit
7. Research and Evidence
8. Data, Compliance and EU North South
    - 8.1. Data Protection
    - 8.2. Health Identity Management Services
    - 8.3. Compliance Unit – Grants to Service Providers
    - 8.4. EU and North South Unit

Optimising investment levels for delivery of care in a complex financial and operational environment is vital to sustainability. Working smarter by optimising our current resources through different and improved ways of working is required to meet the challenge of demand significantly outpacing supply. Our staff and teams are at the core of our national health service and we will continue to develop, support and retain our existing staff and engage a newer generation of healthcare employees. Digital health is a crucial enabler in delivering healthcare, providing innovations and solutions that can improve access, efficiency, and quality of care.

1. Workforce Resourcing and Reform

National Human Resources (HR) works to develop, support, retain and expand our workforce to ensure the continued provision of quality healthcare to the public. Our workforce is our most valuable asset, and as a first principle, our objectives are designed to retain this valuable asset in our services, upon which to further build / expand. Notwithstanding our efforts again this year to grow our workforce to support planned developments, the focus of our activities will be shared on efforts to both expand through recruitment, and equally to retain our existing workforce to fully capitalise on our efforts. National HR contributes to a culture of increased organisational effectiveness, which continues to support the vision of the *HSE Corporate Plan 2021-2024*, the *Health Services People Strategy 2019-2024*, responding to the staff survey 2023 and overall organisational objectives.

Our goal is to ensure that all healthcare workers are informed and encouraged to access services that support them at each stage of their working lives; that self-sufficiency within the Irish State is maximised for the resourcing and delivery of publicly-funded health services for the future; and that our workforce is enhanced both in number and in skill, through actively modernising our approach to workforce planning, recruitment, upskilling and professional service provision. In addition, we will ensure that public health service employers can respond to claims and other grievances in a timely manner, contributing to effective industrial relations, and that creative, robust and agile strategies are developed and implemented across a number of key transactional HR functions.

In 2024, we will:

1. Enhance the development of recruitment and resourcing capacity across the organisation, which supports the delivery of universal healthcare through the Health Regions structure as appropriate to the environment / landscape, enabled by improved digitisation, robust governance and process improvement
2. Continue the development and provision of employee support services to enable response to employee needs, including ensuring physical, psychological and personal supports for employees are in place through implementation and integration of the Healthy Workplace Framework nationally, including roll-out of the WorkPositive^{CI} Tool
3. Continue the strategic development of workforce planning through projections, national datasets and support tools that enable an analytical and proactive approach to the staffing needs of services, and develop a strategic workforce supply model across a range of workforce groups that integrates with and supports the development of the resourcing strategy
4. Provide internal and external educational supports for the training and development of our staff, including leadership, management, team and individual development through the Health Service Leadership Academy, HSeLanD, micro-learning, one-to-one coaching and other education, learning and development

programmes and initiatives; the focus will be on supporting managers and staff in the delivery of safe and high-quality services to patients and service users

5. Ensure opportunities for nurses and midwives to work at the optimum of their professional scope of practice, including through provision of clinical learning environments and education supports, professional development planning, implementation of the Safe Nurse Staffing and Skill Mix Framework, and expansion of roles to include IV cannulation and venepuncture, pronouncement of death, medicinal prescribing, radiological referral and discharge planning
6. Support staff through the provision and signposting of professional HR advisory services, maintaining and expanding our communications pathways and approaches, and providing an agile response to external and internal developments that impact our services and staff
7. Support our HR managers through the provision of compliance and reporting frameworks to support them in meeting the requirements of their roles
8. Continue to digitise HR processes across the HSE through the development of digital recruitment, payroll, personnel management and document management solutions, and training to support staff in expanding their digital skills
9. Agree and roll out industrial relations frameworks including the public services agreement, implementation and monitoring of the new Public Only Consultant Contract and implementation of increased flexibilities contained in the Contract from Monday – Saturday. The HSE will quantify the benefit for patients and impact on services as a result of the introduction of the new Public Only Consultant Contract such as the delivery of additional services out of core hours, including outpatient clinics, and monitoring of consultants on the new contract rostered outside of core hours and on Saturdays to help improve patient flow and discharge, and to optimise the use of resources such as operating theatres.

1.1. Pay and Numbers Strategy

Over the last number of years there has been unprecedented investment in workforce expansion and this, coupled with significant recruitment successes, has led to additional growth of 24,079 Whole Time Equivalent (WTE) / +20% beyond the employment levels reported at December 2019. Of this total, circa 7,000+ WTE will have arrived by the end of 2023. This level of investment has delivered an additional +6,889 WTE nurses and midwives, +2,769 WTE medical and dental staff, +3,728 WTE health and social care professionals (HSCPs) and +3,462 WTE patient and client care staff. This, along with a further +6,388 WTE management and administrative staff and +894 WTE general support staff who provide the infrastructural and administrative support to our clinical staff, has delivered on a substantial range of initiatives and new service developments across our services. This includes the opening of up to 1,186 additional hospital beds (of which 60 are profiled for delivery in 2024) and 1,250 community beds, delivering much needed additional capacity in services across the country; the expansion of specialist services to respond to increasing numbers of patients accessing our cancer services, those living with chronic condition, older people and children; and safe staff levels across our hospital wards. As we approach the end of 2023, there has been a minimum of 75% of approved service developments recruited.

Workforce affordability: strengthening pay bill management and controls

Notwithstanding this level of investment, which has been very welcome, there is a requirement now in 2024, based on our total available funding, for a period of consolidation on the investments made in our workforce.

As we approach the end of 2023, our level of growth has surpassed our level of affordability, with the requirement for measures to control this growth. A key objective of our Pay and Numbers Strategy in 2024, therefore, will be strengthening our pay bill management and controls through the implementation of affordable WTE limits at individual entity level (i.e. hospital / Community Healthcare Organisation service).

The affordable WTE limits, will be underpinned by the principles of:

i. Pay Primacy – primacy of pay and overall budget over any WTE value – alignment and synchronisation of budget, cost and HR WTE
ii. Control Indicator – WTE limit is designed as a control 'indicator' – total pay budget versus actual expenditure is the key metric and the WTE limit is the mechanism to assist
iii. Up to Limit – acknowledging that the use of assumptions to underpin the affordable WTE is not 100% definitive; there will be changes that may alter the cost and therefore the WTE limit in either direction over the course of the year
iv. Average Limit – average limit, not an ending limit, that will require ongoing review and adjustment.

A key deliverable from the implementation of affordable WTE limits is the provision of greater visibility, oversight and governance of pay bill management and control across our services in 2024. Setting affordable WTE limits, underpinned by the above principles, may mean a reduction for some services, compared to 2023, as the key focus is based on affordability.

Enhanced performance monitoring

This year's approach will seek to balance investment in new service developments with demonstrable productivity and, importantly, local control over pay bill and workforce utilisation. To achieve this, a greater level of performance monitoring across services at a lower level of detail that will enable a more targeted and effective approach to controls is being implemented. The approach, therefore, will enable individual services operating within their affordable limit to avoid recruitment control measures, in contrast to services operating outside of their affordable limit, whereby it will be necessary to further extend / implement new recruitment controls to deliver pay bill management and control. This requires further strengthening of our control processes and our performance monitoring (all of which are underpinned by the HSE Performance and Accountability Framework) through:

i. Strengthening our commissioning of new service developments, via the Primary Notifications Process
ii. Firming up the end-to-end process between the HR SharePoint service developments recruitment database and the Primary Notifications Process with commissioners' approvals for funding drawdown
iii. Development of a new detailed WTE limits database, with monthly reporting against WTE limits set at the lower level of entity (e.g. hospital) and by care group (e.g. disability services) alongside pay variance by direct pay, agency and overtime.

As noted earlier, the total pay budget will be the subject of controls, with agency and overtime savings also forming part of this year's Strategy with targeted reductions in agency and overtime that will be based on:

i. Removal of agency and overtime hours – volume reduction in the quantum of hours used
ii. Conversion of agency hours, thereby delivering cost savings on the hours – a first principle in this approach is the conversion of the agency hours into 'funded WTE hours'. The HSE will need additional headcount to facilitate agency conversion. This is under discussion with the Department of Health

(DoH) and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and subject to further agreement as part of the 2024 Pay and Numbers Strategy finalisation.

This brings into clear focus the total pay budget and how we utilise all parts of our affordable workforce, and importantly, does so in a way that delivers resource optimisation while safeguarding services to patients / service users. Undoubtedly, this will be challenging and will require, as part of such plans, services to ensure appropriate risk assessments and risk mitigation. Nonetheless, in the context of the scale of the required agency savings (equating to an approx. 3,500 WTE), it is important to also take stock of the already significant investment made with the addition of over 24,000 staff (noting that there are certain staff disciplines where recruitment and retention remain a challenge). It will be a necessary requirement for every service to consider the growth in their workforce over this period and to leverage this workforce in the context of optimisation of skills and experience to ensure appropriate workforce distribution alongside maximisation of these skills to meet patient / client needs. It will also require services to consider other associated investments, such as those in digital, to harness the additional workforce capacity that these investments have and can make in further maximising our workforce impact. As a collective, the approach is seeking to support services to deliver resource optimisation and, in demonstrating productivity and control, to support greater levels of flexibility in resource utilisation and deployment.

As we complete the detailed work to set out affordable WTE limits, it will be critical to take account of a range of factors, including but not limited to:

i. A comprehensive review of prior approved service developments recruited across the last three years
ii. A detailed assessment of those approved service developments that will, owing to the recruitment process, come onto our employment census in early 2024
iii. All-inclusive review of prior approved service developments in the pre-contracting stages of recruitment with those approved in 2024 to ascertain alignment, to optimise recruitment delivery in 2024 and maximum benefits realisation from these developments.

In addition to the above, and as set out in this year's Letters of Determination, there is further and welcome expansion of our services through additional new service developments of:

i. 2,268 WTE enduring roles (excluding disability services) alongside an indicative 182+ WTE non-enduring roles, funded on a once-off basis. The final WTE will be subject to the finalisation of the Pay and Numbers Strategy
ii. 683 WTE across our disability services
iii. This will in 2024, equate to an indicative total of 3,133 additional WTE that will be further set out in greater detail in the 2024 Pay and Numbers Strategy.

Collectively, these new service developments alongside the detailed work to set out affordable WTE limits, will form the basis of our recruitment profile for 2024.

While the indicative pay bill allocation is set out in the Letters of Determination, this is notably subject to engagement in the context of the finalisation of the HSE Pay and Numbers Strategy 2024. Nonetheless, the above approach will be set out in greater detail in the HSE Pay and Numbers Strategy, and is designed with the objective of strengthening our pay bill management and control in 2024 and to provide greater visibility, oversight and governance. It will also provide the mechanism and necessary governance for review of the WTE limit at scheduled intervals throughout 2024, to enable WTE limit adjustment, inclusive of agency conversion as noted in the Letters of Determination, as agreed, subject to the final HSE Pay and Numbers Strategy.

As part of our approach, we will in 2024, seek to fully realise and further optimise the significant investment we have already made. We will also prioritise our additional growth planned for 2024 for specified developments that include augmenting existing services and progressing strategic new developments to increase our capacity.

Disability Services

Integral to our Pay and Numbers Strategy in 2024, will be the distinct focus on our disability services workforce. Importantly, the approach set out above for our Pay and Numbers Strategy will also apply here, to ensure that there are equally strengthened controls across this specific workforce.

The setting of affordable WTE limits by entity, means that there will be affordable WTE limits set for disability services. As set out above, the setting of affordable WTE limits, including savings and productivity targets, will also apply to disability services in order to strengthen our pay bill management and control across these services. In addition, enhanced performance monitoring will be in place across our disability services, with the requirement for individual services as appropriate to extend / put in place recruitment control measures to manage overall pay bill control.

Under this year's DCEDIY Letter of Determination, there are an additional 683 WTE new service developments that are very welcome and which we aim to recruit and on-board in 2024. Noting that, in previous years, our average net census growth is in the region of 600+ WTE, this is likely to be a stretch target for our services which we will intend to fully pursue in 2024 within the affordable levels. A key support to delivery of this stretch target will be the action-oriented *HSE Resourcing Strategy – Resourcing our Future*, launched in June 2023. The strategy is built on five pillars:

i. Engage and retain our workforce
ii. Attract a high-performing and diverse workforce
iii. Build the healthcare talent of the future
iv. Support the health and wellbeing of our workforce
v. Build a positive and inclusive workplace culture.

The Resourcing Strategy was developed and is being implemented with and by services, and is anchored in robust governance and accountability. This is an overarching resourcing strategy for all care settings in the health and social care environment. This strategy will continue to evolve in early 2024 to reflect the transition to the Health Regions, together with ensuring that the requirements of disability services are met. This will include reviewing the governance frameworks and accountabilities, and identifying additional actions unique to disability services, including ongoing reporting on the strategy for the broader health services and disability services.

In 2024, we will:

1. Enhance the development and implementation of the HSE Resourcing Strategy across the organisation which supports the delivery of *Sláintecare* through the Health Regions, with a targeted strategic focus on the recruitment and retention of the workforce for disability services, including urgent development of a new disability workforce strategy
2. Improve the overall recruitment experience enabled by improved digitisation and candidate engagement underpinned by robust governance aligned with the strategic focus on disability services.

1.2. HR Information

Direct Staffing by Care Group	Total Dec 2022	Medical & Dental	Nursing & Midwifery	Health & Social Care Professionals	Management & Administrative	General Support	Patient & Client Care	Total WTE October 2023	Estimated WTE Dec 2024*
Total Health Service	**137,745**	**13,626**	**45,098**	**20,496**	**25,189**	**10,198**	**29,284**	**143,892**	**147,283**
Of which is Disabilities	**19,903**	**57**	**3,651**	**4,505**	**1,798**	**697**	**9,660**	**20,368**	**21,114**

***Note 1:** The estimated 2024 Dec WTE is based on the following:

a) The 2023 Pay and Numbers Strategy assessed affordable level of 6,586 WTE as the projected December 2023 outturn

b) The additional 2,268 WTE new service developments under the 2024 DoH Letter of Determination

c) The additional 683 WTE new service developments under the 2024 DCEDIY Letter of Determination

d) Excludes any once-off allocated funding that may result in net WTE increase on a temporary basis for 2024 currently unknown but will be the subject of the 2024 Pay and Numbers Strategy finalisation.

It is important to note that the current projected outturn for Dec 2023 is in the region of above 7,000+ WTE. There is however, work currently underway under the auspices of the 2024 HSE Pay and Numbers Strategy, that will set out affordable WTE limits, and once completed will provide a target affordable WTE limit for 2024. This will for mean for some services, a lower figure for 2024 than their actual Dec 2023 outturn. It is for these and the reasons of affordability that the current Dec 2024 estimate is based off the assessed affordable 2023 estimate until such time as this work is completed.

Direct Staffing by Care Group	Total Dec 2022	Medical & Dental	Nursing & Midwifery	Health & Social Care Professionals	Management & Administrative	General Support	Patient & Client Care	Total WTE October 2023	Estimated WTE Dec 2024
Total Health Service	**137,745**	**13,626**	**45,098**	**20,496**	**25,189**	**10,198**	**29,284**	**143,892**	**147,283**
HSE	**89,227**	**8,701**	**29,730**	**11,974**	**18,069**	**6,500**	**18,468**	**93,443**	**95,480**
Section 38 Hospitals	30,874	4,762	12,276	4,417	5,655	2,829	2,616	32,555	33,309
Section 38 Voluntary Agencies	17,645	163	3,091	4,105	1,466	869	8,199	17,893	18,494
Section 38	**48,519**	**4,925**	**15,367**	**8,522**	**7,120**	**3,698**	**10,815**	**50,449**	**51,803**

2. Financial Management Framework

2.1. 2024 context including our focus and high-level ambition for the year ahead

The provision of safe services, and continuing to improve on other aspects of quality, including patient / service user experience, are ongoing priorities for our health service and will remain so in 2024. There have been unprecedented levels of additional Government investment in health in recent years, particularly 2021-2022. This investment has allowed staffing levels to increase by 20% since the start of 2020. That is the equivalent of around 24,000 extra full-time staff, with about 7,000 of these extra staff arriving in 2023.

Despite this very welcome investment, the cost of running our existing services at current levels over the next twelve months will be a significant challenge in the context of the total funding available to the health service in 2024 and, therefore, will likely require supplementary funding support including in relation to the likely first charge (2024 first charge = excess of 2023 costs over final 2023 funding). It is not intended to cut services in 2024 so in financial management terms we will seek to minimise the level of financial deficit that will arise by focusing on:

1. Improving our financial controls particularly around staffing levels, including agency and overtime, so that we operate within an agreed total pay cost envelope for 2024 that is sustainable into 2025
2. Generally maintaining current service levels while growing service levels in areas where this has been specifically funded, particularly in support of our key priorities around:
   - Reducing delays in urgent and emergency care (UEC), with a particular focus on reducing emergency department (ED) delays for our most vulnerable frail elderly patients
   - Improving the timeliness of access to planned services by reducing waiting lists
3. Making savings, for example reducing our total pay and staffing costs by substantially reducing the amount of agency staff hours that we use, as well as reducing overtime hours. We will also seek to avoid cost growth, or reduce costs where practical, in terms of bought in goods and services (non-pay – see below)
4. Improving our productivity. This will be essential if we are to maintain current service levels, while reducing the level of agency hours being used. This means that we need to improve the efficiency and effectiveness of our care and other processes so that we can safely provide more care for patients via the same or less staffing hours. This must be done without reducing quality for patients or over burdening our staff.

This National Service Plan (NSP) deals with the type and volume of services to be provided in 2024, the level of staff to provide those services and the day-to-day costs and funding to run those services, referred to as current funding. In parallel with this plan, the HSE has prepared and submitted two Capital Plans, covering the 2024 element of multi-year investment in the development and upgrade of our estate (€1,056m) and ICT (€155m) infrastructure.

2.2. Significant additional Government investment in health in 2024

A total of €23.5bn has been provided in day-to-day funding to operate the health services in 2024, with €2.8bn of that being provided by the DCEDIY in respect of specialist disability services and the balance of €20.7bn being provided by the DoH.

This is a €997.5m / 4.6% increase on the level of recurring budget (referred to as core) provided for these services in 2023 with a further €919m provided in once-off funding (referred to as non-core), see Table 1 at the end of this chapter.

Table A (1): Summary of Budget Allocation NSP 2024 from Department of Children, Equality, Disability, Integration and Youth Vote (Excludes Capital Budget – see Capital and ICT Plans)

HSE Budget Allocation for 2024 for Operating Costs	DCEDIY
	€m
Recurring budget at the end of 2023 including any opening allocation adjustments (Note 1)	**2,595.8**
Plus Allocations for 2024:	
1. Additional recurring budget - referred to as Core	**198.5**
1.1. To support the Existing Level of Service (ELS)	134.4
1.2 To support the Development of Services	64.1

HSE Budget Allocation for 2024 for Operating Costs	DCEDIY
	€m
2. Once-off budget - referred to as Non-Core	**18.0**
Budget 2024 per Letters of Determination 03/12/2023	**2,812.3**
Estimated Total Costs 2023	**€2,688.2**

Table A (2): Summary of Budget Allocation NSP 2024 from Department of Health Vote (Excludes Capital Budget – see Capital and ICT Plans)

HSE Budget Allocation for 2024 for Operating Costs	DoH
	€m
Recurring budget at the end of 2023 including any opening allocation adjustments (Note 1)	**19,008.2**
Plus Allocations for 2024:	
1. Additional recurring budget - referred to as Core	**798.9**
1.1. To support the Existing Level of Service (ELS)	700.2
1.2 To support the Development of Services	98.7
2. Once-off budget - referred to as Non-Core	**900.7**
Budget 2024 per Letters of Determination 28/11/2023	**20,707.8**
Estimated Total Costs 2023	**€21,285.0**

Table A (3): Combined summary of Budget Allocation NSP 2024 from both Department Vote (Combined the figures from Tables 1(a) and 1(b) above, excludes Capital budget – see Estates and ICT Capital Plans)

HSE Budget Allocation for 2024 for Operating Costs	Total	DoH	DCEDIY
	€m	€m	€m
Recurring budget at the end of 2023 including any opening allocation adjustments (Note 1)	**21,603.9**	**19,008.2**	**2,595.8**
Plus Allocations for 2024:			
1. Additional recurring budget - referred to as Core	**997.5**	**798.9**	**198.5**
1.1. To support the Existing Level of Service (ELS)	**834.7**	**700.2**	**134.4**
a) Pay cost pressures (pay rates)	248.0	231.0	17.0
b) Full year costs of service developments started in 2023	105.8	75.8	30.0
c) Unfunded existing approved measures	41.5	41.5	-
d) Service specific price and volume cost pressures	439.3	351.9	87.4
1.2 To support the Development of Services	**162.8**	**98.7**	**64.1**
a) Access and capacity (including acute and community beds and disability residential, respite and day)	106.1	57.4	48.7
b) Better Services (Including CAMHS staffing and therapy assistant positions for Children's Disability)	19.9	10.0	9.9
c) Workforce and Reform (including surgical hubs, expansion of GP training and Disability PA hours)	36.7	31.2	5.5

HSE Budget Allocation for 2024 for Operating Costs	Total	DoH	DCEDIY
	€m	€m	€m
2. Once-off budget - referred to as Non-Core	**918.7**	**900.7**	**18.0**
a) COVID Measures (Vaccination Programme and Test and Trace Programme)	148.3	148.3	-
b) COVID - Community Disability Responses	13.0	-	13.0
c) Ukraine Responses (including National Transit Centre and Medical Cards)	50.0	50.0	-
d) Inflation / Demographics - Acute Hospital 2023 unfunded price and volume cost pressures	383.1	383.1	-
e) Urgent and Emergency and Care Programme (including acute capacity and GP access to diagnostics)	91.8	91.8	-
f) Waiting List Action Plan (Non-pay supports plus children's psychology and orthodontic services)	38.5	38.5	-
g) ICT / Cyber Measures (including cyber security and integrated Finance, Procurement and HR systems)	122.7	122.7	-
h) Access to care and other measures (including NCH readiness and nursing home compliance)	66.2	66.2	-
i) Disability Assessment of Need	5.0	-	5.0
Budget 2024 per Letters of Determination 28/11/2023 and 03/12/2023	**23,520.0**	**20,707.8**	**2,812.3**
Estimated Total Costs 2023	**€23,973.2**	**€21,285.0**	**€2,688.2**

Note 1: There was an opening allocation adjustment of €0.465m. The best estimate of total 2023 costs is €23,973m, see further details under part 2.4 below.

2.3. How the funding is spent

In contrast to some other countries such as the UK, in Ireland the HSE is responsible for providing and funding a very broad range of both health and social care including long-term residential care for frail older people and day, residential and respite services for people with a disability. The HSE also provides services such as public health, environmental health and the Registry of Births, Deaths and Marriages.

2.3.1 Sources of funding for our public health and social care services

Most of the funding comes from the exchequer in the form of an annual grant from the two Government departments, DoH and DCEDIY, with less than 4% coming from other income sources including pension contributions, patient charges and other income.

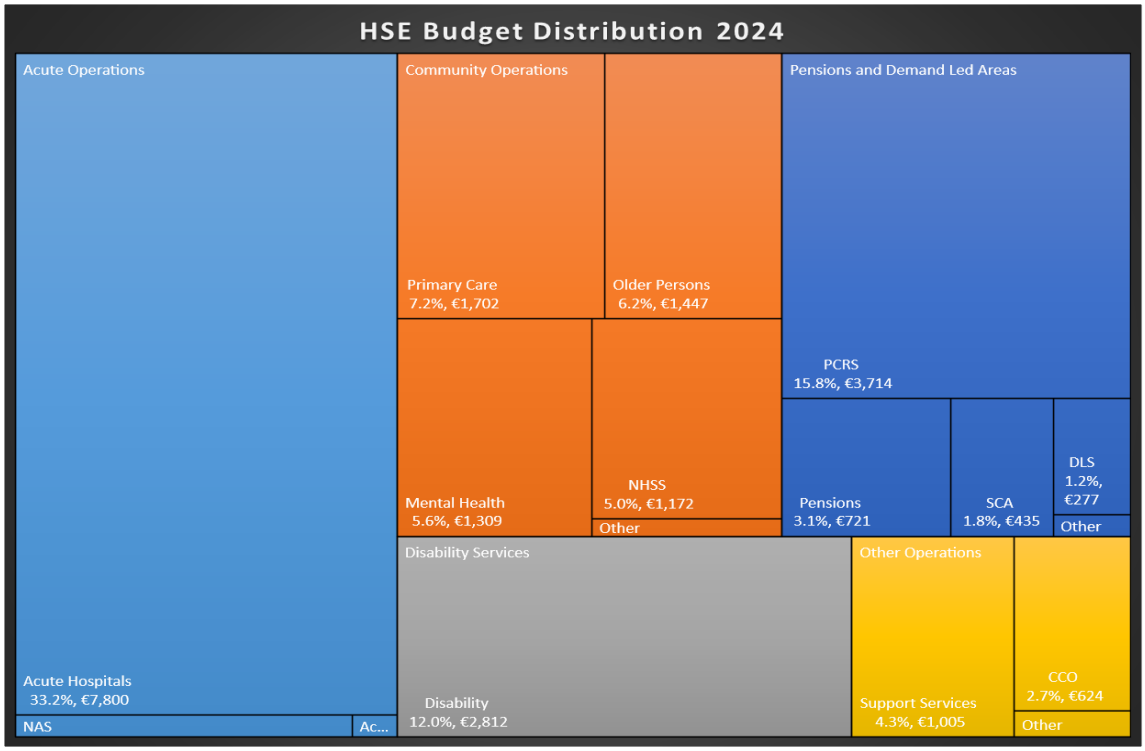
2.3.2 What is the funding spent on?

In terms of costs, often referred to as expenditure, you will see references to net expenditure and gross expenditure as well as to pay, non-pay and income. Gross expenditure refers to the combination of pay costs and non-pay costs. Pay costs are staffing costs, generally broken down between direct pay (the normal costs of directly employed staff), overtime (the costs of directly employed staff when they work additional hours beyond their normally contracted hours) and agency (the costs of staff hours contracted via a number of external agency staff providers to supplement hours worked by directly employed staff). Planning for implementation of agency and overtime reductions has commenced. As part of that, there will be risk identification and assessments undertaken, and mitigations will be in place to ensure the delivery of the plan. This will be undertaken at national, regional and local levels. Non-pay costs refer to the costs of bought in goods or services. Net expenditure refers to gross expenditure less the income the HSE raises

itself and so, in summary, gross expenditure is what it costs to run our services and net expenditure is the element of those costs that are directly funded by Government via the two departments.

The services funded by the HSE are broken down between i) those it provides directly through staff it employs itself and ii) those that it funds a large number of voluntary organisations to provide. Approximately €6bn or 27% of the total 2024 HSE funding will go to over 1,800 voluntary organisations with the largest 220 accounting for over 95% of that. Voluntary organisations are funded by the HSE under either Section 38 or and Section 39 of the *Health Act 2004*. These two sections legally underpin (a) the provision of services by non-statutory agencies on behalf of the HSE (Section 38) and (b) the provision of services similar or ancillary to a service that the HSE may provide (Section 39).

Graph 1: Overall HSE budget 2024 by major care area / service etc.

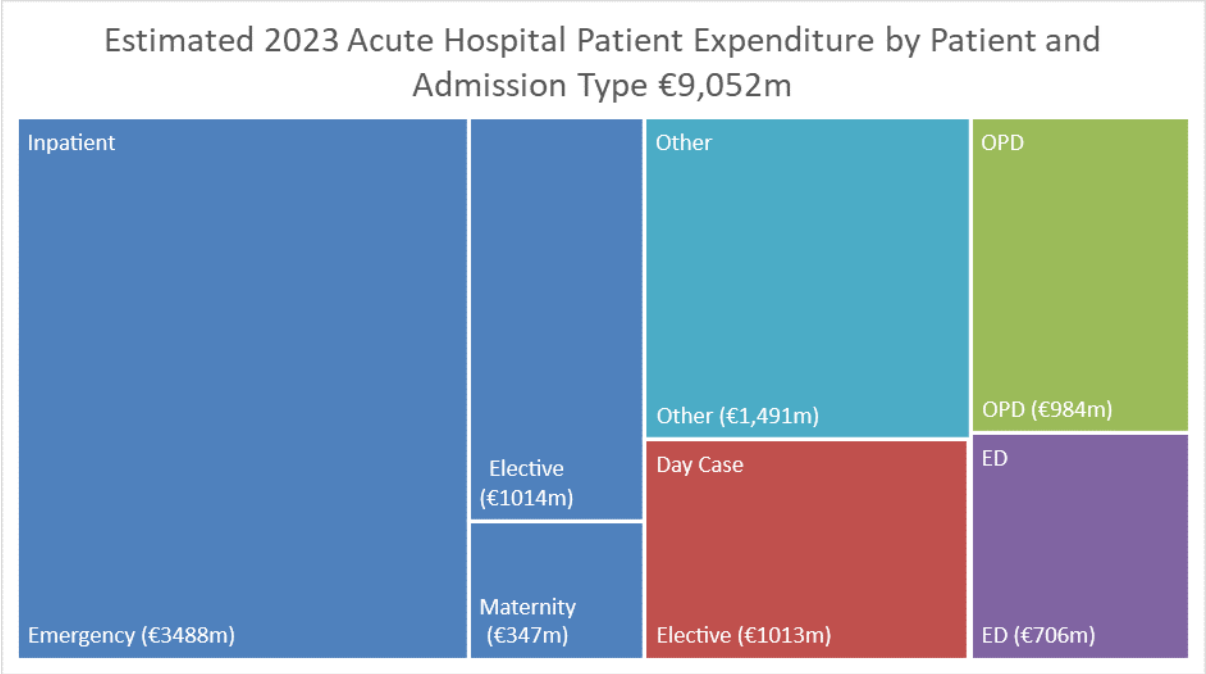


Note: Graph 1 above serves to illustrate where the HSE's budget will be spent in 2024, by Care Area. The allocation % is based on current budget allocations but can be subject to change depending on service provision considerations.

Graph 2: Disability budget showing direct provision (HSE staff) and indirect provision (Section 38 and Section 39[1] Voluntary Organisations) as well as pay and non-pay breakdown within same

Note 1: Funding to Section 39 is classified as non-pay. The percentage split in Graph 3 is based on the most up to date provision data for 2023.

Graph 3: Acute hospital gross expenditure 2023: An illustration of costs across various patient type and admission types



Note: Graph 3 above serves to illustrate the estimated gross cost within an acute setting for 2023. These costs are derived from specialty costing diagnostic related groupings for 2023.

Illustrative cost of some key health service outputs are as follows

Costs of some Key Health Services Outputs	
Hospital inpatient – birth – normal delivery €3,992	Hospital day case – haemodialysis €526
Hospital inpatient – birth – caesarean €5,101	Hospital day case chemotherapy €962
Hospital inpatient – stroke (minor complications) €7,033	Hospital day case – colonoscopy (minor complication) €902
Hospital inpatient – colonoscopy (major complication) €7,928	Community – older persons home support hour €30.08
Hospital inpatient – hip / knee replacement (non-trauma) €13,743 / €14,879	Transitional care bed day €162
Hospital inpatient – stroke (major complications) €34,043	Dementia specific nursing home per week €1,415 (NTPF Rate)
Inpatient – liver transplant €95,304	Long-term care bed night public unit €263
Hospital inpatient – heart transplant – €330,443	

Note: Illustrative costs above based on published prices and diagnostic related groupings for specific acute procedures and also indicative costs within community services.

2.4. Financial context – Influencing factors and risks

In managing a financial allocation of this scale, the HSE has to at all times be clear on limits and targets with an equal connection to the expected level of activity for each budget-holding unit. As we reform our financial and other information systems, we anticipate greater sight of expenditure in real time allowing for more accurate projections and corrective actions where required. The following conditions will impact the overall ability of the organisation in managing the financial allocation to the least level of possible dependency on supplementary adjustment at end 2024:

- Inflation – it is not possible to exactly predict this impact at this time as the headline rate of inflation is slowing down (with reported pricing in a number of items still remaining high). The HSE will benefit from any pricing changes in energy and food to the extent available and where fixed price contracts are not factored. Equally the impact of health specific inflation rates in technology, drugs and health consumables remains a separate factor above headline inflation and this will be monitored
- Control – the significant control focus for 2024 will be in the Pay and Numbers Strategy being agreed with the DoH and DCEDIY. This will clearly demonstrate the available WTE resource and also the associated maximum quantity of agency and overtime within that. Budget-holder management of the allocation is essential and will be a core part of the performance management approach within the HSE. An additional 2,268 WTE is agreed for 2024 with, separately, an additional 683 WTE for disability services, in addition to a maximum funded position of 2,951 WTE at the outturn of 2023. The use and deployment of the workforce will require change and adaptability to both priority services and emerging pressures as the previous pattern of exceeding a funded workforce will not be permitted
- Demand – health and social care systems have proven to be more challenged in accurately predicting demand for services, particularly post COVID-19 and the impact of large-scale inward migration, including the EU protection directive and a twenty year high in international protection applicants all of whom have health needs
- Reporting – the detail and timing of reporting to the DoH, DCEDIY and the Health Budget Oversight Group will be more detailed than in the earlier part of 2023 and this will require a shared ownership of the detail, the performance and any projections or actions resulting from same

- Productivity – the in-house productivity team being established to report to the Chief Executive Officer (CEO) and work within the overall Ministerial Task Force on productivity for the health sector will target 2024 opportunities and permanent changes in resourcing, utilisation, practices and technologies
- Unplanned expenditure – there will need to be a shared understanding by all stakeholders that the many desirable pursuits across the healthcare system will have to be prioritised, on both a needs basis and also a clarity of both the funding and workforce approved availability, before expenditure is incurred. This factor also arises in response to emerging risk
- Prior years' impact – there is an aspect of expenditure that remains inadequately funded through a number of factors including unplanned growth, unapproved additional overhang from crisis situations anticipated at the time to be once-off, and ELS accuracy of previous years in cumulative effect.

2.5. What are we going to do to limit the scale and impact of that financial problem?

It is the responsibility of the HSE working with the DoH and DCEDIY to ensure every means is deployed to respond to need on the one hand and manage within existing resources on the other. Delayed response to need can, of itself, create risk resulting in even greater cost later and any healthcare system must seek to balance the variables of resource against need, a task very often challenged by varying types and scale of demand.

Building on work already started during 2023, we will strengthen our financial controls in 2024, particularly around staffing numbers and costs that we have most control over. This will include delivering substantial savings which means releasing cash by reducing total costs, particularly through reducing the hours of agency staff used by around one third. This reduction in agency staff hours, which currently contribute directly to service provision, means that we will need to increase productivity to be able to maintain current service levels, and grow them where this has been specifically funded.

Productivity in this context refers to increasing the efficiency and effectiveness of our services so that we can safely see, assess, treat and care for more people with the same or less staff, without reducing service quality or overburdening our staff. Productivity is not generally assumed to be cash releasing as it is more likely to reduce average unit costs rather than lowering overall costs.

2.5.1 Governance

An additional feature of 2024 will be the Ministerial-established Productivity Task Force. Co-chaired by the DoH Secretary General and the HSE CEO, and in collaboration with DCEDIY, this will focus on the opportunities to exploit the use of resources in the public interest. The generation of greater levels of activity with the same resource is an essential feature of healthcare reform in the context of the known demographic profile of the population and the emerging modern methods of working and use of technology to enable different ways of working. A HSE Programme Office will be established and will include representation from across the health service, including from disability services. It will report directly to the CEO in this area of work and new additional expertise will be procured for this. Productivity in 2024 is important and will be promoted as a daily task of management and budget-holders with innovation rewarded in further supports. The Task Force will be of particular benefit in identifying productivity

measures for short (1-2 year) and medium term (3-5 year) all of which will be an aid to the future funding models for the health service. The work of the task force will be evidence-informed and will consider key themes such as:

1. Supporting service improvement using analytics
2. Service improvements that have potential for cost savings / productivity improvements
3. Better expenditure management
4. Expenditure sustainability.

2.5.2 Savings targets

Specific Savings Targets for 2024

Savings Area	Target	Notes / Comments
Agency – HSE Wide	Full year €250m / circa 1/3 hours volume reduction – all will directly reduce pay deficit in 2024 and onwards from 2025	Do without basis i.e. straight cost reduction, no conversion i.e. no corresponding increase in direct pay or overtime to offset. Current service levels to be maintained in context of improving productivity and overall growth in staff since the start of 2020
Agency / Overtime	Full year €80m – conversion yields net savings of between 25% and 50% depending on whether agency or overtime is converted => €25m – €40m net reduction to 2024 pay deficit and onwards from 2025	Conversion i.e. replacement with directly employed staff – includes conversion to support the circa 400 WTE staff to complete safe staffing framework implementation in acute general medical and surgical wards. Builds on 10% conversion target being pursued Q3-Q4 2023. The HSE will need additional headcount to facilitate agency conversion. This is under discussion with the DoH
Subtotal	€330m Pay Savings – Full year. Equates to circa €27.5m per month – It is expected that new savings measures will be mobilised in Q1 => assume 10 month delivery in 2024 = €275m with full year 2025 €330m	Savings will be against baseline of latest available three months June to Aug 2023 (Fórsa dispute impacting data availability)
Consultancy	€34m – Total 2024 costs to be €34m minimum below annualised Q1 2023	Building on 33% reduction targeted from Q4 2023
COVID-19 Costs	€48.9m – Full year 2024 cost to be €48.9m below 2023 costs before cessation	Likely combination of subset of originally intended costs to cease and cessation of costs previously expected to transfer
Drugs and Medicine	€10m – by end 2024 combination of savings and efficiencies	Includes bio-similar switching and glucose monitoring
Other areas	The work of the Savings and Productivity Task Force will determine any additional savings targets to be pursued in 2024	

This level of reduction in agency staffing hours is the equivalent of 3,000-4,000 full time staff and will be a challenge for services. It needs, however, to be looked at in the context of the over 24,000 more directly employed staff that are working in our health services today, compared to the start of 2020. Approximately 7,000 of these extra staff have only arrived over the last 11 months or so and, therefore, we have yet to see their impact over a full year. There will also be the equivalent of at least another 3,000 extra full-time staff added during 2024 when we consider the service development funding and posts provided by the Minister for Health (2,268 WTE) and Minister for Children, Equality, Disability, Integration and Youth. It will also require a significant focus on evaluating and improving the productivity of our services. The task force will consider a range of potential areas / themes for further savings measures including:

1. Full cost recovery of public-in-private
2. Procurement, stock management and usage of various goods and services:
    i. Medicines (Note 1)
    ii. Surgical equipment
    iii. Aids and appliances
    iv. Utilities
    v. Catering
    vi. Cleaning
    vii. PPE
    viii. Leases and rental of property
    ix. Minor capital works
    x. GP diagnostics
3. Other digital options to reduce costs of service delivery
4. State claims (Note 1)
5. Cessation or rationalisation of existing schemes / services.

Note 1: Medicines and state claims will both be subject to separate parallel governance structures with savings to be included in overall work of task force.

2.5.3 Productivity measures

The key messages / core principles underpinning our approach to productivity measures include:

1. Acknowledging that delays in care are a quality and safety issue for our patients and service users and therefore improving productivity is a key part of improving safety and quality
2. Productivity measures cannot reduce the overall quality of services or overburden our staff
3. Service managers and their teams will need to be reasonably supported to deliver productivity measures and then firmly but fairly held to account for that delivery
4. Productivity measures should fit within an overall approach to sustainable continuous improvement in services for the benefit of patients and service users
5. Ultimately, they should involve local staff being supported to continuously identify and remove all forms of waste in their processes, including any waste of patient or staff time, skills or insight
6. Productivity measures implementation should be informed by direct observation at the location where services are delivered, as well as utilisation of the best available data.

Identification and publication of key productivity metrics will be an important part of this approach recognising that such metrics point to areas that require additional assessment and action, rather than definitively indicating optimum or poor productivity.

Note: Key productivity measures identified to date include length of stay; % generic and biosimilar drugs; cost of administration; % of services digitised; ratio of input to output; wait times.

Critical success factors will include:

- Support from clinical programmes
- Capability assessment and building

- Definitions, measurement, reporting etc.
- Identification of initial priority focus areas. Initial areas are likely to be chosen from:

Service Area	Focus for productivity measures / continuous process improvement
Primary care – GP out of hours	Establish current level and the optimum level of conversion of GP out of hours visits to ED referrals and take concrete steps toward the latter (UEC Plan = Hospital avoidance)
Primary care	Introduce consistent approach to primary care waiting list management with short, medium, and long-term productivity and reduction targets (Waiting List Action Plan)
Mental health – CAMHS	Increase adherence to standard operating procedure / CAMHS operational guideline including appropriate caseload balancing across team members to reduce waiting time for access (Waiting List Action Plan)
Nursing homes (mostly private)	Establish the current level and optimum level of transfer of frail elderly patients to acute hospitals and take concrete steps towards the latter (UEC Plan – hospital avoidance)
Nursing home (mostly private)	Establish the current level and optimum level of 7-day admissions to nursing homes from acute hospitals and take concrete steps towards the latter (UEC Plan – delayed transfers of care)
Nursing Homes Support Scheme	Re-examine detailed end-to-end process and identify concrete short, medium and long-term steps to improve the effectiveness and efficiency of same
Public long-term care facilities	Cost of care
Acute hospitals	Medical Model – balance admission and discharge – see After Action Review feedback
Acute hospitals	Delayed transfers of care – see report: 1. Definition and implement guide 2. Why not home and why not today 3. Discharge to assess – no assessment in hospital re long-term support / care needs 4. Appropriate use of transitional care (UEC – delayed transfers of care)
Acute Hospitals	Alternatives to ED – Including local injury units
Service Area	**Focus for productivity measures / continuous process improvement – Disability Services**
Autistic spectrum disorder	Progress Children's Disability Roadmap including improving adherence to, and productivity around, the National Access Policy (Primary Care, CAMHS and CDNT)
Assessment of need (disability)	Progress Children's Disability Roadmap including re-examine detailed end-to-end process and improve the effectiveness and efficiency of same
High-cost disability and mental health including emergency placements	High cost including emergency placements – focus on ensuring 1) real time access to essential data (immediate requirement) 2) adherence to entry criteria 3) clinically appropriate staffing inputs 4) appropriate review of those inputs 5) visibility and assessment of reasonableness of costs (National Placement Oversight and Review Team programme)
Overall disability residential	To review and reduce high-cost placements across disability services
Disability day services	Review the current level of funding and service providers in order to explore synergies across the system

In each case in the table above, unless otherwise stated, the assumption is that:

1. Optimum levels refer, in the first instance, to optimum levels that can be achieved while operating within the notified pay / staffing funding limit for each service
2. General indicative metrics and targets will be established at national and regional level but, ultimately, site and context specific targets and actions will be required
3. It is acknowledged and accepted that driving more activity, safely, through the same or less staff resources increases productivity and reduces average unit cost but will marginally increase overall costs.

2.5.4 Strengthened financial and related controls

- Ongoing review of cost controls within the HSE to assess adequacy and make recommendations for improvement. To include pay related controls including rostering practices
- Assess and recommend where incentives can be better aligned to ensure it is in the interest of operational / service areas to deliver maximum productivity / cost savings
- Revert to activity based funding of acute hospitals post pandemic interruption similar to many jurisdictions
- Continue to improve on levels of procurable spend which are covered by compliant contracts (Spend Under Management) and compliance with those contracts.

2.6. Key priorities for our National Finance and Procurement Teams in 2024

National Finance Team

Sub-team / Area	2024 Priority / Notes / Comments
Overall team	i. Providing the necessary professional financial advice analysis and insight to support service colleagues with the operational decisions and actions necessary to manage and improve services, while also enabling delivery of the required productivity, savings, and control improvements ii. Focus on supporting the roll-out of National Finance and Procurement System (IFMS) and the changes necessary to realise its benefits in terms of enhanced reporting and the implementation of a revised organisation design iii. Statutory obligations and transactional processing support
1. IFMS (National Finance and Procurement System)	i. Set out and get agreement to rebased accelerated roll-out plan following impact of initial go-live in HSE East and Fórsa dispute (when latter is over)
2. Cash management	i. Further improve cash management and reporting including better interim linkage of cash and income / expenditure pending IFMS ii. Prepare for and commence usage of IFMS cash to income / expenditure reporting when functionality is live for East
3. Income / expenditure reporting (interim)	i. Close out pre-IFMS improvements including DoH to DPER reporting schedule ii. Achieve five day close and report in first IFMS sites
4. Long-term reporting strategy / Centre of Excellence	i. Develop, secure stakeholder agreement for and commence actions under detailed implementation plan to make use of IFMS capability as it rolls out ii. Enhanced and simplified reporting of consultancy spend
5. Activity based funding (ABF)	i. ABF benchmarking data to assist re savings and productivity
6. Population-based resource allocation (PBRA)	i. Setting out HSE assessment of status and next steps and engagement with DoH on same ii. Supporting ongoing progress towards the objectives of PBRA as set out in *Sláintecare*
7. Payroll strategy	i. Progress implementation of the strategy including moving towards rationalisation payroll sites from nine to five (four payroll and one pensions)
8. Invoice processing	i. Finalise achievement of steady state in terms of supplier payment timelines ii. Calculate and implement steady state in terms of bringing resourcing levels required to maintain payment timelines to sustainable levels
9. Enhanced business partnering	i. Enhance business partnering through the provision of financial and business expertise to key stakeholders to enhance decision-making in service units throughout the organisation

Sub-team / Area	2024 Priority / Notes / Comments
10. Organisation design	i. As part of the Finance Reform Programme, linked to IFMS rollout, progress the setting out of the revised organisational design for the finance and procurement functions, aligned to the establishment of Health Regions and changes to the HSE Centre.

National Procurement Team

Sub-team / Area	2024 Priority / Notes / Comments
Overall team	i. Providing the procurement expertise to support service colleagues with the decisions and actions necessary to deliver required savings, productivity, and control improvements, while managing and improving services ii. Focus on supporting the roll out of IFMS and the changes necessary to realise its benefits in terms of enhanced sourcing, purchasing, compliance and inventory / logistics management and the implementation of a revised organisation design iii. Corporate Procurement Plan
1. Sourcing	i. Hold 75% 2023 Spend Under Management level and grow to 85% by end 2024 ii. Use of OGP Frameworks and Contracts iii. Specific priority target areas for price reduction and cost avoidance
2. Inventory and logistics	i. Optimising efficiency and effectiveness of the National Distribution Centre
3. Compliance	i. Current self-assessment - €25k+ ii. IFMS compliance reporting – automated – move us to €5k+ compliance reporting
4. Data / systems	i. Unique material and service codes etc.

Table 1: Finance Allocation 2024

Service Area / Business Unit	2024 Opening Allocation	ELS: 2024 Pay Rate Funding	ELS Full Year Impact of 2023 New Develop-ments	ELS Core Measures Previous-ly Funded in Non-Core	ELS Measures Previously Approved but Unfunded	Cost Pres-sures / Inflation	ELS Service Specific	Savings	New Measures	Non-Core Once-off Funding	Non-Core: COVID-19	Non-Core: Ukraine	Non-Core: Resilience Fund	2024 NSP Budget	Less: 2024 NSP Budget Held	2024 Opening Budget (Column N-O)	2024 Internal Comm-issioner Funding to be applied	2024 Available Funding (Column P&Q)
	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m
Operational Service Areas	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L	Column M	Column N	Column O	Column P	Column Q	Column R
Acute Hospital Care	7,025.3	84.3	6.9	-	-	165.0	13.5	-	53.9	60.1	-	2.1	383.1	7,794.2	(12.2)	7,782.0	138.4	7,920.5
Access to Care	-	-	-	-	-	-	-	-	-	30.2	-	-	-	30.2	-	30.2	-	30.2
National Ambulance Service	219.2	2.5	-	-	-	-	-	-	2.0	4.0	-	-	-	227.7	(2.0)	225.7	0.4	226.0
Acute Operations	**7,244.5**	**86.7**	**6.9**	**-**	**-**	**165.0**	**13.5**	**-**	**55.9**	**94.3**	**-**	**2.1**	**383.1**	**8,052.0**	**(14.2)**	**8,037.9**	**138.8**	**8,176.7**
Primary Care	1,228.9	13.0	-	-	-	14.0	1.9	-	2.7	45.9	-	19.8	-	1,326.4	-	1,326.4	4.3	1,330.7
Social Inclusion	207.6	0.8	-	-	-	-	-	-	1.9	7.0	-	4.9	-	222.2	(8.9)	213.3	4.7	218.0
Palliative Care	135.6	0.9	-	-	17.6	-	1.3	-	-	-	-	-	-	155.5	-	155.5	0.2	155.7
Primary Care Total	**1,572.2**	**14.8**	**-**	**-**	**17.6**	**14.0**	**3.2**	**-**	**4.6**	**52.9**	**-**	**24.8**	**-**	**1,704.1**	**(8.9)**	**1,695.1**	**9.2**	**1,704.4**
Mental Health	**1,274.3**	**13.8**	**0.2**	**-**	**-**	**16.0**	**-**	**-**	**3.1**	**1.1**	**-**	**-**	**-**	**1,308.4**	**(2.7)**	**1,305.6**	**(9.1)**	**1,296.5**
Older Persons' Services	1,382.1	13.6	-	-	-	25.4	-	-	6.6	19.2	-	-	-	1,446.9	(5.7)	1,441.2	1.5	1,442.7
Nursing Homes Support Scheme (NHSS)	1,126.1	-	-	-	-	-	35.6	-	-	10.0	-	-	-	1,171.7	-	1,171.7	-	1,171.7
Older Persons' Services Total	**2,508.3**	**13.6**	**-**	**-**	**-**	**25.4**	**35.6**	**-**	**6.6**	**29.2**	**-**	**-**	**-**	**2,618.6**	**(5.7)**	**2,612.9**	**1.5**	**2,614.5**
Disability Services	**2,595.8**	**17.0**	**30.0**	**-**	**-**	**-**	**87.4**	**-**	**64.1**	**18.0**	**-**	**-**	**-**	**2,812.3**	**-**	**2,812.3**	**2.6**	**2,814.9**
Health and Wellbeing Community	**36.6**	**0.3**	**0.3**	**-**	**-**	**-**	**0.1**	**-**	**1.1**	**-**	**-**	**-**	**-**	**38.4**	**-**	**38.4**	**0.3**	**38.7**
Quality Patient Safety Community	**29.5**	**0.2**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**29.7**	**-**	**29.7**	**-**	**29.7**
Other Community Services	**34.6**	**0.5**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**35.0**	**-**	**35.0**	**-**	**35.0**
Total Community Operations	**8,051.1**	**60.0**	**30.5**	**-**	**17.6**	**55.3**	**126.3**	**-**	**79.5**	**101.2**	**-**	**24.8**	**-**	**8,546.4**	**(17.4)**	**8,529.1**	**4.6**	**8,533.7**
Chief Clinical Office	**567.5**	**1.6**	**24.6**	**-**	**-**	**-**	**11.7**	**-**	**14.1**	**3.0**	**127.7**	**-**	**-**	**750.2**	**(4.4)**	**745.8**	**(148.4)**	**597.4**
Health and Wellbeing	**10.7**	**0.1**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**10.8**	**-**	**10.8**	**-**	**10.8**

Service Area / Business Unit	2024 Opening Allocation	ELS: 2024 Pay Rate Funding	ELS Full Year Impact of 2023 New Develop-ments	ELS Core Measures Previous-ly Funded in Non-Core	ELS Measures Previously Approved but Unfunded	Cost Pres-sures / Inflation	ELS Service Specific	Savings	New Measures	Non-Core Once-off Funding	Non-Core: COVID-19	Non-Core: Ukraine	Non-Core: Resilience Fund	2024 NSP Budget	Less: 2024 NSP Budget Held	2024 Opening Budget (Column N-O)	2024 Internal Comm-issioner Funding to be applied	2024 Available Funding (Column P&Q)
	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m
Operational Service Areas	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L	Column M	Column N	Column O	Column P	Column Q	Column R
Operational Performance and Integration	77.5	0.8	-	-	-	-	-	-	1.1	-	-	2.4	-	81.7	-	81.7	-	81.7
Support Services	617.9	97.9	-	8.9	-	-	34.0	(34.0)	8.9	75.0	-	0.8	47.7	857.2	(2.0)	855.2	0.2	855.4
Test and Trace	1.6	0.4	-	-	-	-	-	-	-	-	20.6	-	-	22.6	(4.6)	18.1	-	18.1
Other Operations Services	1,275.3	100.8	24.6	8.9	-	-	45.7	(34.0)	24.1	78.0	148.3	3.2	47.7	1,722.5	(10.9)	1,711.6	(148.2)	1,563.5
Total Operational Service Areas	16,570.9	247.6	61.9	8.9	17.6	220.3	185.6	(34.0)	159.5	273.5	148.3	30.0	430.8	18,321.0	(42.4)	18,278.6	(4.8)	18,273.8
Pensions	685.8	0.0	-	-	-	-	35.6	-	-	-	-	-	-	721.4	-	721.4	-	721.4
State Claims Agency	435.0	-	-	-	-	-	-	-	-	-	-	-	-	435.0	-	435.0	-	435.0
Primary Care Reimbursement Service	3,605.3	0.4	43.9	-	15.0	-	18.0	-	3.3	8.0	-	20.0	-	3,713.8	(4.0)	3,709.8	4.8	3,714.6
Demand Led Local Schemes	255.6	0.0	-	-	-	-	13.8	-	-	8.0	-	-	-	277.4	-	277.4	-	277.4
Overseas Treatment	51.4	0.0	-	-	-	-	-	-	-	-	-	-	-	51.5	-	51.5	-	51.5
Total Pensions and Demand Led Areas	5,033.0	0.4	43.9	-	15.0	-	67.4	-	3.3	16.0	-	20.0	-	5,199.0	(4.0)	5,195.0	4.8	5,199.8
Total Budget	21,603.9	248.0	105.8	8.9	32.6	220.3	253.0	(34.0)	162.8	289.5	148.3	50.0	430.8	23,520.0	(46.4)	23,473.6	0.0	23,473.6
Department of Health	19,008.2	231.0	75.8	8.9	32.6	220.3	165.5	(34.0)	98.7	271.5	148.3	50.0	430.8	**20,707.8**	(46.4)	**20,661.4**	(2.6)	**20,658.7**
Department of Children, Equality, Disability, Integration and Youth	2,595.8	17.0	30.0	-	-	-	87.4	-	64.1	18.0	-	-	-	**2,812.3**	-	**2,812.3**	2.6	**2,814.9**
Total Budget - DoH / DCEDIY	21,603.9	248.0	105.8	8.9	32.6	220.3	253.0	(34.0)	162.8	289.5	148.3	50.0	430.8	23,520.0	(46.4)	23,473.6	0.0	23,473.6
Health Regions	13,950.3	144.3	37.4	-	17.6	220.3	104.2	-	133.4	181.5	-	26.8	383.1	**15,199.1**	(29.5)	**15,169.5**	143.0	**15,312.6**

Service Area / Business Unit	2024 Opening Allocation	ELS: 2024 Pay Rate Funding	ELS Full Year Impact of 2023 New Develop-ments	ELS Core Measures Previous-ly Funded in Non-Core	ELS Measures Previously Approved but Unfunded	Cost Pres-sures / Inflation	ELS Service Specific	Savings	New Measures	Non-Core Once-off Funding	Non-Core: COVID-19	Non-Core: Ukraine	Non-Core: Resilience Fund	2024 NSP Budget	Less: 2024 NSP Budget Held	2024 Opening Budget (Column N-O)	2024 Internal Comm-issioner Funding to be applied	2024 Available Funding (Column P&Q)
	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m
Operational Service Areas	Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L	Column M	Column N	Column O	Column P	Column Q	Column R
National Services	6,515.1	4.1	43.9	-	15.0	-	113.0	-	8.1	30.0	-	20.0	-	**6,749.1**	(6.0)	**6,743.1**	5.2	**6,748.3**
Centre Support - Clinical Services & Integration	645.3	2.3	24.6	-	-	-	12.4	-	14.8	3.0	148.3	2.9	-	**853.5**	(8.9)	**844.6**	(148.2)	**696.4**
Centre Support - People, Finance, Technology and Transformation & Communications	493.3	97.3	-	8.9	-	-	23.3	(34.0)	6.5	75.0	-	0.3	47.7	**718.3**	(2.0)	**716.3**	0.0	**716.3**
Total Budget based on new Health Regions	**21,603.9**	**248.0**	**105.8**	**8.9**	**32.6**	**220.3**	**253.0**	**(34.0)**	**162.8**	**289.5**	**148.3**	**50.0**	**430.8**	**23,520.0**	**(46.4)**	**23,473.6**	**-**	**23,473.6**

Note 1: Column A 2024 opening allocation is the 2023 closing recurring budget plus opening adjustment of (€0.5m) in respect of dormant account funding. Disabilities includes €19.9m transferred from Demand Led Schemes (DLS) that will move into a disabilities specific line under DLS in 2024

Note 2: Column B represents the cost of implementing nationally approved pay agreements in 2024 and supports existing staffing levels. It does not include any funding for the new and recently agreed pay deal with Section 39 organisations or the public sector new pay deal

Note 3: Column C represents the additional funding that has been provided in 2024 towards the incremental cost of 2023 new developments

Note 4: Column D is funding for COVID-19 measures previously funded on a non-recurring basis that now form part of core funding allocation to facilitate the mainstreaming of these measures

Note 5: Column E represents funding provided for measures previously approved either at Government or Ministerial level and / or arising from binding agreements

Note 6: Column F represents the funding provided for non-pay inflation and non-pay cost pressures across acute and community areas

Note 7: Column G represents the funding allocated to support specific existing levels of service

Note 8: Column H represents the savings of (€34.0m) which relates to an overall reduction in management consultancy expenditure for 2024. This has been allocated centrally pending further analysis to allocate across divisions

Note 9: Column I Further detail relating to funding provided for New Measures is available on table 2

Note 10: Columns J Non-Core includes once-off funding for Waiting List Initiatives, Private Hospitals, Agency Staffing and Access to Care €289.5m

Note 11: Columns K and L is the additional once-off funding that has been specified for COVID-19 €148.3m and Ukraine €50.0m

Note 12: Column M once-off Health Resilience Fund €430.8m which includes €383.1m non-pay funding for acutes to address systemic cost pressures arising from unfunded volume and price increases in 2023, on a once-off basis

Note 13: The total budget based on new Health Regions is an indicative view of the 2024 allocation based on the new Health Region Structure. It is indicative as this move is in transitional phase and also the service areas listed here may split out further across different areas within the new structure.

Table 2: 2025 Full Year Costs related to NSP 2024

Reference	2024 New Measures	Funding in 2024	Full Year Cost in 2025	2025 Incremental funding requirement
		€m	€m	€m
		Column A	Column B	Column C
	Access and Capacity	**56.0**	**125.0**	**69.0**
NSD 2024 – 1	Acute bed capacity	13.3	43.0	29.7
NSD 2024 – 2	Critical care bed capacity	4.5	13.0	8.5
NSD 2024 – 3	Acute diagnostics capacity	10.6	10.6	-
NSD 2024 – 4	Staffing for new beds in Older Persons' Services	5.7	10.3	4.6
NSD 2024 – 5	Waiting List Action Plan	8.0	19.5	11.5
NSD 2024 – 6	Urgent and Emergency Care Plan	5.4	13.5	8.1
NSD 2024 – 7	Contraception expanding to 31 years	1.3	1.3	-
NSD 2024 – 8	Enhanced service access	5.2	10.3	5.1
NSD 2024 - 47	Pre-Hospital Emergency Care Services	2.0	3.5	1.5
	Better Services	**13.6**	**25.9**	**12.3**
NSD 2024 – 9	Newborn screening	0.7	0.9	0.2
NSD 2024 – 10	Sexual Assault Treatment Units	0.1	0.2	0.1
NSD 2024 – 11	Transgender model of care	0.1	0.1	-
NSD 2024 – 12	Pre-exposure Prophylaxis for HIV prevention (PrEP)	0.7	0.7	-
NSD 2024 – 13	Sexual Health and Crisis Pregnancy Programme	-	-	-
NSD 2024 – 14	HSE Tobacco Free Ireland Programme	1.1	1.1	-
NSD 2024 – 15	Mental Health Crisis Team	0.4	0.7	0.3
NSD 2024 – 16	CAMHS Staffing	2.7	10.2	7.5
NSD 2024 – 17	Medicines Management Programme (MMP)	0.3	0.5	0.2
NSD 2024 – 18	National Centre for Pharmacoeconomics (NCPE)	1.0	1.5	0.5
NSD 2024 – 19	Corporate Pharmaceutical Unit (CPU)	0.6	0.9	0.3
NSD 2024 – 20	National Cancer Control Programme (NCCP)	0.1	0.2	0.1
NSD 2024 – 21	Diabetes Register	0.4	0.7	0.3
NSD 2024 – 22	Drug and Alcohol Task Forces via Section 39 grant arrangements	0.5	0.5	-
NSD 2024 – 23	Dual diagnosis services for young people with addiction and mental health issues	0.6	1.0	0.4
NSD 2024 – 24	Support for people in recovery from drug addiction	0.8	0.8	-
NSD 2024 – 46	Enhanced Community and Social Care Services	2.3	4.1	1.8
NSD 2024 – 48	Home Support Services	0.9	1.3	0.4
NSD 2024 – 49	Antimicrobial Resistance Infection Control (AMRIC)	0.3	0.5	0.2
	Workforce and Reform	**29.1**	**50.8**	**21.7**
NSD 2024 – 25	Surgical hubs	6.9	15.7	8.8
NSD 2024 – 26	Expansion of SHOs to increase GP and NCHD postgraduate training places and clinical practice co-ordinators for nursing and midwifery, HSCPs students co-ordinators for nursing, HSCP students	12.0	17.3	5.3
NSD 2024 – 27	Graduate entry nurses	0.9	0.9	-
NSD 2024 – 28	Development and implementation of a tobacco / e-cigarette retailer licensing system and inspection programme	1.1	1.3	0.2
NSD 2024 – 29	HIQA compliance	0.5	1.0	0.5
NSD 2024 – 30	Staffing for HSE Estates to progress capital plan	1.7	4.2	2.5
NSD 2024 – 31	Delivering organisational reform priorities	1.5	3.2	1.7

Reference	2024 New Measures	Funding in 2024	Full Year Cost in 2025	2025 Incremental funding requirement
		€m	€m	€m
		Column A	Column B	Column C
NSD 2024 – 32	Regional Executive Officers	1.3	1.9	0.6
NSD 2024 – 33	Digital health	3.2	5.3	2.1
NSD 2024 – 34	Safe staffing (Note 1)	-	-	-
	Disabilities	**64.1**	**117.7**	**53.6**
NSD 2024 – 35	Residential placements	15.5	31.0	15.5
NSD 2024 – 36	Tusla placements	5.0	10.0	5.0
NSD 2024 – 37	Respite	10.0	20.0	10.0
NSD 2024 – 38	School leavers - new intake	18.2	36.4	18.2
NSD 2024 – 39	Therapy assistant positions	3.5	7.0	3.5
NSD 2024 – 40	Educational programmes	2.0	2.0	-
NSD 2024 – 41	Children's targeted services	3.0	3.0	-
NSD 2024 – 42	Home support rate equalisation	3.5	3.5	-
NSD 2024 – 43	PA hours	2.0	2.0	-
NSD 2024 – 44	Neuro community	1.4	2.8	1.4
NSD 2024 – 45	Capital projects 2024	-	-	-
	2024 Overall New Measures (pre holdback funding)	**162.8**	**319.4**	**156.6**
	Department of Health	98.7	201.7	103.3
	Department of Children, Equality, Disability, Integration and Youth	64.1	117.7	53.6
	2024 Overall New Measures (pre holdback funding)	**162.8**	**319.4**	**156.6**

Note 1: The timing and profiled costs of development posts will be addressed as part of the Pay and Numbers framework 2024

Note 2: Safe Staffing to be progressed through conversion of agency staff within existing pay budget

Note 3: Column A represents the 2024 funding allocated for new service developments

Note 4: Column B indicates the 2025 full year costs for 2024 initiatives. An exercise will be undertaken as part of the development of the NSP to validate the full year 2025 costs, particularly the non-pay element.

3. eHealth

The eHealth division delivers information and communications technology (ICT) services and support throughout the HSE, facilitating integration within and across community services, hospitals, and other specialised care providers. In 2024, the allocation of funding to the eHealth division will be €155m capital funding, €259m operational budget and €55m for cyber security measures. The funding is expected to cover our ICT capital projects, the Cyber Transformation Plan, and the operational budget to fund pay costs for the largest technology landscape in the State, as well as some revenue funded initiatives such as the O365 programme.

Of the workforce pool at our disposal, more than 50% is dedicated towards the safe and secure upkeep, operation and maintenance of our vast estate of devices, networked sites, users and data. The balance of our resources are primarily dedicated towards the implementation of digital strategic plans as articulated within the eHealth and ICT Capital Plan 2024.

In 2024, we will:

1. Give patients greater access to their health information and care options, while providing greater patient involvement, autonomy and choice in their healthcare
2. Support the health service in providing a digitally skilled and supported workforce with appropriate digital tools and connectivity, allowing for collaborative working which will lead to improved efficiency and accessibility to healthcare services for patients
3. Deliver connected and co-ordinated digital health and social care systems enabling collaborative, evidence-based and timely decision-making, leading to improved patient outcomes, and continue the roll-out of secure telehealth video consultation technology to enable clinical staff to provide consultations to clients including one-to-one and virtual clinics
4. Enhance access to information and analytics to enable the evaluation of service planning and resource management for the enhancement of patient care, including using both historic and current healthcare data to produce actionable insights, improve decision-making and optimise outcomes for patients
5. Provide the guidance, tools, and resources necessary to empower patients and the workforce across the healthcare ecosystem to unlock innovative solutions that improve the experience of both the patient and workforce, including through participation in pilot and prototype technology projects in the areas of Health Informatics (health information systems and infrastructures) that support open innovation and ecosystem development
6. Ensure clear governance, a supportive culture, enablement of the transition to Health Regions, and a secure infrastructure resilient to external factors, aligned to standards and legislation by embedding architecture, service design, cybersecurity, agile delivery, and data engineering within our health service.

4. Capital Infrastructure

Each year, the HSE submits an annual Capital Plan to the DoH and the DCEDIY having regard to contractual commitments, investment priorities and funding available. In 2024, the total investment in healthcare infrastructure, equipment and furnishing of health facilities (from all funding sources) is €1,159.28m.

Funding Category (DoH)	€m
Building, Equipping and Furnishing Allocation (Vote)	1,056.28
Funding Carryover from 2023	70.00
Income	10.00
Total Funding (DoH)	**1,136.28**
Funding Category (DCEDIY)	**€m**
Building, Equipping and Furnishing Allocation (Vote)	23.00
Total Funding (DCEDIY)	**23.00**
Total Available Funding (all sources) €m	**1,159.28**

This funding is managed to achieve value for money in accordance with the requirements of the revised Public Spending Code and the Capital Projects Manual and Approvals Protocol of the HSE. Our goal is to ensure that safe, secure and high-quality infrastructure is provided to support current and future needs,

playing a key role in improving the experience and outcomes of patients, service users, their families and staff who access and work in healthcare facilities.

In 2024, we will:

1. Take forward implementation of the *HSE Capital and Estates Strategy 2022-2050*, working with the DoH and DCEDIY and adopting the multi-criteria Strategic Healthcare Investment Framework to deliver on the *National Development Plan 2021-2030* objectives for healthcare
2. Support delivery of Government priority projects and programmes including completion of the new children's hospital, advancement of the National Maternity Hospital and enablement of other key initiatives, including surgical hubs, additional inpatient capacity and elective hospitals
3. Support specific priority programmes including critical care, trauma care, radiation oncology, enhanced community care, mental health, unscheduled and emergency care, regulatory compliance programmes for older people and other capacity planning initiatives
4. Advance projects for specialist disability services
5. Maintain investment in minor capital initiatives, the delivery of the equipment replacement programme and the ambulance replacement programme to support patient safety and the mitigation of clinical and infrastructural risk
6. Progress the *HSE Infrastructure Decarbonisation Roadmap* in partnership with the Sustainable Energy Authority of Ireland to deliver climate action goals for the HSE
7. Develop new and future focused capabilities in areas of digital innovation, new technologies and modern methods of delivery, and ensure standardisation of approach where appropriate
8. Progress a key objective within the Capital and Estates Strategy of developing workforce capability and capacity by increasing resources to deliver healthcare projects, funded in the Letter of Determination 2024
9. Maintain efficient oversight and effective management of the Capital Plan, through assessment and internal HSE governance arrangements, ensuring delivery of prioritised projects in the context of challenges, including HSE resource allocation, construction inflation, contractor availability and capacity within the construction industry.

5. National Schemes and Reimbursement

The Primary Care Reimbursement Service (PCRS) is responsible for making payments to healthcare professionals – doctors, dentists, pharmacists and optometrists / ophthalmologists – for the free services or reduced cost services they provide to the public across a range of community health schemes.

In 2024, we will:

1. Deliver increased visibility on the steps / progress made by each individual medicine through the HSE assessment and approval processes, and prioritise the recruitment necessary to optimise timelines for each application with the aim of fully publishing data by Q2 2024
2. Work with the DCEDIY to roll out the PCRS components of the redress scheme for former residents of Mother and Baby and County Homes Institutions
3. Continue the roll-out of the extended access to free general practitioner (GP) care for children aged six and seven years, commenced in August 2023, and the roll-out of the extension of access to GP visit

cards in line with the significant increases in financial thresholds, commenced in September 2023

4. Complete the programme of implementation of revised payment supports to GPs and manage the GP assignment process in compliance with the caps and processes set out in Section 9.2 of the GP Agreement July 2023 between the DoH, HSE and Irish Medical Organisation
5. Extend access to the Free Contraception Scheme to women aged 31 years of age
6. Continue to increase the resilience of PCRS services to any pandemic or other risks including the ongoing implementation of learnings from the national review of the 2021 cyberattack on the HSE and continue to enhance the security of PCRS ICT systems
7. Work closely with the DoH and other stakeholders to operationalise and implement the agreed recommendations of the Expert Taskforce to Support the Expansion of the Role of Pharmacy; continue engagement on the expanding role of Pharmacy, ensuring that the supporting processes (contractual and administrative) are maximised; review the potential for streamlining controls and validations within PCRS, while maintaining good governance; and complete a clinical review of medicines suitable for an Over the Counter GMS Scheme, and develop proposals for this scheme including proportionate control mechanisms.

6. Internal Audit

Internal Audit provides independent assurance that the organisation's risk management, governance and internal control processes are operating effectively, and identifies risks and control issues which may have systemic implications for the HSE.

In 2024, we will:

1. Provide assurance to the Audit and Risk Committee, the Board, the CEO and the Executive Management Team on the adequacy and degree of adherence to internal controls, risk management processes and the overall governance structure
2. Ensure that Internal Audit pivots with the evolving risk landscape and undertakes audit activity that is strategically important for the HSE with sufficient audit breath during a period of organisational change
3. Undertake a planning approach for our Internal Audit Plan underpinned by the core pillars of consultation, analysis and research
4. Deliver our assurance, based on topics identified on a strategic, cross-organisational and functional basis, drawing on enterprise risk management information
5. Enable our audit activity to be agile and responsive to emerging issues and priorities during the year.

7. Research and Evidence

HSE Research and Evidence supports the healthcare system to embrace and maximise the use of data, research and evidence to inform patient care, health service management, strategy development and reform. Our goal is to position research, evidence and health intelligence at the core of decision-making for strategy, operational planning, management and patient care during the transition to the Health Regions.

In 2024, we will:

1. Evolve Health Atlas Ireland, the Integrated Service Model, the Health Support System framework and

analytic solutions to inform service planning processes in collaboration with HSE corporate and regional structures so as to optimise the provision of accessible, balanced, equitable, safe and sustainable services

2. Continue the implementation of the HSE research framework to ensure that research governance, management and support infrastructure are embedded within the Health Regions while maintaining a national cohesive and co-ordinated approach that enables research, collaboration and knowledge translation
3. Expand outreach and integration of library services in line with the new Health Regions and develop the next HSE Health Library Ireland strategy.

8. Data, Compliance and EU North South

8.1 Data Protection

The HSE National Data Protection Office (DPO) is both a statutory requirement of a public service body and an essential enabler in providing data protection guidance and advice, supporting all services and functions across the HSE to meet its obligations under General Data Protection Regulation and the *Data Protection Act 2018*. The National DPO office has a number of responsibilities that include oversight, compliance advice, primary liaison with regulatory bodies, as well as communication with the general public in relation to data protection matters.

In 2024, we will:

1. Establish and implement a data protection / privacy transformation programme to improve compliance maturity across HSE services, functions and corporate units
2. Build and augment HSE National DPO team capability
3. Ensure timely delivery of national data privacy capabilities across the HSE
4. Enhance training and awareness available to staff to effect cultural change regarding data protection obligation appreciation
5. Design a Target Operating Model Programme for the Health Regions to enhance and standardise data protection capability across the HSE.

8.2 Health Identity Management Services

The Health Identity Management Service is responsible, as delegated to the HSE by the Minister for Health, for the operational service for the allocation and provision of identifiers for:

- Individuals (individual health identifier (IHI)) and for
- Health service providers (locations, services, organisations and practitioners).

The benefits of an IHI and identity services include patient safety, improved patient care, efficiency of health services and are critical for provision of eHealth systems.

In 2024, we will:

1. Continue deployment of identity management services for priority areas in line with national policy and regulation

2. Update policies, programme and operational procedures to ensure Personal Public Service Number (PPSN) is requested and recorded for patient registrations where the patient has a PPSN, and that the correct IHI is assigned to their digital health records for identification and linkage. We will implement these changes through supporting patient facing operations in introducing these changes to their established business procedures and practices
3. Continue collaboration with DoH, Department of Social Protection and cross-Government partners to ensure alignment with Government policies and regulation: Health Information Bill; *Birth Information and Tracing Act 2022*; *Civil Registration Act 2004*; Digital Health Strategy and Government strategies
4. Implement quality improvement initiatives to ensure the completeness, accuracy and utility of the identity management service and IHI dataset for digital record linkage.

8.3 Compliance Unit – Grants to Service Providers

The HSE is mandated to manage and deliver (or arrange to be delivered on its behalf) health and personal social services, and these services are, by their nature, varied and complex. Where the HSE relies upon non-statutory service providers to deliver services on its behalf, the HSE has a formal Governance Framework in place, which incorporates national standardised documentation and guidance documents that enable the HSE to contractually underpin the grant funding provided to all service providers.

In 2024, we will:

1. Continue to support the implementation of the Governance Framework through monitoring the completion levels of service arrangements and grant aid agreements; monitoring Annual Financial Statements in respect of Section 38 and Section 39 service providers; and completing the 2023 Annual Compliance Statement process for all Section 38 and Section 39 service providers that receive annual funding over €3m
2. Manage the second phase of the external reviews of governance in relevant Section 38 and Section 39 service providers
3. Support the Contract Management Support Unit Managers in the Contract Management Support Units in further developing their roles in the CHOs and Health Regions when established.

8.4 EU and North South Unit

The HSE EU and North South Unit works on behalf of the organisation to promote health co-operation with providers on a north-south, east-west and all-island basis to ensure better outcomes for people, especially those living in border and remote areas. In addition, the unit assists service areas applying to the EU4Health Programme and works in close co-operation with the DoH to identify strategic all-island health innovative projects for the Department of the Taoiseach Shared Island Funding.

While Brexit, COVID-19 and additional cyber security measures posed extra challenges in relation to cross-jurisdictional healthcare delivery and co-operation, it is notable that all cross-jurisdictional services have been maintained throughout 2022 / 2023 with little or no change. In this context, all efforts have been made to ensure the continuation and growth of cross-border co-operation. Responding to the challenges posed by Brexit and other public health challenges will continue to be a key priority, through ongoing review of HSE Brexit work streams and close liaison with the Brexit and UK Strategic Oversight Group, along with positive engagement on external funding programmes such as PEACEPLUS and EU4Health.

The EU North South Unit supports services to identify and fund appropriate healthcare development on a north-south basis; this can be in conjunction with the Cross Border Health and Social Care Partnership, Co-operation and Working together.

In 2024, we will:

1. Lead / partner in the co-ordination and support of closure arrangements for EU Interreg VA cross-border projects in the areas of acute services, mental health services, population health, children's services and medication optimisation, and act as both partner / lead partner for PEACEPLUS projects to support the border population to 2027 and beyond. Engage with EU multiannual financial framework programmes to maximise the opportunities available for HSE under the EU4Health Programme and PEACEPLUS Programme
2. As HSE Brexit Lead, address challenges posed by Brexit through ongoing review of HSE Brexit work streams and close liaison with the Brexit and UK Strategic Oversight Group
3. Continue to monitor and develop Cross-Border and All Island Service Agreements and Memorandums of Understanding in place between health authorities north and south and collectively report on same to DoH. As required, develop new formal agreements on specialist services
4. Explore possible funding opportunities in support of iSIMPATHY (implementing Stimulating Innovation in the Management of Polypharmacy and Adherence through the Years) etc.

Section 4
Building Trust and Confidence across Staff and our Service Users

1. Patient and Service User Feedback and Engagement
2. Safeguarding
3. Clinical, Quality and Patient Safety
4. Communications
5. Broader Social Accountabilities
    - 5.1. Human Rights and Equality
    - 5.2. Global Health
    - 5.3. Emergency Management
    - 5.4. Climate and Sustainability
6. Governance and Risk

People must have trust and confidence in our services. The importance of quality improvement, patient safety and safe reliable delivery of care is central to everything we do; it is not in addition to services provided but rather, part of the way we deliver services. It is strengthened by working with, and learning from, patients / service users and each other to design, deliver, evaluate and continuously improve care.

1. Patient and Service User Feedback and Engagement

Embedding the Patient and Service User Experience and the National Complaints Governance and Learning Team functions as part of Operational Performance and Integration seeks to improve visibility and leadership for patient and public involvement.

To support the provision of high-quality care across health and social care services, we will build real and meaningful engagement, involvement, collaboration and partnerships between patients, service users, families, health professionals and organisations, both voluntary and professional.

Systems and supports will be developed to deliver on the HSE's commitment to provide an enhanced service user feedback process that is accessible, flexible and responsive as well as the mechanisms that enable the narrative and data from feedback to drive learning and quality improvement.

In 2024, we will:

1. Launch the Patient and Service User Strategy in partnership with the National Patients Forum and seek the endorsement by the Department of Health (DoH) and the Department of Children, Equality, Disability, Integration and Youth (DCEDIY). This strategy will detail the HSE's cross-organisational commitment to embed patient partnership, set key objectives and targets, and identify the timelines and the resources needed
2. Learn and build on feedback through the inaugural, and now annual, patient conference while continuing to work with patient and service user groups, the DoH, DCEDIY and the HSE Senior Leadership Team to define patient and service user involvement in structures and processes
3. Maximise all avenues in seeking patient and service user feedback to support continuous improvement across all services, including implementation of Your Service Your Say (YSYS) audits; utilisation of the Healthcare Complaints Analysis Tool; enablement of feedback through the National Care Experience Programmes, family surveys, and publication of national casebooks with patient and service user journeys / stories / experiences; and roll-out of training programmes that are supported by and involve patient and service user advocacy groups to build expertise within the system
4. Continue to listen and respond to feedback through the revised YSYS policy and support positive engagement within the process through the Managing Unreasonable Behaviour by Complainants within the policy.

2. Safeguarding

The safeguarding of adults at risk of abuse is a priority for the HSE. Since 2015, the National Safeguarding Office and regional Safeguarding Protection Teams have been in place, operating the 2014 policy – the HSE's first Safeguarding Policy. At the time of its development, this policy was designed for operation in

Social Care and so has an operational remit for older persons' services and services for people with a disability as well as taking community referrals. This is not enough; the HSE believe that safeguarding operations should be of benefit to all. We also know from National Independent Review Panel reports such as Brandon and Emily that, even within older persons' services and disability services, our safeguarding measures need to be improved. With this in mind an independent review of HSE safeguarding has been commissioned by the Chief Executive Officer.

In 2024, we will:

1. Publish the independent review, and appoint a chief social worker to implement the recommendations made. This work will, in turn, be an important consideration for how the reformed HSE centre and the six Health Regions work together to protect adults at risk of abuse
2. Align the future operating model for HSE safeguarding centrally and regionally to deliver the requirements of both the DCEDIY and the DoH, particularly with regard to the DoH's sectoral policy on safeguarding which is expected in 2024.

3. Clinical, Quality and Patient Safety

Delivery of a high-quality, safe, effective, responsive and person-centred healthcare service is our paramount focus. To meet the changing healthcare needs of the population (a growing and ageing population with an increasing number of people living with complex care needs) and the principles of universal healthcare, it is imperative to address the design and continued implementation of integrated models of care, evolve workforce development and configurations, focus on enhancing patient safety, and empower the patient / service user voice in healthcare decision-making. In addition, it is essential that we maximise learning and development opportunities to empower front-line clinical staff who will lead and shape services as they evolve under the new Health Regions governance structure.

In 2024, we will:

1. Enhance clinical expertise and enable a sustainable medical, nursing and midwifery, pharmacy and health and social care professional (HSCP) workforce through commencing a viable infrastructure to facilitate clinical practice placements and postgraduate development to (a) support more healthcare personnel to be trained in line with workforce planning projections; (b) support international applicants who require placements to work; (c) support the development of specialist and advanced practice pathways; (d) facilitate the conversion of non-training non-consultant hospital doctors (NCHD) posts to training posts
2. Develop and optimise current clinical workforce capacity through continuing support for the implementation of the national nurse staffing IT system, utilisation of the Framework for Safe Nurse Staffing and Skill Mix, implementation of the recommendations of the *Report of the Expert Review Body on Nursing and Midwifery*, implementation of *HSCP Deliver – A Strategic Guidance Framework for Health and Social Care Professions 2021-2026* and implementation of the DoH *National Taskforce on the NCHD Workforce*, and progress the recommended actions following the publication of the report of the expert steering group on consultant recruitment and retention challenges in Model 3 hospitals
3. Strengthen an evidence and needs-based approach to inform strategic and operational decisions in the development of clinical guidelines and in the design and configuration of health services, including progression of models of care (e.g. a comprehensive model of care for the provision of gender identity

clinical services) and pathways, supporting and providing clinical input for clinical innovation and digital healthcare, and supporting the safe and cost-effective use of medicines through health technology and management processes, medicines optimisation and review

4. Establish a HSE Medicines Sustainability Programme to drive immediate savings under the medicines budget, providing funds to reinvest in new drugs and to progress medium to long-term structural reform in respect of medicines expenditure. A systematic review of expenditure will be undertaken to identify *inter alia* key trends, primary drivers of expenditure, and the penetration rates of generics and biosimilars across community, hospitals and national schemes. This work will support the development of proposals for improving sustainability of medicines expenditure. It will be supported and driven by a named senior responsible officer and also by a dedicated jointly-chaired DoH-HSE governance structure with savings included in the overall work of the Productivity Task Force (referenced in Section 3, chapter 2 (2.5))
5. Establish the following HSE Medicines Management Programme work streams for efficiency generation:
    - Ongoing best-value biological programme to include best-value medicines process for generic medicines on the High Tech Arrangement
    - Implementation of a reimbursement application system for continuous glucose monitoring sensors and publication of a preferred product(s) evaluation
    - Identification of preferred high-protein oral nutritional supplement products
    - Further analysis of non-medicine items (ostomy / urostomy products) and analysis to identify other areas for potential efficiencies
    - Testing and formalising of new acute and community key performance indicators (KPIs) relating to medicines expenditure sustainability to be included formally in National Service Plan 2025 (see appendix 1(b) of this document)
6. Drive quality and safety improvement through implementation of the *HSE Patient Safety Strategy 2019-2024*, including implementation of improvement programmes to address the common causes of harm, development of a national quality and patient safety competency framework, delivery and monitoring of the HSE's implementation plan for the *Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023* with the Health Regions, implementation of the Open Disclosure policy in line with National Open Disclosure Framework, and implementation of nationwide electronic incident reporting
7. Implement, on a phased basis, the HSE's *Antimicrobial Resistance Infection Control (AMRIC) Action Plan 2022-2025* which is aligned to *Ireland's Second One Health National Action Plan on Antimicrobial Resistance 2021-2025 (iNAP2)* to integrate infection prevention and control and antimicrobial stewardship across community and acute operations
8. Support improvements in availability, reconfiguration and transformation of services including implementation of national healthcare strategies, the women's health programme, and delivery of programmes enabling the implementation of universal healthcare. In addition, support the roll-out and implementation of the *National Stroke Strategy 2022-2027* and progress implementation of the *National Strategy for Accelerating Genetic and Genomic Medicine in Ireland*, with priority focus on establishing the Genetics and Genomics Operating Model for laboratory and clinical services delivery
9. Consolidate the implementation of the seven prioritised modernised care pathways, progress implementation of additional pathways, and complete the design of remaining pathways, to achieve: (a) improved access time to services, (b) improved quality of services and (c) care delivery in the best place for the patient to transform scheduled care services

10. Continue work on ensuring full compliance with, and embedding of, the EU medical device and in-vitro diagnostic device regulations across the HSE.

4. Communications

HSE Communications provide essential, direct communications services to our patients, the public, our staff and our partners. We also support HSE teams with strategic communications planning and implementation. Our work is delivered by national and regional teams through a wide range of channels, including news media, *hse.ie* and other websites, digital and social media services, social marketing and information campaigns, staff channels and our HSELive contact centre.

In 2024, we will:

1. Secure people's trust and confidence in the HSE, our teams and our progress through collection and sharing of good news stories, improved co-ordination of updates and information provided to public representatives, and improved relationships with our stakeholders by creating communications networks and channels and inviting feedback
2. Build accessible, high-quality digital health services for the public that provide trusted health information and signposting to all health services, ensuring all public facing digital services, apps and digital self-help tools are accessible and part of a seamless digital health service experience, and support the new online health service directory that Health Regions and national services will use for patients and healthcare professionals
3. Support and inform HSE staff and make the HSE a better place to work and learn, with new communications channels to enable effective national and regional communications with staff and teams at all levels
4. Provide communications tools and support for our Health Regions and national services, enabling them to communicate effectively with patients, staff and partners, including development of a new operating model for Health Regions and HSE national communications teams, setting out the skills and standards for all essential communications functions, and working with existing teams to transition to new working arrangements during 2024.

5. Broader Social Accountabilities

5.1. Human Rights and Equality

All public bodies in Ireland, including the HSE, have responsibility, under the Public Sector Equality and Human Rights Duty (Public Sector Duty), to promote equality, prevent discrimination and protect the human rights of their employees, customers, service users, and everyone affected by their policies and plans. This is a legal obligation which is contained in Section 42 of the *Irish Human Rights and Equality Commission Act 2014*.

The HSE National Office for Human Rights and Equality Policy is primarily responsible for the strategic oversight and implementation of the HSE *National Consent Policy* and provides strategic oversight on the implementation of the *Assisted Decision-Making (Capacity) Act 2015*. The Office also provides policy support and guidance on a number of additional human rights and equality issues, including Do Not

Attempt Resuscitation (DNA-CPR), issues pertaining to universal access to health and social care services for people with disabilities, and policies in relation to access of transgender and intersex people to mainstream healthcare. The Office is also engaged in activity to influence legislative and organisational change to ensure the human rights and dignity of each person who uses our health and social care services are respected. This work is delivered in collaboration with the National Office for Clinical Design and Innovation, front-line practitioners and people who use our services.

In 2024, we will:

1. Continue to develop and disseminate resources such as guidance, training, practice guidelines and webinars to support staff and services to implement the *Assisted Decision-Making (Capacity) Act 2015* in their practice
2. Continue to progress the roll-out of the revised HSE *National Consent Policy* and the National Consent Policy eLearning programme to staff
3. Finalise the revision of the DNA-CPR policy and progress its roll-out with related supports to staff and services
4. Provide support and guidance to staff regarding human rights and equality issues to ensure compliance with key policy and legislation including the public sector duty under the *Irish Human Rights and Equality Commission Act 2014* and to influence the development of new legislation and policy that has implications for people using HSE services.

5.2. Global Health

The Global Health Programme ensures a global approach to improving healthcare through co-operation with other countries. It develops and implements initiatives aimed at improving health services and population health outcomes in developing countries. It also co-ordinates the HSE's humanitarian donations of medical supplies and equipment to Ukraine and countries in Africa.

In 2024, we will:

1. Continue bilateral collaboration programmes with health services in Mozambique, Ethiopia, Tanzania, Zambia and Sudan and facilitate new partnerships with counterparts in Africa to strengthen health services and increase health security
2. Develop and share technical expertise and resources focused on improving quality and safety of healthcare in low resource countries, including donation of medical supplies and equipment to Ukraine and Africa
3. Increase the global health knowledge and capacity of staff in order to improve the quality and effectiveness of healthcare in Ireland.

5.3. Emergency Management

The Emergency Management function assists leadership and management across all levels of the HSE in the preparation of major emergency plans and the identification and mitigation of strategic and operational risk to the organisation, to ensure a timely, co-ordinated response to any unforeseen event that impacts the HSE's provision of care to patients and service users.

In 2024, we will:

1. Promote severe weather preparedness across the organisation in order to improve planning and response capacity
2. Plan and facilitate Emergo training and simulation exercises within hospital and pre-hospital settings to enhance preparedness for surge events
3. Engage with the other principal response agencies and Government departments to meet HSE obligations as established under *A Framework for Major Emergency Management, 2006* and *Strategic Emergency Management, National Structures and Framework, 2017*, as well as statutory obligations in regard to upper tier Seveso sites, licensing of outdoor events, ports, airports, road tunnels and rail tunnels.

5.4. Climate and Sustainability

Climate change poses a two-fold challenge to the health sector: dealing with the growing health impacts and curbing its own emissions. Without effective mitigation and adaptation, climate change will have profound implications for the health of the population and the provision of health and social care services.

Launched in June 2023, the *HSE Climate Action Strategy 2023-2050* outlines an ambitious programme for implementation of the national targets set in the Government's *Climate Action Plan, 2023*. The HSE Climate Action Strategy commits to 'achieving net-zero emissions no later than 2050, delivering healthcare which is environmentally and socially sustainable'. This builds on, and further extends, the work of the Capital Plan in reducing carbon emissions which has been ongoing within the healthcare estate for a number of years.

Six priority areas and ten strategic objectives have been identified to underpin delivery of the strategy, and implementation of actions to achieve these objectives is underway. The six key areas of focus within the strategy are:

i. Sustainable buildings and the green environment
ii. Transport and mobility
iii. Sustainable procurement
iv. Greener models of healthcare
v. Water and waste management
vi. Adaptation and resilience.

In 2024, we will:

1. Continue the implementation of the *HSE Climate Action Strategy 2023-2050* to include and build on existing work to decarbonise the HSE estate
2. Build on existing good practice by mobilising implementation opportunities identified through the current state assessment and follow through with implementation of frameworks for each strategic objective to map the medium to long-term plan for delivery of the overarching net-zero target and related goals
3. Continue development of a comprehensive and robust measurement and reporting methodology, to include Scope 3 reporting
4. Roll out a staff information campaign to engage with all staff across the HSE about the strategy, targets, plans and opportunities to participate in the climate change programme

5. Provide guidance on the development of green teams at service levels and develop a structure for climate action implementation through these teams and through six regional green committees.

6. Governance and Risk

Governance and Risk works to support the building of public and wider societal confidence in the health service, enabling the meeting of statutory, regulatory and policy obligations aimed at improving the delivery and administration of our services, and anticipating and managing the risks to the delivery of these services.

In 2024, we will:

1. Continue to promote and support good governance across the HSE in areas including enterprise risk management, compliance, protected disclosures, national appeals service, legal services and Children First.

Appendices

Appendix 1(a): National (Operational) Scorecard

National Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
Quality and Safety	**Complaints investigated within 30 days**	% of complaints investigated within 30 working days of being acknowledged by the complaints officer
	Serious Incidents	% of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident
		% of reported incidents entered onto National Incident Management System (NIMS) within 30 days of notification of the incident
		Extreme and major incidents as a % of all incidents reported as occurring
	Healthcare Associated Infections (HCAI) Rates	Rate of new cases of hospital acquired staphylococcus aureus bloodstream infection
		Rate of new cases of hospital associated C. difficile infection
	Child Health	% of children aged 24 months who have received the measles, mumps, rubella (MMR) vaccine
		% of children reaching 12 months within the reporting period who have had their 9-11 month public health nurse (PHN) child health and development assessment on time or before reaching 12 months of age
		% of infants breastfed exclusively at the PHN three month child health and development assessment visit
		% of infants visited by a PHN within 72 hours of discharge from maternity services
	Urgent Colonoscopy within four weeks	No. of new people waiting > four weeks for access to an urgent colonoscopy
	BreastCheck	% BreastCheck screening uptake rate
	Surgery	% of surgical re-admissions to the same hospital within 30 days of discharge
	Medical	% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge
	Patient Handover at Emergency Department to Clear	% of ambulance crews who are ready and mobile to receive another 999 / 112 call within 20 minutes of clinically and physically handing over their patient at an Emergency Department (ED) or hospital
	CAMHs	% of bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of bed days used by children in mental health acute inpatient units
	Disability Services	Facilitate the movement of people from congregated to community settings
	Smoking	% of smokers on cessation programmes who were quit at four weeks
Access and Integration	**Therapy Waiting Lists**	Physiotherapy – % on waiting list for assessment ≤52 weeks
		Occupational Therapy – % on waiting list for assessment ≤52 weeks

National Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
Access and Integration	**Therapy Waiting Lists**	Speech and Language Therapy – % on waiting list for assessment ≤52 weeks
		Podiatry – % on waiting list for treatment ≤52 weeks
		Ophthalmology – % on waiting list for treatment ≤52 weeks
		Audiology – % on waiting list for treatment ≤52 weeks
		Dietetics – % on waiting list for treatment ≤52 weeks
		Psychology – % on waiting list for treatment ≤52 weeks
	Nursing	% of new patients accepted onto the nursing caseload and seen within 12 weeks
	Ambulance to ED Handover Times	% of patients arriving by ambulance at ED to physical and clinical handover within 20 minutes of arrival
	ED Patient Experience Time	% of all attendees at ED who are discharged or admitted within six hours of registration
		% of all attendees at ED who are in ED <24 hours
		% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration
		% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration
	Waiting times for procedures	% of adults waiting <9 months for an elective procedure (inpatient and day case)
		% of children waiting <9 months for an elective procedure (inpatient and day case)
		% of people waiting <15 months for first access to Outpatient Department (OPD) services
		% of people waiting <13 weeks following a referral for colonoscopy or Oesophago Gastro Duodenoscopy (OGD)
	Ambulance Response Times	% of clinical status 1 PURPLE incidents responded to by a NAS patient-carrying vehicle in 18 minutes and 59 seconds or less
		% of clinical status 1 RED incidents responded to by a NAS patient-carrying vehicle in 18 minutes and 59 seconds or less
	Cancer	% of new patients attending rapid access breast (urgent), lung and prostate clinics within recommended timeframe
		% 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)
	National Screening Service	No. of unique women who have had one or more satisfactory cervical screening tests in a primary care setting
	Disability Services	% of child assessments completed within the timelines as provided for in the regulations
		No. of new Priority 1 Residential Places provided to people with a disability
		No. of intensive support packages for priority 1 cases

National Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
Access and Integration	**Disability Services**	No. of day only respite sessions accessed by people with a disability
		No. of people with a disability in receipt of respite services (intellectual disability (ID) / autism and physical and sensory disability)
		No. of overnights (with or without day respite) accessed by people with a disability
	Older Persons	No. of home support hours provided (excluding provision of hours from Intensive Homecare Packages (IHCPs))
		No. of people in receipt of home support (excluding provision from IHCPs) – each person counted once only
	Mental Health	% of urgent referrals to Child and Adolescent Mental Health Teams responded to within three working days
		% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by General Adult Community Mental Health Team
		% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Psychiatry of Later Life Community Mental Health Teams
	Homeless Services	% of new individual homeless service users admitted to Supported Temporary Accommodations (STA), Private Emergency Accommodations (PEA), and / or Temporary Emergency Accommodations (TEA) during the quarter whose health needs have been assessed within two weeks of admission
	Substance Use	% of substance users (under 18 years) for whom treatment has commenced within one week following assessment
		% of substance users (over 18 years) for whom treatment has commenced within one calendar month following assessment
Finance, Governance and Compliance	**Financial Management**	Net expenditure variance from plan (pay + non-pay - income)
	Governance and Compliance	% of the monetary value of service arrangements signed
		% of internal audit recommendations implemented by agreed due date
Workforce	**Attendance Management**	% absence rates by staff category

Appendix 1(b): National Performance Indicator Suite

Note: 2023 and 2024 expected activity and targets are assumed to be judged on a performance that is equal or greater than (≥) unless otherwise stated (i.e. if less than (<) or, less than or equal to symbol (≤) is included in the target).

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Acute Hospital Services				
Outpatient attendances New: Return Ratio (excluding obstetrics, warfarin and haematology clinics)	M	1:2.5	1:2:5	1:2
Activity Based Funding (MFTP) model Hospital Inpatient Enquiry (HIPE) completeness – Prior month: % of cases entered into HIPE	M (1 Mth in arrears)	100%	100%	100%
Inpatient, Day Case and Outpatient Waiting Times % of adults waiting <9 months for an elective procedure (inpatient)	M	90%	68.5%	90%
% of adults waiting <9 months for an elective procedure (day case)		90%	78.2%	90%
% of children waiting <9 months for an elective procedure (inpatient)		90%	65%	90%
% of children waiting <9 months for an elective procedure (day case)		90%	72.5%	90%
% of people waiting <15 months for first access to OPD services		90%	84.1%	90%
% of routine elective procedures (inpatient) chronologically scheduled		85%	66.3%	85%
% of routine elective procedures (day case) chronologically scheduled		85%	76.2%	85%
% of routine patients on Gastrointestinal (GI) waiting lists that are chronologically scheduled		85%	66.6%	85%
% of routine patients on OP waiting lists that are chronologically scheduled		85%	66.9%	85%
Colonoscopy / Gastrointestinal Service % of people waiting <13 weeks following a referral for colonoscopy or OGD		65%	60.2%	65%
No. of new people waiting > four weeks for access to an urgent colonoscopy		0	1,133	0
% of people waiting <9 months for an elective procedure GI scope		95%	93.4%	95%
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within six hours of registration		70%	55.9%	70%
% of all attendees at ED who are discharged or admitted within nine hours of registration		85%	72.5%	85%
% of ED patients who leave before completion of treatment		<6.5%	6.3%	<6.5%
% of all attendees at ED who are in ED <24 hours		97%	95.8%	97%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration		95%	35.3%	95%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration	M	99%	53.3%	99%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration		99%	90.7%	99%
Ambulance to ED Handover Times % of patients arriving by ambulance at ED to physical and clinical handover within 20 minutes of arrival	M (1 Mth in arrears)	80%	Data not available	80%
Length of Stay Average length of stay (ALOS) for all inpatient discharges excluding LOS over 30 days		≤4.8	5.1	≤4.8
Medical Medical patient average length of stay		≤7.0	7.5	≤7.0
% of medical patients who are discharged or admitted from Acute Medical Assessment Unit (AMAU) within six hours AMAU registration	M	75%	62.7%	75%
% of all medical admissions via AMAU	M (1 Mth in arrears)	45%	32.0%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge		≤11.1%	11.9%	≤11.1%
Surgery Surgical Elective Inpatient average length of stay		≤5.0	4.5	≤5.0
Surgical Emergency Inpatient average length of stay		≤6.0	6.7	≤6.0
% of elective surgical inpatients who had principal procedure conducted on day of admission		82.4%	80.0%	82.4%
% day case rate for Elective Laparoscopic Cholecystectomy		60%	49.3%	60%
% hip fracture surgery carried out within 48 hours of initial assessment (Hip fracture database)	Q (1 Qtr in arrears)	85%	76.6%	85%
% of surgical re-admissions to the same hospital within 30 days of discharge	M (1 Mth in arrears)	≤2%	1.6%	≤2%
Healthcare Associated Infections (HCAI) Rate of new cases of hospital acquired staphylococcus aureus bloodstream infection	M	<0.8/10,000 bed days used	0.8	<0.7/10,000 bed days used
Rate of new cases of hospital associated C. difficile infection		<2/10,000 bed days used	2.0	<2/10,000 bed days used
% of acute hospitals implementing the requirements for screening of patients with Carbapenemase-producing Enterobacterales (CPE) guidelines	Q	100%	92%	100%
% of acute hospitals implementing the national policy on restricted antimicrobial agents		100%	80%	100%
Rate of new hospital acquired COVID-19 cases in hospital inpatients	M	N/A	13.8	N/A

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Medication Safety Rate of medication incidents as reported to NIMS per 1,000 beds	M (2 Mths in arrears)	3.0 per 1,000 bed days	2.9	3.0 per 1,000 bed days
Irish National Early Warning System (INEWS) % of hospitals implementing INEWS in all clinical areas of acute hospitals (as per 2019 definition)	Q	100%	37.5%	100%
% of hospitals implementing Paediatric Early Warning System (PEWS)		100%	42.3%	100%
National Standards % of acute hospitals that have completed and published monthly hospital patient safety indicator reports	M (2 Mths in arrears)	100%	91.0%	100%
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Q (2 Qtrs in arrears)	90%	66.3%	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis		12%	12.0%	12%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		90%	64.4%	90%
Acute Coronary Syndrome % ST-Elevation Myocardial Infarction (STEMI) patients (without contraindication to reperfusion therapy) who get Primary Percutaneous Coronary Intervention (PPCI)	Q (1 Qtr in arrears)	95%	86.9%	95%
% of reperfused STEMI patients (or left bundle branch block (LBBB)) who get timely PPCI		80%	62.8%	80%
Cancer Services				
% of new patients attending rapid access breast (urgent), lung and prostate clinics within recommended timeframe	M	95%	80.2%	95%
Symptomatic Breast Disease Services **Non-urgent** % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)		95%	70%	95%
Clinical Detection Rate – breast cancer % of new attendances to the rapid access clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	Annual	>6%	8.1%	>6%
Clinical Detection Rate – lung cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of lung cancer		>25%	26.3%	>25%
Clinical Detection Rate – prostate cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of prostate cancer		>30%	23.1%	>30%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Radiotherapy % 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)	M	90%	63.4%	90%
National Ambulance Service				
Clinical Outcome Return of spontaneous circulation (ROSC) at hospital in bystander witnessed out of hospital cardiac arrest with initial shockable rhythm, using Utstein comparator group calculation	Q	40%	40%	40%
Audit National Emergency Operations Centre (NEOC) Tallaght and Ballyshannon – % medical priority dispatch system (MPDS) protocol compliance	M	94%	94%	94%
Emergency Response Times % of clinical status 1 PURPLE incidents responded to by a NAS patient-carrying vehicle in 18 minutes and 59 seconds or less		75%	72%	75%
% of clinical status 1 PURPLE incidents responded to by a Dublin Fire Brigade (DFB) patient-carrying vehicle in 18 minutes and 59 seconds or less		New PI NSP 2024	New PI NSP 2024	73%
% of clinical status 1 PURPLE incidents responded to nationally by a patient-carrying vehicle in 18 minutes and 59 seconds or less		New PI NSP 2024	New PI NSP 2024	72%
% of PURPLE calls which had a resource allocated within 60 seconds of call start		New PI NSP 2024	New PI NSP 2024	60%
% of clinical status 1 RED incidents responded to by a NAS patient-carrying vehicle in 18 minutes and 59 seconds or less		45%	46%	45%
% of clinical status 1 RED incidents responded to by a DFB patient-carrying vehicle in 18 minutes and 59 seconds or less		New PI NSP 2024	New PI NSP 2024	43%
% of clinical status 1 RED incidents responded to nationally by a patient-carrying vehicle in 18 minutes and 59 seconds or less		New PI NSP 2024	New PI NSP 2024	45%
% of RED calls which have a resource allocated within 180 seconds of call start		New PI NSP 2024	New PI NSP 2024	75%
Intermediate Care Service % of all transfers provided through the intermediate care service		90%	77%	90%
Patient Handover at ED to Clear % of ambulance crews who are ready and mobile to receive another 999 / 112 call within 20 minutes of clinically and physically handing over their patient at an ED or hospital		New PI NSP 2024	New PI NSP 2024	75%
% of DFB ambulance crews who are ready and mobile to receive another 999 / 112 call within 20 minutes of clinically and physically handing over their patient at an ED or hospital		New PI NSP 2024	New PI NSP 2024	75%
Note: DFB services are not delivered or governed by HSE. DFB Target for 2024 included for reporting purposes only.				

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Health and Wellbeing				
Tobacco % of smokers on cessation programmes who were quit at four weeks	Q (1 Qtr in arrears)	48%	50%	48%
National Screening Service				
BreastCheck % BreastCheck screening uptake rate	Q (1 Qtr in arrears)	70%	71.4%	70%
% of women offered hospital admission for treatment in BreastCheck host hospital within three weeks of diagnosis of breast cancer	Bi-annual (1 Qtr in arrears)	90%	70.8%	90%
CervicalCheck % eligible women with at least one satisfactory cervical screening test in a five year period	Q (1 Qtr in arrears)	80%	73.3%	80%
BowelScreen % BowelScreen screening uptake rate		45%	45.1%	45%
Diabetic RetinaScreen % Diabetic RetinaScreen uptake rate		69%	54.9%	69%
Public Health				
% of IHR alerts received by Health Projection Surveillance Centre (HPSC) that are risk assessed and actioned as appropriate within 24 hours of the alert.	Q	New PI NSP 2024	New PI NSP 2024	100%
Immunisations and Vaccines % of children aged 24 months who have received three doses of the 6 in 1 vaccine	Q (1 Qtr in arrears)	95%	85.8%	95%
% of children aged 24 months who have received the MMR vaccine		95%	87%	95%
% of first year students who have received one dose of Human Papillomavirus (HPV) vaccine	Annual	85%	N/A	85%
% of healthcare workers who have received seasonal Flu vaccine in the 2023-2024 influenza season (acute hospitals)		75%	54%	75%
% of healthcare workers who have received seasonal Flu vaccine in the 2023-2024 influenza season (long-term care facilities in the community)		75%	54%	75%
% uptake in Flu vaccine for those aged 65 and older		75%	73%	75%
% uptake of Flu vaccine for those aged 2-12 years old		New PI NSP 2024	New PI NSP 2024	50%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
COVID-19 Vaccination Programme				
Uptake % uptake of booster doses for eligible adult population by approved cohorts: • >70 years (based on census 2022 data) • Health and social care workers (based on HSE Healthcare Workers recorded on HSE HR-SAP) • Residents of Long Term Care Facilities (based on Residents of Residential Care Facilities who avail of the HSE Fair Deal Scheme)	M	New PI NSP 2024	New PI NSP 2024	To be determined in 2024 following NIAC advice
Reporting will be in line with cohorts as approved by NIAC in the context of public health recommendations Targets may require adjustment during 2024 to reflect updated clinical advice.				
Primary Care Services				
Healthcare Associated Infections: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 population) per day based on wholesaler to community pharmacy sales – not prescription level data	Q (1 Qtr in arrears)	<21.5	20.5	<21.0
Nursing % of new patients accepted onto the nursing caseload and seen within 12 weeks	M (1 Mth in arrears)	100%	97%	100%
Physiotherapy % of new patients seen for assessment within 12 weeks	M	81%	74%	81%
% on waiting list for assessment ≤52 weeks		94%	79%	94%
Occupational Therapy % of new service users seen for assessment within 12 weeks		71%	65%	71%
% on waiting list for assessment ≤52 weeks		95%	74%	95%
Speech and Language Therapy % on waiting list for assessment ≤52 weeks		100%	88%	100%
% on waiting list for treatment ≤52 weeks		100%	78%	100%
Podiatry % on waiting list for treatment ≤12 weeks		33%	20%	33%
% on waiting list for treatment ≤52 weeks		77%	64%	77%
Ophthalmology % on waiting list for treatment ≤12 weeks		19%	20%	20%
% on waiting list for treatment ≤52 weeks		64%	52%	64%
Audiology % on waiting list for treatment ≤12 weeks		30%	27%	30%
% on waiting list for treatment ≤52 weeks		75%	78%	75%
Dietetics % on waiting list for treatment ≤12 weeks		40%	25%	40%
% on waiting list for treatment ≤52 weeks		80%	65%	80%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Psychology % on waiting list for treatment ≤12 weeks	M	36%	19%	36%
% on waiting list for treatment ≤52 weeks		81%	63%	81%
Orthodontics % of patients seen for assessment within six months	Q	45%	41%	45%
% of orthodontic patients (grades 4 and 5) on the treatment waiting list longer than four years		<6%	24%	<6%
Child Health % of children reaching 12 months within the reporting period who have had their 9-11 month PHN child health and development assessment on time or before reaching 12 months of age	M (1 Mth in arrears)	95%	87%	95%
% of infants visited by a PHN within 72 hours of discharge from maternity services	Q	99%	99%	99%
% of infants breastfed (exclusively and partially (not exclusively)) at the PHN primary (first) visit	Q (1 Qtr in arrears)	64%	61%	64%
% of infants breastfed exclusively at the PHN primary (first) visit		50%	40%	50%
% of infants breastfed (exclusively and partially (not exclusively)) at the 3 month PHN child health and development assessment visit		46%	42%	46%
% of infants breastfed exclusively at the PHN 3 month child health and development assessment visit		36%	32%	36%
Social Inclusion				
Opioid Agonist Treatment Average waiting time from referral to assessment for opioid agonist treatment	M (1 Mth in arrears)	4 days	3.7 days	4 days
Average waiting time from opioid agonist assessment to exit from waiting list or treatment commenced		28 days	44.5 days	28 days
Homeless Services % of new individual homeless service users admitted to Supported Temporary Accommodations (STA), Private Emergency Accommodations (PEA), and / or Temporary Emergency Accommodations (TEA) during the quarter whose health needs have been assessed within two weeks of admission	Q	85%	86.8%	86%
% of new individual homeless service users admitted to Supported Temporary Accommodations (STA), Private Emergency Accommodations (PEA), and / or Temporary Emergency Accommodations (TEA) during the quarter whose health needs have been assessed and are being supported to manage e.g. their physical / general health, mental health and / or addiction issues as part of their care / support plan		85%	84.3%	85%
Substance Use % of substance users (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q (1 Qtr in arrears	100%	98.2%	100%
% of substance users (under 18 years) for whom treatment has commenced within one week following assessment		100%	94.2%	100%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Problem Alcohol Use % of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q (1 Qtr in arrears)	100%	98.8%	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment		100%	29.6%	100%
Palliative Care Services				
Inpatient Palliative Care Services Access to specialist inpatient bed within seven days during the reporting year	M	98%	98%	98%
Community Palliative Care Services				
% of all Category 1 triaged patients who received specialist palliative care within 2 days in the community		New PI NSP 2024	New PI NSP 2024	90%
%of all Category 2 triaged patients who received specialist palliative care within 7 days in the community		New PI NSP 2024	New PI NSP 2024	90%
% of all Category 3 triaged patients who received specialist palliative care within 14 days in the community		New PI NSP 2024	New PI NSP 2024	80%
% of patients triaged within one working day of referral (community)		96%	95%	96%
Disability Services				
Day Services including School Leavers % of school leavers and rehabilitation training (RT) graduates who have been provided with a placement	Annual	95%	88%	95%
***Disability Act* Compliance** % of child assessments completed within the timelines as provided for in the regulations	Q	100%	15.9%	100%
Mental Health Services				
General Adult Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks by General Adult Community Mental Health Team	M	≥90%	88%	≥90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by General Adult Community Mental Health Team		≥75%	70.3%	≥75%
% of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and did not attend (DNA) in the current month		≤22%	21.7%	≤22%
Psychiatry of Later Life Community Mental Health Teams % of accepted referrals / re-referrals offered first appointment within 12 weeks by Psychiatry of Later Life Community Mental Health Teams		≥98%	93%	≥98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Psychiatry of Later Life Community Mental Health Teams		≥95%	90.3%	≥95%
% of new (including re-referred) Psychiatry of Later Life Psychiatry Team cases offered appointment and DNA in the current month		≤3%	3.1%	≤3%

Improving Access to Care and Performance				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Child and Adolescent Mental Health Services (CAMHS) Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total no. of admissions of children to mental health acute inpatient units	M	>85%	91.6%	>85%
% of bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of bed days used by children in mental health acute inpatient units		>95%	98.6%	>95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks by Child and Adolescent Community Mental Health Teams		≥80%	66.6%	≥80%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Child and Adolescent Community Mental Health Teams		≥78%	63%	≥78%
% of new (including re-referred) child / adolescent referrals offered appointment and DNA in the current month		≤10%	6.6%	≤10%
% of accepted referrals / re-referrals seen within 12 months by Child and Adolescent Community Mental Health Teams excluding DNAs		≥95%	95.5%	≥95%
% of urgent referrals to Child and Adolescent Mental Health Teams responded to within three working days		≥90%	92.7%	≥90%
Women's Healthcare				
Irish Maternity Early Warning System (IMEWS) % of maternity units / hospitals with full implementation of IMEWS (as per 2019 definition)	Q	100%	100%	100%
% of all hospitals implementing IMEWS (as per 2019 definition)		100%	100%	100%
% of maternity hospitals / units that have completed and published monthly Maternity Safety Statements	M (2 Mths in arrears)	100%	100%	100%
% of Hospital Groups that have discussed a quality and safety agenda with National Women and Infants Health Programme (NWIHP) on a bi / quarterly / monthly basis, in line with the frequency stipulated by NWIHP		100%	100%	100%
Sexual assault services (>14yrs) % of patients seen by a forensic clinical examiner within 3 hours of a request to a Sexual Assault Treatment Unit (SATU) for a forensic clinical examination	Q	90%	90%	90%
Older Persons' Services				
Residential Care % occupancy of open short stay beds	M	90%	82%	90%
Intensive Homecare Packages (IHCPs) % of clients in receipt of an IHCP with a key worker assigned		100%	100%	100%
Nursing Homes Support Scheme (NHSS) % of population over 65 years in NHSS funded beds		≤3.5%	≤3.5%	≤2.9%
% of clients with NHSS who are in receipt of ancillary state support		15%	15.5%	17%
% of clients who have Common Summary Assessment Reports (CSARs) processed within six weeks		90%	90%	90%

Resource Optimisation Delivering Accountable Implementation				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Human Resources				
Attendance Management % absence rates by staff category	M	≤4%	5.1%	≤4%
European Working Time Directive (EWTD) <24 hour shift (acute – non-consultant hospital doctors (NCHDs))		97%	Data not available*	97%
<24 hour shift (mental health – NCHDs)		97%	Data not available*	97%
<24 hour shift (disability services – social care workers)		95%	Data not available*	95%
<48 hour working week (acute – NCHDs)		95%	Data not available*	95%
<48 hour working week (mental health – NCHDs)		95%	Data not available*	95%
<48 hour working week (disability services – social care workers)		95%	Data not available*	95%
Respect and Dignity % of staff who complete the Health Services eLearning and Development (HSeLanD) Respect and Dignity at Work module	Annual	80%	80%	80%
Performance Achievement % of staff who have engaged with and completed a performance achievement meeting with his / her line manager	Q	70%	70%	70%
*Industrial action has impacted on the availability of this data.				
Finance				
Net expenditure variance from plan (pay + non-pay - income)	M	≤0.1%	To be reported in Annual Financial Statements 2023	≤0.1%
Gross expenditure variance from plan (pay + non-pay)		≤0.1%		≤0.1%
Pay expenditure variance from plan		≤0.1%		≤0.1%
Non-pay expenditure variance from plan		≤0.1%		≤0.1%
Governance and Compliance Procurement – expenditure (non-pay) under management	Q (1 Qtr in arrears)	72%	75%	85%
Capital and Estates				
Capital expenditure versus expenditure profile	Q	100%	90.3%	100%
Primary Care Reimbursement Services				
Medical Cards % of completed medical card / general practitioner (GP) visit card applications processed within 15 days	M	99%	99%	99%
% of medical card / GP visit card applications, assigned for medical officer review, processed within five days		95%	96%	95%

Resource Optimisation Delivering Accountable Implementation				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
% of medical card / GP visit card applications which are accurately processed from a financial perspective by National Medical Card Unit staff	M	96%	99%	96%
Compliance Unit				
Service Arrangements / Annual Compliance Statement % of number of service arrangements signed	M	100%	100%	100%
% of the monetary value of service arrangements signed		100%	100%	100%
% annual compliance statements signed	Annual	100%	100%	100%
Internal Audit				
% of internal audit recommendations implemented by agreed due date	Q	New PI NSP 2024	New PI NSP 2024	90%

Building Trust and Confidence across Staff and our Service Users				
Indicator	**Reporting Period**	**NSP 2023 Target**	**Projected Outturn 2023**	**Target 2024**
Quality and Safety				
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	Q	75%	69%	75%
'Your Service Your Say' Policy % of complaints where an Action Plan is identified as necessary, is in place and progressing		65%	88%	65%
Serious Incidents % of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident	M	70%	46%	70%
Incident Reporting % of reported incidents entered onto NIMS within 30 days of notification of the incident	Q	70%	75%	70%
Extreme and major incidents as a % of all incidents reported as occurring		<1%	0.6%	<1%
Safeguarding % of community concerns that have been reviewed by a social worker on the Community Healthcare Organisation (CHO) Safeguarding and Protection Team and an initial response has been generated by a social worker on the Safeguarding and Protection Team within 3 working days	Q (1 Mth in arrears)	85%	82%	85%
% of service concerns that have been reviewed by a social worker on the CHO Safeguarding and Protection Team where a response has been sent to the notifying service within 10 working days		70%	81%	81%

Trialling of community and acute medicine expenditure for inclusion in NSP 2025 will include, but is not limited to, the following:

New Medicines Expenditure Sustainability KPIs for trialling in 2024
Community – Percentage uptake in the prescribing of the Medicines Management Programme 'preferred drugs'
Community – Percentage uptake of the best value biologic/medicine (BVB/BVM)
National Drug Management Schemes ODMS – ODMS claims audited are confirmed as administered to patients with a cancer diagnosis in line with the HSE approved reimbursement indication

Appendix 1(c): Activity 2024

Note: 2023 and 2024 expected activity and targets are assumed to be judged on a performance that is equal or greater than (≥) unless otherwise stated (i.e. if less than (<) or, less than or equal to symbol (≤) is included in the target).

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Acute Hospital Services				
Discharge Activity Inpatient	M (1 Mth in arrears)	634,115	634,882**	639,021
Day case (includes dialysis)		1,128,411	1,160,283**	1,218,297
Total inpatient and day cases		**1,762,526**	**1,795,165****	**1,857,318**
Emergency inpatient discharges		455,111	453,209	453,209
Elective inpatient discharges		83,582	82,785**	86,924
Maternity inpatient discharges		95,422	98,888	98,888
Inpatient discharges ≥75 years		138,549	139,643**	142,003
Day case discharges ≥75 years		234,540	235,328**	236,388
Level of GI scope activity		98,620	108,844**	114,286
Level of dialysis activity		188,859	191,930	201,526
Level of chemotherapy (R63Z) and other Neoplastic Dis, MINC (R62C)		224,361	236,274	248,088
Emergency Care New ED attendances	M	1,350,913	1,362,256	1,350,913
Return ED attendances		112,963	113,076	112,963
Injury unit attendances		154,816	161,263	166,405
Other emergency presentations		47,844	50,368	49,073
Births Total no. of births		54,552	54,444	54,589
Outpatients No. of new and return outpatient attendances		3,389,402	3,579,180**	3,758,139
No. of new outpatient attendances		933,878	1,006,224**	1,056,535
Delayed Transfers of Care No. of acute bed days lost through delayed transfers of care		≤127,750	199,830	≤127,750
No. of beds subject to delayed transfers of care		≤350	514	≤350
Healthcare Associated Infections (HCAI) No. of new cases of CPE		N/A	1,030	N/A

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Venous Thromboembolism (VTE) Rate of defined and suspected venous thromboembolism (VTE, blood clots) associated with hospitalisation	M (1 Mth in arrears)	N/A	10.5	N/A
Note: All Acute Hospital Appendix 1(c) KPIs exclude National Treatment Purchase Fund (NTPF) **Includes activity delivered through additional access to care funding in 2023				
National Ambulance Service				
Total no. of AS1 and AS2 (emergency ambulance) calls • *NAS* • *DFB*	M	407,040	394,680	407,087 *327,968* *79,119*
Total no. of AS3 calls (inter-hospital transfers)		24,400	33,627	25,811
No. of intermediate care vehicle (ICV) transfer calls		19,080	29,015	22,275
No. of clinical status 1 PURPLE calls activated • *NAS* • *DFB*		7,208	6,736	7,208 *5,619* *1,589*
No. of clinical status 1 PURPLE calls arrived at scene (excludes those stood down en route) • *NAS* • *DFB*		6,784	6,400	6,784 *5,382* *1,402*
No. of clinical status 1 RED calls activated • *NAS* • *DFB*		175,960	170,515	176,483 *139,341* *37,142*
No. of clinical status 1 RED calls arrived at scene (excludes those stood down en route) • *NAS* • *DFB*		162,180	155,741	162,180 *128,663* *33,517*
HEMS Athlone – Hours (Department of Defence)		480	480	480
HEMS National – Calls (Department of Transport, Tourism and Sport)		260	260	260
HEMS South West – Tasking		600	600	600
Note: DFB activity is not under NAS governance.				
Health and Wellbeing				
Tobacco No. of smokers who received face to face or telephone intensive cessation support from a cessation counsellor	Q (1 Qtr in arrears)	18,849	18,000	20,648
No. of smokers who are receiving online cessation support services	Q	6,000	7,000	6,300
Making Every Contact Count (MECC) No. of front-line staff to complete the eLearning MECC training in brief intervention		5,748	3,391	5,935
No. of front-line staff to complete the face to face / virtual module of MECC training in brief intervention		1,150	1,495	1,826
Environmental Health				
No. of initial tobacco sales and / or nicotine inhaling product sales to minors test purchase inspections carried out	Q	384	384	384

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
No. of test purchases carried out under the *Public Health (Sunbeds) Act 2014*	Bi-annual	32	32	32
No. of mystery shopper inspections carried out under the *Public Health (Sunbeds) Act 2014*		32	32	32
No. of establishments receiving a planned inspection under the *Public Health (Sunbeds) Act 2014*	Q	188	188	188
No. of official food control planned, and planned surveillance, inspections of food businesses		33,000	33,000	33,000
No. of inspections of e-cigarette and refill container manufacturers, importers, distributors and retailers under *E.U. (Manufacture, Presentation and Sale of Tobacco and Related Products) Regulations 2016*		40	40	40
National Screening Service				
BreastCheck No. of women in the eligible population who have had a complete mammogram	M	185,000	179,190	195,000
CervicalCheck No. of unique women who have had one or more satisfactory cervical screening tests in a primary care setting		264,000	254,326	178,000***
BowelScreen No. of clients who have completed a satisfactory BowelScreen FIT test		140,000	164,046	148,000
Diabetic RetinaScreen No. of Diabetic RetinaScreen clients screened with final grading result		110,000	113,858	112,000
***CervicalCheck activity forecasting is based on the number of women who have a call date within a given year. 2024 predicts fewer CervicalCheck screening programme participants compared to 2023. This is due to a number of reasons: 1. Large number of cervical screening attendees in 2018 and 2019 who returned in 2021 and 2022 and are now on a 5-year cycle. 2. The change in screening intervals following the transition to the HPV programme in 2020 (move from a 3-year cycle for women aged between 30 -49 to a 5-year cycle). 3. Better understanding and forecasting of when women are likely to book their screening appointment following receipt of an invite letter i.e., those who are invited to attend in the second half of 2024 are most likely to attend in 2025. Laboratory and colposcopy capacity is monitored monthly to ensure the KPIs are within agreed QA standards.				
Primary Care Services				
Community Intervention Teams (CITs) Total no. of CIT referrals	M	81,372	92,758	81,372
Paediatric Homecare Packages Total no. of Paediatric Homecare Packages		651	357	651
***Health Amendment Act*: Services to people with State Acquired Hepatitis C** No. of *Health Amendment Act* card holders who were reviewed	Q	74	250	300
GP Activity No. of contacts with GP Out of Hours Service	M	1,143,000	1,153,350	1,217,015

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Chronic Disease Structured Management Programme (excluding high risk reviews) No. of reviews undertaken (2 reviews per patient in a 12 month rolling period)	Bi-annual	452,802	529,212	529,212
Nursing No. of patients seen	M (1 Mth in arrears)	474,366	410,000	474,366
Therapies / Community Healthcare Network Services Total no. of patients seen	M	1,597,487	1,406,500	1,597,487
Physiotherapy No. of patients seen		587,604	525,000	587,604
Occupational Therapy No. of patients seen		389,256	353,000	389,256
Speech and Language Therapy No. of patients seen		282,312	194,000	282,312
Podiatry No. of patients seen		85,866	67,500	85,866
Ophthalmology No. of patients seen		79,836	96,000	79,836
Audiology No. of patients seen		54,216	56,500	54,216
Psychology No. of patients seen		49,757	43,000	49,757
Dietetics No. of patients seen		68,640	71,500	68,640
No. of people who have completed a structured patient education programme for type 2 diabetes	Q	1,480	2,300	1,480
Orthodontics No. of patients seen for assessment within six months		845	1,500	845
Oral Health No. of new Oral Health patients in target groups attending for scheduled assessment	M	New PI NSP 2024	New PI NSP 2024	98,016
GP Trainees No. of trainees	Annual	285	285	350
National Virus Reference Laboratory No. of tests	M	885,619	981,363	981,363
Social Inclusion				
Opioid Agonist Treatment No. of clients in receipt of opioid agonist treatment (outside prisons)	M (1 Mth in arrears)	10,800	10,509	10,800

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Needle Exchange No. of unique individuals attending pharmacy needle exchange	Q (1 Qtr in arrears)	1,500	1,461	1,500
Traveller Health No. of people who received information on or participated in positive mental health initiatives	Q	3,735	10,156	3,735
No. of people who received information on cardiovascular health or participated in related initiatives		3,735	9,234	3,735
Substance Use No. of substance users (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q (1 Qtr in arrears)	4,940	4,188	4,940
No. of substance users (under 18 years) for whom treatment has commenced within one week following assessment		360	580	360
Problem Alcohol Use No. of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment		3,000	2,048	3,000
No. of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment		34	108	34
Palliative Care Services				
Inpatient Palliative Care Services No. accessing specialist inpatient beds within seven days (during the reporting year)	M	4,000	4,239	4,128
Community Palliative Care Services No. of patients who received specialist palliative care treatment in their normal place of residence in the month		3,484	3,671	3,612
Children's Palliative Care Services No. of children in the care of the Clinical Nurse Co-ordinators for Children with Life Limiting Conditions (children's outreach nurse)		320	320	320
No. of children in the care of the acute specialist paediatric palliative care team (during the reporting month)		60	66	65
No. of children / family units who received therapeutic support from Laura Lynn Children's Hospice (during the reporting month)		100	137	140
No. of admissions to Laura Lynn Children's Hospice (during the reporting year)		456	497	500
Disability Services				
Personalised Budgets No. of adults with disabilities participating in personalised budgets demonstration projects (Stage 4 Living Phase)	Q	45	36	To be determined in 2024****
Residential Places No. of residential places for people with a disability (including new planned places)	M	8,305	8,359	8,431

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
New Priority 1 Residential Places Provided to People with a Disability No. of new Priority 1 Residential places provided to people with a disability	M	43	107	96
No. of intensive support packages for priority 1 cases		447	447	469
Congregated Settings Facilitate the movement of people from congregated to community settings		73	66	73
Day Services including School Leavers No. of people (all disabilities) in receipt of RT		2,290	2,000	2,290
No. of people with a disability in receipt of other day services (excl. RT) (adult) (ID / autism and physical and sensory disability)	Bi-annual	19,100	18,800	20,300
Respite Services No. of day only respite sessions accessed by people with a disability	Q (1 Mth in arrears)	24,444	38,000	40,400
No. of people with a disability in receipt of respite services (ID / autism and physical and sensory disability)		5,758	6,086	6,200
No. of overnights (with or without day respite) accessed by people with a disability		129,396	154,000	160,000
Personal Assistance (PA) No. of PA service hours delivered to adults with a physical and / or sensory disability		1.77m	1.77m	1.85m*****
No. of adults with a physical and / or sensory disability in receipt of a PA service		2,690	2,708	2,740*****
Home Support Service No. of home support hours delivered to persons with a disability		3.12m	3.48m	3.48m
No. of people with a disability in receipt of home support services (ID / autism and physical and sensory disability)		7,326	7,039	7,326
***Disability Act* Compliance** No. of requests for assessment of need received for children	Q	6,555	7,612	8,050
****The personalised budget 2024 demonstration project will optimise participation in the Stage Four living phase and move towards evaluation of the project in 2024 *****A new HSE-led Disability Services procurement framework for home support is planned to be developed and agreed in Q2 2024. Targets may be adjusted accordingly				
Mental Health Services				
General Adult Community Mental Health Teams No. of adult referrals seen by mental health services	M	29,482	25,861	31,164
No. of admissions to adult acute inpatient units	Q (1 Qtr in arrears)	11,460	11,240	11,465

Improving Access to Care and Performance				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Psychiatry of Later Life Community Mental Health Teams No. of Psychiatry of Later Life referrals seen by mental health services	M	9,883	7,903	9,882
Child and Adolescent Mental Health Services (CAMHS) No. of CAMHS referrals received by mental health services		21,224	21,761	22,999
No. of CAMHS referrals seen by mental health services		12,635	10,957	13,688
Older Persons' Services				
InterRAI Ireland (IT based assessment) No. of people seeking service who have been assessed using the interRAI Ireland Assessment System	M	18,100	3,050	18,100
Home Support No. of home support hours provided (excluding provision of hours from IHCPs)		23.9m******	21.45m	22m
No. of people in receipt of home support (excluding provision from IHCPs) – each person counted once only		55,910******	54,100	54,100
Intensive Homecare Packages (IHCPs) Total no. of persons in receipt of an IHCP		235	65	235
No. of home support hours provided from IHCP		360,000	95,870	360,000
Total home support hours (including IHCP)		**24.26m**	**22.40m**	**22.36m**
Transitional Care No. of persons in receipt of payment for transitional care in alternative care settings	M (1 Mth in arrears)	916	916	916
No. of persons in acute hospitals approved for transitional care to move to alternative care settings		8,637	10,516	10,681
Nursing Homes Support Scheme (NHSS) No. of persons funded under NHSS in long-term residential care during the reporting month	M	22,712	23,200	23,280
No. of NHSS beds in public long-stay units		4,501	4,791	4,501
Residential Care No. of short stay beds in public units		2,182	1,720	2,182
******NSP 2023 target for home support hours amended during the year to 22m. No. of people is an associated KPI with amendment in 2024 target to align both KPIs				

Resource Optimisation Delivering Accountable Implementation				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Primary Care Reimbursement Services				
Medical Cards				
No. of persons covered by medical cards as at 31st December	M	1,630,367	1,618,630	1,681,266

Resource Optimisation Delivering Accountable Implementation				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
No. of persons covered by GP visit cards as at 31st December	M	1,069,391	633,310	1,069,391
Total		**2,699,758**	**2,251,940**	**2,750,657**
General Medical Services Scheme Total no. of items prescribed	M	66,849,425	67,109,145	68,892,511
No. of prescriptions		19,493,292	19,569,026	20,089,056
Long-Term Illness Scheme Total no. of items prescribed		10,767,975	10,982,097	11,561,158
No. of claims		3,020,299	3,080,358	3,242,778
Drug Payment Scheme Total no. of items prescribed		14,312,334	15,894,526	16,555,523
No. of claims		4,293,700	4,768,358	4,966,657
Other Schemes No. of high tech drugs scheme claims		1,070,793	1,085,923	1,191,526
No. of dental treatment services scheme treatments		855,480	1,005,442	1,081,642
No. of community ophthalmic services scheme treatments		745,000	667,740	745,000

Building Trust and Confidence across Staff and our Service Users				
Activity	**Reporting Period**	**NSP 2023 Expected Activity**	**Projected Outturn 2023**	**Expected Activity 2024**
Quality and Safety				
Safeguarding No. of staff undertaking safeguarding training (eLearning module via HSeLanD)	Q (1 Mth in arrears)	32,000	65,000	40,000

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