Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Service Plan 2005

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1.0 OVERVIEW OF THE CHIEF EXECUTIVE OFFICER

INTRODUCTION

The Health Service Executive came into existence on January 1st, 2005, following the enactment of the *Health Act 2004*. Under the terms of the Act, the Executive is required to prepare a Service Plan for the financial year. Once adopted by the Board of the Executive, the plan must be submitted to the Minister for Health and Children for approval.

The Service Plan outlines the agreed level of health and social services to be provided by the Executive for the coming year within the voted allocation of the Oireachtas* and the approved employment levels as established in Government policy. In setting out the planned objectives, actions, and outputs for 2005, the Service Plan is supported by a comprehensive business planning process (inclusive of a performance monitoring framework) that will facilitate its delivery by the Executive.

STRATEGIC FOCUS

The overall policy framework, which governs the preparation of the Service Plan, is set out in the National Health Strategy *Quality and Fairness*: *A Health System for You* (2001). This strategy remains the blueprint for the development of the health and social care services over the coming decade and beyond and is the benchmark against which all elements of the Service Plan have been constructed. The principles of equity, people-centredness, quality and accountability are supported in this plan and each of the actions in the plan is linked to the Strategy.

In 2005, a Corporate Plan for the period 2005 to 2007 will be prepared and submitted by the Executive for the Minister's approval. This first such Corporate Plan, guided by *Quality and Fairness: A Health System for You*, will outline the corporate strategy of the Executive, and map out the future direction for the health and social services to be delivered through comprehensive annual Service Plans. The Corporate Plan, based on assessed needs, will aim to ensure equality of access to high quality services for the entire population, regardless of status or location. The mechanism by which the Corporate Plan is developed will be based on consultation and will be a key enabler of the change agenda.

Since the Corporate Plan for the period 2005 to 2007 will not be completed until June 2005, this first national Service Plan has been prepared in the context of *Quality and Fairness*: *A Health System for You* and associated national policy documents. It is underpinned by a population health approach, which seeks to promote and protect health and well being, with particular emphasis on integration and reducing health inequalities. Some of the determinants of health are, however, affected by factors outside the control of the Executive, therefore health is also the responsibility of individuals, communities and many other sectors.

Planning for health is not just about health and social services, it is about working with others, in partnership to improve the overall health of the population. It is also about early interventions, reorientation of services from hospital to primary care, about safe, effective, efficient and integrated care delivered in a timely manner. Planning must also be supported by research and development programmes, by evidenced based decision making and above all by a commitment to respond to the choices and preferences of service users.

*The services to be delivered as outlined in the Service Plan are consistent with the approved Vote to be published in the Revised Book of Estimates 2005, including the reference in that book to specified technical items to be provided by way of a Supplementary Estimate in 2005.

The Executive aspires to the delivery of health and social care that does not vary in quality, irrespective of geographic location, and embraces all groups in society equally.

HEALTH SERVICE REFORM

The preparation and presentation of this Service Plan has been a unique challenge. It has been developed against a backdrop of reform and change within the health service.

The reform programme currently underway is the most substantial change programme ever undertaken in the public service. A hugely complex task, the establishment of the Executive has brought the former Health Boards/Eastern Regional Health Authority, along with a number of specialist agencies, under the management control of a single organisation. In so doing, this has created the biggest single employer in the State. With the development of this unified system many opportunities emerge, together with the ability to deliver on the aspirations articulated above.

I urge the members of the Board of the Executive, National Directors, all staff and contractors, members of other statutory, non-statutory and voluntary sectors, patients and service users - in fact all of us throughout this country, to seize this opportunity and begin to realise the potential to develop a world class health service for Ireland. In this context, I acknowledge the dedicated commitment and support of staff within the health system, who have already demonstrated significant capacity for change through innovation and new ways of working.

There are many, many talented staff involved in service delivery who are passionate and committed to the achievement of a quality health system. By empowering and enabling staff in this new and developing organisation, frustrations can be removed and workplaces can become inspiring places in which to care. From the point of first contact with the service, whether that is at home or in the community, or with the receptionist, the attendant, clinician or manager in an outpatient clinic, an operating theatre, hospital ward or rehabilitation unit, such experiences should demonstrate commitment to a quality continuum of care.

Yes, there are challenges ahead; capacity deficits in many sectors, historic under-funding of some services, skills shortages in nursing and other health professions, an increasing population, and clear expectations of improved performance and accountability throughout the health system. By working in collaboration and communicating with each other, building relationships, and working as true partners and teams, we, the Executive and our partners, can deliver much, much more, together.

Recognising the depth and complexity of change now underway, it is essential to stress that progress will take a number of years to complete. Transition to the new organisational structure is facilitated by the delegation of functions to the Chief Officers of the former Health Boards/ERHA for an initial period, and I wish to acknowledge their support and co-operation.

To ensure continuity of experience and expectations, it is important to build on the acknowledged strengths within the existing system, but it is equally necessary to address the deficits. Investment in areas such as health promotion, illness prevention and primary healthcare, in consultant provided services, in health and information technologies, and in modern health facilities, will enable and enhance new ways of working and the patient/customer experience.

Our focus on improved patient experiences, a better working environment for staff and enhanced value for money for the taxpayer is at the core of this Service Plan. These principles

underpin all elements of the reform programme and it is only when they are achieved that reform will be deemed to have been fully successful.

For the service user, the commitment to underpinning system reform with clear service improvements means that, in 2005, with the allocation of specific development funding, improvements will be targeted on key areas such as Accident & Emergency services, disability services and the extension of eligibility for medical cards.

For the taxpayer, the services set out in this Plan will be delivered within the funds voted by the Oireachtas. Value for money is an essential part of all public services and the Executive, through this detailed plan, sets out publicly how that investment will be realised in 2005.

GOVERNANCE

The funding made available will deliver the existing levels of service at December 31st 2004 levels, and the funded service developments outlined above. The Service Plan will be supported by a defined value for money programme incorporating more effective utilisation of existing facilities and services.

The new National Directors have worked with the current Chief Officers to identify and agree specific measures to ensure that the services as set out will be delivered within the voted funding. The Directors carry responsibility for Primary Community and Continuing Care, National Hospitals Office, Shared Services and Corporate Functions which include Population Health; Change Management and Organisational Development; Finance; Human Resources; Information and Communications Technology; Strategic Planning and Development; and Corporate Affairs.

Monitoring of the performance in implementing the national Service Plan will be the means by which those responsible for the delivery of this Service Plan will be held accountable. In 2005, for the first time, planned activity levels and targets are presented on a consolidated basis at national level, for the health delivery system. This is an approach that we will develop and extend in the coming years as we improve our management information and reporting systems. For this year, the Executive has had to rely, in some instances, on information presented by other bodies in formulating its performance targets, and I acknowledge their support in this regard.

A standardised approach to performance monitoring will enable the Board to oversee the implementation of the Service Plan in accordance with its legal obligations, and account to the Minister for Health and Children for the provision of the services as specified within the plan.

CONCLUSION

I am aware of the substantial work that has led to the creation of this comprehensive document and I would like to thank the many members of staff across the country for their important contribution to its development.

It is through the dedicated efforts of our staff, and indeed through the partnership with many voluntary agencies and providers, that we already achieve so much in our health service. We are all aware of the challenge ahead, not only in the current year but in the immediate future, as we implement our ambitious organisational development programme.

There is agreement that change and reform cannot occur for its own sake. It must not neglect what works well and what is good within the current system. Blending the current with the

new, this Service Plan aims to deliver a service that will become comprehensive, seamless and standardised across the country.

This Plan represents an important first tangible and documented step on our reform journey.

In accordance with Section 31.1 of the Health Act, 2004, on Friday, 18th February 2005, the Board of the Health Service Executive considered and adopted this Service Plan for the financial year 2005.

On behalf of the Executive, I am now formally submitting the Plan, so adopted, to the Minister for Health and Children for approval.

This service plan was approved by the Tanaiste & Minister for Health & Children in accordance with Section 31.8 of the Health Act 2004 on Wednesday 16th March 2005.

Kevin Kelly
Interim Chief Executive Officer
Health Service Executive

6th April 2005

2.0 EXECUTIVE SUMMARY

2.0 EXECUTIVE SUMMARY

The Health Service Executive came into operation on the 1st January 2005 following the enactment of the *Health Act,* 2004. The Act established the Health Service Executive and provided for the dissolution of the Health Boards, the Eastern Regional Health Authority (ERHA) and other agencies.

Under the terms of the *Health Act*, 2004 the Executive is required to prepare a national Service Plan for the financial year, adopt the plan and submit it to the Minister for Health and Children for approval.

Quality and Fairness: A Health System for You sets out the national policy framework that governs service development and delivery in this national Service Plan.

The national Service Plan is an annual agreement between the Minister for Health and Children and the Executive. This plan is the first national Service Plan. It sets out at a high level, the type and volume of health and personal social services to be provided by the Executive for the population of Ireland within the voted allocation of the Oireachtas for 2005, and the approved employment levels as set out in Government policy.

The national Service Plan is supported by a comprehensive business planning model which will facilitate the delivery of the plan at all levels of the Executive in 2005.

Health and social services are provided to the population of Ireland by staff working across a broad range of service areas under the auspices of one of the ten National Directorates.

The national Service Plan has been prepared in accordance with the new organisational structures and is set out broadly as follows:

- Primary, Community and Continuing Care
- National Hospitals Office
- Shared Services
- Corporate Services.

This Executive Summary provides a high level overview of the health and social services that will be provided by each of the Directorates in 2005.

3.0 POPULATION HEALTH STATUS

This Service Plan is underpinned by a population health approach – this approach aims to promote and protect the health of the whole population or subgroups of the population, with particular emphasis on reducing health inequalities. The population of Ireland in 2002 was 3,917,203 persons. Data provided by the Central Statistics Office (CSO) shows an increased birth rate and an increase in the life expectancy of the population. Estimates for 2004 indicate that the population now exceeds 4 million.

Table 3.0.1: Population by Age 2002

Age Group	Total Persons	Males	Females
0-14	827,428	424,044	403,384
15-19	313,188	160,413	152,775
20-24	328,334	165,292	163,042
25-44	1,180,259	588,308	591,951
45-54	480,447	241,566	238,881
55-59	197,294	99,827	97,467
60-64	154,252	77,559	76,693
65 and over	436,001	189,155	246,846
Total	**3,917,203**	**1,946,164**	**1,971,039**

Source: Census 2002

The leading causes of death in Ireland are conditions of the circulatory system followed by cancer, respiratory diseases, injuries and poisonings. While the death rates for circulatory diseases have declined over the past number of decades, the rates are still considerably higher than the pre-enlargement EU average. Cancer of the lung is the most common type of cancer causing death followed by colorectal cancer and breast cancer. Infectious diseases (pneumonia and influenza) and chronic obstructive airways disease are the leading causes of death from respiratory disease while suicide is the most common mode of death registered under 'injuries and poisonings'.

There are a number of key emerging public health issues which need to be addressed. These include alcohol misuse and obesity, which is now recognised as a major public health problem in Ireland.

Responding to these public health issues, on a population health basis, will be central to the development of the Corporate Plan for the Executive for the period 2005 to 2007, and the priorities will be reflected in the national Service Plan and supporting Business Plans in accordance with available funding over the period.

KEY OBJECTIVES

Four key objectives have been identified for both the Primary, Community and Continuing Care (PCCC) and the National Hospitals Office (NHO) Directorates. These objectives reflect the population health approach which underpins this national Service Plan. They are as follows:

- To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety
- To provide person-centred, needs led services, which are responsive to user preferences and choices, and reflect best practice
- To develop and deliver services in accordance with a population health approach
- To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services.

The philosophy underlying the objectives recognises the importance of placing the service user or patient at the centre of planning and delivery of health and social services. This approach seeks to achieve a satisfactory blend of professional, managerial and service user perspectives in the determination of needs and the planning and implementation of service responses. Adopting this approach will necessitate the empowerment and participation of individuals, their carers and families and whole communities, and responding in a way that maximises the choices and preferences of those who require services.

4.0 PRIMARY, COMMUNITY AND CONTINUING CARE SERVICES (PCCC)

The PCCC Directorate is responsible for the provision of primary care as well as community based health and personal social services. The Directorate encompasses services in the areas of primary care, children, adolescents and families, persons with disabilities, mental health, older people and social inclusion. In the context of progressing all objectives, the PCCC Directorate will work to establish effective relationships and interface arrangements with all other Directorates and introduce new management structures for the National Directorate, and Local Health Offices.

4.1 PRIMARY CARE SERVICES

In line with the four key objectives outlined above, Primary Care Services will focus on providing an additional 230,000 people with medical cards/doctor visit medical cards, supporting the implementation of the Accident and Emergency Services Action Plan, supporting influenza pandemic planning and progressing implementation of the recommendations contained in the National Review of Immunisation/Vaccination programmes. In 2005, over 1.5 million people will avail of community drugs schemes, almost 1.4 million people will have eligibility for medical cards/doctor visit cards and 238,000 people will avail of the Dental Treatment Services Scheme. Over 5,000 contractors provide services.

4.2 CHILDREN, ADOLESCENTS AND FAMILIES

In addition to the general Child and Adolescent Services, specialist services will be provided to children, young people and their families who are considered to be in need or vulnerable for a variety of reasons. Other areas of importance include the progressing of plans relating to Child and Adolescent Psychiatry Treatment Services and the development of partnerships with parents to enable a dynamic child-centred service based on best practice and the empowerment of children/parents. In 2005, as in 2004, it is intended that 90% of children in care will be placed in foster care.

4.3 PERSONS WITH DISABILITIES

Services for persons with disabilities seek to enable each individual with a disability to achieve his/her full potential and maximise independence including living as independently as possible. A number of services for persons with disabilities will be developed in 2005 including:

- 270 additional funded residential places, approximately 400 new funded day places and 90 additional funded respite places for persons with intellectual disability and autism
- 60 new places for persons with significant disabilities who are currently placed inappropriately, 90 extra funded rehabilitative training places and 200,000 extra hours of home support and personal assistance. These will be provided over and above 2004 existing funded levels.

4.4 MENTAL HEALTH SERVICES

In addition to continuing to provide existing levels and standards of services, mental health promotion, suicide prevention/intervention and postvention services, home, community, acute mental health and residential services, a number of key initiatives are planned for 2005.
These include:

- An acute psychiatric unit at the Connolly Memorial Hospital
- Providing and staffing of an additional 14 Beds at the Central Mental Hospital, Dublin

- Expanding community based adult mental health teams and providing additional community residential places.

4.5 SERVICES FOR OLDER PEOPLE

Services for Older People will focus on the continued provision of existing levels of service and standards of home, community, hospital and continuing care. Key initiatives to be progressed in 2005 will include the provision of additional services for older people, including home care packages and the commissioning of additional community nursing beds. In 2005, 29,195 older people will receive home help services, with almost seven million hours of services provided. 25,374 older people will avail of day care and almost 5,500 respite care. Almost 19,500 people aged 75 and over will receive continuing care in a residential setting.

4.6 SOCIAL INCLUSION

Social Inclusion Services refer to services that are targeted at those who are living at the margins of society which includes Homeless, Ethnic Minorities, Travellers and persons with Addictions. The provision of existing levels and standards of culturally appropriate home, community and residential based health promotion, prevention, intervention services, materials and programmes will continue in 2005. In addition, provision of services to Asylum Seekers will be further improved.

5.0 NATIONAL HOSPITALS OFFICE (NHO)

The NHO Directorate is responsible for the provision and management of all acute Medical, Surgical, and Specialist Services delivered by each of the 10 hospital networks, the delivery of Ambulance and other Pre-hospital Emergency Care Services, and the approval of specialist treatment for patients in other countries.

In 2005, the NHO Directorate will seek to maintain existing service delivery levels and facilitate the integration of hospital services with primary, community and continuing care services and the implementation of the A & E Services Action Plan.

5.1 ACUTE HOSPITALS

The role of the NHO Directorate is to manage and co-ordinate the delivery of acute hospital services in the 53 statutory and non-statutory acute hospitals. The NHO service plan supports the implementation of the four national objectives as outlined above, and will work to establish effective relationships and interface arrangements with all other Directorates and introduce new management structures for the national Directorate, and hospital networks. Additionally in 2005 the NHO Directorate will focus specifically on a number of key areas.

These include:

- Responding to current A & E service pressures
- Optimising the commissioning of additional bed capacity
- Ensuring an equitable provision of Public/Private patient care
- Enhancing efficiency through analysis of activity and utlisation of Casemix
- Promoting the provision of accessible information to the public
- Auditing and targeting of infection control initiatives
- Enhancing the cleanliness of hospitals
- Developing the hospital services ICT capability

- Integration of hospital related functions of Comhairle na nOspidéal into the NHO Directorate
- Progressing negotiations on the Consultants Common Contract

In 2005, it is expected that the Acute Hospital services will provide over 1 million patient treatment episodes, of which over 564,000 will be inpatients and over 504,000 day patients. It is anticipated that there will be in excess of 2.5 million outpatient attendances, and over 1.23 million A & E Department attendances.

5.2 AMBULANCE SERVICES

The Ambulance Service provides clinically appropriate and timely Pre-hospital Emergency Care and transportation services. Services are categorised into two distinct services – Emergency Medical Services and non-emergency patient transport services. It is anticipated that there will be 235,000 emergency and 250,000 non-emergency calls dealt with in 2005.

In 2005, an integrated national Ambulance Service will be established. This will include the standardisation of communications and dispatch systems, pre-hospital training programmes and implementation of an ambulance fleet upgrade programme in line with national and European standards.

6.0 NATIONAL SHARED SERVICES (NSS)

The NSS Directorate will provide a range of customer focused shared services, on a national basis, for the Executive which will support front line service delivery. This is a new and innovative approach to processing activities in the health sector. The NSS Directorate will concentrate on the delivery of high volume transaction based processing initially in five core functional areas:

- Finance
- Human Resources
- Information and Communications Technology
- Procurement
- Primary Care Reimbursement Services.

The new shared services model, when fully implemented, will provide flexibility to deliver a range of essential administrative support services, independently of front line service activities. Some of the key initiatives planned for 2005 include:

- Developing organisational structures for the NSS Directorate
- Maintaining the provision of existing funded levels and standards of shared services during the transition period
- Integrating services provided by the former Eastern Health Shared Services and the General Medical Services (Payments) Board into the NSS
- Developing an implementation programme for each of the proposed functions within NSS.

7.0 CORPORATE FUNCTIONS

Corporate functions include the following areas:

- Change Management and Organisational Development
- Finance

- Human Resources
- Information and Communications Technology
- Population Health
- Strategic Planning and Development
- Capital
- Corporate Affairs

7.1 CHANGE MANAGEMENT AND ORGANISATIONAL DEVELOPMENT (CMOD)

The CMOD Directorate will work with internal and external stakeholders to agree, develop and support the most appropriate design and supporting processes for a unitary system. It will also ensure that managers and staff possess and utilise the necessary skills/tools to implement the agreed organisational design and supporting processes.

The CMOD Directorate will operate at both national and regional levels, to support all levels of the system in the application of best practice to the design and delivery of services.

In 2005 its key objectives will include:

- Developing the corporate strategy and plan
- Implementing structured organisational design, service improvement and development programmes
- Continuing existing and developing new management development programmes and resources

7.2 FINANCE

The Finance Directorate will provide strategic and financial governance, and management support, to the Board. Within the Executive, it will advise the Board, and Chief Executive Officer/Management Team on all aspects of financial management and control, and will be responsible for the preparation of monthly, bi-monthly and annual financial reports. In 2005 a number of key areas will be progressed by the Finance Directorate, including:

- Developing the systems and processes necessary for the management of the Vote of the Executive and supporting the Accounting Officer obligations of the Chief Executive Officer
- Developing corporate financial policies
- Transitioning existing arrangements under former Health Boards/ERHA/Streamlined Agencies through a partnership process with staff in existing Finance Units in these organisations
- Defining a new integrated management reporting model to include financial performance of all units directly or indirectly funded by the Executive
- Implementing a Treasury/Cash Management system
- Implementing new system wide procurement processes and contracting arrangements

7.3 HUMAN RESOURCES (HR)

The HR Directorate will be responsible for developing human resource management and development throughout the Executive to support excellence in service delivery. The main priorities for the HR Directorate in 2005 include:

- Supporting the establishment of the management structure of the Executive
- Developing and implementing HR strategy and policy
- Maintaining continuity of HR services and supports

- Consolidating the current HR functions of the Health Boards/ERHA/Streamlined Agencies into a single, integrated HR system
- Developing and implementing an employment control and monitoring framework for the Executive in conformity with Government policy.

7.4 INFORMATION AND COMMUNICATIONS TECHNOLOGY (ICT)

The ICT Directorate provides information and communications technology services within the Executive, and to external service providers who provide health and social services. In 2005 the Directorate will focus on the following:

- Enabling integrated, person-centred service delivery though the provision of relevant patient care information
- Increasing effectiveness, efficiency and economy of ICT operations
- Developing and enabling ICT capacity for service improvement
- Supporting eGovernment and eEurope.

7.5 POPULATION HEALTH

The Population Health Directorate will lead, inform and support a population health approach to corporate and service planning. It will also have an advocacy role with other Government Departments, State Agencies and external service providers.

The Directorate will play a key role in providing knowledge, information and evidence to support corporate decision making and strategic planning in response to identified needs. It will support the re-engineering of service delivery in a manner, which increases its impact on health and social well-being and the achievement of value for money. In 2005 the Directorate will focus on the following:

- Transitioning core population health functions from current organisations to the Executive
- Ensuring that population health underpins the planning and delivery of health and social services
- Developing a national approach to population health
- Establishing effective working arrangements with HIQA
- Overseeing the Executive's emergency planning capability and response.

7.6 STRATEGIC PLANNING AND DEVELOPMENT

The Strategic Planning and Development Directorate will manage specific corporate services on behalf of the Executive. It will maintain and support effective service and capital planning systems/processes and co-ordinate the activities of the Regional Executive Corporate Offices.

In 2005 the Directorate, will pursue the following priorities:

- Developing and managing the Executive's strategic and Service Planning functions
- Managing the development of the physical resources of the Executive including estates and assets
- Supporting the Regional Health Forums.

7.7 CAPITAL

The overall aim of the capital plan of the Executive is to maintain a health infrastructure which enables services to be delivered effectively and efficiently.

The annual capital plan is part of a wider capital framework (CIF) 2005-2009 for the health delivery system.

The main priorities in 2005 will be to:

- Manage the capital plan and the CIF within available resources
- Procure individual projects
- Build the Executive's capacity to independently plan and deliver a capital programme
- Manage the estate of the Executive

7.8 CORPORATE AFFAIRS

The Corporate Affairs Directorate will support all the activities of the Board of the Executive, the interface between the Executive and the Oireachtas and the functions of the office of the Chief Executive Officer of the Executive. Additionally it will support the development of comprehensive service governance, quality, safety and risk management processes. The key priorities for 2005 include:

- Developing a national Parliamentary Affairs Unit to respond to all requests from the Oireachtas that are referred to the Executive
- Establishing a national Customer Service Unit, to ensure that the customer voice is central to the planning and delivery of health services and to develop a complaints framework as required in the *Health Act 2004*
- Developing, agreeing and implementing a Service Governance Framework for the Executive
- Establishing a Communications Unit to provide a full internal and external communications service for the Executive.

SUMMARY OF HSE STAFFING FOR 2005

The services referred to within this Service Plan will be delivered by a staff of 97,255 whole time equivalents.

There are also 5,247 independent contractors providing state funded health and services – these include General Practitioners, Community Pharmacists, Dentists and Optometrists.

ADDITIONAL FUNDING FOR SERVICE DEVELOPMENTS

Additional funding has been provided for the following:

- Improvements in A & E Services
- Development of services for persons with disabilities
- Extension of medical card eligibility

The application of this funding as summarised above is detailed within the plan.

MONITORING MECHANISMS

A National Performance Monitoring Framework has been developed to support the national Service Plan and the associated Business Planning model. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Specific monitoring mechanisms are detailed within the individual Business Plans that support this national Service Plan.

RESEARCH, QUALITY EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

3.0 POPULATION HEALTH STATUS

This Service Plan facilitates the implementation of measures to enhance population health. While the health of the population of Ireland has improved substantially over the past 30 years, we still have higher premature mortality than many of our European neighbours. Cardiovascular disease and cancer account for half of all deaths. Many conditions are lifestyle and social class related e.g. heart disease, cancer, obesity, injury and infectious diseases. Inequalities in health and social class gradients are major factors in determining health status.

POPULATION HEALTH

A population health approach reflects the evidence that factors outside the health care system significantly affect health, and that delivery of healthcare is only part of what contributes health.

Investment aimed at improved population health is increasingly seen in developed countries as an economically valuable activity and contributing to economic competitiveness and is an important factor of economic success.

This first national Service Plan is underpinned by a population health approach, which seeks to promote and protect the health of the whole population, or of subgroups of the population, with particular emphasis on reducing health inequalities. It takes account of the determinants of health and recognises that health is the responsibility of all sectors, communities and individuals. This definition supports the four goals of the *National Health Strategy: Quality and Fairness: A Health System for You (2001)*, and in particular Goal Number 1 of the Strategy – 'Better health for everyone'.

A population health approach will underpin the Executive's corporate planning, ensuring a single interpretation of national policy and that health and social interventions are based on best available evidence.

The functions of the Population Health Directorate will enable the Executive to distribute its funding in a manner which reflects best possible return in health terms and, therefore, value for money. This approach will be evident in annual service planning.

A population health approach includes the following:

- Using the best health intelligence for planning, evaluation and performance management
- Planning for health and not just health services
- Promoting equity as a strong value in the health system
- Applying research evidence to improve health outcomes
- Adopting a formal approach to needs assessment to identify gaps in services
- Re-orienting service delivery from hospital to primary care and health promotion
- Providing services which are integrated within the health sector and with those of other sectors
- Working with other sectors to improve health
- Demonstrating a better return for society from investment in health.

The adoption and implementation of a population health approach to service planning and delivery is the responsibility of all those who manage and deliver services that impact on the health of the population. The Population Health Directorate will lead and support the implementation of a population health approach and assess the health impact of services.

HEALTH STATUS IN IRELAND

DEMOGRAPHY

The 2002 census recorded a population of 3,917,203 persons in the state, the highest population recorded since the census of 1871. It reflects an increase in population of 8% or 291,116 persons since the 1996 census.

In April 2004 the Central Statistics Office estimated that the total population of the state exceeded four million persons (4,040,000). This increase is due to an increase in the number of births, and immigration both of returning Irish Nationals and Foreign Nationals (EU and non-EU).

BIRTHS

There were 61,517 births registered in 2003, 31,414 males and 30,103 females, an increase of 996 on 2002.

The 2003 total is 28% higher than in 1994, when 47,929 births were registered. This represents an annual birth rate of 15.5 per 1,000 of the population, the same as 2002.

AGE-PROFILE

Table 3.0.1 shows the age distribution for the population of Ireland. Since the last census (1996) there has been a decrease in the number of people in the younger age group (0-14 years) and an increase in all the older age groups. The biggest increase (18.21%) was seen in the 45-54 year age group. Those aged over 65 years have increased by 5.34%.

The largest increase in the older age group is in the over 75 and over 85 age groups.

Table 3.0.1: Population by Age 2002

Age Group	Total Persons	Males	Females
0-14	827,428	424,044	403,384
15-19	313,188	160,413	152,775
20-24	328,334	165,292	163,042
25-44	1,180,259	588,308	591,951
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55-59	197,294	99,827	97,467
60-64	154,252	77,559	76,693
65 and over	436,001	189,155	246,846
Total	**3,917,203**	**1,946,164**	**1,971,039**

Source: Census 2002

LIFE EXPECTANCY

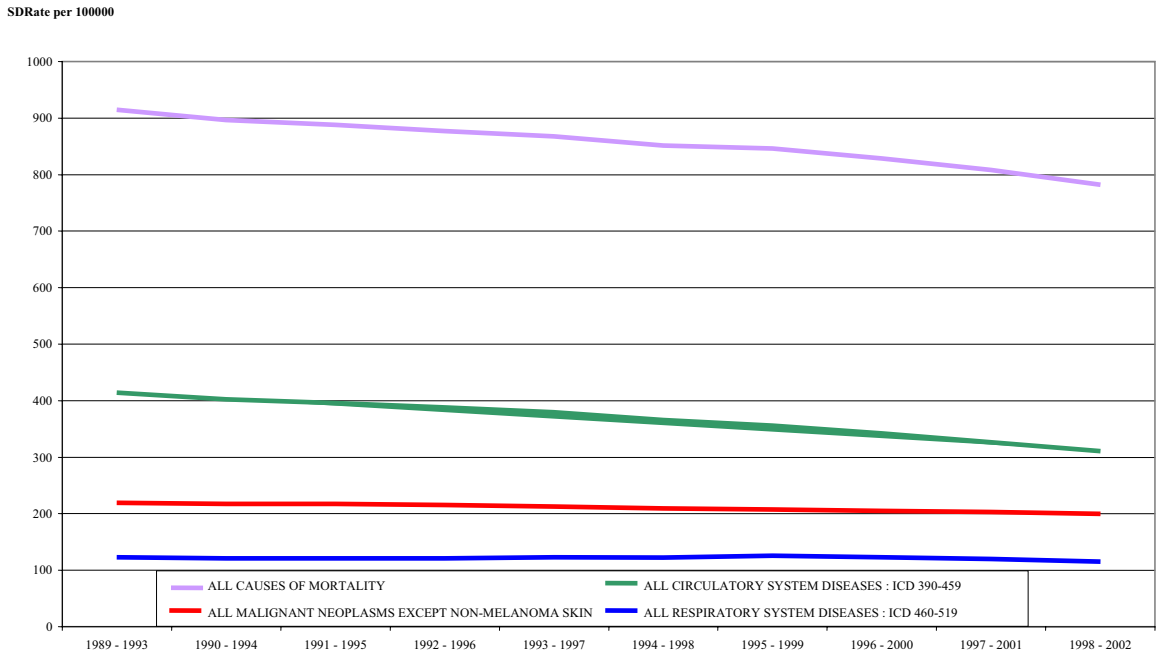
Life expectancy at birth in 2002 was 75.1 years for males and 80.3 years for females. Between 1996 and 2002 life expectancy increased by 2.1 years for males and 1.8 years for females. This rate of improvement was the highest recorded in several decades (CSO).

In 2002 a 65-year-old male could expect to live for 15.4 years, an improvement of 2 years or 14.9% over the previous decade. This is above the corresponding EU 15 (EU member states prior to enlargement in 2004) average improvement in the same period of 1.7 years (11.6%).

A 65-year-old female could expect to live 18.7 years, an increase of 1.6 years or 9.4% over the last decade. This is also above the corresponding EU 15 (EU member states prior to enlargement in 2004) average improvement in the same period of 1.5 years (8.2%).

MORTALITY RATES

Fig 3.0.1: All Ages mortality for Ireland



The total number of deaths registered in the state in 2003 was 28,823. This figure is 6% lower than in 1994 when 30,744 deaths were registered.

Table 3.0.2: Number of Deaths in Ireland 2003

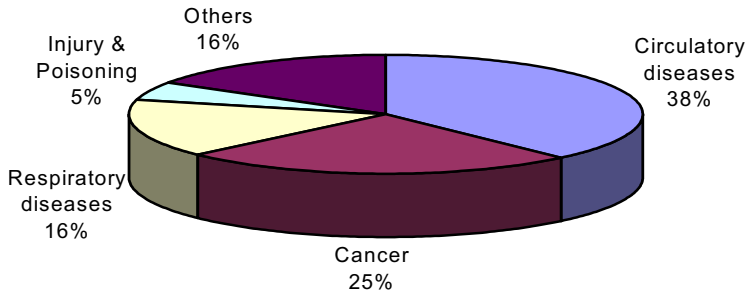
Number of Deaths	2003
Males	14,735
Females	14,088
Total	**28,823**

Source: CSO 2004

PRINCIPAL CAUSES OF DEATH IN IRELAND

Disease of the circulatory system is the leading cause of death in Ireland followed by cancer, respiratory diseases and injuries and poisonings (Fig. 3.0.2)

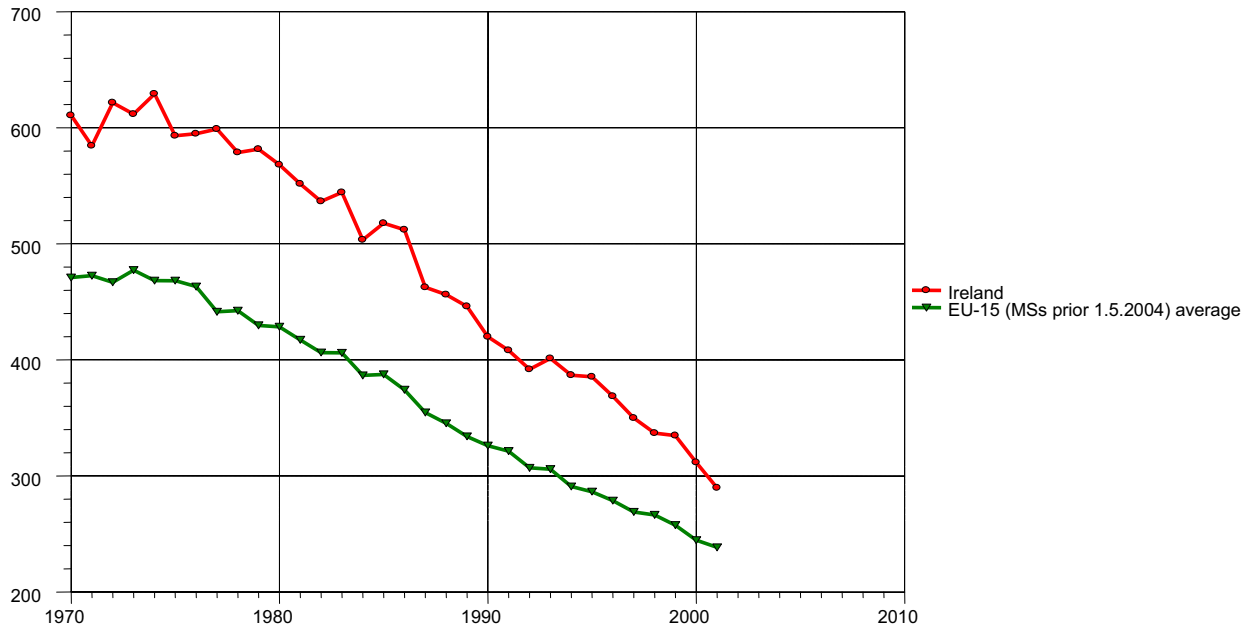
Fig 3.0.2: Principal Causes of Death in Ireland



Source: Census 2004

While death rates for circulatory diseases have been steadily declining in Ireland over the past few decades, the rates are still considerably above the pre-enlargement EU average. 10,984 people died from circulatory diseases in 2003. The majority of these deaths (51%) were due to ischaemic heart disease.

Fig 3.0.3: Age Standardised Death Rates for Circulatory Diseases per 100,000 Ireland and EU-15 Average



Source: European Health For All Database, WHO 2003

Cancer of the lung was the most common type of cancer causing death (21% of cancer deaths) followed by colorectal cancer (12%) and breast cancer (8%). Lung cancer was the most common cause of death from cancer in men while breast cancer was the most common cause for women.

Infectious diseases (pneumonia and influenza) and chronic obstructive airways disease are the leading causes of death from respiratory disease in Ireland.

Suicide is the most common mode of death registered under 'injuries and poisonings' followed by motor vehicle accidents and falls.

The majority of motor vehicle accident deaths occur in males. For young males aged 15-24 years the most common cause of death is from injuries and poisonings.

SUICIDE

The number of suicides registered in Ireland in 2003 was 451 with Ireland's overall rate of suicide ranks 17th out of the 25 EU countries. The rate of youth suicide (15-24 years) is among the highest in Europe.

The suicide rate among men has more than doubled over the past 20 years, while the rate in women has remained fairly constant. On average there are 26.3 years of "potential life lost" for every male suicide in Ireland *(National Suicide Review Group Annual Report 2003).*

INFANT MORTALITY RATE

Infant mortality rate is an important indicator of population health. Over the past decade the rate has fallen by 37% from 8.15 per 1,000 live births in 1990 to 5.1 per 1,000 live births in 2003.

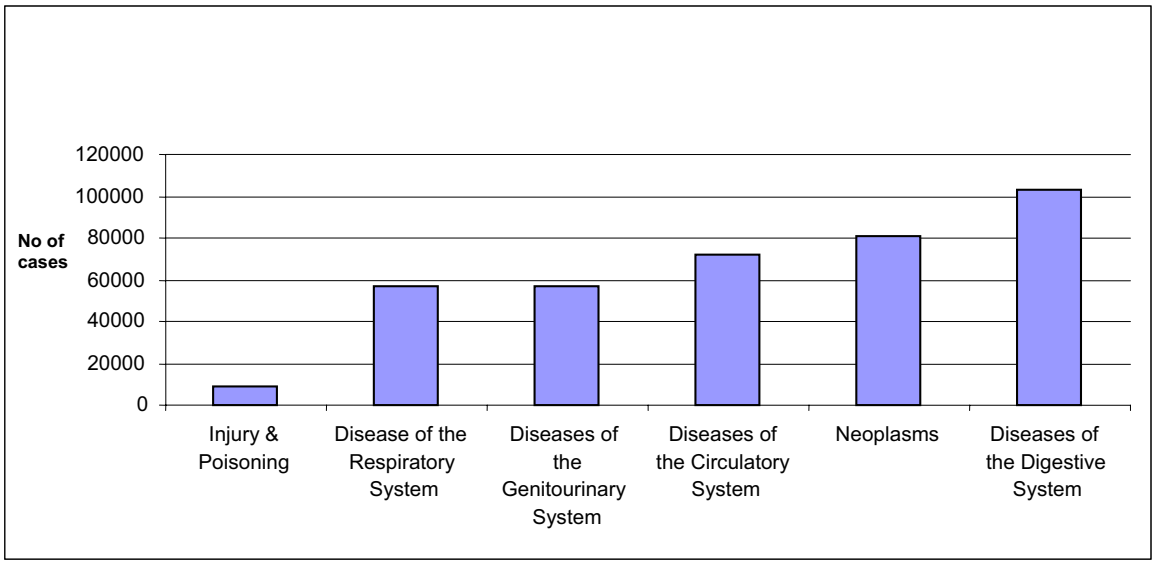
ILLNESSES REQUIRING HOSPITALISATION

The Hospital In-Patient Enquiry (HIPE) system is a reliable source of information on illnesses requiring hospitalisation. This records the number of discharges and procedures performed in publicly funded hospitals. Only two private hospitals are included in the system.

Data from HIPE shows that in 2002 there were 895,050 discharges (direct age standardised rate 23,183 per 100,000) from hospitals in Ireland.

Diseases of the digestive system accounted for over 1 in 9 hospital discharges; neoplasms for 1 in 11 discharges and diseases of the circulatory system for 1 in 12 discharges.

Fig 3.0.4: Most Common Diagnosis on discharge from Hospital, 2002



Source: HIPE 2002

CANCER

The latest report from the National Cancer Registry, *Cancer in Ireland 1994-2000* states that 20,000 new cancers were registered each year between 1994 and 2000. 88% were invasive, the remainder being mainly in-situ cancers of skin, breast and cervix. The most common invasive cancer was non-melanoma skin cancer (5174; 29%).

The most common non-cutaneous cancer was colorectal cancer, followed by breast, lung and prostate cancer.

The prostate was the most common site of cancer in men, while breast was the most common site in women. *(Cancer in Ireland 1994-2000).*

INEQUALITIES IN HEALTH

While life expectancy has improved over the last 50 years, major inequalities in health exist. Those at the higher end of the socio-economic scale live longer and enjoy better health than those at the lower end, who are also more likely to experience the effects of social exclusion.

Death rates in Ireland have also fallen over the past 50 years amongst men and women in all socio-economic groups. However, the difference in rates between those at the top and bottom of the social scale has widened. From 1989 to 1998 all cause mortality was 3.5 times higher in the lowest occupational class (*Public Health Alliance Ireland*, *2004*). Chronic physical illness is 2-5 times higher among the poor in relation to obesity, hypertension, accidents and mental illness.

There is a clear social class gradient for both men and women in the proportion who smoke. In Ireland in 2002, 32% of men aged 35-54 years in the lowest educational group (primary/no education) and 18% in the highest educational group (tertiary education) were smokers. The same trend is seen in women i.e. 35% in the lowest group and 16% in the highest group were

smokers. People in lower socio-economic groups tend to eat less fruit and vegetables, and less food which is rich in fibre. Perinatal and infant mortality is three times higher in poorer families. Travellers live 10-12 years less on average than the population as a whole.

The weight of scientific evidence supports a socio-economic explanation of health inequalities. The approach to addressing inequalities needs to be broadly based, address the broad determinants of health and adopt as policy the proofing of all policies and developments occurring within services for their impact on health inequalities and social inclusion. Health Impact Assessment (HIA), which examines the health consequences of the policies and plans of all sectors, not just health, should be utilised in developing a broad-based strategy with greater emphasis on the socio-economic determinants of health. This would include a variety of components including consultation, advocacy for health, monitoring of inequalities and a greater awareness by individual services of how they can address inequalities and social inclusion.

EMERGING PUBLIC HEALTH ISSUES

ALCOHOL

Alcohol misuse is a serious public health problem. The Chief Medical Officer's *Annual Report 2004* shows that since 1960 the consumption of alcohol has increased from 5 litres of pure alcohol per adult (15 years and over) to 14.2 litres. Much of this increase is characterised by younger drinking, binge drinking and the consumption of higher volumes.

Over half of Ireland's young people begin experimentation with alcohol before the age of 12 years, with over one-third of 15-16 year olds binge drinking three or more times in the previous month. In the 18-24 year age category more females than males engage in binge drinking. The adverse effects extend beyond physical health issues (such as cancer, heart disease and liver disorders) to mental, social and financial problems.

Between 1992 and 2002, while all age standardised case mortality in Ireland decreased by 15%, alcohol related mortality increased by over 25%.

Indicators of alcohol related harm include alcohol related mortality, unintentional injuries, road traffic accidents (RTA), mental health problems and sexual health problems. While all causes total mortality has decreased in Ireland during the 1990s by about 15% there has been a rise in alcohol related mortality ranging from 90% (alcohol poisoning), through (70%) for cirrhosis to (60%) for chronic alcoholism. It is estimated that approximately 25% of A & E attendances are alcohol related. Up to 40% of fatal RTAs and 30% of all RTAs are attributed to alcohol. One quarter of male admissions and one tenth of female admissions to mental health services are alcohol related. Much of the rise in sexually transmitted infections has been linked to alcohol *(Reports of the Strategic Task Force on Alcohol).*

OBESITY

Obesity was declared a 'global epidemic' by the World Health Organisation (WHO) in 1998.

Increased consumption of energy-dense, nutrient-poor foods with high levels of sugar and saturated fats, combined with reduced physical activity, have led to obesity rates that have risen three-fold or more since 1980 in some areas of North America, the United Kingdom, and other parts of the world. In Ireland, the SLAN survey from 2002 revealed that 13% of the Irish population are obese, a rise of three percentage points from 1998, while an additional 34%

are overweight. This means that approximately half the population is either overweight or obese.

Health problems associated with obesity include respiratory problems, chronic arthritis and infertility. More serious consequences include increased risk of cardiovascular disease, increased risk for type 2 diabetes, an association with certain types of cancer, especially hormone-related cancer (breast and prostate), colon cancer and gall-bladder disease. Obesity is also associated with a 50-100% increased risk of premature death from all causes, compared to individuals with a normal weight. The WHO estimates that overweight and obesity leads to three million deaths per annum at present and that this will increase to five million by 2020.

Obesity is now recognised as a major public health problem in Ireland, with the establishment of a National Task Force in 2004, the development of a major health promotion campaign by the Department of Health and Children and the development of physical activity and nutrition projects to counter obesity.

PLANNING FOR IMPROVED POPULATION HEALTH

Health status in Ireland is at an all time high. However, the emerging public health problems mentioned above will inevitably impede improvement in health status in the future. For example the twin epidemics of diabetes and obesity have the potential to hinder and perhaps, at sometime in the future even reverse, the current favourable trends in circulatory disease mortality. While tackling the major problems which currently face the health services, the Executive will also invest in preventative strategies which will bring future rather than immediate benefits.

The Corporate Plan, when prepared, will identify priorities for improvements in population health. These priorities will be reflected in the annual Service Plan and supporting Business Plans as funding permits.

The Population Health Directorate will produce a periodic report on the health status of the population, reporting on changes in population health status, other population health indicators and the health impact of the services provided.

4.0 PRIMARY, COMMUNITY AND CONTINUING CARE SERVICES

4.0.1 CONTEXT

ROLE AND PURPOSE

The Primary, Community and Continuing Care (PCCC) Directorate is responsible for the provision of Primary Care as well as community based health and personal social services.

These services aim to support, maintain and promote the health and social well-being of individuals and their families. This is achieved through a partnership approach with individuals, families, communities, health and social care providers, including Acute Hospital Services and other statutory, non-statutory, voluntary and community groups to ensure the delivery of person-centered, needs led, integrated services.

Services include those services which have traditionally been described as Community Care (including Child Health, Child and Family Services, Children's Residential Services, Home Support and Public Health Nursing Services), Continuing Care (Residential Services for Older People, Services for Persons with Disabilities and Mental Health Services) as well as services provided by independent contractors (e.g. General Practitioners, Pharmacists, Optometrists, Dentists), non-statutory, voluntary and community groups.

Service delivery in 2005 will include a range of services that are preventive, designed to keep people well and to maximise health and social potential in response to identified needs. This will include services that:

- Promote health and well-being
- Screen for disease.

It will include appropriate:

- Assessment, diagnosis, treatment
- Rehabilitation
- Continuing care
- Personal social services.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

The aim of the organisational framework and service delivery model for PCCC Services is to enable individuals, families and communities to be at the centre of planning and delivery of services by building on existing strengths and working together for improved health and well-being by using a population health approach.

NEEDS ANALYSIS

PCCC Services are available to all people regardless of who they are or where they live. Therefore our entire population (3,917,203 people as per Census 2002, estimated at 4.04m people by the Central Statistics Office in 2004), can access primary care services. However, contact with the health services arises most often in the context of an individual's life-stage, or due to the impact of one's lifestyle, environmental or social factors, or an inherited/ acquired condition or disability.

Needs in respect of the broad range of children, young people (1,013,031 persons aged 0- 17 years as per Census 2002) and their families exist in respect of universal screening, preventative and health promotion services to promote and protect their health and social well-being. Additionally, some children, young people and families, who, for a variety of reasons are more vulnerable or experience greater adversity, have additional needs that are met through targeted and specialist services.

Adult requirements (2,468,171 persons aged 18-64 years as per Census 2002) include the need to maintain health and well-being through health promotion, education and preventive measures, information access, appropriate use of existing services and interagency requirements.

Persons with Disabilities (45,093) – 25,416 as per the National Intellectual Disability Database 2004 and 19,677 as per the Physical and Sensory Disability Database 2004 have needs for the broad range of primary and community based services as well as specialist day, personal assistance, support, aids and appliances, respite and residential care services.

Mental Health needs include the promotion of optimal mental health, minimisation of the affects of mental illness and needs to increase the awareness of the issues associated with suicide and parasuicide. Additional needs exist in respect of individuals who require a secure environment through the national Forensic Psychiatric Service.

Older people are living longer and many are active, healthy and socially involved. Therefore needs to support and maintain quality of life exist. The broad range of home and community based services help to support older people to remain in their own homes and communities for as long as possible and to access care in acute hospitals and community/district hospitals and short and long-term residential care services in response to needs.

Individuals and families experiencing social disadvantage have needs for sustainable social integration, improvement in health and social gain, alleviation of poverty, and reduction in health inequalities.

Considerable needs analyses and consultation processes to identify the needs of individuals, families and communities have been undertaken to inform and shape national policy and influence the delivery of Primary Care Services. Additionally, the ongoing process of needs identification is undertaken in consultation/partnership with individuals, families, communities and other representatives to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choices, and which reflect best practice.

Initiatives aimed at delivering existing resources to areas of maximum need e.g. areas identified as part of the Government's geographically targeted social inclusion programmes- RAPID (Revitalising Areas by Planning, Investment and Development) Programme for urban

areas and CLÁR (Ceantair Laga Ard-Riachtanais) Programme for rural areas are also supported where possible.

4.0.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The PCCC Directorate is responsible for the provision of all health and welfare services provided in a community setting, including primary care, mental health, community hospital and continuing care services.

These services are delivered through 32 Local Health Offices (LHOs) (comprising existing community care areas/regional services). Four Regional Health Offices to be established during 2005 will have a significant function in relation to co-ordination, facilitation, integration, consultation and performance management. A key design element at PCCC national level is the establishment of Care Group Units, which will focus on the areas of Primary Care, Children, Adolescents and Families, Disabilities, Mental Health, Older People and Social Inclusion. Additionally, in 2005, a specific unit for Chronic Illness will also be established. These Units will facilitate the translation of existing and emerging policy and strategy into implementation frameworks, the development of appropriate Performance Indicators, and the use of appropriate monitoring mechanisms to ensure integrated system wide collaboration.

Services to individuals, families, and communities, provided through the LHO structures include:

- Primary and Community Care Services
- Services for Children, Adolescents and Families (including Child and Adolescent Health, Immunisation, Childcare and Family Support and Child and Adolescent Psychiatry)
- Services for Persons with Disabilities
- Mental Health Services
- Services for Older People (including Psychiatry of Old Age Services)
- Social Inclusion Services (including Homeless, Ethnic Minorities, Travellers and Addiction Services).

Liaison between services provided by the PCCC, NHO and NSS Directorates is critical to the effective delivery of services. Management responsibility for the PCCC liaison function rests with the proposed Regional Directors, the LHO Managers and with the National PCCC Director.

4.0.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

The Executive recognises the critical role that GPs and other Primary Care practitioners have in ensuring the successful implementation of a population health based approach as outlined in the Primary Care Strategy *Primary Care: A New Direction (2001)*. During 2005 we are committed to the commencement of a major change management programme to reorient current service organisation arrangements so that these can better respond to the requirements of this strategy, to ensure that the learning from the existing Primary Care Projects is evaluated and transferred across the system, and that this experience/learning influences further funding investment.

4.0.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

There are four significant objectives reflected throughout this Service Plan:

- To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety
- To provide person-centred, needs led services which are responsive to user preferences, and choices and reflect best practice
- To develop and deliver services in accordance with a population health approach
- To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services.

Specific actions to support the implementation of these objectives are detailed in the individual Care Group Plans.

In 2005, the Primary Community and Continuing Care Directorate will pursue the following:

- Continued effective implementation of *Quality and Fairness: A Health System for You* and *Primary Care A New Direction*, and application of all relevant legislation through which its services and the services of contracted providers give effect to national strategy and policy
- The smooth integration of former health board and streamlined agencies into the new organisational structure
- The establishment of effective relationships and interface arrangements between the PCCC, NHO, NSS and Population Health Directorates to ensure a high impact on population health
- Development of better integration and collaborative arrangements between PCC Services and the NHO, thus ensuring continuity of care for service users in their interaction with health and social care services
- Implementation of systems to ensure that PCCC services will continue to work closely with NHO services in the development of integrated care, facilitating the early discharge to home of service users
- Introduction of the new management structure for the National Directorate, Regional Health Offices and Local Health Offices
- Participation in the development and implementation of the Executive's Corporate Plan
- Establishment of effective monitoring and reporting arrangements in respect of the effective transition to the new organisational structures and service delivery
- Introduction of significant change management programmes to promote inter-disciplinary working between professionals
- Improvement in the quality and consistency of responses to major emergencies dealing with threats ranging from transport accidents to serious outbreaks of communicable diseases.

ACTIVITY

Specific activity measures/performance indicators in respect of PCCC services are included in the individual care group plans and associated Business Plans that support this national Service Plan.

4.0.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Establishment of PCCC structures at regional and local level
- Promotion and development of multi-disciplinary team working
- Reliance on the effective establishment of shared services arrangements.

4.0.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Monitoring to ensure the effective transition to the new organisational structures will also be undertaken.

Specific monitoring mechanisms are detailed in the individual Care Group and Business Plans that support this national Service Plan.

4.0.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

4.1 PRIMARY CARE SERVICES

4.1.1 CONTEXT

ROLE AND PURPOSE

Primary Care Services aim to support, maintain and promote the health and social well-being of individuals and their families through the provision of integrated, inter-disciplinary, high quality team based and user friendly services. The focus of these services is to enhance disease prevention, rehabilitation and personal social services to complement the existing diagnosis and treatment focus in line with the team/network model described in *Primary Care: A New Direction.*

Needs led, person-centred, integrated services are delivered in partnership with individuals/ families and communities, health and social care professionals, independent contractors and non-statutory, voluntary and community groups.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 Census of Population indicated that there were 3,917,203 people in the country. The Central Statistics Office, in 2004, estimated the national population to have risen to 4.04m.

Primary care is readily available to all people regardless of who they are or where they live; therefore the population of the entire country can access primary care services. Table 4.1.1 below presents a profile of this population by age groups.

Table 4.1.1: Population Profile by Age Group

Age Group	Ireland No. of Persons			% Population
	Total	Male	Female	
Children 0-17 years	1,013,031	519,483	493,548	26
Adult 18 – 64 years	2,468,171	1,237,526	1,230,645	63
Older people (> 65 years)	436,001	189,155	246,846	11
TOTAL	**3,917,203**	**1,946,164**	**1,971039**	**100**

Source: Census 2002

Table 4.1.1 reflects the proportions of the population that are young and old. This is significant for primary care service provision in that the greatest need for health care is in the young and old populations. In respect of the adult population the emphasis for primary care service provision is on maintaining health and well-being through health promotion, education and preventive measures, information access, appropriate use of existing services and interagency requirements.

As noted in Chapter 3 (Population Health Status) the principal causes of death in Ireland are diseases of the circulatory system, cancer, respiratory diseases, injuries and poisonings. Lung

cancer is the most common cause of death from cancer in men, while breast cancer is the most common cause for women. Suicide, motor vehicle accidents and falls account for most deaths from injuries and poisonings. Major inequalities in health exist between those at the higher and lower end of the socio-economic scale and significant differences exist in the life expectancy of men and women. Lifestyle factors and health behaviours impact on health and social well-being with alcohol misuse and obesity emerging as public health issues.

Primary Care as the first point of contact that most individuals have with health services is therefore the appropriate setting to meet the needs of individuals, families and communities in relation to these lifestyle issues and health behaviours. Primary Care Services support and empower individuals in relation to preventative measures, screening, early diagnosis and appropriate intervention to help promote and protect their health and well-being while facilitating independence and promoting quality of life.

Persons who are unable, without undue hardship, to arrange general practitioner medical and surgical services for themselves and their dependants, and all persons aged 70 years and over have an entitlement to free General Medical Services (GMS). These include free GP (family doctor) services; prescribed drugs and medicines (with some exceptions); in-patient public hospital services; out-patient services; dental, optical and aural services; medical appliances and maternity and infant care services.

Approximately 1.149 million people had eligibility for General Medical Services at December 2004, representing 28.4% of the total estimated 2004 population of 4.04 million people.

Furthermore, in 2005, an estimated 230,000 people will have access to free GP Services through the provision of extra medical cards and the introduction of new 'Doctor Visit' Medical Cards.

In addition, other persons have eligibility for the following schemes:

- Drugs Payment Scheme (DPS)
- Long Term Illness Scheme (LTI)
- Dental Treatment Services Scheme (DTSS)
- High Tech Drugs (HTD)
- Primary Childhood Immunisation Scheme
- Health (Amendment) Act 1996 – Persons with Hepatitis C
- Methadone Treatment Scheme
- Community Ophthalmic Services Scheme.

There are also a number of entitlements to re-imbursement of health related expenses (relief of €192m for 600,000 people in 2003) through private health insurance and tax relief (relief of €41m for 108,000 people in 2000/01).

Table 4.1.2 below indicates the number of eligible persons in respect of General Medical Services, Drugs Payment and Long Term Illness Schemes at December 2004.

Table 4.1.2: Number of Eligible Persons as at 31st December 2004

Number of Eligible Persons			
	General Medical Services	Drugs Payment Scheme	Long Term Illness Scheme
Total	**1,148,914**	**1,458,231**	**93,500**

Source: Primary Care Reimbursement Service 2005

Considerable needs analyses and consultation processes to identify the needs of individuals, families and communities have been undertaken to inform and shape national policy and influence the delivery of Primary Care Services. Additionally the ongoing process of needs identification is undertaken in consultation/partnership with individuals, families, their representatives and communities to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choices, and which reflect best practice.

4.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Primary Care Services encompass health and welfare services provided at home and in the community. Services are provided across a continuum from information, health promotion and prevention, to diagnosis, treatment, rehabilitation and support services in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups.

Services are currently delivered from a number of settings including health centres, primary care centres and, in the case of most independent contractors i.e. general practitioners, pharmacists, dentists and optometrists, in privately owned premises.

Directly provided and contracted services include:

- General Practice including practice based nursing and other services
- Men's Health
- Entitlement & Benefit Schemes
- Sexually Transmitted Infection, Prevention and Treatment
- Information Services and Information Lines
- Community Pharmacy
- Food Safety/Environmental Health
- Ophthalmology/Optometry
- Audiology
- Adult Counselling
- Dental
- Cardiovascular Health:
  - Smoking Cessation Clinics
  - Secondary Prevention Programme – Heart Watch
  - Cardiac Rehabilitation
  - Pre-Hospital Emergency Care
  - First Responder Programmes
- Community Welfare
- Civil Registration
- Women's Health
- Cancer Prevention and Treatment
- Palliative Care
- Community Health
- Public Health
- Therapy.

Table 4.1.3 below indicates the number of agreements with GPs, Pharmacists, Dentists and Optometrists for the provision of services.

Table 4.1.3: Number of Agreements with GPs, Pharmacists, Dentists and Optometrists for Services as at 31st December 2004

	General Practitioners	Pharmacists	Dentists	Optometrists
Number of Agreements for Services	2,219	1,346	1,187	495

Source: Primary Care Reimbursement Service 2005

Although the general practitioner, public health nurse, practice nurse and community pharmacist are most frequently involved with service users, other key staff also provide front line services. These include area medical officers, audiologists, community mental health nurses, home helps, dieticians, dentists, chiropodists, community welfare officers, environmental health officers, occupational therapists, physiotherapists, psychologists, social workers and speech and language therapists as well as members of non-statutory, voluntary and community groups. Administrative staff support the processing of a number of entitlements and schemes for claimants as well as supporting professionals in service provision/delivery.

The Primary Care Reimbursement Service (formerly the General Medical Services (Payments) Board) makes payments to General Practitioners, Pharmacists, Dentists and Optometrists who have contracts to provide services under the GMS Scheme to medical cardholders and to qualifying persons under other community drug schemes nationally. The significance of such locally accessible services is recognised in supporting the maintenance and promotion of health and social well-being of individuals and families.

4.1.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing levels and standards of directly provided and contracted information, home and community based services *(Q & F Actions 70,72,73)*
- Maintain existing Primary Care Teams and transfer the learning from the Primary Care Pilot Projects across the system *(Q & F Actions 74,75,76,77)*
- Promote multi-disciplinary team working *(Q & F Action 104)*
- Meet the specific obligations arising from the statutory frameworks that have developed in respect of certain services / populations for example, child care, disability and mental health *(Q & F Actions 5,14,15,18,20,22,23,25,34).*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences and choices and reflect best practice

- Enhance links with service users by promoting their involvement in planning, consultative and decision making forums *(Q & F Actions 50,51,52,68)*
- Ensure service users have access to specific, accurate and timely information on service provision *(Q & F Actions 36,46)*
- Improve access to health services through the development of a 24 hour Health Service Direct Telephone Contact Line *(Q & F Actions 116, 117).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Provide more GP Out of Hours Services, expand Palliative Care facilities and promote measures to enhance direct access for GPs to diagnostic services as part of the A & E Action Plan *(Q & F Actions 31,77)*

- Support influenza pandemic planning through the stockpiling of antivirals *(Q & F Action 5)*
- Progress implementation of the recommendations contained in the National Review of Immunisation/Vaccination programmes regarding Primary Childhood Immunisation Programme and Influenza and Pneumococcal Immunisations *(Q & F Actions 14,26)*
- Improve childhood immunisation vaccination uptake in 2005 *(Q & F Action 14)*
- Improve appropriate uptake of immunisation among adults who are 'at risk' *(Q & F Action 26)*
- Provide an additional 230,000 people with medical card / 'Doctor Visit' Medical Cards *(Q & F Action 38)*
- Undertake needs assessment in partnership with communities, non-statutory, voluntary and community groups *(Q & F Actions 19,52,54)*
- Encourage individuals in the maintenance of their own health and social well-being and increase healthy lifestyle behaviours amongst the general population *(Q & F Actions 5,6,18,19,20,21,22,23,24)*
- Target behaviours in relation to smoking, nutrition and food intake (related to obesity), alcohol and exercise *(Q & F Actions 5,6,7,8,17)*
- Facilitate access to appropriate health and welfare services targeted at men and women *(Q & F Actions 9,11,15,16,28)*
- Target high risk mortality and morbidity areas for women in relation to cardiovascular disease (primary and secondary prevention) and breast cancer and to provide services for women experiencing violence, abuse or sexual assault *(Q & F Actions 5,11,34)*
- Target high risk mortality and morbidity areas for men in relation to cardiovascular disease (primary and secondary prevention), lung cancer, motor vehicle accidents, parasuicide and suicide *(Q & F Actions 5,15,25)*
- Promote and protect public health through the appropriate enforcement of Food Hygiene and Tobacco Control legislation *(Q & F Actions 6,17)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID / CLAR Programmes *(Q & F Actions 19,50,52,70)*
- Continue ongoing collaborative work through established forums including: Primary Care Steering Committees; Planning Committees on Violence against Women and Palliative Care Committees *(Q & F Actions 50,52)*.

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Develop common standards for GP Out of Hours services *(Q & F Actions 63,77)*
- Promote models of person-centred integrated care *(Q & F Actions 49,50,51,52)*
- Promote integration and shared care in respect of cardiovascular, dental, mental health, palliative care and other services *(Q & F Actions 26,63,74)*
- Promote the implementation of action plans agreed by the National Client Index and existing National Schemes Modernisation Projects *(Q & F Actions 68,115, 116,117)*.

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/performance indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005 is attached (Appendix 2).

National PI Reference No	Category	Out-turn 2004		Target 2005	
	DENTAL SERVICES				
PC12 (b)	The number and percentage uptake of the Dental Treatment Services Scheme by eligible population	No	%	No	%
		237,828	21	237,828	21
	GP OUT OF HOURS SERVICES				
PC10 (b)	The number of persons with GMS eligibility covered by GP Co-operatives as a percentage of the total GMS population	No	%	No	%
		717,130	62	717,130*	62*
	**Commentary: ***Provision of more GP Out of Hours Services, in 2005, in addition to increased medical card eligibility, will increase the number and percentage coverage though it is not possible to predict the precise increase at this time.				
	ELIGIBILITY FOR SERVICES				
	Number of persons with medical cards/Doctor Visit Medical Cards	1,148,914		1,378,914	

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the additional funding received in respect of the 2005 funded service developments listed below has yet to be determined. This funding is provided to:

- Provide additional 230,000 people with medical card / 'Doctor Visit Medical Cards'
- Support the implementation of the A & E Action Plan by:
  - Providing more GP Out of Hours Services
  - Expanding Palliative Care Facilities
  - Promoting measures to enhance direct access for GPs to diagnostic services
- Support influenza pandemic planning – stockpiling of antivirals and public health emergency planning €9.3m
- Progress implementation of the recommendations contained in the National Review of Immunisation/ Vaccination programmes regarding Primary Childhood Immunisation Programme and Influenza and Pneumococcal Immunisations €3.378m
- Support Health Promotion €2.237m
- Support implementation of the Public Health Doctors Agreement €0.353m.

These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.1.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Increasing costs of Schemes to which individuals have an entitlement in the context of defined budgets (Demand Led Schemes)
- Failure to promote and develop multi-disciplinary team working
- Recruitment and retention of staff in particular disciplines/areas.

4.1.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Specifically, integrity and validity of eligibility/benefit registers for GMS and other Schemes/ Allowances e.g. Drugs Payment Scheme, Long Term Illness Scheme will be maintained. Monitoring of a range of schemes and programmes to ensure probity, e.g. Dental Treatment Services Scheme, will take place and returns will be made to the Food Safety Authority of Ireland.

A Primary Care Strategy Implementation Review Group will monitor all actions under the Framework to Guide Development of Primary Care Teams and Primary Care Networks against agreed timeframes, once completed.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

The National (Health Board) Pharmacists Group will consider how best to implement the findings of the research undertaken to establish the current procedures in place for the prescribing and dispensing of drugs used in home care/palliative care settings. Clinical audits will be implemented through the expansion of the Dental Information Communications Technology Database. Public Analyst Laboratory ISO 17025 and Environmental Health Service ISO 9002 accreditation standards will be maintained. Specific details are included within the individual Business Plans that support this national Service Plan.

4.2 CHILDREN, ADOLESCENTS AND FAMILIES

4.2.1 CONTEXT

ROLE AND PURPOSE

Services for Children, Adolescents and Families aim to promote and protect the health and well-being of children, adolescents and families. Responsive services based on best practice, delivered in partnership with children and adolescents, their families, carers, local communities and non-statutory, voluntary and community groups enable them to realise their potential. The emphasis is on provision of universal preventive services, with positive discrimination in favour of the most vulnerable and those experiencing greatest adversity.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 Census of Population indicated that there were 1,013,031 young people (i.e. people aged 0-17 years) in the country, representing 26% of the overall population. Table 4.2.1 below presents a profile of this population by age category and compares it to the 1996 Census.

Table 4.2.1: Young People Population Profile by Age Group 1996 and 2002

	No. of Persons							
	Total Population	**Aged 0-17 Years**	**Aged under 1 year**	**Aged 1-4 Years**	**Aged 5-9 Years**	**Aged 10-14 Years**	**Aged 15-17 Years**	**Percentage Aged 0-17 Years**
Ireland 2002	**3,917,203**	**1,013,013**	54,499	223,131	264,090	285,708	185,603	**26%**
Ireland 1996	**3,626,087**	**1,071,972**	48,854	201,540	282,943	326,087	212,548	**29%**
Variance 1996-2002	+291,116	**-58,941**	+5,645	+21,591	-18,853	-40,379	-26,945	
Percentage Variance 1996-2002		**-5.5%**	+11.5%	+10.7%	-6.6%	-12.4%	-12.7%	

Source: Census 1996 and 2002

Overall the children and adolescent population has decreased by 58,941 (-5.5%) in the period since 1996. However, this decrease has been mainly in the age groups from 5–17 years with an increase recorded in respect of the age groups from 0-4 years. A profile of the 2002 children and adolescents population by gender is presented in Table 4.2.2 below.

Table 4.2.2: Young People Population Profile by Gender 2002

	Total Number of Persons Aged 0-17 Years	Number of Persons Aged under 1 year	Number of Persons Aged 1-4 Years	Number of Persons Aged 5-9 Years	Number of Persons Aged 10-14 Years	Number of Persons Aged 15-17 Years	Percentage Population Aged 0-17 Years
Males	519,483	27,805	114,235	135,890	146,114	95,439	51%
Females	493,548	26,694	108,896	128,200	139,594	90,164	49%
Total	**1,013,013**	**54,499**	**223,131**	**264,090**	**285,708**	**185,603**	**100%**

Source: Census 2002

There are more males than females in each age group. Male adolescents are at greater risk of injury from motor vehicle accidents, injuries, poisoning and suicide. Children from lower income groups are most likely to have accidents in the home.

Immunisation is crucial in the prevention of a range of childhood illnesses. Improving national immunization uptake will be an important priority for the Directorate in 2005 based on uptake levels as illustrated in Table 4.2.3 below.

Table 4.2.3: National Immunisation Uptake up to 24 months

Vaccination		Diphtheria	Polio	Tetanus	Haemophilus Influenza Type b	Polio	Meningococcal Group C
	BCG	D3	P3	T3	Hib3	Polio 3	Men C3
Immunisation percentage uptake level for children born in September 2002	90	90	89	90	89	90	88

Source: National Disease Surveillance Centre Quarter 3 2004

All children need the foundations of a good education which focuses on personal development, health services which address their particular physical and mental health needs and access to a range of opportunities to develop positive relationships and supportive networks through sport, play, leisure and cultural activities. All children need the support of family and community *(National Children's Strategy, 2000).*

Nearly one in ten Irish children lived in consistent poverty, while one in four lived in relative poverty in 2001 (*Health in Ireland 2004*). These children, because of social exclusion/ disadvantage, have additional needs as they experience barriers which prevent them from achieving a better quality of life.

Over a half of Ireland's young people begin experimentation with alcohol before the age of 12 years, with over one third of 15-16 year olds binge drinking three or more times in the previous month (*SLAN, 2003*).

In the *Irish Health Behaviour in School Aged Children Survey (HBSC) 1999*

- 49% of young people (51% boys and 48% girls) reported ever having smoked a cigarette
- 29% of children reported having had a drink in the previous month
- Overall, 29% of children reported having been drunk (boys 35% and girls 24%)

- 62% of boys and 45% of girls exercised four or more times per week.

Children and Adolescents, are a particularly important target group for health promotion because initiatives can help form lifelong habits for healthy lifestyles.

20% of adolescents have psychological disturbances. *(Second Report of the Working Group on Child and Adolescent Psychiatric Services, 2003)*.

Considerable needs analyses and consultation processes to identify the needs of children, adolescents and families have been undertaken to inform and shape national policy and influence the delivery of Children, Adolescent and Family Services. These processes continue to be undertaken in consultation/partnership with children, adolescents, their families, representatives and communities to ensure that children have a 'voice' in keeping with the *National Children's Strategy,* thereby promoting the development of person-centred, needs led services which reflect best practice.

4.2.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided in a variety of community and residential settings including the home, community, schools, health centres and acute hospitals, in partnership with communities, children, young people, families and carers, by a range of statutory, non-statutory, voluntary and community groups.

A range of universal health and social services are provided to the general population of children and young people. Additionally, targeted and specialist services are available to children, young people and their families who are considered to be in need or vulnerable for a variety of reasons and interagency links are critical in this regard.

The Programme of Action for Children is a national initiative, which focuses on developments of best practice and associated training and acts as an engine for co-operation across all services in relation to children.

Children, Adolescents and Family services are broadly structured as:

- Child Health including Immunisation
- Community Development and Family Support Services
- Child Protection and Welfare Services
- Specialised alternative care services including adoption, foster care and residential care
- Child and Adolescent Psychiatry.

Services provided include:

- Information / Health Promotion
- GP Services
- Antenatal education
- Breastfeeding support
- Parenting Programmes
- Primary Immunisation Scheme and Booster Immunisation Programmes
- Child Health Surveillance and Screening
- Generic and Specialised Family Support
- Pre-School Inspection
- Fostering
- Adoption
- Residential Child Care
- Young People Out of Home
- Aftercare
- Child and Adolescent Psychiatry including:
  - Advice and consultation

- Early Intervention
- School Health
- Child Protection
- Home visiting and family support
- Health Education and Promotion for children and their carers
- Assessment, diagnosis and treatment
- Inpatient care
- Support services provided to Special Schools.

4.2.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.2.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing levels and standards of health promotion/prevention, screening, home, community, pre-school/school, family support, residential, in-patient, homelessness and aftercare services *(Q & F Actions 8,14,27)*
- Progress plans relating to Child and Adolescent Psychiatry Treatment Services *(Q & F Action 14)*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences and choices and reflect best practice

- Develop a framework for active user involvement in planning, delivery and evaluation of services at both strategic and operational levels *(Q & F Actions 50,51,52,70)*
- Develop partnerships with parents to enable a flexible child centred dynamic service based on best practice and the empowerment of children/parents *(Q & F Actions 14,50,68).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Analyse breastfeeding rates to identify trends *(Q & F Action 9)*
- Support initiatives that promote breastfeeding *(Q & F Action 9)*
- Promote the achievement of the national target of 95% uptake in childhood immunisation and vaccination *(Q & F Action 14)*
- Implement the recommendations of *Best Health for Children* and *Get Connected* through the provision of standardised, evidence-based training in Child Health Surveillance *(Q & F Actions 14,50,51,52,68)*
- Promote and focus on health benefits and disease protection opportunities for children regarding obesity and diabetes prevention *(Q & F Actions 5,8)*
- Develop an approach to deliberate self-harm and suicide prevention strategies in line with best practice *(Q & F Actions 14,25,52)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID/CLAR Programmes *(Q & F Actions 19,54)*
- Review and consider the National Family Support Strategy due for publication in 2005 *(Q & F Action 27)*

- Continue ongoing collaborative work through established forums including Child Care Advisory Committees (*Q & F Actions 50,52).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Deliver child health and child care training on an inter-disciplinary basis where appropriate to ensure a consistent response in line with national policy *(Q & F Action 51)*
- Develop an action plan for the phased implementation of the *National Standards for Foster Care (Q & F Action 14)*
- Develop appropriate information systems in the context of the National Programme of Action for Children (to encompass child health, adolescent health, child welfare and protection, acute services, health promotion, child and adolescent mental health, disabilities and other relevant issues) *(Q & F Action 117)*.

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/performance indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005, is attached (Appendix 2).

NATIONAL PI REFERENCE NO	CATEGORY	OUT-TURN 2004		TARGET 2005	
	BIRTH VISITATION				
CH1 (a)	Number and percentage of new born babies visited by a Public Health Nurse (PHN) within 48 hours of hospital discharge	No	%	No	%
		37,104	69	37,104	69*
	**Commentary: ***The Directorate will endeavour to increase this percentage in 2005.				
	BREASTFEEDING				
CH7 (a)	Number and percentage of babies who are exclusively breastfed on discharge from hospitals	No	%	No	%
		21,962	41	21,962	41*
	**Commentary: ***The Directorate will focus on breastfeeding rates and support initiatives to increase this percentage during 2005.				
	PRE-SCHOOL SERVICES				
CC4 (a)	Total number of notified current operational pre-school centres	4,141		4,141	
CC4 (c)	Number and percentage of pre-school annual inspections that took place	No	%	No	%
		2504	60	2504	60*
	**Commentary: ***The Directorate will endeavour to increase this percentage in 2005.				
	FAMILY WELFARE CONFERENCES				
	Number of Family Welfare Conferences held	173		173	
	CHILDREN IN CARE				
CC7 (a)	Number and Percentage of children in:	No	%	No	%
	i. Residential care (including Special Arrangements)	496	10	496	10
	ii. Foster care + Foster care with relatives (combined)	4,393	90	4,393	90

National PI Reference No	Category						
	PRIMARY CHILDHOOD IMMUNISATION						
CH5 (a) **Out-turn 2004**	Number and percentage of children 12 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus (T3) Haemophilus Influenzae Type b (Hib3), Polio (Polio3), Meningococcal group C (MenC3)	**D 3**	**P 3**	**T 3**	**Hib 3**	**Polio3**	**MenC 3**
		No	No	No	No	No	No
		15,261	15,212	12,402	15,240	15,254	15,137
		%	%	%	%	%	%
		84	84	84	84	84	83
CH5 (a) **Target 2005**	Number and percentage of children 12 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus (T3) Haemophilus Influenzae Type b (Hib3), Polio (Polio3), Meningococcal group C (MenC3)	**D 3**	**P 3**	**T 3**	**Hib 3**	**Polio3**	**MenC 3**
		No	No	No	No	No	No
		15,261	15,212	12,402	15,240	15,254	15,137
		%	%	%	%	%	%
		84	84	84	84	84	83
	Commentary: Improving national immunisation uptake will be an important priority of the Directorate in 2005. This will require targeted actions in those local areas or for particular groups where uptake is below current norms, as well as more general promotional actions.						
CH5 (b) **Out-turn 2004**	Number and percentage of children 24 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus (T3), Haemophilus influenza type b (Hib3), Polio (Polio3), and an age appropriate number of doses of Meningococcal group C (MenC3)	**D 3**	**P 3**	**T 3**	**Hib 3**	**Polio3**	**MenC 3**
		No	No	No	No	No	No
		16,430	16,356	13,413	16,372	16,405	16,087
		%	%	%	%	%	%
		90	89	90	89	90	88
CH5 (b) **Target 2005**	Number and percentage of children 24 months of age who have received three doses of vaccine against Diphtheria (D3), Pertussis (P3), Tetanus (T3), Haemophilus influenza type b (Hib3), Polio (Polio3), and an age appropriate number of doses of Meningococcal group C (MenC3)	**D 3**	**P 3**	**T 3**	**Hib 3**	**Polio3**	**MenC 3**
		No	No	No	No	No	No
		16,430	16,356	13,413	16,372	16,405	16,087
		%	%	%	%	%	%
		90	89	90	89	90	88
	Commentary: Improving national immunisation uptake will be an important priority of the Directorate in 2005. This will require targeted actions in those local areas or for particular groups where uptake is below current norms, as well as more general promotional actions.						
CH5 (c) **Out-turn 2004**	Number and percentage of children who have received MMR at 24 months of age	No	14,827				
		%	81%				
CH5 (c) **Target 2005**	Number and percentage of children who have received MMR at 24 months of age	No	14,827				
		%	81%				
	Commentary: Improving national immunisation uptake will be an important priority of the Directorate in 2005. This will require targeted actions in those local areas or for particular groups where uptake is below current norms, as well as more general promotional actions.						

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the €14.5m additional funding received in respect of the 2005 funded service developments for mental health services has yet to be determined. Within this overall funding, provision is made to develop Child and Adolescent Psychiatry Treatment Services over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.2.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Increasing birth rates which impact on the planning and delivery of services
- The geographic mobility of families within the population, mainly from ethnic minorities, has significant implications for the delivery of Child Health Services
- The need to ensure appropriate linkages between all Child and Family Services to ensure a whole-child perspective
- Requirement to respond to children with high support special needs.

4.2.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Returns on the Child Care Minimum Dataset will be submitted in line with national requirements. Current practice and compliance will be examined against the *National Standards in Foster Care*. The Irish Social Services Inspectorate will undertake inspection of Children's residential services. The annual review of the adequacy of services for Children and Families, in accordance with the *Child Care Act 1991*, will be undertaken.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.2.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

A review of *Children First Child Protection Guidelines* will be undertaken, together with an assessment of the service delivery systems capacity to meet statutory obligations towards children. Work will continue with the Mental Health Commission and the Department of Health and Children Working Group on Child and Adolescent Psychiatric Services. A template for the costing and resourcing of the *National Standards for Foster Care* and a framework for decision-making for legal opinion/action will be developed.

Specific details are included within the individual Business Plans that support this national Service Plan.

4.3 PERSONS WITH DISABILITIES

4.3.1 CONTEXT

ROLE AND PURPOSE

Services for persons with disabilities seek to enable each individual with a disability to achieve his/her full potential and maximise independence including living as independently as possible. Disability Services are needs led, person-centred and underpinned by the principle of equity. A range of services are provided in partnership with people with disabilities, their families, carers, statutory, non-statutory, voluntary and locally based community groups.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 Census of Population indicated that there were 323,707 people with a disability (i.e. people with a physical, mental or emotional condition) in the country, representing 8% of the overall population. Table 4.3.1 below presents a profile of this population by age category.

Table 4.3.1: Profile of Persons with a Disability

	Total Population	Total Number of Persons with a Disability	Number of Persons with a Disability Aged 0-17 years	Number of Persons with a Disability Aged 18-64 years	Number of Persons with a Disability Aged >65 years	Percentage Population with a Disability
Ireland 2002	3,917,203	323,707*	22,346	165,665	135,696	8.0

*Includes all disabilities -physical, mental or emotional conditions *Source: Census 2002*

This data also indicates that the prevalence of disability increases significantly with age, from a 2% prevalence rate in young people (aged 0-17 years), to a 7% rate in the 18-64 years group, to a 31% rate in the 65 years and over group.

The needs of people with Intellectual Disability are identified and planned for through the National Intellectual Disability Database. This database details the existing level of specialised health service provision and an assessment of need for the upcoming five-year period.

The *2004 Annual Report of the National Intellectual Disability Database Committee* shows a total register of 25,416 persons. A profile of this group is presented in Table 4.3.2 below.

Table 4.3.2: Profile of Persons with an Intellectual Disability

Degree of Disability	No of Persons			Percentage
	Total	Male	Female	
Mild	9,011	5,141	3,870	35.5
Moderate	9,587	5,210	4,377	37.7
Severe	3,968	2,257	1,711	15.6
Profound	1,050	580	470	4.1
Not Verified	1,800	1,058	742	7.1
TOTAL	**25,416**	**14,246**	**11,170**	**100.0**

Source: Annual Report of the National Intellectual Disability Database Committee 2004

Of the 25,416 persons registered on the National Intellectual Disability Database, needs have been identified for the period 2005-2009 as outlined in Table 4.3.3 below.

Table 4.3.3: Needs of Persons with an Intellectual Disability

Service Requirement	No of Persons
Persons currently without major component of service	2,210
Persons requiring service enhancement / change	11,419
Persons with unmet need for residential support services	1,722
Persons within Psychiatric Services requiring Intellectual Disability Services	312
Persons with no identified service requirements in period to 2009	1,216
TOTAL	**16,879**

Source: Annual Report of the National Intellectual Disability Database Committee 2004

The remaining 8,537 persons identified on the National Intellectual Disability Database are deemed to be in receipt of adequate services.

Specifically, needs have been identified in respect of day, residential support and residential services as outlined in Table 4.3.4 below.

Table 4.3.4: Profile of Needs of Persons with an Intellectual Disability

	Persons currently without Services		Persons requiring service enhancement/change	
	No of places required 2005-2009	No of places required 2005	No of places required 2005-2009	No of places required 2005
Day Placements	347	338	10,100 (7,155)*	8,718 (6,158)*
Residential Support Services (e.g. respite services)	1,763	1,664	1,263	1,225
Residential Places	1,893	1,675	2,947	2,820

**Health service related places*

Source: Annual Report of the National Intellectual Disability Database Committee 2004

Implementation of the Physical and Sensory Disability Database, which is a tool that supports the identification of the numbers of persons requiring or expecting to require a range of specialised services to address aspects of their disabilities, commenced in 2002. A preliminary analysis of data (which excludes the Northern and East Coast HSE Areas) has been undertaken by the Health Research Board and use of that data here, is cognisant of the interpretation qualifications specified in their preliminary report. Participation in the Database is voluntary and therefore, the numbers of persons requiring services may be greater than reflected.

There were 19,677 persons registered on the database at June 2004. Profiles of this group are presented in Tables 4.3.5 and 4.3.6 below. Responsibility for the provision of services to persons over 65 years lies with Older Peoples' Services and are not included in this profile.

Table 4.3.5: Profile of Persons with a Physical or Sensory Disability

	No of Persons			Percentage
Age Profile	**Total**	**Male**	**Female**	
0-17 years	6,412	3,916	2,496	33
18-65 years	13,265	6,457	6,808	67
TOTAL	**19,677**	**10,373**	**9,304**	**100**

Source: National Physical and Sensory Disability Database A Preliminary Analysis June 2004

Table 4.3.6: Profile of Persons with a Physical or Sensory Disability by Type of Disability

Type of Disability	**No of Persons**			**Percentage**
	Total	**Male**	**Female**	
Physical Disability Only	16,246	8,652	7,594	83
Hearing Loss / Deafness Only	1,347	658	689	7
Visual Disability Only	1,193	606	587	6
Combined Disability Types	890	457	433	4
TOTAL	**19,676***	**10,373**	**9,303**	**100**

***1** *person did not provide a response*

Source: National Physical and Sensory Disability Database A Preliminary Analysis June 2004

The top three most frequently reported diagnoses were multiple sclerosis (9%), cerebral palsy (7%) and diabetes (6%). Needs of the 19,677 persons registered on the National Physical and Sensory Disability Database, have been identified as outlined in Table 4.3.7 below.

Table 4.3.7: Profile of Needs of Persons with a Physical and Sensory Disability

Service Requirement	**Number of people awaiting Assessment for Services**	**Number of people Assessed but Waiting for Services**
Day Services / Activities		209
Personal Assistance	6,262 (44% of this group require more than one type of service in this category)	359 (19% of this group require more than one type of service in this category)
Respite Services	4,693 (44% of this group require more than one type of service in this category)	336 (14% of this group require more than one type of service in this category)
Residential Services		91
*Support Services	11,740 (62% of this group require more than one type of service in this category)	1,299 (15% of this group require more than one type of service in this category)
Technical Aids / Appliances		8,446 (requests for a least one future technical aid/ appliance)

** Support services include therapeutic, intervention and rehabilitation services*

Source: National Physical and Sensory Disability Database A Preliminary Analysis June 2004

Considerable needs analyses and consultation processes to identify the needs of persons with disabilities have been undertaken to inform and shape national policy and influence the delivery of Disability Services. Additionally, the ongoing process of needs identification is undertaken in consultation/partnership with persons with disabilities, their families, carers and representatives to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choices, and which reflect best practice. Intellectual Disability Consultative and Development Committees and Regional Co-ordinating Committees on Physical and Sensory Disabilities will continue to inform the process in 2005.

4.3.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided in a variety of community and residential settings in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups. The broad range of Primary and Community based services are accessed as well as specialist services, which include:

- Early Childhood/Family Support
- Early intervention
- Child education and development
- Home support
- Pre-school
- Counselling for crisis intervention
- Respite for carers - residential and non-residential - recreational and social activity programmes, summer camps and holiday / family breaks
- Aids and Appliances
- Developmental day care for children
- Day activation
- Special high-support
- Special intensive day services for adults
- Community based Medical, Nursing and Therapy
- Rehabilitative Training - foundation level personal, social and work-related skills
- Sheltered Workshops - work activation, supported work in the community and personal and social development
- Services for Persons with Autistic Spectrum Disorder include day, outreach/family supports, respite and residential
- Residential Care is provided on a five-day, seven-day or shared care basis ranging from high, medium to low levels of support
- Financial Entitlements and Allowances include Mobility, Domiciliary and Blind Welfare Allowances
- Information and advice, advocacy, counselling, and general support.

In 2004, 23,843 persons (93.8% of the total population registered on the National Intellectual Disability Database) with an intellectual disability were in receipt of services. Table 4.3.8 below presents a profile of this service provision.

Table 4.3.8: 2004 Service Provision for Persons with an Intellectual Disability

Service Provision	No of Persons in Receipt of Services
Day Services	15,709
Residential Services-5 or 7 Day	7,619
Residential Support Services only	41
Resident in Psychiatric Hospital	474
Multi-disciplinary Support Services (including Early Intervention Services)	17,256
In receipt of no service	357
No identified service requirements	1,216

Source: Annual Report of the National Intellectual Disability Database Committee 2004

At June 2004, 17,611 persons (89.5% of the total population registered on the National Physical and Sensory Disability Database) were accessing at least one of the following services: therapeutic intervention and rehabilitation services, personal assistance and support services, respite, day or residential services. However, as participation in the National Physical and Sensory Disability Database is voluntary, the number of persons accessing or requiring services may be greater than that reflected. Table 4.3.9 below presents a profile of this service provision.

Table 4.3.9: 2004 Service Provision Persons with a Physical or Sensory Disability

Service Provision	Number of Persons in Receipt of Services
Therapeutic, Intervention and Rehabilitation Services	15,492
Personal Assistance and Support Services	5,255
Day Services and Activities	10,099
Respite Services ▪ Planned Respite ▪ Emergency Respite	 2,060 334
Technical Aids and Appliances	12,554
Residential Services	628

Source: National Physical and Sensory Disability Database A Preliminary Analysis June 2004

4.3.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.3.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Provide additional day, residential and respite services for people with Autism and Intellectual Disabilities and specialist services for people with challenging behaviours *(Q & F Actions 53,72)*
- Provide additional home support, personal assistance, rehabilitative training, aids and appliances and residential services for people with Physical and Sensory Disabilities *(Q & F Actions 53,72)*
- Examine measures to improve access and use of acute hospital services by people with Intellectual Disabilities and people with higher support needs *(Q & F Action 43)*
- Continue to provide existing levels and standards of home, community, day, respite, aids and appliances and residential services to ensure integration of individuals into their local communities *(Q & F Actions 35,53,68,72,104)*
- Develop and maintain National Disability Databases to identify current and future health care and related support service trends and needs *(Q & F Action 120).*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences, and choices and reflect best practice

- Enhance links with service users by promoting their involvement in planning, consultative and decision making forums *(Q & F Actions 50,52)*
- Establish clear pathways for people with disabilities and their families, to enable them to access services effectively *(Q & F Actions 53, 63)*

- Promote advocacy services *(Q & F Action 48).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Continue ongoing collaborative work through established forums including Intellectual Disability and Physical and Sensory Disability Consultative, Development and Co-ordinating Committees *(Q & F Actions 50,52)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID/CLAR Programmes *(Q & F Actions 19,54)*
- Work with statutory, non-statutory, community and voluntary groups to address the housing needs of persons with disabilities *(Q & F Action 21).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Enhance and strengthen links between and within statutory, non-statutory, voluntary and community groups so that services, delivered in partnership, facilitate provision of a continuum of care for persons with disabilities *(Q & F Actions 50,51,52,53,54).*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/performance indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005, is attached (Appendix 2).

NATIONAL PI REFERENCE NO	CATEGORY	OUT-TURN 2004		TARGET 2005	
	INTELLECTUAL DISABILITY				
ID3(b)	*The number and percentage of clients on the intellectual disability database assessed as requiring day services and who are receiving the service	No	%	No	%
		23,486	97	23,486	97
ID3(f)	**Commentary: *** Increased services will be provided in 2005 within the additional funding allocations. This will be the subject of a separate report to the Board, and, when approved the target for 2005 will be revised.				
	*The number and percentage of clients on the intellectual disability database assessed as requiring residential services and who are receiving the service	No	%	No	%
		8,127	81	8,127	81
	Commentary: *Increased services will be provided in 2005 within the additional funding allocations. This will be the subject of a separate report to the Board, and, when approved the target for 2005 will be revised.				

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the €56.35m additional funding received in respect of the 2005 funded service developments listed below has yet to be determined. This funding is provided for:

Services for Persons with Intellectual Disability and Autism - €41.225m to:

- Provide 270 additional residential places
- Provide approximately 400 new day places
- Provide approximately 90 additional respite places
- Improve specialist support services for people with major challenging behaviour
- Meet costs associated with moving individuals to more appropriate placements
- Open new Intellectual Disability Units as agreed in 2004.

Services for Persons with Physical and Sensory Disability- €15.125m to:

- Provide approximately 60 new places for people with significant disabilities who are currently placed in inappropriate settings
- Provide approximately 200,000 extra hours of home support and personal assistance
- Provide approximately 90 extra rehabilitative training places
- Provide additional funding to Voluntary Organisations
- Provide aids and appliances
- Open new Physical and Sensory Disability Unit as agreed in 2004.

These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.3.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- The impact on services of the Disability Bill 2004 and *Education for Persons with Special Educational Needs Act 2004*
- Compliance with the *National Standards for Disability Services*
- Provision of specialist services for specific groups, particularly those with multiple disabilities, persons with autistic spectrum disorder, challenging behaviours and significant physical disabilities.

4.3.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Service delivery will continue to be monitored through the collation and reporting of data collected directly from service providers and by information generated from the National Intellectual Disability, Physical and Sensory Disability and Occupational Guidance Databases.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.3.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

Work will continue with the National Disability Authority and the Department of Health and Children on the implementation of the *National Standards for Disability Services*.

Specific details are included within the individual Business Plans that support this national Service Plan.

4.4 MENTAL HEALTH SERVICES

4.4.1 CONTEXT

ROLE AND PURPOSE

Mental Health Services aim to promote optimal mental health and enhance mental well-being by minimising the effects of mental illness. Suicide Prevention Services also fall within the Mental Health Service domain and aim to increase awareness of the issues associated with suicide and parasuicide. The National Forensic Psychiatric Service provides a specialist service to individuals, who require care in a secure environment.

Specialist mental health services for Children, Adolescents and Families and Older People i.e. Child and Adolescent Psychiatry and Psychiatry of Old Age Services are reflected within the Children, Adolescents and Families and Services for Older People sections of this service plan. Therefore the focus here is on adult mental health needs and services.

Services are provided in partnership with persons with mental health needs, their families, carers, statutory, non-statutory, voluntary and locally based community groups with the aim of achieving the best quality of life for each individual through the provision of seamless, high quality person-centred services.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 Census of Population indicated that of the overall population of 3,917,203 there were 2,468,171 adults (i.e. people aged 18–64 years) in the country, representing 63% of the overall population.

Between 20% and 25% of the population (between approximately 494,000 and 617,000 adults) will be affected by a mental health problem (*Mental Health Commission Annual Report* 2002). Studies indicate that GPs are presented with the largest proportion of psychiatric morbidity (90% of diagnosed mental illness), leaving a smaller proportion (10%) to the specialised psychiatric services (*Planning for the Future*, 1984).

The Health Research Board annual analysis shows that almost 1% of the adult population experience mental health difficulties that require hospital admission. Their findings also indicate a difference in hospital admission rates between socio–economic groups, with poorer sections of the community having a greater reliance on services. In 2003, depressive disorders, schizophrenia and alcoholic disorders accounted for two-thirds of all admissions to Psychiatric In-patient Units and Hospitals, with the highest rate of admission in the 45-54 year old age group.

The Central Statistics Office recorded 444 (358 males and 86 females) registered suicides in Ireland in 2003. 23% of all deaths in the 25-34 age group were recorded as suicide in 2003, the largest cause of death in this age group.

Considerable needs analyses and consultation processes to identify the needs of persons with mental health needs have been undertaken to inform and shape national policy and influence the delivery of Mental Health Services. Additionally the ongoing process of needs identification is undertaken in consultation/partnership with persons with mental health needs, their families, carers and representatives to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choices, and which reflect best practice.

4.4.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Mental Health Services are provided across a continuum of home and community based services to high quality community and in-patient acute mental health services and residential care services when required. The broad range of Primary and Community based services are accessed as well as services, which include:

- Mental Health Promotion
- Primary Care
- GP/Community Pharmacy
- Acute In-patient Care
- Outpatient Clinics
- Community Based Residences
- Rehabilitation
- Liaison Services
- Day Hospitals
- Day Centres
- Community Psychiatric Nursing
- Accident & Emergency Crisis intervention nursing
- Detoxification
- Peer support groups
- Bereavement support
- Provision of appropriate responses to both suicide and parasuicide
- Forensic Psychiatry – including assessment, treatment, rehabilitation, satellite, out-patient and prison in-reach services.

A profile of mental health service provision is presented in Table 4.4.1 below.

Table 4.4.1: Profile of Mental Health Service Provision 2003

Service Category	Number	Number of Places	Attendances
Out–Patient Clinics	235		238,650
Day Centres	110	2,357	426,576
Day Hospitals	66	1,090	171,196
Community Residences	418	3,210	

Source: Health Research Board 2004, Report of Inspector of Mental Hospitals 2003

4.4.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.4.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Provide an acute psychiatric unit in the Connolly Memorial Hospital, Dublin *(Q & F Action 25)*
- Provide additional residential places in the community and in the Central Mental Hospital *(Q & F Action 25)*
- Expand community based adult mental health teams *(Q & F Action 25)*
- Continue to provide existing levels and standards of mental health promotion, suicide prevention/intervention and postvention services, home, community, acute mental health and residential services *(Q & F Actions 25,63,72).*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences, and choices and reflect best practice

- Provide appropriate care that is comprehensive, flexible and located in the most appropriate setting to meet the care needs of service users *(Q & F Actions 51,55,84)*
- Develop consumer panels and involve stakeholders in the planning and development of policies and future service provision *(Q & F Action 52)*
- Develop networks for users and carers and capacity build to empower service users *(Q & F Actions 50,52)*
- Strengthen individual and community capacities by supporting key projects which promote mental health *(Q & F Actions 50,52)*
- Support initiatives that promote the reduction of stigmatisation associated with mental illness *(Q & F Action 25).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Work with statutory, non-statutory, community and voluntary groups to address the housing needs of persons with a mental illness *(Q & F Action 21)*
- Support non-statutory, voluntary and community groups to become more actively involved in mental health issues, particularly in the area of advocacy, through involvement with the Irish Advocacy Network *(Q & F Actions 25,54)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID / CLAR Programmes *(Q & F Actions 19,54).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Support the re-engineering of services to community based models *(Q & F Action 55)*
- Support the Mental Health Commission and existing National Working Group in the implementation of the Mental Health Act 2001
- Agree a national Forensic Psychiatric Service framework
- Support those with acute episodic and enduring mental health difficulties through improved liaison and communication between Acute Day Hospital personnel and stakeholder networks *(Q & F Action 51)*
- Develop mechanisms to strengthen an integrated service response to the homeless *(Q & F Action 21)*

- Continue the integration of existing acute mental health services within Acute Hospital services *(Q & F Action 55)*
- Support the development of a national strategy for action on suicide prevention *(Q & F Action 25)*
- Review and consider the report of the Department of Health and Children Expert Group on Mental Health Policy due for completion in 2005 *(Q & F Action 25).*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures / performance indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005, is attached (Appendix 2).

NATIONAL PI REFERENCE NO	CATEGORY	OUT-TURN 2004*	TARGET 2005
	ACUTE UNIT ADMISSION RATES		
MH5 (b)	Admission rates to acute units per 100,000 population	152.44	152.44
MH5 (c)	First admission rates to acute units (first ever admission), per 100,000 population	39.49	39.49
MH5 (e)	In-patient re-admission rates to acute units per 100,000 population	112.95	112.95
	INVOLUNTARY ADMISSIONS		
MH8	Rate of people admitted involuntarily per 100,000 population	20.1	20.1

**Relates to Quarter 3 2004*

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the €15.2m additional funding received in respect of the 2005 funded service developments listed below has yet to be determined. This funding is provided to:

- Provide and staff an additional 14 Beds at the Central Mental Hospital, Dublin
- Expand Community based adult mental health teams
- Provide additional community residential places
- Open new mental health facilities
- Support Voluntary Organisations
- Open an acute psychiatric unit at Connolly Memorial Hospital, Dublin.

These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.4.3.2 KEY ISSUES FOR THE YEAR AHEAD

A Key issue for 2005 includes:

- Implementation of the *Mental Health Act 2001*.

4.4.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Activity data will also be collected and provided for the Health Research Board and Inspector of Mental Hospitals. Where they exist, Consumer Panels/forums will continue to monitor and review services.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.4.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

Research on suicidal behaviour and its prevention in Ireland will be undertaken. The implementation of the recommendations of the Mental Health Inspectorate will be supported. Co-operation with the Mental Health Commission will take place in the fostering and promotion of high standards of care and best practice in the delivery of mental health services, ensuring that the interests of those involuntarily detained are protected.

Specific details are included within the individual Business Plans that support this national Service Plan.

4.5 SERVICES FOR OLDER PEOPLE

4.5.1 CONTEXT

ROLE AND PURPOSE

Services for Older People aim to support older people to remain at home in independence for as long as is possible, or where this is not possible, in an alternative appropriate residential setting. A range of services is provided in partnership with older people themselves, their families, carers, statutory, non-statutory, voluntary and community groups. The principles of person-centredness and empowerment of service users underpin service delivery.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in the *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 Census of Population indicated that there were 436,001 older people (i.e. people aged > 65 years) in the country, representing 11% of the overall population. Table 4.5.1 below presents a profile of this population by age category and compares it to the 1996 Census, while Table 4.5.2 presents a profile of older people living alone.

Table 4.5.1: Older People Population Profiles 1996 and 2002

	Total Population	Total Number of Persons Aged > 65 Years	Number of Persons Aged 65-74 Years	Number of Persons Aged 75- 84 Years	Number of Persons Aged 85 Years and over	Percentage Population Aged > 65 Years
Ireland 2002	**3,917,203**	**436,001**	245,603	148,672	41,726	**11**
Ireland 1996	**3,626,087**	**413,882**	239,351	139,868	34,663	**11**
Difference No of People 1996-2002	+29,1116	**+22,119**	+6,252	+8,804	+7,063	
Percentage Difference No of People 1996-2002		**+5%**	+2.6%	+6%	+20%	

Source: Census 1996 and 2002

Table 4.5.2: Profile of Older People Living Alone 2002

	No of People Living Alone	Percentage of All Persons in the Age Group
Total Persons > 65 years living alone	**113,826**	**26**
Males Aged >65 years living alone	38,014	
Females Aged >65 years living alone	75,812	
Total Persons > 70 years living alone	**88,411**	**29**
Males Aged >70 years living alone	27,169	
Females Aged >70 years living alone	61,242	

Source: Census 2002

The emerging changing demographic profile i.e. of an 'ageing' older people population, with over one in four older people living alone, together with increased life expectancies as outlined in Chapter 3 (Population Health Status), as well as 38% of pensioners living in the lowest 20% of households in terms of income, present particular challenges for future service provision, particularly the maintenance of quality of life.

It is recognised that older people continue to have a zest for life, remain active, healthy and socially involved for longer, often with the support of statutory, non-statutory, voluntary and community groups. Emphasis is therefore on empowering older people in the promotion and maintenance of their own health and well–being in the community, supporting them to remain in their own homes and communities and anticipating their future needs.

The main causes of death in older people are circulatory disease, stroke and cancer. Infectious diseases (pneumonia and influenza) and chronic obstructive airways disease are the leading causes of death from respiratory disease in Ireland. Annually a vaccine is made available to key 'at risk' groups, including older people, to prevent pneumonia and influenza. Based on uptake levels as illustrated in Table 4.5.3 below, there is a need to further promote the uptake of this vaccination.

Table 4.5.3: National Average Influenza Immunisation Uptake 2003-2004

Age Group - Years	Percentage Uptake GMS Population
65 – 69	52
70 – 74	59
75+	68

Source: National Disease Surveillance Centre 2004

It is estimated that one in five people over the age of 80 years will develop dementia or dementia related illnesses.

With increasing life expectancies older people may require admission to hospital services thereby necessitating the development of clear care pathways between hospital and Primary, Community and Continuing Care services. Appropriate 'step-down' facilities to assist the transition home to the community need to be available together with effective and integrated links between acute and other services to support a holistic and person-centred approach to care.

As the population ages the demand for long-term residential care beds continues to increase resulting in waiting lists for these services.

Considerable needs analyses and consultation processes have been undertaken to identify the needs of older people. The findings have been used to inform and shape national policy and

influence the delivery of Older Peoples' Services. Additionally, the ongoing process of needs identification is undertaken in consultation and partnership with older people themselves, their families, carers and representatives to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choice, and which reflect best practice.

4.5.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided across a continuum from services at home and in the community through to high quality hospital and residential care services when required. Specialist psychiatric services for older people are provided for persons with mental disorders arising for the first time in people over the age of 65 years and persons with dementia with behavioural or psychological problems.

Such services are provided in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups. The broad range of Primary and Community based services are accessed as well as specialist services, which include:

Home and Community

- Information/Health Promotion
- General Practice including practice based nursing and other services
- Community Pharmacy
- Public Health and Home Nursing
- Dental/Aural/Ophthalmics
- Chiropody
- Home Help and Home Care Assistant
- Meals-on-wheels
- Day Centres/Clubs
- Support for Carers
- Pilot Home Care Subvention Schemes
- Integrated Home Care Schemes
- Assessment, supply and fitting of medical appliances
- Occupational Therapy
- Physiotherapy
- Speech and Language Therapy
- Continence Advice
- Nutritional Advice
- Grant Aid to Voluntary Organisations
- Special Housing Aid for the Elderly Scheme (Dept of the Environment)
- Boarding Out
- Respite Care
- Short-term Convalescent Care
- Community Rehabilitation
- Multidisciplinary Psychiatry of Old Age Team.

Hospital Services

- Acute Services including Departments of Medicine for Older People
- Psychiatry of Old Age
- Rehabilitation Care
- Day Hospitals for older people
- Discharge Co-ordination.

Continuing Care

- Public long term residential care
- Private nursing homes.

Profiles of existing levels of home/community services and long-stay beds are presented in Tables 4.5.4 and 4.5.5 below.

Table 4.5.4: Profile of Home/Community Based Service Provision 2004

Home Help Service	No of Persons over 65 years in receipt of service	No of hours of Home Help Service Provided
	29,195	6,923,247

Service	No of Persons over 65 years in receipt of service
Day Care	25,374
Respite Care	5,491

Table 4.5.5: Profile of Long-Stay Beds 2003

	No of Public Beds	No of Private Beds
TOTAL	**12,339**	**11,486**

Source: Long–Stay Activity Statistics 2003 Department of Health and Children

4.5.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.5.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing levels and standards of home, community, hospital and continuing care services *(Q & F Actions 26,63,70,71,72)*
- Provide Home care packages for older people as part of the A & E Action Plan thereby facilitating early discharge to home and reducing inappropriate admission to hospital for acute or episodic illness *(Q & F Actions 26,53,55)*
- Continue implementation of existing programmes to prevent and address the abuse of vulnerable older people *(Q & F Actions 34,63,70,71,72)*.
- Commission additional beds in Birr Community Nursing Unit *(Q & F Actions 26,53).*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences, and choices and reflect best practice

- Ascertain and respond to user preferences by ensuring participation in planning and decision making forums *(Q & F Actions 26,46,47,50,52,68,70).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Continue provision of health, wellness and activity programmes including programmes delivered in partnership with voluntary organisations *(Q & F Actions 5,13,26,30,52,54)*

- Continue to work with national groups, Local Authorities and County Development Boards in developing public policies that reflect the needs of older people in the areas of housing, transport, security, environment etc. *(Q & F Actions 26,45,52,68,70,71,72)*
- Facilitate and strengthen partnerships with the voluntary sector, consumers and carers *(Q & F Actions 26,41,70,71,72)*
- Promote the uptake of influenza vaccine among the population aged over 65 years *(Q & F Action 26)*
- Continue to work in partnership with local non-statutory, voluntary and community groups to re-prioritise available resources under the RAPID / CLAR Programmes *(Q & F Actions 26,52,53,54,70,71,72)*
- Continue ongoing collaborative work through established forums including Co-ordinating Committees for Services for Older People *(Q & F Actions 50,52)*
- Work with statutory, non-statutory, community and voluntary groups to address the housing needs of persons with a mental illness *(Q & F Actions 21,26).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Promote the development of consistent services nationally *(Q & F Actions 50,51,52,112*)
- Ensure effective and co-ordinated delivery of services through the organisations funded by the Primary Community and Continuing Care Directorate *(Q & F Actions 26,53)*
- Continue the development of multi-disciplinary teams to ensure the development and delivery of person-centred and efficient services for older people *(Q & F Actions 26,51)*
- Develop and strengthen linkages and clear pathways of care between acute hospitals/ tertiary services and Primary, Community and Continuing Care Services to ensure co-ordinated, appropriate and timely on-going care where required, with a particular focus on returning older people to their home / community environments as soon as possible *(Q & F Actions 26,40,41,51,53,70,71,72)*
- Review acute hospital admission and discharge policies, taking cognisance of HeBE *Admission and Discharge Protocols & Policies Guidelines* (2004) *(Q & F Actions 26,53)*
- Establish agreed model of Psychiatry of Old Age Service and relationships with Older Peoples' Services and Adult Psychiatry *(Q & F Actions 25,26,51).*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/Performance Indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005 is attached (Appendix 2).

NATIONAL PI REFERENCE NO	CATEGORY	OUT-TURN 2004		TARGET 2005	
	INFLUENZA VACCINATION				
OP3 (a)	Number and percentage among the GMS population 65 years and over who have received influenza vaccine	No	%	No	%
		225,212	60	225,212	60*
	**Commentary: ***Improving national immunisation will be an important priority of the Directorate in 2005. This will require targeted actions in those local areas or for particular groups where uptake is below current norms as well as more general promotional actions.				
	HOME /COMMUNITY BASED SERVICE PROVISON				
OP5 (a)	Number and percentage of people over 65 years of age who were in receipt of the following services				
		No	%	No	%
	a) Home Help Services	29,195	7	29,195	7
	b) Day Care	25,375	6	25,375	6
	c) Respite Care	5,491	1	5,491	1
OP5 (b)	Number of Hours of Home Help service provided	6,923,247		6,923,247	
	RESIDENTIAL CONTINUING CARE				
OP4 (b)	Number of people aged over 75 years in residential continuing care settings as a percentage of the total population over 75 years	No	%	No	%
		19,496	10	19,496	10
	PRIVATE NURSING HOME INSPECTIONS				
	No. of Private Nursing Homes Inspected	466		466	
	NURSING HOME SUBVENTIONS				
	Number of people in receipt of:				
	a) Basic Subvention	3,872		3,872	
	b) Enhanced Subvention	3,362		3,362	

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the €21.61m additional funding received in respect of the 2005 funded service developments listed below has yet to be determined. This funding is provided to:

- Implement the A & E Action Plan by providing additional services for older people including home care packages €20.4m. This will facilitate early discharge to home and reduce inappropriate admission to hospital for acute or episodic illness
- Commission 20 additional beds in the Community Nursing Unit in Birr €1.21m.

These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.5.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Demand for Older Peoples' Services due to an increasing population aged over 65 years
- Responsiveness to care requirements of older people following completion of acute phase of hospital treatment
- The potential for a significant influenza outbreak.

4.5.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.5.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

Links with academic institutions and professional groups for the purpose of research and the development of evidence-based practice in Psychiatry of Old Age Services will continue to be developed.

Specific details are included within the individual Business Plans that support this national Service Plan.

4.6 SOCIAL INCLUSION

4.6.1 CONTEXT

ROLE AND PURPOSE

Social Inclusion Services refer to services that are targeted at those who are living at the margins of society. While the public can access all of the general services available, these specific services aim to promote sustainable social integration, improve health and social gain, alleviate poverty, and reduce health inequalities for individuals and families experiencing social disadvantage. This focus is in recognition that those at the higher end of the socio-economic scale live longer and enjoy better health than those at the lower end, and that people on the margins of society are at greatest risk of poverty and exclusion.

Needs led, person-centred services are delivered in partnership with individuals, families, their representatives and communities.

For the purposes of this service plan Social Inclusion Services include the Homeless, Ethnic Minorities, Travellers and persons with Addictions.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

Persons experiencing social disadvantage have a variety of needs, with some individuals/communities in some concentrated geographic areas experiencing cumulative disadvantage having particular needs. Individuals/communities at risk of social exclusion also need to be supported in order to facilitate inclusion.

The Mean Deprivation Index (4.6% Ireland) captures the key determinants of poverty and social exclusion in an area. The most important causes identified in the index are unemployment, isolation, lone parenthood, poor educational achievement and housing. Inequalities in health exist because of a combination of the foregoing factors.

Needs include information, accommodation, health and welfare, work, education and training which require a range of responses including statutory, non-statutory, voluntary and community groups.

- **Homeless**

Persons who are homeless may include young persons leaving care, older people who are inappropriately placed in institutions and persons with mental health and addiction problems. Estimating the number of homeless can be very difficult due to either their transient existence, the fact that they are involuntarily sharing with family or friends or are not accessing homeless services (i.e. the hidden homeless), or the fact that housing waiting lists do not necessarily reflect the true level of need given that many single people do not register

knowing they will be low on the priority list. In 2002, the Department of the Environment and Local Government estimated that there were 48,413 households on the housing waiting lists nationally, with 3,773 families (5,581 people) homeless.

The needs of homeless persons with regard to accommodation comes within the remit of the Local Authorities as part of their overall housing responsibility. The Executive is responsible for the health care needs of homeless persons. Involvement is therefore on a joint basis, together with other statutory, non-statutory, voluntary and community groups.

- **Ethnic Minorities**

The 2002 Census of Population indicated that there were 3,535,700 Irish nationals in the country, representing 91.6% of the overall population. Non-Irish nationals made up just 5.8% of the population in 2002, of whom 2.7% were UK nationals, followed by other EU nationals, nationals of other European countries, Asian, African and US nationals in that order. Table 4.6.1 below presents a profile of this population by nationality and gender.

Table 4.6.1: Usually resident population* 2002 by main nationality group and gender

Nationality	No. of Persons			% Population
	Total	Male	Female	
Irish	3,535,700	1,754,700	1,781,000	91.6
Dual Irish / Other	49,300	23,900	25,400	1.2
United Kingdom	103,500	50,700	52,800	2.7
Other European Union	30,000	14,000	16,000	0.8
Rest of Europe	23,100	12,900	10,200	0.6
Asia	21,800	12,000	9,800	0.6
Africa	21,000	11,000	9,900	0.5
United States of America	11,400	5,200	6,200	0.3
Other Countries	11,200	5,700	5,500	0.3
Multiple Nationality/ No Nationality	3,100	1,600	1,500	0.08
Not Stated	48,400	24,500	23,900	1.2
Total	**3,858,500**	**1,916,200**	**1,942,300**	**100**

**Excludes visitors* *Source: Census 2002*

Migrants and ethnic minorities are vulnerable to social exclusion and research shows that this applies to emigrants from Ireland as much as to immigrants to this country. Women within these groups are especially vulnerable *(National Anti-Poverty Strategy 2003 – 2005).*

The particular needs of migrants and ethnic minorities require the provision of culturally appropriate services by an informed and culturally aware workforce throughout statutory, non-statutory, voluntary and community services.

- **Travellers**

The 2002 Census of Population indicates that there were 23,681 Irish Travellers in the country, representing 0.6% of the overall population. Table 4.6.2 below presents a profile of this population by age category and gender.

Table 4.6.2: Traveller population profile 2002 by age group gender

	Irish Travellers No. of Persons			% Population
	Total	Male	Female	
Children 0-17 years	11,725	5,981	5,744	50
Adult 18 – 64 years	11,180	5,373	5,807	47
Older people (> 65 years)	776	354	422	3
TOTAL	**23,681**	**11,708**	**11,973**	**100**

Source: Census 2002

When compared to the age profile of the overall population as indicated in Table 4.1.1 of Chapter 4 (section 4.1 Primary Care Services) the age profiles of the two populations differ markedly. While the young population aged 0-17 years accounted for 26% of the general population, the corresponding proportion was 50% for Travellers. Older Travellers (i.e. those aged 65 years and over) accounted for just 3% of the total Traveller population compared with 11% for the general population.

The high birth rate prevalent in the Traveller Community contributes to both higher proportions in the younger age groups and consequentially lower proportions in the older age groups. In addition, the latter is also affected by higher mortality rates for the Traveller Community.

Living conditions impact on health status. Table 4.6.3 below presents an accommodation profile of Travellers.

Table 4.6.3: Accommodation Profile of Travellers 2002

	Permanent Housing Units	Temporary Housing Units	No Description
Percentage of the overall Traveller population	58.6%	33.9%	7.5%

Source: Census 2002

Responses to the particular needs of Travellers are developed and delivered in partnership with Travellers themselves, their representative organsations, statutory, non–statutory, voluntary and community groups.

- **Addiction Services**

Drug Misuse

Recent research on illegal drug use in Ireland showed cannabis as the most widely used drug, the highest prevalence rate being 8% among the adult population, as compared to 3% for ecstasy and 2% for cocaine. Cannabis use was higher among young adults (15-34 years) than older adults (35-64 years). 14,452 people were estimated as using heroin *(National Advisory Committee on Drugs (2003)*). In general, men report higher prevalence rates of drug use than women.

An analysis of drug misuse in Ireland from 1998-2002 by the Health Research Board found that the numbers treated for problem drug use and residing in the eastern region increased by 24% during that period, while the numbers treated for problem drug use residing outside the eastern region increased by 163%.

Alcohol

SLÁN, 2003 found that 30% of males and 22% of females consume over the recommended upper limit of 21 standard drinks for men and 14 for women, with higher levels in the younger age group. It also reported an increase from 1998 to 2002 in the number of people drinking six or more drinks on one drinking occasion, (defined as binge drinking by the World Health Organisation). This level of over consumption of alcohol is also linked to educational achievement as illustrated in Table 4.6.4 below.

Table 4.6.4: Percentage Consuming more than the Recommended Upper Weekly Drinks Limits (14/21 standard drinks) by Sex, Age and Educational Status

	Males	Males	Males	Females	Females	Females
	*ED1	ED2	ED3	ED1	ED2	ED3
18-34 yrs	44	34	35	27	27	26
35- 54yrs	25	30	21	25	20	20
55+ yrs	28	20	34	8	20	22

Source: National Health & Lifestyle Surveys 2003

**ED1= some secondary education; ED2=complete secondary education; ED3 = some or complete third level education*

As a consequence, alcohol related problems present at different levels in the health service including attendance at Hospital A & E Departments, especially late at night and at weekends. Alcohol use during pregnancy is a growing concern. Alcohol is also involved in 42% of parasuicide cases (3,468 of all cases) in Ireland with a higher incidence among males (46%) than females (38%). In 2003, there were 3,685 admissions to Psychiatric In-patient Units and Hospitals for alcoholic disorders. This accounted for 16% of all admissions (Health Research Board 2004).

The harm experienced as a result of alcohol misuse has personal, economic and social consequences. The vast majority of alcohol harm occurs among the adult population. Young Irish men (18-29 age group) reported experiencing more acute harm (work, fights) than any other group in the population, while older men (50-64 age group) reported experiencing more chronic harm (home-life or marriage, health) than others. Young women (18-29 years) reported experiencing more negative consequences than older women, especially harming their work and friendships, getting into fights and having accidents.

Response to the particular needs of those dependent on drugs/alcohol requires a partnership approach across organisational boundaries by statutory, non–statutory, voluntary and community groups together with clear strategies to prevent and reduce levels of drug/alcohol misuse and harm.

Considerable analyses and consultation processes to identify the needs of persons who are experiencing social disadvantage have been undertaken to inform and shape national policy and influence the delivery of services to minimise disadvantage. Additionally the ongoing process of needs identification is undertaken in consultation/partnership with individuals, their families, representatives and communities to ensure the development and delivery of person-centred, needs led services which are responsive to user preferences and choice, and which reflect best practice.

4.6.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services are provided across a continuum, from prevention services at home and in the community through to high quality hospital and residential care services when required. Specialist services are provided for people with specific needs arising from their marginalisation. Services are provided in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups.

A broad range of Primary, Community based and specialist services are accessed including:

- Culturally appropriate health information/ health promotion including peer led initiatives and services
- Helplines
- Community Education
- Community work
- Primary Health Care including GP, Community Pharmacy and Public Health Nursing
- Antenatal care
- Community Welfare
- Mental Health
- Emergency accommodation
- Psychiatric outreach
- Programmes to address needs of homeless people with alcohol or addiction dependencies
- Specific medical and dental services operating within centres for homeless persons
- Screening and Vaccination
- Primary Health Care for Traveller Projects
- Psychology
- Cultural mediation
- Needle exchange/harm reduction programmes
- Outreach
- Counselling
- Residential
- Day treatment
- Detoxification
- Rehabilitation
- Aftercare
- Relapse prevention
- Acute Hospital
- Referral to other services.

The Government's geographically targeted social inclusion programmes RAPID and CLAR are fast-track initiatives aimed at delivering existing resources to areas of maximum need and extend to a number of areas throughout the country.

4.6.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/ implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

4.6.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing levels and standards of culturally appropriate home, community and residential based health promotion, prevention, intervention services, materials and programmes *(Q & F Actions 18,19,20,21,22,23)*
- Provide specified additional services to Asylum Seekers (*Q & F Action 23).*

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences, and choices and reflect best practice

- Support the statutory, non-statutory, voluntary and community sector to empower marginalised people to participate in decision making and planning regarding their own health and support needs *(Q & F Actions 18,19,20,21,22,23)*
- Develop a National Service Users Charter for all drug initiatives *(Q & F Action 22).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Continue ongoing collaborative work through established national and regional forums *(Q & F Actions 19,20,21,22,23)*
- Promote the uptake of appropriate health screening for communicable diseases *(Q & F Action 23)*
- Develop and implement targeted culturally appropriate health promotion programmes based on agreed, identified community needs *(Q & F Actions 18,19,20,21,22,23)*
- Contribute to local partnership initiatives combating social exclusion, e.g. RAPID, CLAR Programmes, Area Partnerships, City and County Development Boards, Minority Support groups, Local and Strategic Drug Task Forces *(Q & F Actions 18,19,20,21,22,23,54)*
- Continue ongoing collaborative work through established forums including Traveller Health Units and other Co-ordinating Committees *(Q & F Actions 50,52).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Promote the development of consistent services nationally (Q & F Actions 50,51,52,112)
- Promote culturally appropriate service provision *(Q & F Actions 20,21,22,23)*
- Foster partnerships with key stakeholders working in the area of social inclusion to advance the integration of marginalised groups into mainstream services *(Q & F Actions 20,21,22,23)*
- Promote improved accessibility to health care information and services *(Q & F Actions 18,19,20,21,22,23)*
- Develop and implement a National Code of Practice to address issues of discrimination and racism *(Q & F Actions 18,19,20,21,22,23).*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/Performance Indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite, which will form part of the National Performance Monitoring Framework for 2005, is attached (Appendix 2).

NATIONAL PI REFERENCE NO	CATEGORY	OUT-TURN 2004	TARGET 2005
	SERVICES FOR ASYLUM SEEKERS		
AR2 (a)	The number of Asylum Seekers offered screening	9,506	In response to needs
AR2 (b)	The number of Asylum Seekers who completed screening for:		
	Hepatitis B	2,964	In response to needs
	TB	4,632	In response to needs

FUNDED SERVICE DEVELOPMENTS

The specific allocation of the €2m additional funding received in respect of the 2005 funded service developments listed below has yet to be determined. This funding is provided to provide services to Asylum Seekers. These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

4.6.3.2 KEY ISSUES FOR THE YEAR AHEAD

A key issue for 2005 is:

- Capacity of statutory, non-statutory, voluntary and community groups to meet identified needs in an integrated way.

4.6.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

The Addiction Services will provide six monthly reports to the Department of Community Rural and Gaeltacht Affairs on the implementation of the National Drug Strategy. The Addiction Services will also support the Health Research Board and the National Drug Treatment Reporting System.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

4.6.3.3 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes.

Participation in the All Ireland Travellers' Health Study and the Strategic Task Force on Alcohol, and implementation of the work programme of the National Advisory Committee on Drugs will continue. Equality proofing mechanisms will be developed and built into planning, implementation and evaluation of all mainstream and targeted services.

Specific details are included within the individual Business Plans that support this national Service Plan.

5.0 NATIONAL HOSPITALS OFFICE

5.0.1 CONTEXT

ROLE AND PURPOSE

The National Hospitals Office (NHO) Directorate is responsible for the provision of all Acute Hospital and Ambulance Pre-hospital Emergency Care services throughout the country. The NHO is also responsible for approving specialised treatment for patients in countries outside the State.

The establishment of the Executive has presented the opportunity to develop alternative organisational arrangements within the acute hospital sector. This has enabled the NHO to realign, on an interim basis, the 53 statutory and non-statutory acute hospitals into one unified structure, which is comprised of 10 networks, and to commence the integration of regional ambulance services into a national service.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

The 10-point A & E Action Plan announced by the Minister for Health and Children in November 2004 will also influence the planning and delivery of services within the National Hospitals Office in 2005.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The 2002 census recorded a population of 3,917,203 persons in the State, the highest population recorded since the census of 1871. It reflects an increase in population growth of 8% or 291,116 persons since the 1996 census. This population is now estimated to exceed 4 million.

Demographic factors such as the ageing of the population; morbidity factors; lifestyle choices such as smoking and alcohol consumption; and access to Primary Care Services all impact on the need for acute services.

A detailed overview of the health status and the consequent health needs of the population for acute services are included in Chapter 3 (Population Health Status).

5.0.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The NHO is responsible for the management of all acute Medical, Surgical, and Specialist Services delivered by each of the 10 hospital networks, and for the delivery of Ambulance Pre-hospital Emergency Care Services, which are co-ordinated centrally.

The funding for Acute Mental Health services is also currently held by the NHO Directorate, although the planning and delivery of these services sits within the remit of the PCCC Directorate.

A comprehensive range of assessment, diagnosis, treatment and rehabilitation services are provided on either a national or a supra-regional basis through acute hospitals. Designated national specialist services incorporate areas of care such as heart/lung transplantation, liver transplantation, cochlear implants, metabolic screening, bone marrow transplants, adult cystic fibrosis, spinal injuries, paediatric cardiac services, medical genetics, renal transplantation and haemophilia. Supra-regional services include neurosurgery and cardiac surgery, as well as complex cancer surgeries and radiotherapy.

The Major Academic Teaching Hospitals also provide tertiary and national/supra-regional specialist services for persons from outside their region, although there may be regional variations in the organisation and delivery of some of these services.

In addition to direct service provision there are a number of arrangements in place with other service providers in Ireland and abroad for delivery of specific services. These include agreements to provide clinical services including renal dialysis, paediatric cardiothoracic surgery, lung transplants and radiotherapy.

Ambulance services are currently delivered through an area based model, with the operational responsibility assigned to a Chief Ambulance Officer in each area. In the eastern area, in addition to the Ambulance Service, Dublin Corporation Fire Service provides Ambulance Services in the greater urban area of Dublin City.

5.0.3 THE YEAR AHEAD

During 2005 the NHO will seek to maintain existing service delivery levels and introduce specific targeted actions, particularly in relation to A & E services.

In relation to service delivery, the NHO will place significant emphasis on developing regional self sufficiency and on the integration of hospital services with primary, community and continuing care services, focusing on the needs of individuals, their families and communities at local level.

Specific focus will be given to the following key areas:

- Responding to current A & E service pressures
- Optimising the commissioning of additional bed capacity
- Ensuring an equitable provision of Public/Private patient care
- Enhancing efficiency through analysis of activity and utlisation of Casemix
- Promoting the provision of accessible information to the public
- Auditing and targeting of infection control initiatives
- Enhancing the cleanliness of hospitals
- Developing the hospital services ICT capability
- Establishment of a National Ambulance Service
- Integration of hospital related functions of Comhairle na nOspidéal into the NHO
- Progressing negotiations on the Consultants Common Contract.

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual hospital network Business Plans that support this national Service Plan.

5.0.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

There are four significant objectives reflected throughout this Service Plan:

- To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety
- To provide person-centred, needs led services, which are responsive to user preferences and choices and reflect best practice
- To develop and deliver services in accordance with a population health approach
- To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services.

Specific actions to support the implementation of these objectives are detailed in the Acute Hospitals and Ambulance Services plans.

In 2005, the NHO Directorate will pursue the following:

- Greater integration through co-operation and clinical exchange to ensure best practice and best outcomes for patients. Integration will be promoted within and between networks, between national and local, secondary and tertiary levels and between the hospital sector and primary, community and continuing care services
- The application of parity of treatment in our relationship with all hospitals. This will be underpinned by the following principles:
  - Fairness in resource allocation and staffing
  - Alignment of clinical decision making and accountability
  - Standardised performance measurement in line with the new National Performance Monitoring Framework
- Continued implementation of national policy and strategy within available resources
- Continued participation in the Major Emergency Planning activities of the Executive.

ACTIVITY

Specific activity/performance measures in respect of National Hospitals Office Services are included in the individual Acute Hospitals and Ambulance Services plans, and in the associated Business Plans that support this national Service Plan.

5.0.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues in 2005 include:

- The implementation of the EU Working Time Directive for non consultant medical staff
- Recruitment and retention of staff in particular disciplines and areas
- Management of patient flows through the Acute Sector
- Shortfall in the required resource levels to ensure that effective technological advancement is maximised.

5.0.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Monitoring to ensure the effective transition to the new organisational structures will also be undertaken.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

5.0.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible.

The Executive will examine research evidence on patient outcomes to help determine the best balance in public private mix of services and research evidence on issues surrounding patient safety.

Specific details are included within the individual Business Plans that support this national Service Plan.

5.1 ACUTE HOSPITALS

5.1.1 CONTEXT

ROLE AND PURPOSE

The role of the NHO is to manage and co-ordinate the delivery of acute hospital services in the 53 statutory and non-statutory acute hospitals, through 10 hospital networks, and to manage the Ambulance and Pre-hospital Emergency Care Services.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

The 10-point A & E Action Plan announced by the Minister for Health and Children will also influence the planning and delivery of services within Acute Services in 2005.

The various published Comhairle na nOspidéal reports including those on accident and emergency services, vascular, haematology, dermatology, acute medical units, neurology and neurophysiology services also inform policy and planning of acute service provision. Other Comhairle reviews currently underway include ENT, pathology, rheumatology, plastic surgery and urology.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The *National Acute Hospital Bed Capacity Report (2002)* acknowledged the requirement for 3,000 additional beds in the acute hospital sector. To date, 709 additional beds have been provided. Significant shortage of convalescent and rehabilitation provision has been identified in certain parts of the country, and the need to address these non-acute capacity issues is critical to the effective management of acute hospitals beds, in-patient waiting lists and emergency medical admissions.

The executive will commence an analysis of bed use in acute hospitals to identify the home support and the step down services required to accommodate patients medically fit for discharge. The outcome of this analysis will inform an assessment of the need for additional beds and their infrastructure requirements. The Executive will determine the most efficient way of providing this infrastructure.

Additionally in order to ensure equity of success to specialist medical services, the Executive wishes to ensure that public patients have access to consultant provided services and this will be prioritised in the investment of resources in additional consultant manpower.

There are particular needs in relation to Renal, Maternity and Cardiovascular Services as follows:

RENAL SERVICES

Kidney failure becomes more common with increasing age. The projected population growth in the population aged 65 years and the increase in longevity, are likely to place considerable demand on medical services for the treatment of End Stage Renal Disease (ESRD).

Increases in the incidence of diseases known to have direct links with ESRD will also contribute to the number of patients presenting with ESRD. In particular, type II diabetes has been shown by WHO to have increased at a global level of 35% between 1995 and 2000. It is predicted to increase by 50% by the year 2010. Internationally, it is recognised that 2-3 % of the population will have diagnosed diabetes with a further 2% are undiagnosed. In the population over 65 years the prevalence is 10%. This will influence the incidence of patients presenting with ESRD, as diabetes accounts for approximately 14% of all such patients. Allied to the management of ESRD is the need for prevention, particularly in terms of management of diabetes.

In light of the above it is estimated that growth in the incidence of patients presenting with ESRD will at a minimum be somewhere between 10 and 15% per annum nationally for at least the next 5 years. This will necessitate significant expansion of dialysis services for the future.

MATERNITY SERVICES

The principal objective for maternity services in Ireland is to ensure choice, continuity of care and safety for all women in all phases of pregnancy and childbirth. Projected activity levels, together with the changing demographic profile and risk management issues, indicate that there are significant challenges in meeting demand from within current maternity services. It is therefore recognised that there is an ongoing need to review and re-engineer maternity service provision in order to meet changing needs.

This will involve expanding the range of models of care available to women, ensuring choice and continuity of care. Other initiatives will include increasing the availability and accessibility of services as well as improving the level and flexibility of available resources.

CARDIOVASCULAR SERVICES

Hospital Services have seen substantial expansion of non-invasive specialised cardiac investigation services, with most networks now being self-sufficient in the range of non-invasive diagnostic tests. Nationally the waiting list for cardiology procedures has fallen by 24%, from 1,102 in June 1999 to 841 in June 2002. The waiting lists for cardiac surgery have fallen more markedly in the same time period, by 75% from 1,106 to 273. The number of invasive procedures has increased substantially since 1996, with a 53% increase in angiography and a 198% increase in Coronary Angioplasty.

Cardiac Rehabilitation, Phase 1 & 2 are now available in all acute hospitals with cardiology services, with Phase 3 available in 29 hospitals, compared to 12 in 1998. Phase 4 is developing in a small number of centres with community outreach programmes.

5.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The Acute Hospital Services are being delivered through a network of 10 hospital groupings since January 2005 as detailed below:

GROUPING	CONSTITUENT HOSPITALS
Network 1:	Waterford Regional Hospital Wexford General Hospital St. Luke's Hospital, Kilkenny South Tipperary General Hospital Kilcreene Orthopaedic Hospital, Kilkenny
Network 2:	Cork University Hospital Erinville Hospital St. Mary's Orthopaedic Hospital Kerry General Hospital Mallow General Hospital Bantry General Hospital Mercy University Hospital South Infirmary/Victoria Hospital
Network 3:	Lourdes Hospital, Drogheda Louth County Hospital Cavan General Hospital Monaghan General Hospital Our Lady's Hospital, Navan
Network 4:	Sligo General Hospital Letterkenny General Hospital Our Lady's Hospital, Manorhamilton
Network 5:	University College Hospital, Galway Merlin Park Regional Hospital Mayo General Hospital Roscommon County Hospital Portiuncula Hospital, Ballinasloe
Network 6:	Midland Regional Hospital, Mullingar Midland Regional Hospital, Tullamore Midland Regional Hospital, Portlaoise
Network 7:	Mid-Western Regional Hospital, Dooradoyle Mid-Western Regional Maternity Hospital Mid-Western Regional Orthopaedic Hospital, Croom Mid-Western Regional Hospital, Ennis. Mid-Western Regional Hospital, Nenagh St. Johns Hospital, Limerick
Network 8:	St. Vincent's University Hospital St. Michael's Hospital St. Columcille's Hospital National Maternity Hospital City of Dublin Skin and Cancer Hospital St. Luke's Hospital The Royal Victoria Eye and Ear Hospital

Network 9:	St. James's Hospital Adelaide & Meath Hospital incorporating the National Children's Hospital Naas General Hospital The Coombe Lying In Hospital Our Lady's Hospital for Sick Children
Network 10:	Mater Misericordiae Hospital Beaumont Hospital/St. Joseph's Hospital Connolly Memorial Hospital The Rotunda Hospital Cappagh National Orthopaedic Hospital The Children's University Hospital

A range of treatments comprising medical, surgical, specialist and national specialist services are provided through the hospital groupings at local, regional or national level as appropriate.

5.1.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

5.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

The NHO aims to provide, within available resources, a comprehensive range of acute services in response to identified need and in accordance with the principles of equity, people centredness, quality and accountability.

In order to achieve this aim the following objectives and actions have been identified:

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to give effect to national strategy and policy in service areas under the remit of the NHO, notably optimising the commissioning of additional bed capacity as per the *Acute Hospital Bed Capacity Report, 2002* *(Q & F Action 2)*
- Continue to provide existing levels and standards of acute hospital services *(Q & F Action 2)*
- Work with the National Treatment Purchase Fund (NTPF) to target a reduction in waiting times, especially for cases waiting longer than 12 months *(Q & F Actions 43, 78, 79, 80, 81, 82, 88, 91)*
- Review procedures and systems for risk management, infection control and waste management and develop a national plan which implements best practice *(Q & F Action 63)*
- Participate in robust monitoring mechanisms in respect of delivery and standards of care with specific focus on casemix and control of public/private patient mix *(Q & F Action 68)*
- Commence performance improvement initiatives within, and between, hospital networks which recognise and reward optimum performance *(Q & F Action 70)*.

OBJECTIVE: To provide person-centred, needs led services, which are responsive to user preferences and choices and reflect best practice

- Develop better integration and collaborative arrangements between hospitals and primary, community and continuing care services, thus ensuring continuity of care for service users in their interaction with health and social care services *(Q & F Action 51)*
- Implement systems to ensure that hospitals will continue to work closely with community partners in the new structures to develop integrated care, facilitating early discharge to home and avoiding the need for residential non-acute care *(Q & F Action 52)*
- Utilise service user feedback effectively in the development and enhancement of services while ensuring that best practice guidelines are reflected and that all attempts are made to improve information access *(Q & F Action 49)*.

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Participate in the measurement and analysis of population health status and health status inequalities to identify core health issues *(Q & F Action 5)*
- Utilise best evidence in all stages of policy and programme development, specifically in addressing A & E service pressures *(Q & F Actions 53, 120)*
- Collaborate with other service providers and agencies (where appropriate) in the implementation of strategies/plans to reduce inequalities in health status between population groups in conjunction with the PCCC Directorate *(Q & F Actions 6,24)*
- Participate in setting targets for health improvement by promoting the use of health impact assessment tools *(Q & F Actions 4,73)*
- Collaborate with national strategic working groups, as they evolve *(Q & F Action 52)*.

OBJECTIVE: To promote harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Prioritise equity of access and regional self-sufficiency as a key element of the allocation of resources within the acute services *(Q & F Actions 43, 84)*
- Implement the new management and organisational structures within the National Hospitals Office *(Q & F Action 110)*
- Participate in the National Accreditation programme and focus on developing the Clinicians in Management Initiative *(Q & F Action 63)*
- Ensure compliance with regulatory and professional bodies in relation to standards of clinical practice and training *(Q & F Action 105)*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The tables below present key activity measures/Performance Indicators (PIs) for 2005. A summary of the entire National Performance Indicator Suite which will form part of the Performance Monitoring Framework for 2005 is attached (Appendix 2).

In 2004, the Acute Hospital services provided in excess of 1.06m episodes of treatment as detailed below.

DISCHARGES	TOTAL FOR ALL NETWORKS	
	OUT-TURN 2004	TARGET 2005
TOTAL INPATIENT DISCHARGES	564,320	564,320
TOTAL DAY CASE DISCHARGES	504,213	504,213
TOTAL DISCHARGES	**1,068,533**	**1,068,533**

ACTIVITY	TOTAL FOR ALL NETWORKS	
	OUT-TURN 2004	TARGET 2005
TOTAL NUMBER OF BIRTHS	58,871	58,871
TOTAL NUMBER OF A& E ATTENDANCES	1,230,908	1,230,908
TOTAL OUTPATIENT ACTIVITY	2,519,047	2,519,047
BED DAYS USED	3,569,439	3,569,439
AVERAGE LENGTH OF STAY	6.0 Days	6.0 Days

NATIONAL TOTAL	ADULT INPATIENT WAITING LIST TOTALS
All Networks	**12,130**

In collaboration with the NTPF, the NHO Directorate will focus on waiting list activity, in particular with respect to those cases waiting over 12 months

National PI Reference No AS 1	INPATIENT WAITING LIST AND DISCHARGE ACTIVITY - ADULT				
	Number of Public Elective Discharges	Number waiting over 12 months	Number waiting over 6 months	Patients waiting over 12 months as % of public discharges in reporting period	Patients waiting over 6 months as % of public discharges in reporting period
Achievement 2004	64,811	4,130	7,701	6.37%	11.8%
Target 2005	64,811	4,130	7,701	6.37%	11.8%

** Note: The number of Paediatric Public Elective Discharges for Network 5 (Western Region) is included in the Adult figure above*

National PI Reference No AS 1	INPATIENT WAITING LIST AND DISCHARGE ACTIVITY - CHILD				
	Number of Public Elective Discharges	Number waiting over 6 months	Number waiting over 3 months	Patients waiting over 6 months as % of public discharges in reporting period	Patients waiting over 3 months as % of public discharges in reporting period
Achievement 2004	5,380	856	1,384	15.9%	25.7%
Target 2005	5,380	856	1,384	15.9%	25.7%

National PI Reference No AS 2	OUT-PATIENT SERVICES		
	Total number of new patients seen	**% seen within 13 weeks**	**% seen within 26 weeks**
Achievement 2004	194,161	60.9%	64.4%
Target 2005	194,161	60.9%	64.4%

The Directorate will endevour to increase the percentages seen within 13 and 26 weeks during the course of 2005.

FUNDED SERVICE DEVELOPMENTS

Additional funding of €49.6m has been allocated to the National Hospitals Office Directorate in respect of funded service developments in 2005. Whilst the allocation of this funding is yet to be determined, initiatives aimed at addressing the issues highlighted in the A & E Action Plan are priorities for the Directorate.

These developments are over and above 2004 existing funded levels.

The specific application of this funding in 2005, as appropriate, will be subject to a Business Case Development Process to be completed by the end of March 2005 and will be submitted to the Board.

5.1.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Increasing levels of emergency medical admissions, impacting on scheduled, elective workload
- Increasing demand on national centres in meeting the needs of their catchment population for general acute services
- Increasing attendance levels at A & E Departments
- Over dependence on the acute hospital sector due to the under development of primary care services

5.1.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

5.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans to support this national Service Plan.

5.2 AMBULANCE SERVICES

5.2.1 CONTEXT

ROLE AND PURPOSE

The role and purpose of the Ambulance Service is to provide a clinically appropriate and timely pre-hospital care and transportation service. Pre-hospital Emergency Care and transportation services are provided as an integral part of an integrated continuum of care which requires partnership working with other health care providers at primary and community level, and in both acute and community care settings.

Current roles and responsibilities include:

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in *Quality and Fairness: A Health System for You*.

- The care and transportation of the seriously ill and injured to and between hospitals
- Provision of non-emergency patient transport services
- Provision of routine non-ambulance patient transport within the health care sector
- Provision of the health services primary response in Major Emergencies
- Provision of pre-hospital specialist professional training and related services

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004 and within the overall policy context set out in the *Quality and Fairness: A Health System for You*.

Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

5.2.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Ambulance Services are broadly categorised into two distinct services, emergency medical services (EMS) in response to requests for services through the 999/112 emergency network and non-emergency patient transport services (PTS) in response to the needs of individuals, communities and the health care sector. The national Neo-natal programme, and the national mobile intensive care ambulance service are also provided as part of the national ambulance service.

Ambulance services are provided from a network of ambulance stations linked by radio and data communications at a series of regional control centres and in respect of the greater urban area of Dublin city, through the Dublin Fire Brigade Service.

The Ambulance Service operated a vehicle fleet of 280 ambulances and responded to approximately 235,000 emergency and urgent calls (EMS) and approximately 250,000 non-urgent patient transport (PTS) in 2004.

5.2.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed /implemented in 2005. Specific details are reflected within the individual Business Plans.

5.2.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver health and social care services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing levels and standards of ambulance and Pre-hospital emergency care services *(Q & F Action 93)*.

OBJECTIVE: To provide person-centred, needs led services which are responsive to user preferences and choices and reflect best practice

- Complete the technical review of the service command and control function and commence implementation of the findings of the technical review *(Q & F Action 93)*
- Implement the pre-hospital training programmes of the National Ambulance Training School with priority to the roll-out of the Emergency Medical Technician – Advanced (EMTA) to meet the needs of pilot regional areas identified *(Q & F Action 57)*
- Deploy EMTA grades in line with agreed deployment needs for enhanced delivery of service. *(Q & F Action 57)*
- Establish and implement an ambulance fleet up-grade and replacement programme in line with national and European standards *(Q & F Action 93).*

OBJECTIVE: To develop and deliver services in accordance with a population health approach

- Develop and maintain emergency planning arrangements in the Ambulance Service *(Q & F Action 57).*

OBJECTIVE: To promote the harmonisation and equity of all services nationally while demonstrating an improvement in access to services

- Complete a needs analysis and strategic plan for a patient transport scheme and plan the migration to a separate role and implement on a phased basis *(Q & F Action 45)*
- Evaluate and continue the roll-out of Community First Responder Programmes in the Executive Areas, to supplement and improve emergency response times *(Q & F Action 45)*
- Progress developments in the National Ambulance Training School to meet the current and future demands on Emergency Medical Technician (EMT) and EMTA training *(Q & F Action 57)*
- Continue to monitor and develop the following national services:
  - National Neo-Natal Programme
  - National Mobile Intensive Care Ambulance Service *(Q & F Action 57)*

ACTIVITY / PERFORMANCE INDICATORS / FUNDED SERVICE DEVELOPMENTS

The table below presents key activity measures/performance indicators for 2005. A summary of the entire National Performance Indicator Suite which will form part of the Performance Monitoring Framework for 2005 is attached (Appendix 2).

AMBULANCE CALLS

National PI Reference No AM1 and AM2	TARGET 2004	OUT-TURN 2004	TARGET 2005
Emergency and Urgent Calls (EMS)	224,000	235,000	235,000
National PI Reference No AM3	**TARGET 2004**	**OUT-TURN 2004**	**TARGET 2005**
Non Emergency Patient Transport (PTS)	240,000	250,000	250,000

FUNDED SERVICE DEVELOPMENTS

Additional funding of €0.600m additional funding has been allocated to the NHO Directorate in respect of funded service developments in 2005. Whilst the allocation of this funding is yet to be determined, a priority has been identified in terms of re-grading Ambulance Personnel in line with the Labour Relations Commission finding in February 2004.

These developments are over and above 2004 existing funded levels.

5.2.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005, as outlined in the *Strategic Review of Ambulance Services*, 2001 include:

- The lack of standardisation in the national Ambulance Service, specifically in respect of communications and dispatch systems
- The need to separately manage the core components of EMS and PTS
- The need for further enhancement of the staff training and development programmes.

5.2.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components which include objectives and actions, finance, human resources, service activity levels and performance indicators.

5.2.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service provision is evidence-based and will deliver the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

6.0 NATIONAL SHARED SERVICES

6.0.1 CONTEXT

ROLE AND PURPOSE

The development of National Shared Services (NSS) for the health service is a new and innovative approach to the transformation of processing activities across the health sector.

The role and purpose of the NSS Directorate is to provide a range of customer focused shared services on a national basis to support front line service delivery.

The development and implementation of the shared services model will be based on the following three tenets:

- Improvements for the patient/client
- Improvements to the working environment for staff
- Value for money

NSS will concentrate on the delivery of high volume transaction based processing, initially in five core functional areas:

- Finance
- Human Resources
- Information and Communications Technology
- Procurement
- Primary Care Reimbursement Service (formerly General Medical Services (Payments) Board)

The new shared services model, when fully implemented, will provide flexibility to deliver a range of essential administrative support services independently of front line service activities. The transfer of the processing function from front line services to shared services will enable service managers to concentrate on core service delivery.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in the *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The establishment of the NSS Directorate is critical to the effective operation of the administrative processing functions of the Executive. It will lead and deliver on improved value for money and efficiencies in processing functions by consolidating existing distributed functions and operations.

6.0.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

The processing functions which will transfer to the NSS Directorate are currently provided and managed by the Executive Areas/Streamlined Agencies in the current health and social services system.

There are two key organisations that currently provide shared services for specific functions within the health sector, namely Primary Care Reimbursement Service (formerly General Medical Services Payments Board) and Shared Services Eastern Region (formerly Eastern Health Shared Services) which provided shared services to the former three Area Health Boards and the ERHA in the eastern region.

The Primary Care Reimbursement Service calculates and makes almost all payments for services which are provided in the community by General Practitioners, Community Pharmacists, Dentists and Optometrists/Ophthalmologists under the following schemes:

- General Medical Services
- Drugs Payments Scheme (DPS)
- Long Term Illness Scheme (LTI)
- Dental Treatment Services (DTSS)
- European Economic Area (EEA)
- High Tech Drugs (HTD)
- Primary Childhood Immunisation Scheme
- Health Amendment Act 1996 – Persons with Hepatitis C
- Methadone Treatment Scheme
- Community Ophthalmic Services Scheme.

The range of services currently provided by Shared Services Eastern Region is as follows:

- Information and Communications Technology
- Employee Services
- Procurement and Materials Management
- Property and Capital Projects
- Financial Services.

The experience gained in the eastern region in delivering shared services, will be of significant value in the development of the NSS.

6.0.3 THE YEAR AHEAD

6.0.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

The NSS Directorate will work with other Directorates in each of the functional areas and service areas to ensure that the objectives listed below are met.

There will be particular emphasis on the establishment of effective working relationships with the PCCC Directorate, particularly in relation to Primary Care Reimbursement Services. Particular attention will be devoted to ensuring continuity of processing operations during the transition and change programme.

OBJECTIVE: To deliver services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing funded levels and standards of shared services during the transition from the current Shared Services Eastern Region and Primary Care Reimbursement Services *(Q & F Action 63)*

- Develop an implementation programme for each of the proposed functions within NSS *(Q & F Action 71)*
- Commence on a phased basis implementation plans for Finance, Human Resources, Procurement, ICT and Primary Care Reimbursement Services *(Q & F Actions 71,120)*

OBJECTIVE: To commence transition of relevant functions from the Department of Health and Children to National Shared Services

- Consult with the Department of Health and Children regarding the proposed transfer of Superannuation for Voluntary agencies from the Department of Health and Children *(Q & F Action 72)*
- Develop consultation process with the voluntary agencies concerned *(Q & F Action 72)*
- Develop and implement a comprehensive transition plan to migrate Superannuation for voluntary agencies from the Department of Health and Children *(Q & F Action 72)*.

OBJECTIVE: To transition of Shared Services Eastern Region to the National Shared Services

- Implement specific plan to transition and integrate Shared Services Eastern Region to NSS Directorate *(Q & F Action 71)*.

OBJECTIVE: To transition the Primary Care Reimbursement Services to National Shared Services

- Implement a specific plan for transition and integration of Primary Care Reimbursement Service to the NSS Directorate *(Q & F Action 71)*
- Produce new unitary medical cards and Drugs Payment Scheme cards for the eligible population *(Q & F Actions 117,118)*

ACTIVITY

Specific activity in respect of the Primary Care Reimbursement Services are detailed below.

Table 6.0.3.1: Primary Care Reimbursement Services – Indicative Levels 2005

Category	Number of Claim Items	Value
Doctors/Capitation Payments and Allowances for Medical Card Holders	1,391,243	€326.7 m
Drug Target Refund	1,600	€24.4 m
GMS Pharmacy Claims	40,950,212	€960.7 m
DPS Pharmacy Claims	10,430,399	€254.0 m
LTI Pharmacy Claims	1,799,613	€97.6 m
EEA Pharmacy Claims	76,552	€1.7 m
Dental Treatment Services	1,182,332 Claim Treatments	€57.6 m
High Tech Drugs	198,851	€191.1 m
Methadone Treatment	191,774	€11.5 m
Health Amendment Act 1996	20,716	€2.0 m
Community Ophthalmic Services	478,460 Claim Treatments	€18.2 m

6.0.3.2 KEY ISSUES FOR THE YEAR AHEAD

A key issue for 2005 is:

- The effective transition and integration of the Primary Care Reimbursement Services and the Shared Services Eastern Region into NSS.

6.0.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed within the individual Business Plans that support the national Service Plan.

6.0.3.4 Research, Quality, Evaluation and VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that shared service delivery is evidence-based, in line with best practice and capable of delivering on both value for money and the most effective outcomes.

In particular a quality and efficiency review of current schemes will commence. Specific details are included in the individual Business Plans that support this national Service Plan.

7.0 CORPORATE FUNCTIONS

The Corporate Functions section of this national Service Plan includes separate sections in respect of the following:

- Change Management and Organisational Development
- Finance
- Human Resources
- Information and Communications Technology
- Population Health
- Strategic Planning and Development
- Capital
- Corporate Affairs

7.1 CHANGE MANAGEMENT AND ORGANISATIONAL DEVELOPMENT

7.1.1 CONTEXT

ROLE AND PURPOSE

The development of the Executive as a single organisation to deliver a unitary system for health and personal social services requires us to embark on a programme of significant change and development. The enormity of the change management and organisational development challenges ahead cannot be underestimated and it must be recognised that we are only starting out.

The Change Management and Organisational Development (CMOD) Directorate exists to support the Executive in operating and delivering its services in an optimal way. This is achieved by enabling effective design and implementation of the Executive's organisational structure and processes. The Directorate will provide ongoing leadership and support as the Executive's organisational structure is put in place.

The role of the CMOD Directorate is to:

- Work with internal and external stakeholders to agree, develop and support the most appropriate organisational design and supporting processes for the Executive
- Ensure that managers and staff possess and utilise the necessary skills and methodologies to deliver the agreed organisational design and supporting processes.

The work of the CMOD Directorate will be responsive to the corporate priorities of the Executive as identified in the Corporate Strategy being developed in 2005.

The CMOD Directorate will operate at both national and business unit levels, to support all levels of the health and social services delivery system in the application of best practice to the design and provision of services.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

NEEDS ANALYSIS

The CMOD Directorate will be critical to the achievement of the reformed health delivery system. It will be a key strategic support to the Board and the Corporate Management Team in the implementation of the Executive's organisational structure and processes.

7.1.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services consist of elements of the work of organisations/groups now streamlined into the Executive (such as the Office for Health Management (OHM), the Health Boards Executive (HeBE), the Executive's Transition Team) and of those currently engaged in organisational development in the health services.

7.1.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

7.1.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

Objective: To work with the National Directors to agree, develop and support the most appropriate organisational design and supporting processes for the Executive

- Lead and facilitate the Corporate Management Team in the development and implementation of the Executive's transition arrangements *(Q & F Actions 71,110)*
- Commence a structured organisational design, service improvement and process development programme to deliver on the agreed corporate priorities *(Q & F Actions 63,68,70)*

OBJECTIVE: To ensure that managers and staff have the necessary skills and methodologies to deliver on the agreed organisational design and supporting processes

- Continue existing, and develop new, relevant management development programmes and resources *(Q & F Actions 104,107)*
- In conjunction with the Corporate Management Team, facilitate staff involvement in organisational and process design (for example through establishing collaborative links with the National Partnership Forum and the partnership processes within the health delivery system) *(Q & F Action 110).*

OBJECTIVE: To develop a governance structure for the CMOD Directorate

- Identify and implement appropriate national and regional structures *(Q & F Actions 63,68,110)*
- Integrate the change management/organisation design functions/capabilities of the former HeBE and the former OHM into the CMOD Directorate *(Q & F Actions 68,71,110).*

7.1.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- The development of the Executive's corporate strategy and plan
- Effective transition and integration of streamlined services

7.1.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed within the individual Business Plans that support the national Service Plan.

7.1.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that the corporate and customer affairs service delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible.

As part of its brief to bring best practice to bear on all aspects of organisational and process design within the Executive, CMOD Directorate will commission/undertake relevant research and service/process reviews. The detail of these will emerge in response to the corporate strategy agreed by the Executive. Specific details are included within the individual Business Plans that support this national Service Plan.

7.2 FINANCE

7.2.1 CONTEXT

ROLE AND PURPOSE

The Finance Directorate will provide strategic and financial governance, and management support, to the Board and other National Directorates. This includes the development of policies for financial planning and control to be approved by the Board, and supporting and assuring the implementation of these policies throughout the management system of the Executive.

The Directorate is also responsible for advising the Board, and Chief Executive Officer/ Management Team on all aspects of financial management and control, and for the preparation of monthly, bi-monthly and annual financial reports. Specifically, the Finance Directorate will prepare the Annual Financial Statement.

The setting up of a financial management system for the Executive will involve moving from many different systems and procedures in the former Health Boards/ERHA and the agencies streamlined to one single national system. The implementation of the new system wide financial information system – FISP - will assist in the integration of financial management and control processes and information within the Executive.

From January 2005, revised accounting arrangements will apply to the Executive and the Chief Executive Officer will be the Accounting Officer for the Executive's Vote. This will have particular implications for the Finance Directorate in supporting the CEO in this role and in respect of working arrangements on behalf of the Executive with the Department of Health and Children, the Department of Finance, the Comptroller and Auditor General and the Paymaster General.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

The *Accounting Standards for Health Boards 1994* provide the statutory basis for the services to be provided by the Executive's Finance Directorate.

Compliance is required with best practice as set out in the Code of Practice for the Government of State Bodies issued by the Department of Finance (2001). Other policy/directives in respect of procurement include:

- EU and Public Procurement Directives/Guidelines
- Procurement Strategy for Irish Health Sector
- National Health Service Procurement Policy
- Guidance from the National Public Procurement Policy Unit - Department of Finance

In accordance with the Health Act, 2004, the Chief Executive Officer is the Accounting Officer for the Executive. In this regard, the role of Accounting Officer is guided by the Comptroller

and Auditor General Acts 1866 to 1998, and by the provisions of the Public Financial Procedures.

7.2.2 Brief Outline of Services Currently Provided

Finance, and financial support services, are currently delivered by staff in the Finance Departments/functions of the Executive areas and the streamlined agencies.

The services currently provided include:

- Strategic and financial governance
- Financial Policy definition/assurance
- Financial planning and budgeting
- Financial management and control
- Management reporting
- Financial systems development
- Forecasting/modelling
- Preparation of Annual Financial Statement.
- Financial risk management
- Internal Audit
- Financial Compliance
- Contracting and procurement advice
- Capital Financing
- Bank reconciliation
- Cash management

7.2.3 The Year Ahead

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are included within the individual Business Plans that support this national Service Plan.

The main thrust of the work of the Directorate in 2005 will be to establish the financial management structure of the Executive; develop the financial policies and controls; implement the required reporting arrangements and consolidate the current finance functions of the streamlined agencies into a single, integrated finance system.

7.2.3.1 Objectives and Actions to Achieve Objectives

Objective: To develop the Financial Management Structure of the Executive

- Commence transition of existing arrangements in the Executive Areas and the streamlined agencies through a partnership process with staff *(Q & F Actions 70,72,104,110)*
- Agree the support arrangements to meet the financial management needs of the Executive at Corporate level, and to meet the needs at Directorate sub structure levels *(Q & F Actions 68,71,92,98,110)*
- Prepare financial allocations for the Directorates and Business Units of the Executive *(Q & F Actions 92,98)*
- Develop and implement an appropriate budgetary control process for the Executive *(Q & F Actions 68,70,72,92,98)*
- Complete the 2004 statutory financial accounts and facilitate the Comptroller and Auditor General audit for the Executive Areas former Health Boards/ERHA and streamlined agencies *(Q & F Action 98)*.

Objective: To develop Effective Financial Reporting Models

- Define new integrated management reporting model to include financial performance of all units directly or indirectly funded by the Executive. This model will be developed to

satisfy the requirements of the Chief Executive Officer in fulfilling the role of Accounting Officer *(Q & F Action 70)*

- Pending full implementation of the new national financial system in all Business Units of the Executive, ensure that the existing financial systems can meet the Executive's reporting needs *(Q & F Actions 70,98)*.

OBJECTIVE: To develop Financial Systems & Processes

- Implement Treasury/Cash Management system and begin the process of consolidation of banking arrangements *(Q & F Actions 70,92,120)*
- Collaborate with the NSS Directorate in developing new system-wide financial processing services *(Q & F Actions 70,72,119,120)*
- Finalise the roll-out/implementation plan of FISP *(Q & F Actions 70,120)*.

OBJECTIVE: To develop Accounting & Control Policies

- Develop corporate financial policies and ensure implementation/conformance across the entire Executive (inclusive of all streamlined agencies) and with external service providers *(Q & F Actions 70,72,110)*
- Ensure compliance with statutory obligations
- Develop the Executive's procedures in relation to Public Private Partnership *(Q & F Action 94)*.

OBJECTIVE: To promote and develop Procurement Function

- Lead and ensure implementation of the new system-wide procurement processes and contracting arrangements within the Executive *(Q & F Actions 68,120)*.

7.2.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Establishment of an integrated national financial management system for the Executive
- Effective transition and implementation of the finance function for NSS.

7.2.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed in the individual Business Plans to support this national Service Plan.

The Finance Directorate has particular monitoring functions in respect of supporting the Accounting Officer obligations of the Chief Executive Officer, and the mechanisms to fulfill this support role will be further developed during 2005.

7.2.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that financial services delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

7.3 HUMAN RESOURCES

7.3.1 CONTEXT

ROLE AND PURPOSE

The Human Resources (HR) Directorate within the Executive will be responsible for developing human resource management and development throughout the Executive to support excellence in service delivery. This will be achieved by building on the many initiatives already underway, including the *Action Plan for People Management (APPM)*.

The Executive aims to become one of Ireland's employers of choice by providing a better working environment for staff and respecting a balance between work and personal lives. There will be a strong focus on learning and career development and on encouraging creativity and innovation among staff together with new ways of working.

Line managers, supported by corporate and local HR staff, will take responsibility for the management and development of their staff. The HR Directorate will support line managers in improving the working environment and the effective development and performance of all staff. There are a number of factors in the workplace environment which can have a positive impact on the quality of working life for staff and consequently on the quality of care. These include a manageable workload, the relationship between control and accountability in relation to work, recognition for contribution to the job, the organisation's social environment, consistent and equitable rules for all employees, and a sharing of organisational values. The Executive will endeavour to balance these issues to enhance the work environment for staff and contribute to the quality of care.

The Executive will build on existing significant HR relationships with external health service providers and contractors to ensure a consistent approach to HR throughout the health service. The HR Directorate will involve all relevant agencies in the development of HR policies, practices and procedures and ensure their standard application to staff throughout the sector.

The Executive also recognises the fundamental need to significantly build manpower planning capacity and capabilities in order to ensure the best available match between service needs and available manpower resources. This will include the strengthening of the relationship/s between the Executive and the educational and training bodies while at the same time recognising the significant work that is ongoing within the business units of the Executive across all disciplines. Additionally, the Executive will also need to enhance its research capacity in the development of the human resource function and in staff development throughout the organization.

In developing this approach, the importance of full engagement with our staff and contractors is valued and recognised. The need to build further on initiatives such as the Clinicians in Management programme, and the partnership framework is also recognised.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

The APPM will guide HR policy and strategy development and implementation.

The seven objectives of the APPM are:

- Managing people effectively
- Improve the quality of working life
- Implementing best practice employment policies and procedures
- Developing the partnership approach further
- Investing in training, development and education
- Promoting improved employee and industrial relations
- Developing performance management.

The national social partnership programme *Sustaining Progress 2003 - 2005*, sets out a comprehensive modernisation agenda for the Health Services. It identified eight areas for modernisation of the Health Services:

- Creating a stable Industrial Relations Environment
- Matching Working Patterns to Service Needs
- Implementing Improved Skill Mix in the Health Service
- Delivering a Modern People Management Service
- Cross sectoral review of recruitment issues arising from the Common Recruitment Pool
- Complying with the provisions of the Public Service Management (Recruitment and Appointments) Act 2004
- Improving Performance Management
- Organisation and System Reform.

The HR Directorate of the Executive will work with key stakeholders, including the staff representative bodies and staff/contractors, to continue implementation of the modernisation agenda during 2005.

EMPLOYMENT CONTROL

Government Policy on employment levels in the health service is currently determined by the Government Decision of 4th December 2002, which provided that employment in the health service was to be capped at 96,000 staff in whole-time equivalent terms (excluding home helps).

To reflect developments in the interim, this figure was revised to reflect projected employment ceilings of 96,950 at end-2004, 97,550 at end 2005 and 96,550 at end 2006.

A further adjustment was made in December 2004 to reflect new approved developments in 2004. The approved employment ceiling for the sector at 31st December 2004 is 97,255.

This approved ceiling will be subject to further adjustment for:

(a) new employments to support approved service developments in relation to A & E and Disability services; and
(b) employment adjustments to comply with the Public Sector Employment Policy – i.e. reduction of 600 posts.

Table 7.3.1 : Employment ceiling (excluding home helps)

Health Service Executive Area	Employment Ceiling*
Eastern	38,340
Southern	13,337
South Eastern	8,647
Mid Western	7,956
Midland	5,224
Western	9,921
North Eastern	6,919
North Western	6,911
Total	**97,255**

** as notified in December 2004*

The key priorities for the Executive in 2005 in relation to employment control are:

- To maintain employment within the approved employment limits as determined by Government
- To ensure that any additional employment is directly and only linked with approved and funded service developments and priority afforded to front line service staff.

7.3.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Human Resource services are currently delivered by staff in the HR Departments/functions of the Executive Areas with certain specialist services delivered by the streamlined agencies.

The services currently provided include:

- Employee/Management development
- Workforce Planning
- Employment Control
- Recruitment/Selection
- Personnel Administration
- Employee Relations
- Industrial Relations
- Retirement Planning
- Superannuation
- HR Policy/Strategy development.

Currently the Department of Health and Children provides certain HR policy interpretation, and executive services, and these will transfer to the Executive during 2005.

7.3.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed / implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

7.3.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

The HR Directorate will work with the Directors of HR and their teams within the Executive Areas and streamlined agencies in implementing the objectives and actions to achieve objectives, outlined below.

OBJECTIVE: To deliver services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing funded levels and standards of HR services during the transition from the Executive Areas and streamlined agencies into the single, integrated Executive *(Q & F Action 107)*
- Work towards the development of HR Shared Services in conjunction with the NSS Directorate *(Q & F Actions 100,101,103,104,107,108,110).*

OBJECTIVE: To develop a Human Resource Strategy

- Develop a HR strategy with a clear and focused objective to develop the Executive as an employer of choice *(Q & F Action 107)*
- Create a single approach to leadership and management development across the Executive *(Q & F Actions 100,103,107)*
  Communicate the HR strategy to the staff of the Executive *(Q & F Actions 100,103,107)*
- Develop a code of conduct and confidentiality for staff and contractors *(Q & F Action 100).*

OBJECTIVE: To establish the Corporate Human Resource Structure

- Develop the corporate design for the delivery of HR services *(Q & F Actions 100,107)*
- Manage the transition from the existing HR organisation structures to the new single, integrated HR structure of the Executive *(Q & F Actions 100,101,102,103,104,105, 106,107).*

OBJECTIVE: To develop an Employee Performance and Development programme

- Develop and implement a comprehensive national framework for the disbursement of APPM funding that incentivises creativity, innovation and new ways of working *(Q & F Action 108)*
- Roll out a Personal Development Planning programme for staff in the Executive *(Q & F Action 103)*
- Facilitate the implementation of the management competency frameworks *(Q & F Action 103)*
- Promote an environment that enhances employee well-being *(Q & F Actions 100,103,104,107,108)*
- Cultivate a climate that nurtures and promotes diversity *(Q & F Actions 100,103,107, 108)*
- Integrate the HR functions/capabilities of the relevant streamlined agencies into the new HR structure *(Q & F Actions 100,103,107,108).*

OBJECTIVE: To manage the Executives application for the Public Appointments Service licence

- Manage the application for the Executive's recruitment licence from the Public Appointments Service *(Q & F Actions 102,103,10,107)*
- Conduct a recruitment process to fill the management posts of the Corporate Directorates *(Q & F Action 103)*
- Develop a specific recruitment programme for key staff grades required *(Q & F Action 103).*

OBJECTIVE: To maintain a stable staff and industrial relations environment

- Provide advice, support, and assistance to line managers, in relation to all aspects of the employer/employee relationship *(Q & F Action 100)*
- Establish the Employer Representative Division of the Executive (formerly the Health Service Employers Agency) *(Q & F Action 107)*
- Maintain harmonious Industrial Relations with all staff associations *(Q & F Actions 100,103,104,107,108)*
- Promote and develop a partnership and participative approach to the implementation and management of change *(Q & F Action 110)*
- Enhance the management of industrial relations issues at all levels of the organisation through further development of the joint Union/Management Forum and delivery of joint Union/management training *(Q & F Actions 100,107).*

OBJECTIVE: To develop an employment control management framework through the roll-out of Personal, Payroll, Attendance Recording System (PPARS)

- Continue with the roll-out of PPARS, which will allow the development of a consistent approach and a clear alignment and reconciliation between hours worked and the sector pay bill *(Q & F Actions 117,120)*
- Develop the quarterly census reporting system in line with the National Performance Monitoring Framework
- Establish, as part of performance management, clear accountabilities and responsibilities for employment control and payroll management as an integral part of line/service management responsibility *(Q & F Actions 70,110,120).*

OBJECTIVE: To transfer of certain HR policy functions from the Department of Health and Children

- To manage the transfer of certain HR policy functions (including employment control) from the Department of Health and Children *(Q & F Actions 101,103,110).*

7.3.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Developing and maintaining a partnership and participative approach throughout the health delivery system
- Maintaining a positive Industrial Relations environment
- Effective transition and integration of HR executive functions from the Department of Health and Children.

7.3.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed in the individual Business Plans to support this national Service Plan.

The HR Directorate will also be responsible for monitoring achievement of the objectives of the APPM and for co-ordinating the Executive's reporting obligations in accordance with the Performance Verification Process of *Sustaining Progress.*

Health service staff census data will be maintained on a monthly and quarterly basis.

7.3.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that HR service delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

7.4 INFORMATION AND COMMUNICATIONS TECHNOLOGY

7.4.1 CONTEXT

ROLE AND PURPOSE

The Information and Communications Technology (ICT) Directorate provides services to other Directorates, Business Units, and external service providers who provide health and social services. The service is managed on a national basis by the ICT Directorate and is delivered through locally based ICT resources in specific service areas. ICT services embrace all voice, video, data communications technologies and provides the necessary services and facilities to enable the Executive achieve its corporate objectives.

The work undertaken by the ICT Directorate is to:

- Develop, operate and manage ICT infrastructure
- Provide ICT support and advice as required
- Facilitate and provide business analysis services throughout the Executive
- Provide project management services to assist in the implementation of ICT projects
- Evaluate, procure and implement ICT solutions, equipment and services to satisfy identified service needs
- Support the development of national strategies and implementation of relevant national programmes
- Adopt a partnership approach to work with other services in the Executive to support the delivery of the Executive's services
- Adopt a partnership approach with other external service providers, State Departments and agencies to support the delivery of the health and social services for example, external service providers in the Acute Hospital Sector, Department of Finance, Department of An Taoiseach, Department of Social and Family Affairs, Department of the Environment, Heritage and Local Government and the General Register Office.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents which, govern service provision are listed in Appendix 1.

The direction of the ICT directorate is also influenced by other national strategies and service modernisation programmes, such as the national Schemes Modernisation Programme.

NEEDS ANALYSIS

The ICT Directorate is a support service, providing a robust and reliable infrastructure, while supporting, modernising and improving services through the introduction and continuous exploitation of ICT.

The value of this ICT investment will be optimised in conjunction with extensive reform of work practices by all health professionals in the delivery system.

7.4.2 Brief outline of services currently provided

ICT services are provided through a combination of national programmes, management and support. Currently there is significant use of appropriate strategic sourcing in the provision of services. Further, significant use has been made in recent years of external hosting and managed service arrangements (e.g. PPARS is hosted by IBM and Shared Services – Eastern Region use HP Data Centre and Disaster Recovery facilities). Software applications, the majority of which are supported by 'in-house' operations staff, are critical to the delivery of a range of direct patient/user and clinical/administrative services.

7.4.3 The Year Ahead

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

7.4.3.1 Objectives and Actions to Achieve Objectives

Objective: To deliver services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing funded levels and standards of ICT services during the transition into the single, integrated organisation *(Q & F Actions 117,120)*

Objective: To enable integrated, person-centred service delivery though the provision of relevant patient care information

- Complete the strategic review of ICT requirements within the PCCC domain and commence implementation of same *(Q & F Actions 116,117,118)*
- Define requirements for an Information System that supports standard processes and definitions within Children's services, in line with the Programme of Action for Children.
- Continue the roll-out of the National Electronic Dental Record project *(Q & F Actions 117,118,120)*
- Continue to roll-out electronic communications with Primary Care contractors, i.e. GPs and Pharmacists *(Q & F Actions 117,118,120)*
- Complete roll-out of Environmental Health System within specific regions *(Q & F Actions 117,120)*
- Develop an implementation plan for the National Client Index project, the Personal Public Service Number (PPSN) in PCCC and develop ongoing plans for management of data quality *(Q & F Actions 116,117,120)*
- Continue to support national initiatives to facilitate the development of Client Identity Services *(Q & F Actions 117,118,120)*
- Finalise the National Hospital Information System (HIS) contract and commence implementation of Hospital Information System (HIS) in the acute hospitals *(Q & F Actions 116,117,118,120)*
- Complete procurement, seek approval and commence implementation of National Laboratory system *(Q & F Actions 116,117,120)*
- Continue with the deployment of the Computerised Infectious Diseases Register (CIDR) *(Q & F Actions 116,117,120)*

- Implement National Public Health laboratory system with the Food Safety Promotion Board *(Q & F Actions 116,118,120)*
- Develop telemedicine support for care delivery *(Q & F Actions 116,117,120)*
- Develop and implement, on a pilot basis, accessible ICT system solutions to support staff in accessing the most up-to-date evidence on best practice and protocols to inform management of clinical problems *(Q & F Action 117)*.

OBJECTIVE: To increase effectiveness, efficiency and economy of ICT operations and Enterprise Resource Planning (ERP)

- Establish a national ICT governance structure, including developing and implementing national policies and governance arrangements for ICT incorporating the role of Shared Services in ICT delivery *(Q & F Actions 116,117,119,120)*
- Develop the Executive's overall ICT programme and provide for ICT implications of/for NSS *(Q & F Actions 116,117,118,119,120)*
- Agree an overarching governance arrangement for all aspects of the ERP programme *(Q & F Actions 116,117,120)*
- Continue the roll-out of PPARS as the National HR and Payroll system, in conjunction with the HR Directorate *(Q & F Actions 110,116,120)*
- Agree an implementation strategy and roll-out plan for FISP in conjunction with the Finance Directorate *(Q & F Actions 110,116,120)*
- Develop an approach to and commence implementation of information management and business intelligence *(Q & F Actions 110,116,120).*

OBJECTIVE: To develop an enabling ICT capacity for service improvement

- Ensure that the ICT environment is continuously available in a secure and supported manner, thereby ensuring robust and efficient ICT services at all times *(Q & F Actions 110,116,119,120)*
- Undertake a review of the Executive's ICT infrastructure requirements *(Q & F Actions 110,116,119,120)*
- Develop a unified enterprise-wide technical architecture to support the implementation of national systems and services *(Q & F Actions 116,117,119,120).*

OBJECTIVE: To support e-Government and e-Europe

- Develop a national implementation plan for eHealth in accordance with the eEurope Action Plan *(Q & F Actions 110,116,117,119,120)*
- Develop a programme for co-operation with other national eGovernment initiatives, for example Public Services Broker, eProcurement, ePayments, Directive 182/20 *(Q & F Actions 116,120)*
- Encourage industry, third-level institutions, and other publicly-funded research institutions to develop a focus on eHealth *(Q & F Actions 68,116,117,120)*
- Proactively seek to benefit from the funding and expertise available from participating in the forthcoming EU Research Programme (FP7) *(Q & F Actions 110,120)*
- Continue with the deployment of the Health Services Portal and provide for interoperability with the European Health Portal *(Q & F Actions 110,116,120)*
- Develop and implement a programme for achievement of the recommendations of the Information Society Commission in respect of eHealth *(Q & F Actions 110,116,119,120).*

7.4.3.2 KEY ISSUES FOR THE YEAR AHEAD

A key issue for 2005 is:

- Developing and implementing short term ICT solutions to meet critical business needs in respect of management and control reporting.

7.4.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

7.4.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that ICT services delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

7.5 POPULATION HEALTH

7.5.1 CONTEXT

ROLE AND PURPOSE

A population health approach promotes and protects the health of the whole population or subgroups, with particular emphasis on reducing health inequalities. Within the Executive, and in its commissioning, influencing and advocacy role with other Government Departments, State Agencies and external service providers, the Population Health Directorate will lead, inform and support the population health approach.

A key role of the Directorate will involve providing knowledge, information and evidence to support corporate decision making and strategic planning in response to identified needs. The Directorate will support the re-engineering of service delivery in a manner which increases its impact on health and social well being and the achievement of value for money. It will also develop culturally appropriate responses to the new and emerging needs of a diverse population, widespread inequalities in health, key health challenges including obesity, alcohol and drug misuse, an ageing population and the growing burden of chronic diseases such as diabetes.

The population health approach implies a greater focus on a social model of health, which acknowledges the range of factors, which affect health. The areas of work which contribute to the approach are defined in the Ottawa Charter (1986):

- Building healthy public policy
- Creating supportive environments for health
- Strengthening community action
- Developing personal skills
- Reorienting health services.

The development and maintenance of Major Emergency Planning is also led by the Population Health Directorate. In this regard, the Irish health services have undertaken a number of initiatives designed to improve the level of preparedness of all its services to respond in a coordinated fashion to a wide range of major emergencies. These initiatives have included the work of the Expert Committee – Contingency Planning for Biological Threats, the SARS Expert Committee, the Influenza Pandemic Preparedness Committee, the Public Health Contingency Planning Steering Group and the Major Emergency Planning Project.

There are a number of services within the health delivery system involved in emergency planning; these include the NHO Directorate, the PCCC Directorate and a range of corporate services. In addition major public emergencies are responded to by a number of external agencies including the Gárda Síochana, the Department of the Environment, Heritage and Local Government, the Local Authorities, the Department of Defence and the Civil Defence.

During 2005 the Population Health Directorate will be responsible for the transition of key population health functions including health protection and major emergency planning from the Executive Areas and Streamlined Agencies to the Executive.

Health Information and Quality Authority (HIQA)

It is expected that the Health Information and Quality Authority will come into operation in 2005.

The responsibility of HIQA will primarily relate to three broad functions:

- Developing health information
- Promoting and implementing quality assurance programmes nationally
- Overseeing health technology assessment.

The Executive will develop health information, quality and other systems internally which will mirror the functions of HIQA.

In this way, the Executive will be in a position to work in partnership with HIQA and will be better placed to benefit from that partnership.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents which govern service provision are listed in Appendix 1.

Inter service Major Emergency Planning is organised in accordance with the 1984 Government document – *Emergency Planning: Framework for Co-ordinated Response to Major Emergency.* Health service emergency planning is guided by the report *A National Health Services Approach to Major Emergency Planning* (2002) and the *Public Health Emergency Plan* (2004).

7.5.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Population Health services are provided by:

- Public Health Departments – the function of Public Health Departments includes formal needs assessment evaluation of services, supporting evidence based planning and delivery of services, strategic advice on environmental health, communicable diseases and emergency planning.

- Health Promotion Departments - Health Promotion services are based on identified need, in settings such as education, workplace (including hospitals), health care and communities. The services seek to improve the health of individuals and communities across a wide range of population groups. In addressing risk factors and issues including mental health promotion, sexual health promotion, tobacco control, alcohol use, drug use, physical activity, nutrition and accident prevention, service providers engage in partnerships with statutory, non statutory, community and voluntary agencies. Services include programmes, initiatives and information to strengthen community development, reorient health services, develop personal skills, strengthen public policy and create supportive environments.

A population health approach is reflected in the services of the PCCC e.g. promotion of breast feeding, smoking cessation clinics, immunisation clinics and also in the activities of the NHO eg. the Health Promoting Hospital movement.

7.5.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are included within the individual Business Plans that support this national Service Plan.

7.5.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing funded levels and standards of population health services, including levels and standards of emergency services in responding to a national public health emergency *(Q & F Actions 4,95).*

OBJECTIVE: To ensure that a population health underpins the planning and delivery of health and social services

- Play a lead role in supporting the development of the Corporate Plan and the corporate planning process of the Executive *(Q & F Action 4)*
- Work with other Directorates in the conduct of population health functions, including needs assessment and service evaluation *(Q & F Action 104)*
- Contribute to the development of national health, disease and care group strategies in partnership with other Directorates to respond to identified health and social needs. *(Q & F Action 104).*

OBJECTIVE: To ensure that policy, planning and service delivery are based on the best available health intelligence

- Analyse data from information systems, research evidence and other sources for the purpose of improving performance *(Q & F Action 68)*
- Work with the Health Research Board (HRB), HIQA and other relevant stakeholders in the establishment of a research and development culture in the health services *(Q & F Action 111).*

OBJECTIVE: To support a multi-sectoral, partnership based approach to illness/ disease prevention and health promotion

- Contribute to, and lead, the development of healthy public policy in partnership with policy makers in all sectors *(Q & F Actions 4,104)*
- Contribute to the creation of supportive environments to promote health in key settings (education, workplace and community) in partnership with key stakeholders *(Q & F Actions 8,104)*
- Contribute to the reorienting of health services towards increased promotion of health in sectors including acute and primary, community and continuing care services *(Q & F Action 8).*

OBJECTIVE: To promote fairer access to all health services and to improve the health status of those who are disadvantaged

- Ensure the National Anti-Poverty Strategy (NAPS) targets are addressed in the context of the Corporate Plan *(Q & F Action 18)*

- Strengthen community action by supporting and developing evidence based, focused and sustainable initiatives to promote and improve health, prioritising disadvantaged groups and communities and addressing inequalities in health *(Q & F Action 19)*
- Contribute to the development of an equality action plan in partnership with the Department of Health and Children and the Equality Authority *(Q & F Action 19)*.

OBJECTIVE: To prevent and reduce the impact and consequences of communicable diseases

- Continue to promote disease prevention programmes and respond to the increasing numbers of legally notifiable infectious diseases reported as a result of the Infectious Disease legislation (2003) *(Q & F Actions 32,33)*
- Work with laboratories so that they can fulfil their obligations to notify infectious diseases, and hence improve the quality of surveillance information for action *(Q & F Action 87)*
- Refine, update and further develop protocols and guidelines for surveillance, prevention and control of communicable diseases *(Q & F Action 87)*
- Investigate and manage local, regional and national outbreaks of communicable diseases
- Promote immunisation as the most effective way to prevent infection, and work progressively in collaboration with business units to increase childhood immunisation uptake towards the national target of 95% *(Q & F Action 14)*
- Ensure that a comprehensive national public health emergency plan, and disease specific (SARS, pandemic influenza, smallpox) plans, are developed, continuously reviewed and tested *(Q & F Action 5)*
- Continue to develop guidance for the control of antimicrobial resistance in Ireland (SARI) *(Q & F Action 5)*.

OBJECTIVE: To improve preparedness of responses to public health emergencies including those caused by major accidents, communicable diseases or other environmental agents

- Improve communicable disease surveillance and control *(Q & F Action 1)*
- Co-ordinate and further develop methods for detecting and responding to outbreaks of communicable disease *(Q & F Actions 1,2)*
- Work with the Department of Health and Children to ensure that major emergency plans are integrated with those of other agencies/government department agencies *(Q & F Actions 1,2)*
- Enhance capacity at national and local level for effective responses to emergencies *(Q & F Actions 1,2)*
- Test the level of preparedness for emergencies at national and regional levels *(Q & F Actions 1,2)*

OBJECTIVE: To develop the Executive's emergency planning capabilities and responses

- Develop consistent response capacity within the organisational structures of the Executive at national and regional levels *(Q & F Action 2)*

- Continue the development of crisis management capacity at national and regional levels
- Develop and provide training in all areas as appropriate *(Q & F Actions 1,2)*
- Facilitate the holding of exercises to assess the level of preparedness at all levels
- Continue to develop capacity to deal with chemical, biological and radiological contaminants

- Continue the preparation and development of guidance for responding to national and local emergencies.

7.5.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- Effective transition and integration of core population health functions from the Executive Areas and Streamlined Agencies to the Executive
- Successful establishment of HIQA

7.5.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the National Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed in the individual Business Plans to support this national Service Plan.

The Population Health Directorate will also conduct specific national service evaluations and through its health intelligence function, will monitor the incidence of infectious disease.

7.5.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that service delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible.

Specifically in 2005, the Population Health Directorate will seek to: improve the capacity of the Executive in Health Impact Assessment methodologies and tools; work with HIQA in the conduct of health technology assessment; expand the research and development capacity of the Executive; and support the further development of national performance indicators.

Specific details are included within the individual Business Plans that support this national Service Plan.

7.6 STRATEGIC PLANNING AND DEVELOPMENT

7.6.1 CONTEXT

ROLE AND PURPOSE

The role and purpose of the Strategic Planning and Development Directorate is to manage the strategic and corporate functions of the Executive; to maintain effective service, corporate and capital planning systems/processes; co-ordinate the activities of and manage the Regional Executive Corporate Offices. The Directorate will also support the interface with the Regional Health Forums.

The Regional Health Forums will be established by the Minister for Health and Children under Section 42 of the *Health Act, 2004,* and their function is to make representations to the Executive (subject to defined exclusions) on the range and operation of health and personal social services provided in the functional area of the forum. The Forums will comprise of elected representatives from specified local authorities within the functional area.

The planning and management of the capital investment framework is a major component of the work of the Strategic Planning and Development Directorate – see section 7.8 of this Plan for further details.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

7.6.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services currently provided by the Strategic Planning and Development Directorate include:

- Management of the health estate
- Capital Planning and management of the rolling five year Capital Investment Framework
- Corporate and Service Planning
- Development of Performance Indicators

Service planning expertise has been developed within the Executive Area's and streamlined agencies and will be further refined to meet the Executive's needs.

7.6.3 THE YEAR AHEAD

A number of actions that commenced in 2004 will continue to be progressed/implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

The main priorities in 2005 will be to:

- Support and enable the work of the Corporate Management Team
- Meet the 2005 planning requirements and develop the planning capacity of the Executive

- Manage the capital programme/plan
- Manage the estate of the Executive.

7.6.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To develop and manage the Executive's Strategic Planning function

- Develop appropriate and robust systems for strategic and operational planning including multi-annual corporate plan, annual service plan, multi–annual and annual capital plans and other development plans, and the supporting business planning processes *(Q & F Actions 70,71,93,95,99,110)*
- Prepare and implement in 2005 a National Performance Monitoring Framework and associated management reporting system for the Executive *(Q & F Actions 70,110)*
- Prepare standardised processes and tools for Business Case Development and Service Level Agreements, with external service providers, for implementation by Business Units in 2005 *(Q & F Actions 72,110)*
- Manage the process to produce the Executive's Corporate Plan for the period 2005 to 2007 *(Q & F Actions 70,71,110)*
- Manage the process to prepare the Service Plan for 2006 *(Q & F Actions 70,110)*

OBJECTIVE: To establish Regional Health Offices

- Establish four Regional Executive Corporate Offices in Cork, Galway, Kells and Tullamore *(Q & F Action 110)*
- Establish processes at Regional Executive Corporate Office level which facilitate and support the Regional Health Forums to be established under the *Health Act, 2004 (Q & F Action 110).*

7.6.3.2 KEY ISSUES FOR THE YEAR AHEAD

A key issue for 2005 is:

- The development of supporting processes for the Regional Health Forums.

7.6.3.4 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators.

Specific monitoring mechanisms are detailed within the individual Business Plans that support this national Service Plan.

7.6.3.5 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that Strategic Planning and Development delivery is evidence-based, in line with best practice and capable of delivering on both value for money and the most effective outcomes. Specific details are included within the individual Business Plans that support this national Service Plan.

7.7 CAPITAL

7.7.1 CONTEXT

As part of the service planning process for 2005, the Executive must indicate any capital plans proposed for the year.

The planning and management of the capital programme is a major component of the work of the Strategic Planning and Development Directorate.

ROLE AND PURPOSE

The overall aim of the capital plan of the Executive is to maintain and develop a health infrastructure which enables services to be delivered effectively and efficiently in an environment that respects the dignity of patients and service users.

The annual capital plan is part of the wider Capital Investment Framework (CIF) 2005-2009 (the rolling 5 year capital investment framework) for the health delivery system.

NATIONAL POLICY FRAMEWORK

Capital planning and development is delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents which govern service provision are listed in Appendix 1.

The procurement of capital projects is conducted in accordance with the Public Procurement Guidelines of the Department of Finance, the capital project guidelines of the Department of Health and Children and the Capital Investment Framework.

7.7.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

A wide range of projects are supported by the CIF across the health sector. Individual projects are procured using, for the present, the Department of Health and Children's planning and approval process.

Services currently provided by the Strategic Planning and Development Directorate in respect of the capital programme include:

- Management of the health estate
- Capital planning and management of the rolling five year Capital Investment Framework

Prior to the establishment of the Executive, the national Health Capital Programme was managed by the Department of Health and Children, and at local level, by Capital Projects/Technical Services Units in the Health Boards/ERHA. In 2005, the functions carried out by the Department of Health and Children will transfer to the Executive.

7.7.3 THE YEAR AHEAD

A number of projects and actions that commenced in 2004 will continue to be progressed or implemented in 2005. Specific details are reflected within the individual Business Plans that support this national Service Plan.

The main priorities in 2005 will be to:

- Manage the capital plan and CIF within available resources
- Procure individual projects
- Build the Executive's capacity to independently plan and deliver a capital programme
- Manage the estate of the Executive

7.7.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To manage and develop the physical resources of the Executive including estates and assets

- Review systems for management of Capital projects during the transition period *(Q & F Actions 70,99,110)*
- Establish a Health Estate Unit within the Directorate, and develop an estate management policy/framework *(Q & F Actions 93,97)*
- Complete a comprehensive review of the assets of the Executive (including land) during 2005 *(Q & F Action 99)*
- Commence implementation of a comprehensive Estate Management Register *(Q & F Action 93,99)*
- Continue provision of environmental management advice and support in relation to energy management, waste management and water quality *(Q & F Actions 93,99).*

OBJECTIVE: To agree a Capital Plan, and multi-annual Capital Investment Framework

- Finalise the Executive Capital Plan for 2005, and prepare the integrated Capital Investment Framework 2005 to 2009 for the Executive (in line with the requirements of the Department of Finance) *(Q & F Actions 93,95,99).*

- The Executive's capital vote will be applied to:

  - Major Capital Projects (>€20m)

    The major projects are already largely committed for 2005 as a result of approvals under the previous CIF/National Development Plan. These projects are mainly in the Acute Hospital sector.

  - Other Capital Projects (€2m to €20m)

    A wider range of projects will be progressed in this category. A number of these projects can be commissioned before the end of 2006 but will require additional revenue funding. A submission will be made to the Minister for Health and Children with a view to securing the funding to enable these high priority projects to be commissioned.

- Minor Capital

  The quality of the health estate is variable and minor capital allows smaller projects to be undertaken which can, nevertheless, make a positive impact especially in areas where major projects are not being procured. It is also used to cope with contingencies and carry out upgrading/refurbishment works.

- Nursing Degree Programme

  In effect, this is a transfer from the health sector to the education sector to facilitate nurse education.

- Information and Communications Technology (ICT)

  The ICT investment is included in the overall capital vote. Recent investment has supported the development and implementation of enterprise-wide systems in service delivery and support areas (detailed in section 7.4 of this Service Plan)

- Capital funding towards specific service developments in 2005

  In addition to above, capital resources are being made available through specific development funding for Disability Services and for A&E infrastructure development.

7.7.3.2 KEY ISSUES FOR THE YEAR AHEAD

A key issue for 2005 is:

- Effective transition and integration of capital functions from the Department of Health and Children

7.7.3.3 MONITORING MECHANISMS

The cash-flows for the individual projects and the overall capital programme will be monitored to ensure compliance with project approvals and to comply with the overall Vote and CIF limits.

7.7.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVES

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that Strategic Planning and Development delivery is evidence-based, in line with best practice and capable of delivering on both value for money and the most effective outcomes. Specific details are included within the individual Business Plans that support the national Service Plan.

7.8 CORPORATE AFFAIRS

7.8.1 CONTEXT

ROLE AND PURPOSE

The role and purpose of the Corporate Affairs Directorate is to support and manage all the activities of the Board of the Executive, the interface between the Executive and the Oireachtas and the functions of the office of the Chief Executive Officer of the Executive; and to develop comprehensive service governance, quality, safety and risk management processes.

Improving quality in the health system requires implementation of internationally recognised evidence based guidelines and protocols, and ongoing education and commitment from health care institutions and professions.

Service governance is a system by which an organisation is directed and controlled. Key elements of successful service governance include:

- Clarity of roles, responsibilities and accountability of managers, staff and contractors
- Patient/service user focus
- A guiding service governance framework

Effective clinical, social care and service governance is essential for health and welfare organisations to achieve objectives and to meet the necessary standards of accountability and openness.

NATIONAL POLICY FRAMEWORK

Services are delivered within the legislative framework of the Health Acts 1947 to 2004, and within the overall policy context set out in the *Quality and Fairness: A Health System for You*. Additional relevant legislation and national policy documents, which govern service provision are listed in Appendix 1.

The Executive was established under the *Health Act 2004* which legally defines/guides the role of the Board and its governance functions.

NEEDS ANALYSIS

The Corporate Affairs Directorate will be critical to the effective operation of the governance arrangements for the Executive. It will be a key support to the Board and the Chief Executive Officer in delivering the corporate requirements.

The establishment of the Executive, and the agreed organisational design, brings an increasing emphasis on the devolution of decision-making and accountability closer to the point of service delivery.

The Executive therefore needs assurance that the systems, policies and staff/contractors are operating in an effective way. This will require systems which provide a high level of assurance, both internally and externally, in respect of all aspects of the Executive's business.

7.8.2 BRIEF OUTLINE OF SERVICES CURRENTLY PROVIDED

Services provided include:

- Consumer services (including appeals, complaints, Freedom of Information and data protection initiatives)
- Quality and accreditation
- Risk management
- Clinical/service governance
- Monitoring and inspection units for services (internal provision and liaison with external units/bodies)
- Library and information services

Most of the above services are currently provided and managed by the Executive Areas.

Parliamentary requests and responses are currently managed by the Department of Health and Children. The Executive Areas and Streamlined Agencies also provide significant levels of support and information to national and local public representatives.

Resources are also dedicated to supporting specific service user feedback mechanisms including processes for dealing with user complaints, appeals, and requests for information (including *Freedom of Information Act 1997* requests). Consumer consultation through panels and other methods of engagement with community representative/interest groups are also supported.

Directors of Communications, and their support teams, in the Executive Areas and in the voluntary agencies provide internal and external communications services including a 24 hour media service. These staff are deployed in managing the significant volumes of enquiries and requests for information received from the media and other interested parties.

7.8.3 THE YEAR AHEAD

The following priorities will be pursued in 2005:

- Supporting and enabling the work of the Board
- Developing a national parliamentary affairs division to respond in a timely fashion to all requests from the Oireachtas that are referred to the Executive
- Establishing a national customer service unit, to ensure that the customer voice is central to the planning and delivery of health services and to develop a complaints procedure as required in the *Health Act 2004*
- Developing, agreeing and implementing a Service Governance Framework for the Executive.

7.8.3.1 OBJECTIVES AND ACTIONS TO ACHIEVE OBJECTIVES

OBJECTIVE: To deliver services to an existing funded level at a minimum, and to a standard that maximises quality and safety

- Continue to provide existing funded levels and standards of corporate services during the transition from the Executive Areas/Streamlined Agencies into the Executive *(Q & F Actions 70,110)*

- Support the transition of existing arrangements in the Executive Areas/Streamlined Agencies through a partnership process with staff in relevant corporate functions in those organisations *(Q & F Actions 52,70,110).*

OBJECTIVE: To develop a Parliamentary Affairs Unit within the Corporate Affairs Directorate

- Establish a Parliamentary Affairs Unit that will respond to requests for information from the Oireachtas. *(Q & F Actions 52,110).*

OBJECTIVE: To develop a Customer Service Unit to ensure customer focus for service planning and delivery

- Establish a customer service unit, integrating all existing customer service units to provide support to the Executive in creating a comprehensive, integrated service for customers *(Q & F Actions 48,49,52)*
- Develop and implement the statutory complaints framework *(Q & F Action 49).*

OBJECTIVE: To develop a Communications Unit to enhance the internal and external communications and information mechanisms of the Executive

- Establish a communications unit to provide a full internal and external communications service for the Executive to:
    - Inform the public of the work of the Executive, the range of health and personal social services available, and their entitlements to and eligibility for different services *(Q & F Actions 44,50,52)*
    - Provide rapid and accurate information on public health issues, including public health alerts *(Q & F Actions 50,51,52)*
    - Provide a wide ranging internal communications service to directly and indirectly employed staff *(Q & F Action 120)*
- Provide a comprehensive media information service in line with the commitment of the Executive to openness and transparency *(Q & F Actions 50,51,52,120)*
- Develop a communications network with Government Departments, Local Authorities, Gardai and Emergency services and with Northern Ireland health services *(Q & F Actions 63,94,120)*
- Develop a communications strategy for the Executive *(Q & F Action 117).*

OBJECTIVE: To develop an integrated service governance framework for the health services

- Develop a comprehensive and robust service governance framework, inclusive of a Code of Governance for the Executive *(Q & F Actions 70,110)*
- Develop an action plan for service governance in the services provided by, and delivered on behalf of, the Executive *(Q & F Actions 70,110).*

OBJECTIVE: To develop, deploy and review appropriate risk, quality management and accreditation systems

- Develop and implement appropriate arrangements for liaison with the Ombudsman and Ombudsman for Children *(Q & F Actions 70,110)*
- Assist National Directorates and their Business Units in the development, monitoring and review of safety statements, risk assessments and safe systems of work to support

staff/service contractors in the working environment and in the interest of safety for service users and the public *(Q & F Actions 70,110)*

- Contribute to Risk Management development and implementation in the Executive's Business Units, particularly in relation to non-clinical assessment and reporting *(Q & F Action 63)*.

7.8.3.2 KEY ISSUES FOR THE YEAR AHEAD

Key issues for 2005 include:

- The effective transition and integration of functions from the Department of Health and Children, the Executive Areas and Streamlined Agencies
- Development of an effective approach to meet the communication needs of all the Executive's stakeholder groups.

7.8.3.3 MONITORING MECHANISMS

Service Plan monitoring will take place in accordance with the National Performance Monitoring Framework. This framework will ensure that monitoring progress against the national Service Plan is undertaken in respect of each of the components, which include objectives and actions, finance, human resources, service activity levels and performance indicators. Specific monitoring mechanisms are detailed in the individual Business Plans that support this national Service Plan.

The respective responsibilities between the Executive and the Department of Health and Children in respect of the monitoring of parliamentary responses will be defined, agreed and implemented.

7.8.3.4 RESEARCH, QUALITY, EVALUATION AND VFM INITIATIVE

A range of ongoing and new research, quality, evaluation and value for money initiatives will ensure that the corporate affairs delivery is evidence-based, in line with best practice and capable of delivering the best outcomes possible. Specific details are included within the individual Business Plans that support this national Service Plan.

GLOSSARY OF ACRONYMS

APPM	Action Plan for People Management
CLAR	Ceantair Laga Ard-Riachtanais
EMS	Emergency Medical Services (part of ambulance services)
ERHA	Eastern Regional Health Authority
ESRD	End Stage Renal Disease
FISP	Financial Information Systems Project
GMS	General Medical Service
HBSC	Health Behaviour in School-aged Children Survey
HIQA	Health Information and Quality Authority
NAPS	National Anti-Poverty Strategy
NTPS	National Treatment Purchase Fund
PPARS	Personnel Payroll Attendance Recording System
PTS	Patient Transport Service (part of ambulance services)
RAPID	Revitalising Areas by Planning Investment and Development
SARS	Severe Acute Respiratory Syndrome
SLAN	Survey of Lifestyle, Attitudes and Nutrition
Q&F	Quality and Fairness
VFM	Value for money

NATIONAL DIRECTORATES

CMOD	Change Management and Organisation Development
HR	Human Resources
ICT	Information and Communications Technology
NHO	National Hospitals Office
NSS	National Shared Services
PCCC	Primary, Community and Continuing Care Services

APPENDIX 1: HEALTH AND SOCIAL POLICY STRATEGY DOCUMENTS AND OTHER SOURCES

POLICY DOCUMENTS

- *A Strategy for Equality, Report of the Commission on the Status of People with Disabilities* (1996). Dublin: Stationery Office
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- Department of Health (1994) *National Breastfeeding Policy for Ireland.* Dublin: Stationery Office
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- Department of Health (1996) *Cancer Services in Ireland: A National Strategy*. Dublin: Stationery Office
- Department of Health and Children (1997) *Enhancing the Partnership: Report of the Working Group on the Implementation of the Health Strategy in relation to Persons with a Mental Handicap*. Dublin: Stationery Office.
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- Department of Health and Children (2000) *Development of Services for Symptomatic Breast Disease, Report of the Sub-Group to the National cancer Forum*. Dublin: Stationery Office
- Department of Health and Children (2000) *National Health Promotion Strategy 2000 – 2005*
- Department of Health and Children (2000) *The National Children's Strategy: Our Children – Their Lives*. Dublin: Stationery Office

- Department of Health and Children (2000) *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*
- Department of Health and Children (2000) *Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group*
- Department of Health and Children (2001) *Primary Care A New Direction.* Dublin: Stationery Office
- Department of Health and Children (2001) *Quality and Fairness: A Health System for You*. Dublin: Stationery Office
- Department of Health and Children (2001) *Youth Homelessness Strategy.* Dublin: Stationery Office
- Department of Health and Children (2001) *First Report of the Working Group on Child and Adolescent Psychiatric Services* Dublin: Stationery Office
- Department of Health and Children (2001) *National Standards for Children's Residential Centres.*
- Department of Health and Children, *Strategic Task Force on Alcohol: Interim Report* (2002).
- Department of Health and Children (2002) *Report of the Advisory Committee on Palliative Care*. Dublin: Stationery Office
- Department of Health and Children (2002). *Protecting our Future: Report of the Working Group on Elder Abuse*, Dublin: Stationery Office.
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- Department of Health and Children (2002) *Action Plan for People Management.* Dublin: Stationery Office
- Department of Health and Children (2002) *Traveller Health: A National Strategy 2002 to 2005.* Dublin: Stationery Office
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- *Acht na dTeangacha Oifigiula 2003 /Official Languages Act* (2003). Dublin: Stationery Office
- *Adoption Act 1952-1998*. Dublin: Stationery Office
- *Adoptive Leave Act 1995*. Dublin: Stationery Office
- *Child Care Act 1991* and subsequent regulations. Dublin: Stationery Office
- *Education for Persons with Special Educational Needs Act* 2004. Dublin: Stationery Office
- *Education Act 1998*. Dublin: Stationery Office
- *Employment Equality Act 1998*. Dublin: Stationery Office
- *Equality Act 2004*. Dublin: Stationery Office
- *Equal Status Act 2000*. Dublin: Stationery Office
- *Freedom of Information Act 1997*. Dublin: Stationery Office
- *Health (Nursing Homes) Act 1990* and subsequent regulations. Dublin: Stationery Office
- *Health Act* 2004. Dublin: Stationery Office
- *Maternity Protection (Amendment) Act 2004*. Dublin: Stationery Office
- *Mental Health Acts* 1945 and 2001. Dublin: Stationery Office
- *Minimum Notice and Terms of Employment Acts 1993-2001*. Dublin: Stationery Office
- *Organisation of Working Time Act 1997.* Dublin: Stationery Office
- *Public Health (Tobacco) (Amendment) Act 2004.* Dublin: Stationery Office
- *Public Service Management (Recruitment and Appointments) Act 2004.* Dublin: Stationery Office
- *Public Service Superannuation (Miscellaneous Provision) Act* (2004). Dublin: Stationery Office
- *Protection of Employees (Fixed Term Work) Act 2003*. Dublin: Stationery Office
- *Safety, Health and Welfare at Work Act 1989*. Dublin: Stationery Office

EU DIRECTIVES

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- Council Directive 2000/43/EC Equal treatment between persons irrespective of racial or ethnic origin
- Council Directive 2002/73/EC Equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions
- Council Directive 2000/78/EC Framework for equal treatment in employment and occupation
- Council Directive 2004/33/EC Blood and blood products

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APPENDIX 2: NATIONAL PERFORMANCE INDICATORS

BACKGROUND AND OVERVIEW

The National Service Plan for 2005 is underpinned by a Business Planning model comprising of key elements to support both the monitoring and delivery of services within the sector. A key element of the Business Planning model is the National Performance Monitoring Framework.

A significant aspect of the National Performance Monitoring Framework, which has existed within the sector since 2000, is the National Performance Indicator Suite (PI's).

Key PIs, which provide the most comprehensive and robust data, have been included alongside activity tables within each of the relevant sections of the 2005 national Service Plan. A summary of the entire National PI suite for 2005, which will be used to monitor service delivery is detailed below.

1. PRIMARY CARE SERVICES

This set of PI's covers key elements of the implementation of the *Primary Care Strategy – Primary Care - A New Direction* (2001), including monitoring of Primary Care Implementation Projects, Multi-disciplinary team Working, Community Involvement and Needs Assessment.

PI Ref	what is being measured?
PC1	The Organisation and structure of GP Practices
PC2	Primary Care Immunisation contracts
PC3	Computerisation of GMS GP Practices
PC5	Pharmacy contracts and electronic claiming
PC6	Fluoridation of Water Schemes
PC7	Access to school Dental Screening Programmes
PC10	Development of GP Cooperatives
PC12	Access to adult Dental Treatment Services
PC13	Establishment of Primary Care Teams and Networks

2. CHILD ADOLESCENTS AND FAMILIES

The Child and Adolescent Health PI set monitors the activity of both acute and community services in terms of newborn, child and adolescent health, including the implementation of policies such as the Baby Friendly Hospital initiative. Collective working has been undertaken in the development of the PI set with the 'Best Health for Children' Project Group.

PI Ref	what is being measured?
CH1	Public Health Nurse monitoring of newborn babies
CH2	Prevention of Crytporchidism (undescended Testes in males)
CH4	Efficiency of surgical services for childhood conditions (grommets, hernia repair)
CH5	Immunisation uptake rates
CH6	Uptake of Child Health Core Screening and Surveillance Programmes
CH7	Breastfeeding Rates

The Childcare suite of Performance Indicators monitors the statutory obligations of services in the provision of Childcare and adoption services. It covers all key policy areas such as fostering, preschool care and inter-country adoption activity.

PI Ref	what is being measured?
CC2	Implementation of the National Foster Care Standards 2003
CC3	Children in Care
CC4	Inspection and supervision of pre-schools
CC5	Waiting lists for Inter Country Adoption initial assessments
CC6	Child Protection Case Conference attendances, reports and assessment
CC7	Compliance with the 1995 Childcare regulations in terms of childcare placements and care planning

3. PERSONS WITH DISABILITIES

The Disability Services Performance Indicator Suite comprises both Intellectual and Physical and Sensory Disabilities, monitoring the provision of services to both groups.

PI Ref	what is being measured?
ID1 (i)	Person-Centred Care Planning for Intellectually Disabled clients in residential care settings
ID1 (ii)	Person-Centred Care Planning for Intellectually Disabled clients in a day service setting
ID2	Implementation of the Immunisation Guidelines for Ireland (1999) in terms of Hepatitis B
ID3	Access to Intellectual Disability services
ID5	Obligations set out in the National Health Strategy (Obj 3) in terms of transferring clients from long stay settings
ID6	Governance and management of Intellectual Disability voluntary providers
PS4	Person-Centred Care Planning for Physical and Sensory Disability clients in residential care settings

PS5	Governance and management of Physical and Sensory Disability voluntary providers

4. MENTAL HEALTH SERVICES

The Mental Health Performance Indicator suite covers the broad spectrum of mental health services from community services, including outpatients, to acute and long-stay services.

PI Ref	what is being measured?
MH2	Evidence of parasuicide and interaction of persons who have attempted suicide
MH3a	Availability of residential Mental Health Services
MH3b	Availability of outpatient Mental Health Services
MH4	Admissions to acute units with a primary diagnosis of Alcohol disorder
MH5	Efficiency of Community based services
MH6	Delays in discharge from acute units
MH7	Delays in discharge from Intensive Care Units
MH8	Profile of admissions – involuntary versus voluntary
MH9	Identification of long-stay patients within services
MH10	Implementation of Government policy to close long stay institutions
MH11	Consumer Consultation/involvement in service planning
MH12	Mix of new to return attendances at Out-patient level
MH13	Availability of Mental Health Personnel

5. SERVICES FOR OLDER PEOPLE

The Older Persons set of Performance Indicators monitors delivery, planning and access to services by Older People.

PI Ref	what is being measured?
OP2	Waiting times for surgical procedures and procedures completed
OP3	Uptake of Influenza vaccine
OP4	Number of older people continuing to live at home versus those in residential care settings
OP5	Home help, day care and respite services uptake levels

6. SOCIAL INCLUSION

SERVICES FOR HOMELESS PERSONS

This set of Performance indicators focus on the development of services for homeless persons, and the support systems available for this group of the population.

PI Ref	what is being measured?
HO1	Individual care planning within homeless accommodation centres
HO2	Access for Homeless Persons to GP services
HO5	Homelessness and discharge planning prevention and aftercare support services

SERVICES FOR ASYLUM SEEKERS

These Performance Indicators focus on the provision of information, advocacy and service delivery to Asylum seekers within the population.

PI Ref	what is being measured?
AR1	Provision of information to Asylum Seekers
AR2	Screening of Asylum Seekers
AR3	Asylum Seeker/Refugee awareness training provision

TRAVELLER HEALTH SERVICES

This set of Performance Indicators monitors the implementation of the Traveller Health Strategy by focusing on provision of services, and cultural awareness in terms of the Traveller Community within Ireland.

PI Ref	what is being measured?
TH1	Provision of Cultural awareness and sensitivity training
TH2	Establishment of Traveller Health Units, and specifically involvement by Traveller Health representatives
TH3	Training (specifically in relation to members of Traveller Health Units)

ADDICTION SERVICES

This set of Performance Indicators examines the provision of addiction services as part of the overall Social Inclusion group of PIs. This sub set also comprises Services to Homeless Persons, Traveller health and services for Asylum Seekers.

PI Ref	what is being measured?
AD3	Timely access to assessment and treatment services
AD4	Access to addiction services specifically for those aged under 18 years

7. ACUTE SERVICES

The acute services group of Performance Indicators focus solely on monitoring services that are delivered out of hospital settings (inpatient and outpatient services). The set captures only information that is not otherwise part of routine monitoring returns from hospitals, and focuses on efficiency, equity of access (waiting times) and activity data.

PI Ref	what is being measured?
AS1	Waiting times for Inpatient Services
AS2	Waiting times for Outpatient Services
AS3	Monitoring of the Patient Charter in terms of Individual appointment slots for Outpatient appointments
AS4	Patient satisfaction – Outpatient services
AS6	Efficiency of Outpatient services in terms of ratio of new to return patients
AS7	Efficiency of Outpatient services in terms of Did not Attend patients
AS8	Use of Acute Sector Beds
AS9	Efficiency of Inpatient services in terms of Average lengths of stay
AS10	A & E Attendances
AS12	Throughput/demand on Orthopaedic services
AS13	Efficiency of services in terms of day case/inpatient procedure mix
AS14	Discharge activity

8. AMBULANCE SERVICES

The Ambulance service set of PI's is concerned with the efficiency of the delivery of Pre Hospital Emergency Care services, and has been developed in conjunction with the National Chief Ambulance Officers Group.

PI Ref	what is being measured?
AM1	Completion of Patient Report Forms
AM3	Ambulance Personnel Training
AM6	Ambulance Response Efficiency
AM7a	Use of Defibrillation equipment

AM7b	Provision of Defibrillation Training

9. POPULATION HEALTH

Population Health (previously known as Overall Health) include PI's which do not fit neatly into care groups, but focus instead on outcome measures in terms of longer term interventions (cancer survival rates etc). They also include indicators that relate to services provided to entire populations as opposed to specialty services such as Food Hygiene and Tobacco Control Indicators.

PI Ref	what is being measured?
PH1	Inspection of Food Premises
PH2	Stage of Presentation of Common Cancers
PH3	Cancer Survival Rates
PH4	Breast Cancer Screening
PH5	Hospital Surgical Procedure rates
PH6	Teenage Birth Rates
PH7	Mortality Rates
PH8	Surgical Procedure Rates for Acute Myocardial Infarctions (MI)
PH9	Infant and Perinatal Mortality rates
PH10	Suicide and Undetermined death rates
PH11	Cigarette Smoking Prevalence
PH12	Compliance with anti-smoking legislation
PH13	Breast Cancer Surgical Procedure rates
PH14	Osteoporosis rates
PH15	Diabetes Prevalence
PH16	Primary Care Prescribing Rates
PH17	Renal Transplant procedure Rates
PH18	MRSA Notification Rates
MH19	Appropriateness of Surgery

10. HEALTH PROMOTION

This set of five PIs cover key service areas primarily focusing on performance in relation to Health Promotion settings, and a service's commitment to enhancing staff capability in terms of Health Promotion training.

PI Ref	what is being measured?
HP3	Membership of the Health Promoting Hospitals Network Number of Health Promotion policies within a service i.e. Smoke free and Baby friendly initiatives Linkages to Health Promotion Policies and Service Planning
HP4	The provision of Health Promotion Training (excluding schools)
HP5	Health Promotion Activity
HP6	Health Promotion Training in schools
HP7	Promotion of Partnerships