Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Health Service Executive

Primary Care Division

Operational Plan 2016

Promote health and wellbeing as part of everything we do so that people will be healthier

Provide fair, equitable and timely access to quality, safe health services that people need

Foster a culture that is honest, compassionate, transparent and accountable

Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them

Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

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Primary Care Division

Executive Summary

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

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

Primary Care services include primary care teams (PCTs) and general practice, schemes reimbursement, social inclusion and palliative care services. A key priority for 2016 is the continued implementation of the recommendations of *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, 2014.* There will be a continued emphasis on integrated care and accountability for primary care services. This will strengthen the Accountability Framework and outline explicit responsibilities for staff at all levels.

Primary Care

Over the last number of years work has been underway to realise the vision for primary care services whereby the health of the population is managed, as far as possible, within a primary care setting with people very rarely requiring admission to hospital. This approach is now aligned with the *Healthy Ireland* framework, noting the importance of primary care to the delivery of health improvement gains. Primary care can play a central role in co-ordinating and delivering a wide range of integrated services in collaboration with other service areas. The primary care team is the central point for service delivery which actively engages to address the medical and social care needs of the population in conjunction with a wider range of Health and Social Care Network (HSCN) services.

PCRS

The Primary Care Schemes are the means of delivery for a significant proportion of primary care services. Scheme services are delivered by over 7,000 primary care contractors e.g. GPs, pharmacists, dentists, optometrists and/or ophthalmologists. The schemes include:

- General Medical Services (GMS) – Medical Card Scheme, including GP Visit Cards
- Drug Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Services Scheme (DTSS)
- High Tech Drug Arrangements
- Primary Childhood Immunisation Scheme
- Community Ophthalmic Scheme
- Certain services under Health (Amendment) Act 1996 and Redress for Women Resident in Certain Institutions Act 2015
- Methadone Treatment Scheme.

Social Inclusion

The core objective of social inclusion services is the improvement of health outcomes for the most vulnerable in society. This includes provision of targeted interventions for people from traditionally marginalised groups who experience health inequalities, have difficulties accessing services and present with multiple, complex health and support needs. Vulnerable people and communities falling within the remit of social inclusion include Irish Travellers and Roma, asylum seekers, refugees and Lesbian, Gay, Bisexual, Transgender (LGBT) service users. Issues of addiction, substance misuse, homelessness and domestic, sexual and gender based violence are overarching themes within the service user groups. Social inclusion services work with mainstream services and voluntary sectors to ensure accessibility for disadvantaged service users.

Social inclusion services are developing appropriate activity metrics to more accurately reflect the health needs and outcomes of vulnerable groups. These metrics will be aligned with the objectives of the *Healthy Ireland* implementation plan.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment and management of pain and other physical, psychosocial and spiritual problems. In recent years, the scope of palliative care has broadened and includes not only cancer related diseases but supporting people through non-malignant and chronic illness also. A new plan involving a stakeholder representative working group is being prepared which will provide direction for palliative care services for the next three years; this will be published early in 2016. The *plan is being developed in collaboration with the* Clinical Programme for Palliative Care.

In 2016 engagement will continue with voluntary service providers to ensure that emerging needs and related solutions can be identified and addressed. Palliative Care recognises the potential of the five Integrated Care Programmes (ICPs) to improve integration, access and outcomes and will actively support the development and implementation of the priority work streams in 2016.

Improving Quality and Safety

Quality improvement and patient safety is everybody's business and is embedded in all work-practices across primary care services. The Primary Care Division is committed to promoting a “”quality and safety” culture by ensuring effective governance, clear accountability and robust leadership. In accordance with the National Framework for Quality the following are the 5 key drivers for the Primary Care Quality & Safety programme in 2016:

- Governance: The National Director will ensure that the division has structures in place to ensure accountability for the quality and safety of services within Primary Care.
- Safe care and support: The Division will ensure that there are structures and processes in place to avoid, prevent and minimise harm to patients/service users and to learn from situations when things go wrong.
- Person centre care and support: The service user will at all times be at the centre of the delivery of care.
- Effective care and support: The primary care services will deliver best achievable outcomes for patients/service users.
- Measuring and learning for improvement: Systems and structures will be put in place to measure performance in relation to quality and safety and to ensure learning is shared across primary care.

Ensuring the Provision of Integrated Care and Clinical Care Programmes

The provision of care, which is provided through CHOs, Hospital Groups and the National Ambulance Service will be person centred and coordinated, providing better and easier access to services which are close to where people live. This is a long term programme of improvement and change and will involve people at every level of the health services working together to create improved experiences and outcomes for the people in their care, in a way which puts them at the centre of all services. In 2016 the clinical and integrated care programmes will lead a number of priority programmes to design, develop and progressively implement models of care which will incorporate cross

service, multi-disciplinary care and support and which will facilitate the delivery of high quality evidence based and coordinated care. The Primary Care Division will collaborate with the clinical and integrated care programmes to ensure the changes implemented are consistent with the frameworks, models of care, pathways and guidelines designed by the integrated and clinical care programmes.

Accountability Framework

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

The Accountability Framework was developed and implemented in 2015 and strengthens governance arrangements by measuring, monitoring and reporting on performance. The Framework sets out the arrangements between the National Performance Oversight Group (NPOG) and the National Directors in accounting for and responding to areas of underperformance across the balanced scorecard in relation to access to services, quality, financial management and human resources. The Framework sets out the responsibilities of all managers to deliver the targets set out in the Service Plan. An Escalation and Intervention Framework is also part of this process and sets out four levels of escalation identifying supports, interventions and sanctions when service areas are underperforming against defined thresholds.

2015 was the first year of operation of the new Accountability Framework. A formal review was commissioned and completed in 2015. The Framework has been updated for 2016 to ensure its operation, effectiveness and application best meets the evolving needs of the organisation and drives overall performance improvement. Recommendations for further enhancement from the review will be implemented early in 2016.

Health Service Reform

2016 will be another important year in the ongoing reform of the HSE with continued focus on programmes of work to bring about strategic reform of the health services. A formal charter that lists out these projects for the Primary Care Division has been developed with the System Reform Group and agreed with the leadership team. In 2016 we will be progressing key projects within that charter. Infrastructural changes and service improvements to support safe patient care and the development of quality services are included in the Charter. The following are some of the key reform programmes for Primary Care in 2016:

- GP/GMS Contract(s) review
- Community Referral and Patient Management System procurement
- Implementation of prioritised chronic disease management programmes
- Individual Health Identifier implementation
- Direct access to diagnostics for GPs
- Roll out of minor surgery in general practice
- PCRS – Clinical Advisory Group recommendations and online medical card processing
- Quality Information Management System procurement
- CIT/OPAT System – Portal developments and infrastructural deployment.

Children First

The Children First implementation plan sets out key actions to ensure compliance with both the Children First legislation and national policy. Under legislation, the HSE and funded organisations providing services to children and young people will be required to undertake an assessment of risk and to use this risk assessment to develop and publish a Child Safeguarding Statement. The Safeguarding Statement will also outline how staff/volunteers will be

provided with information to identify abuse which children may experience outside of the organisation, and what they should do with concerns about child safety.

In 2016, high level actions include the development of Children First implementation plans by CHOs and Hospital Groups with support from the Children First National Office; and the delivery of a suite of Children First training programmes for HSE staff and HSE funded organisations. Child protection policies at CHO and Hospital Group level will also be developed and reports will be tracked and monitored by the Children First Office. Children First compliance will also be included in the performance assurance process.

Supporting Service Delivery

Direct service provision is dependent on a number of key business support functions. The Division will work with Health Business Services (HBS) and other corporate support services (HR, Finance, Office of the Chief Information Officer, Communications, and Internal Audit) which are essential enablers for the CHOs to deliver direct patient services. A number of common support business services are now delivered on a shared basis. This allows operational services to focus management attention on core service provision and also helps services to be compliant with National EU Directives, legislation and regulation.

Relationships will be further enhanced during 2016 through Business Partnership Arrangements (BPAs) between HBS and each CHO, setting out clearly the quantum of support services the functions within HBS (Estates, Procurement, HBS HR, HBS Finance and Enterprise Resource Planning Services) will provide. The National Service Plan 2016 sets out in detail all corporate support service priorities and actions for 2016.

Funding

The National Service Plan 2016 sets out the details of the primary care budget of €3,624.4m for 2016, which is an increase of 5.5% on the Budget for 2015.

	2016 NSP Budget €m	2015 Projected Outturn €m	2015 Closing Budget €m	2016 Budget vs 2015 Projected Outturn %
Primary Care	764.8	757.5	749.0	1.0%
PCRS	2417.1	2,408.5	2,268.2	0.4%
Local Demand Led Schemes	242.6	232.2	218.1	4.5%
Social Inclusion	127.1	127.0	128.0	0.0%
Palliative Care	72.8	71.8	71.8	1.4%
Totals	**3,624.4**	**3,597.0**	**3,435.1**	**5.5%**
€13.5m additional funding held by DoH				

The DoH is holding funding on behalf of primary care of **€13.5m** in respect of GP Contract developments including extending care without fees to children up to 12 and provision for rural GP practices, access to diagnostics and minor surgery.

Additional funding was received to deal with unfunded cost pressures carried forward from 2015 as follows:

- Primary Care Core Services €5m
- Local DLS €15m
- PCRS €142m

The revenue allocation for the division is net of assumed savings and efficiency measures of €112.9m.

In 2016 all services will be required to operate within the planned budget levels in order to deliver a breakeven position. There are significant challenges in containing expenditure in areas that have experienced growth over a number of consecutive years, such as drug expenditure on Local Demand Led Schemes and complex discharges to the community and these will continue to be a source of pressure in 2016 with limited scope for growth.

Whilst the PCRS budget shows an overall net increase of 6.57% there is significant growth in drug costs in existing run rates, combined with savings targets linked to numbers availing of schemes and volume of medical cards which are not within the division's control. In addition a successful conclusion to sectoral discussions around the cost of medicines involving DPER, DoH, HSE and industry is a critical component of the PCRS breakeven plan.

The cost of increments to the division estimated at **€1.3m** will also have to be funded from existing resources.

Workforce

The Division's staff are its most valuable resource. In addition to key objectives such as recruitment and retention of staff, maintaining a motivated workforce is of paramount importance to ensuring the quality of service delivered to the public. This requires effective workforce planning and resource allocation arrangements, together with appropriate structures for positive engagement with staff. 2016 will see a focus on *The People Strategy 2015 -2018* which has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare.

Government policy focuses on ensuring that the number of people employed is within the pay budget available. The management of human resources in 2016 will be based on the Paybill Management and Control Framework. This approach is a transition from the moratorium to an accountability framework designed to support multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. Service managers who meet budget targets will have greater discretion and flexibility in how they manage their workforce and payroll costs, while ensuring services are delivered in line with the national service plan. The Primary Care Division will operate control mechanisms to monitor staff numbers and work with CHOs to evaluate vacancies in the context of workforce composition, skill mix, cost and capacity to deliver core services. Current WTE numbers in the Division are 10,370 (including Section 38 organisations).

Developments

The 2016 DoH held funding allocation of €13.5m will facilitate progress in relation to:

- Extension of free GP care to children up to 12 years, subject to negotiation under the Framework Agreement.
- Improved access to diagnostics (ultrasound and x-rays) for GPs.
- Expansion of minor surgery services in primary care.

In addition, combined approaches with the mental health and social care divisions will facilitate:

- Improved access to primary care psychology and counselling.
- Improved access to primary care speech and language therapy services.

Risks to Service Delivery 2016

The budget allocation for primary care in 2016 presents significant challenges for the maintenance of existing levels of service for the division, particularly so for the PCRS range of demand-led services. A range of measures has been identified to manage the Primary Care Division services within budget, they include the following:

Core Services

- Reviewing service delivery models for primary care services
- The development of prioritisation protocols for the delivery of services
- The introduction of quality improvement initiatives across the division
- Further roll out of the Performance Management Framework
- Further reduction in agency costs
- Enhanced procurement and process measures to improve the management of consumables
- Adherence to the Pay Bill Framework in relation to staff replacements
- Containing activity on 2015 new developments to 2015 expenditure levels
- Containing activity in primary care core services to existing levels of service
- Maintaining activity in dental treatment to existing levels of service.

Local Demand-Led Schemes

- Delivering activity under local demand-led schemes to funded levels.

PCRS Assumptions

Primary Care Reimbursement Service (PCRS) – €2,417m available to HSE (with a further €10m held by DoH)

The PCRS budget has been set at the level indicated by the letter of determination received by the HSE.

In summary, the various schemes including the medical card scheme are operated by the HSE on the basis of legislation as well as policy and direction provided by DoH.

Eligibility under these schemes is administered by PCRS. Its key task in this regard is to ensure that those who have eligibility can have this confirmed and access their entitlements under the schemes in as efficient and responsive a way as possible. PCRS also has a role in ensuring appropriate application of the various scheme rules. This includes ensuring probity in claims processing and payments to primary care contractors and PCRS will pursue the targets set under this heading.

Thereafter demographic, economic and other variable factors, given the demand-led nature of the schemes, will dictate the actual numbers of eligible persons and the cost of their entitlements to be paid by PCRS in 2016 under each scheme. The PCRS plan for 2016 is based on a number of assumptions around demographics, economic growth and these other factors which have been agreed with the DoH following an extensive series of engagements.

As regards drugs, the growth in costs related to existing drugs is largely a feature of the entitlements of individuals as determined by their eligibility and the demographic and other factors outlined above including prescribing practices. In relation to new drug costs, primarily High-Tech drugs, sectoral agreements and the assessment process in place to establish whether new drugs can be introduced on the basis of funding available will be a significant feature in 2016.

The PCRS budget for 2016 has been framed by reference to a series of working assumptions. These have been developed in detailed discussion with the DoH. They have been accepted as the basis on which, in respect of the PCRS, the HSE should address the statutory requirement to indicate the type and volume of services to be provided during the year to include the following:

- Persons eligible for medical cards will continue to receive them in a timely manner and in accordance with the turnaround times for processing applications as outlined in the plan.
- Appropriate measures will continue to ensure the accurate administration of the various schemes. This will involve savings being achieved from continued enhanced monitoring of claims and payments to primary care contractors.
- The medical card profile outlined in the plan (see table below and in appendix 3) reflects the funding allocated for 2016. It is jointly acknowledged that the actual level of activity will depend on the number of eligible patients availing of services.
- The savings targets in relation to drugs / medicines will be achieved in full – this is a key shared assumption that is dependent on the outcome of engagement with the pharmaceutical industry, prescribers and retailers.

- Overall net expenditure on High Tech drugs in 2016 is maintained at 2015 outturn levels (which includes provision for new drugs in 2016) – this is dependent on the HSE's capacity to contain approvals for new medicines to overall funded levels and the outcome of negotiations with key stakeholders.
- Efficiencies and stock management improvements in the High Tech medicines area will reduce costs.
- Savings in relation to administration costs will also be achieved.
- GMS activity is in accordance with funded levels as follows:

Schemes	Projected Outturn 2015	Activity Level 2016
GMS (medical card numbers)	1,725,767	1,675,767
GP Visit Cards	435,785	485,192*

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Expenditure in the PCRS budget will be the subject of close monitoring and assessment from the beginning of 2016. The implications of any emerging variations from the working assumptions underpinning the budget will be the subject of engagement with the DoH through the reporting and oversight arrangements which operate in relation to the NSP. In this context the HSE will indicate to the DoH the nature and extent of any interventions that it considers necessary to ensure that the available budget for PCRS is not exceeded and will seek direction in this regard.

Conclusion

This plan sets out details of funded services and/new service developments provided for in the Letter of Determination; it is not anticipated that it will be possible to expand or put in place additional services outside of these, which will be challenging in the context of ever increasing demands for services.

The Primary Care Division will work to maximise the delivery of services within the resources available while at the same time ensuring that quality and patient safety remains a key priority.

John Hennessy, National Director, Primary Care Division.
January 2016

Operational Framework

Financial Framework

The National Service Plan 2016 sets out the details of the primary care budget of €3,624.4m for 2016, which is an increase of 5.55% on the Budget for 2015. The tables below further allocate this budget by Pay, Non Pay and income by CHO, National Services and the Primary Care Reimbursement Service.

Incoming Deficit

Additional funding was received to deal with unfunded cost pressures carried forward from 2015 as follows:

- Primary Care Core Services **€5m**
- Local DLS **€15m**
- PCRS **€142m.**

Existing Level of Service

Funding was received in respect of Existing level of service as follows:

- **€9m** – Primary care core services 2016 Non Pay Funding
- **€4.8m** – Primary care core services full year cost of 2015 commitments
- **€10m** – Local DLS
- **€117m** – PCRS.

A significant portion of the primary care core services funding will be required to cover the increasing cost of primary care leases and the costs associated with complex paediatric home care packages.

Savings and Extra Revenue Targets

The revenue allocation for the Division is net of assumed savings and efficiency measures of €112.9m as follows;

- **€2.9m** - General reductions in non-pay budgets including savings to be made through the procurement process.
- **€110m** - Targeted reductions in drug and prescribing costs; this will involve additional measures in areas such as probity and prescribing behaviour.

HSE Prioritised Initiatives

The DoH holds further funding on behalf of primary care of **€13.5m** in respect of GP Contract developments including extending care without fees to children up to 12 and provision for rural GP practices, access to diagnostics and minor surgery.

Pay and Pay Related Savings

The Division commenced the implementation of a plan for the conversion of agency in 2015 and this will continue in 2016. In line with Pay Bill Management Policy, the replacement of existing posts will be dependent on individual CHO being able to deliver its planned services within allocated funding.

Financial Risk Areas

In 2016 all services will be required to operate within the planned budget level set out in table below. Whilst the PCRS budget shows an overall net increase of 6.57%, there is significant growth in drug expenditure in existing run rates combined with savings targets linked to numbers availing of schemes and volume of medical cards. In addition a successful conclusion to sectoral discussions on the cost of medicines involving DPER, DoH, HSE and industry is a critical component of the PCRS breakeven plan.

This is a significant risk to the overall primary care division delivering a balanced budget and as such the assumptions around volume and type of services underlying the budget was the subject of significant engagement with the DoH. Accordingly, expenditure in the PCRS budget will be the subject of close monitoring and assessment from the beginning of 2016. The HSE will avail of the existing oversight arrangements which operate in conjunction with the DoH to indicate interventions it considers necessary to ensure that the available PCRS budget is not exceeded and will seek direction from the DoH in this regard.

Furthermore, the cost of increments to the division estimated at **€1.3m** in 2016 will have to be funded from existing resources.

2016 Primary Care Division - Net Expenditure Allocations

	Primary Care	Palliative Care	Social Inclusion	Local DLS	PCRS	Total
	€m	€m	€m	€m	€m	€m
Budget 2015	748.683	71.765	127.166	217.600	2,268.166	3,433.380
Incoming Deficit Funding	5.000			15.000	142.000	162.000
Opening Base Budget 2016	753.683	71.765	127.166	232.600	2,410.166	3,595.380
Programme for Government Funding						
LRA	1.069	0.459			0.041	1.569
PSPR & Other Pressures	0.004	0.012				0.016
Chairman's Notes	0.006					0.006
Non Pay 2016 Cost Pressures	8.960		0.140	10.000	116.893	135.993
NSP 2015 Full Year Cost of Commitments	3.900					3.900
ED-Winter Plan	0.900					0.900
2016 Initiatives		0.700				0.700
	14.839	**1.171**	**0.140**	**10.000**	**116.934**	**143.084**
Savings Measures						
2016 Savings Measures	2.839	0.012	0.012		110.000	112.863
Adj. for ICPs other	1.283	0.124	0.194			1.601
	4.122	0.136	0.206	0.000	110.000	114.464
Budget 2016	**764.400**	**72.800**	**127.100**	**242.600**	**2,417.100**	**3,624.000**

Workforce Plan

Introduction

Primary Care services are delivered in or as close as possible to people's homes. The Division's people are its most valuable resource. In addition to key objectives such as recruitment and the retention of staff, maintaining a motivated workforce is of paramount importance in ensuring the quality of service delivered to the population. This requires that the Division has effective workforce planning and resource allocation arrangements in place, together with appropriate structures for positive engagement with staff. 2016 will see a focus on *The People Strategy 2015 - 2018* which has been developed in recognition of the vital roles the workforce plays in delivering safer and better healthcare.

Staff Engagement

Employee engagement is central to the *People Strategy 2015-2018*, with a focus on developing mechanisms for more effective internal communications to support listening and learning across services. The Primary Care Division will facilitate staff opportunities to discuss their professional and career aspirations with their managers in a way that informs learning and development.

The Workforce Position

Government policy focuses on ensuring that the number of people employed is within the pay budgets available. The management of funding for human resources in 2016 will be based on the Paybill Management and Control Framework. This approach sees a transition from the moratorium to an accountability framework designed to support the creation of annual and multi-annual workforce plans based on models of care that will deliver services within allocated pay resources. Service managers who meet budget targets will have greater discretion and flexibility in how they manage their workforce and payroll costs, while ensuring services are delivered in line with the national service plan. The Primary Care Division will operate control mechanisms to monitor staff numbers and work with CHOs to evaluate vacancies in the context of workforce composition, skill mix, cost and capacity to deliver core services. Current staff numbers in primary care, by CHO, are set out in Appendix 2.

Primary Care Division – Staff Numbers

	WTE Dec 2014	WTE Sept 2015	Projected Outturn Dec 2015
HSE	9,469	9,633	9,705
Section 38	634	661	665
Total Primary Care	**10,103**	**10,294**	**10,370**

Workforce Planning

The Division will work on the development of a workforce planning project for community services during 2016. This will include a review of issues related to workforce profile, population demographic trends, skill mix and utilising resources across divisions.

Public Service Stability Agreement 2013-18

The Lansdowne Road Agreement 2015 extends the arrangements as originally set out in the Haddington Road Agreement until 2018. This includes an extension of enablers such as additional working hours to support reform, reconfiguration and integration of services. The new agreement includes a strengthened oversight and governance arrangement for dealing with matters of implementation and interpretation in the event of disputes that may arise.

The Division will utilise the agreement, in collaboration with staff and other stakeholders, to support the roll out of planned new community structures.

Reducing Agency and Overtime Costs

There was a particular focus in 2015 on agency and overtime to reduce direct expenditure and release funding to invest in essential posts. This focus will continue in 2016, with pay costs managed and monitored through funded workforce plans within the CHOs.

The Division will monitor and review agency and overtime costs whilst working to support CHOs in implementing initiatives to reduce costs such as redeployment, skill mix review and changes in work practices. Oversight and governance arrangements as set out in the Lansdowne Road Public Service Stability Agreement will support implementation and interpretation in the event of a dispute or of issues requiring clarification.

Service Developments

The Primary Care Division will continue service developments commenced in 2015 in the areas of Integrated Care and Chronic Disease Projects, Children First and Palliative Care, supported by the completion of the recruitment process for these projects.

Attendance and Absence Management

The Primary Care Division will build on progress made over the past year on improving attendance levels. The performance target for 2016 remains a 3.5% staff absence rate. Monitoring of attendance will be further enabled by new reporting arrangements whereby absenteeism will be reported by division rather than on a combined basis for non-acute services.

Health and Safety at Work

In 2016 there will be a corporate emphasis on reviewing and revising the Corporate Safety Statement, developing key performance indicators (KPIs) in Health and Safety Management and Performance, launching a new statutory Occupational Safety and Health training policy, and developing a national audit and inspection programme. Staff will be supported to become healthier in their workplaces and an Occupational Health Business Unit will be established.

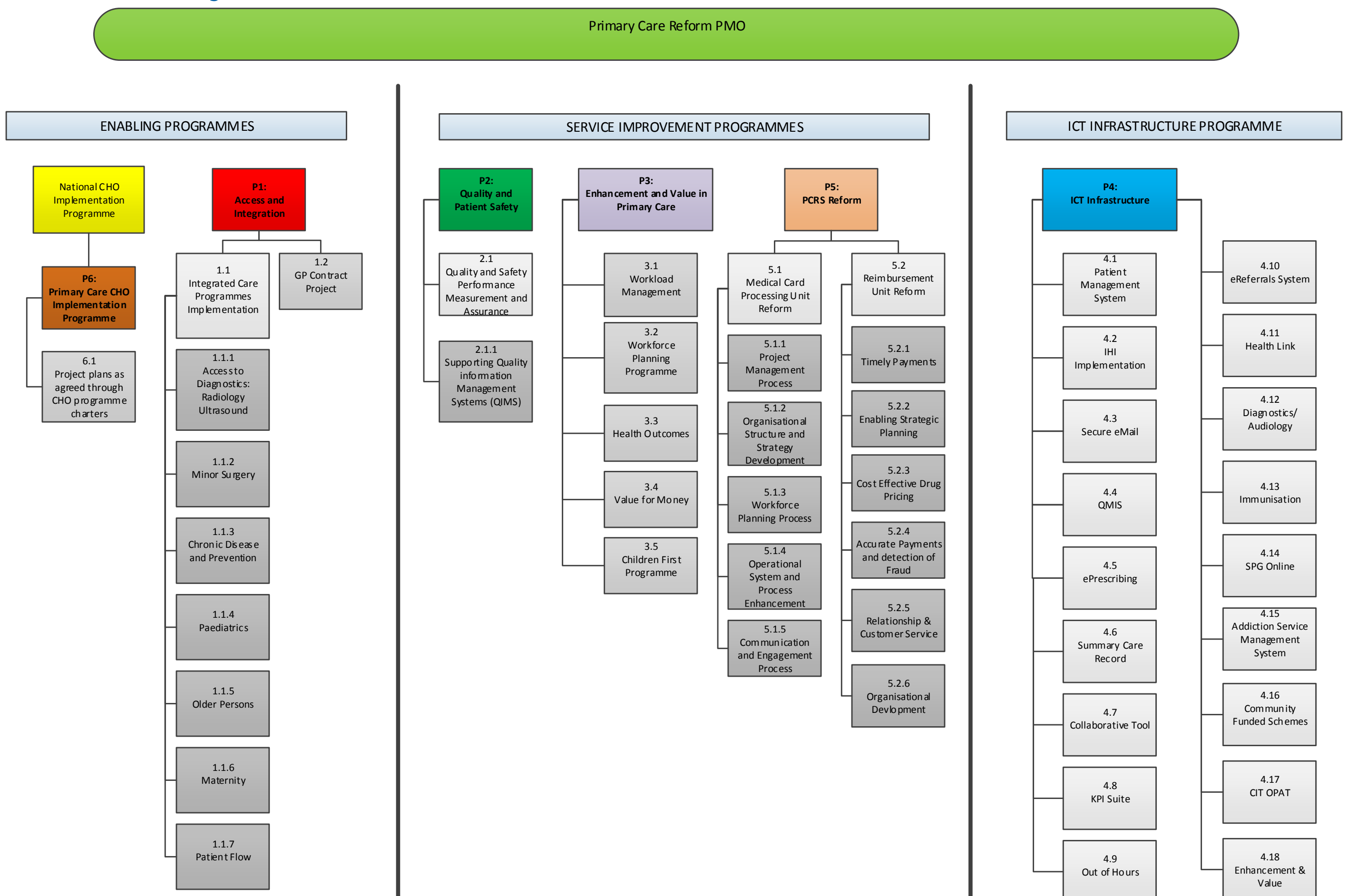
Health Service Reform

2016 will be an important year in the reform of the HSE, with continued focus on infrastructural changes within CHOs and service improvements to support safe patient care and the development of quality services. The following are key reform programmes for the Primary Care Division:

- Programme 1 – Access and Integration
- Programme 2 – Quality and Patient Safety
- Programme 3 – Enhancement and value in primary care
- Programme 4 – ICT Infrastructure
- Programme 5 – PCRS Reform
- Programme 6 – Primary Care CHO Implementation Programme.

The figure below sets out the various service improvement and enabling programmes aligned to each of these programmes.

2016 Work Breakdown Structure for Primary Care – System Reform Projects



Delivery of Services

Delivery of Services

Legend

ND – National Director HOP – Head of Operations HPPPM – Head of Planning, Performance and Programme Management OHL – Oral Health Lead	Q&S – Quality and Safety ADL – Addiction Lead SIL – Social Inclusion Lead PCL – Palliative Care Lead NL – Nursing Lead	HIPL – Health Identifier Project Lead CFL – Children First Lead HOC – Head of Contract NCAGL – National Clinical Advisory Group Lead NCAGL – GP Lead	ANDPCRS – Assistant National Director, Primary Care Reimbursement Service COCCP – Community Oncology Cancer Control Programme GPTPL – GP Training Project Lead NCLAS – National Clinical Lead Addiction Services

Key Priorities and Actions to Deliver on Goals in 2016

Promote health and wellbeing as part of everything we do so that people will be healthier

Primary Care and Health and Wellbeing Collaborative Actions for Healthy Ireland Implementation Plan

In partnership with health and wellbeing services the following will be delivered in 2016:

- Support CHOs to develop implementation plans for *Healthy Ireland*.
- Engage with LCDCs to ensure relevant health and social care priorities are addressed.
- Implement the Healthy Workplace Policy with supporting initiatives for staff to look after their own Health and Wellbeing.

Operational Plan Actions	End Q	Owner
▪ Support CHOs on development of Primary Care, PCRS, Social Inclusion and Palliative Care actions for inclusion in their CHO implementation plans for Healthy Ireland. ▪ Support each CHO in their engagement with the LCDCs and in the development of the Local Economic and Community Plans in collaboration with Health and Wellbeing.	Q1-Q4	HPPPM AND PCRS SIL PCL

Implement child health programmes / initiative to improve health outcomes for children

- Implement the revised child health programme.

Operational Plan Actions	End Q	Owner
▪ Engage with the National Steering Group on Implementation of revised Child Health Model.	Q3	HPPPM
▪ Engage with the Health and Wellbeing Division to agree a governance structure to support all child screening programmes.	Q4	HPPPM

- Implement the Nurture - Infant Health and Wellbeing programme in primary care settings.

Operational Plan Actions	End Q	Owner
▪ Implement the plan for the rollout of the Nurture Programme – Infant Health and Wellbeing.	Q1	HPPPM
▪ Support the development of a dedicated 'Child Health' webpage on the HSE's website	Q4	HPPPM
▪ Agree the framework for the provision of child health training modules to frontline staff.	Q4	HPPPM
▪ Review and update the child safety training programme.	Q4	HPPPM

Improve national immunisation rates

- Improve influenza vaccination uptake rates among persons aged 65 and over.
- Improve influenza vaccine uptake rates among staff in front line settings.

- Implement recommendations of the review of models of delivery and governance for immunisation services.
- Expand the current Primary Childhood Immunisation schedule to address agreed public health priorities. *(New Funding included in Health and Wellbeing)*

Operational Plan Actions	End Q	Owner
▪ Increase the percentage of children who receive vaccines to the target percentages: - % of children 24 months of age who have received the MMR vaccine – target 95%. - % of children 12 months of age who have received the 6-in-1 vaccine – target 95%. - % of children 24 months of age who have received the third of Men C vaccine – target 95%. - % of first year girls who have received third dose of HPV vaccine – target 80%. - % uptake in flu vaccine > 65 years – target 75%.	Q1-Q4	HPPPM

Support health promotion and improvement initiatives in primary care

- Support the implementation of the Sexual Health Strategy.
- Support brief intervention training for staff on smoking cessation.

Operational Plan Actions	End Q	Owner
▪ Implement primary care actions as set out in the Sexual Health Strategy.	Q1-Q4	CHOs
▪ Each CHO to release a further 5% of front line Primary Care Division staff to attend brief intervention on smoking cessation.	Q1-Q4	CHOs
▪ Map the catering facilities in primary care settings with a view to implementation of calorie positing.	Q1-Q4	CHOs

HCAI / Decontamination programme

- Implement the HCAI / AMR clinical care training programmes.

Operational Plan Actions	End Q	Owner
▪ Implement hand hygiene guidelines. ▪ Participate in National HALT Study 2016. ▪ Complete work force planning and quality improvement of infection prevention and control services. ▪ Work with HCAI / AMR programme to implement the HIQA IPC standards on antimicrobial stewardship. ▪ Target out of hours services to improve IPC standards, antimicrobial stewardship and patient education on self care and appropriate use of antibiotics.	Q1-Q4	NCAGL & GPL

Primary Care Reimbursement Service

- Reimburse primary care contractors in line with health policy, regulations and within service level agreements governing administration of the health schemes.

Operational Plan Actions	End Q	Owner
▪ Implement the recommendations of the Deloitte Prospectus Review of Reimbursement Functions Report (July 2015). Items to be addressed include: - Alternative administrative service provision mechanisms i.e. shared services with HR, Payroll, etc. - Drug pricing and procurement. - Lean review of reimbursement. - Maximising electronic claims from contractors. - Targeted inspection and investigation. - Engaging with stakeholders on service culture.	Q4	AND PCRS

▪ Develop and implement action plans to ensure that the reimbursement function has a clear vision, proper staffing and appropriate structures to implement these recommendations. ▪ Assess eligibility of new applicants for medical cards and GP visit cards and review eligibility of existing cardholders in line with health legislation, policy, regulations and service level arrangements governing administration of the GMS Scheme. - Implement the recommendations of the Clinical Advisory Group.	Q3 Q4	AND PCRS AND PCRS

Provide fair, equitable and timely access to quality, safe health services that people need

Primary Care Quality and Safety

Work with national Quality Improvement Division in supporting the roll-out of patient safety programmes

Quality Improvement / Enablement Programme

- Develop a programme to improve the quality and safety of addiction, homelessness and palliative care services.

Operational Plan Action	End Q	Owner
▪ Implement three specific quality improvement initiatives in each of the areas of addiction, homelessness and palliative care.	Q4	Q&S

Pressure Ulcers to Zero Collaborative

- Support the Primary Care Teams (PCTs) participating in the Pressure Ulcer to Zero Collaborative.
- Provide awareness training to multi-disciplinary team members involved in the collaborative on the management and prevention of pressure ulcers within primary care.

Operational Plan Action	End Q	Owner
▪ Arrange training and awareness on the management and prevention of pressure ulcers within primary care and supporting PCTs participating in the Pressure Ulcer to Zero Collaborative.	Q1-Q4	Q&S

Provide improved and additional services at primary care (PCT and Network) level

- Progress the review of GP contracts under the Framework Agreement. Negotiations between the DoH, the HSE and the IMO on a comprehensive new contractual framework with GPs will continue with a view to reaching a successful outcome during 2016.

Operational Plan Action	End Q	Owner
▪ Progress negotiations in respect of GP Contracts to reflect a focus on health promotion, improved chronic disease management, changes to Primary Childhood Immunisation Programme, retention of GP services in rural and deprived areas, and strengthening governance provisions.	Q2	HOC

- Extend access to free GP care to children aged up to 12 years subject to negotiations under the Framework Agreement. This service development will be implemented in the context of the new contractual framework with GPs. *(Held Funding as part of DoH €13.5m)*

Operational Plan Action	End Q	Owner
▪ Conclude negotiations to facilitate commencement of free GP care for children aged 6-11 years (inclusive).	Q4	HOC

► Extend the 2015 minor surgery project to further practices and target activity transfer from acute hospitals of up to 10,000 procedures. *(Held Funding as part of DoH €13.5m)*

Operational Plan Action	End Q	Owner
▪ Finalise the minor surgery project governance arrangements.	Q1-Q4	GPL
▪ Finalise the accreditation process for minor surgery in primary care.	Q2	GPL
▪ Extend the project up to a further 40 practices in 2016.	Q2-Q4	GPL
▪ Undertake an evaluation of the project to inform 2017 planning and delivery of minor surgery in the primary care setting.	Q3-Q4	GPL

► Extend direct access for GPs to ultrasound and x-ray. *(Held Funding as part of DoH €13.5m)*

Operational Plan Actions	End Q	Owner
▪ Establish a Primary Care Division Diagnostics oversight group.	Q1	HPPPM
▪ Extend direct GP access to ultrasound to the midlands and east coast.	Q4	HPPPM
▪ Map and identify existing access gaps for GP direct access to x-ray, in liaison with the National Clinical Programme for Radiology,	Q2	HPPPM
▪ Develop and agree a plan to roll out provision of GP direct access for x-ray focusing on gaps identified.	Q4	HPPPM

► Develop primary care psychology services including primary care counselling services for children in collaboration with mental health and addiction services. *(Held Funding as part of DoH Mental Health €35m)*

Operational Plan Actions	End Q	Owner
▪ Engage with primary care psychology managers on the model and delivery of service	Q1	HPPPM
▪ Develop and agree business plan for the delivery of counselling services to children (0-18 years) for submission to the DoH.	Q1	&HOP
▪ Roll out of service model agreed.	Q2	

► Implement the recommendations of the *Primary Care Eye Services Review Report.*

Operational Plan Actions	End Q	Owner
▪ Agree a standard operating procedure for provision of school vision screening	Q1	HPPPM
▪ Standardise school vision screening.	Q2	HPPPM
▪ Arrange school vision screening training for PHNs.	Q3	HPPPM
▪ Procure an ophthalmology clinical and patient management system.	Q4	HPPPM
▪ Review COSS/COSMTs contracts and negotiate updated contracts to include provision of ophthalmic care to patients in nursing homes.	Q4	HPPPM
▪ Agree a process to handover treatment of children aged 8 or 9 years and over to local optometrists, as part of contractual reviews.	Q4	HPPPM
▪ Establish an integrated eye clinic in the Dublin area.	Q4	HPPPM

► Progressing Disability Services Programme for Children and Young People in collaboration with social care services *(Held DoH Funding as part of Social Care €8m)*

Operational Plan Actions	End Q	Owner
Children and Young People	Q3	HOP
▪ Implement the Progressing Disability Services Programme for Children and Young People, in collaboration with Social Care.		

Disability Services – Other Operational Plan Action	End Q	Owner
Children and Adults - National guidelines on accessible health and social care		

services		
▪ Implement the National Policy on Access to Services for Children with Disability or Developmental Delay - in collaboration with the Social Care Division.	Q4	HOP
Adults - Comprehensive Employment Strategy for People with Disabilities	Q4	HOP
▪ Ensure primary care representation on a working group to oversee implementation - in collaboration with the Social Care Division.		

► Undertake a review of the model and provision of primary care speech and language therapy services, particularly for children.

Operational Plan Actions	**End Q**	**Owner**
▪ Convene a Speech and Language Therapy Expert Steering Group (and Project Group).	Q1	HOP
▪ Conduct a review of speech and language therapy services within the primary and social care Divisions.	Q1-Q4	
▪ Develop a consistent model for the provision of speech and language therapy services.	Q4	

► Undertake waiting list initiatives to reduce waiting times for primary care speech and language therapy particularly for children.

Operational Plan Action	**End Q**	**Owner**
▪ Review and validate existing primary care speech and language therapy waiting lists targeting patients waiting over 52 weeks for assessment and therapy.	Q1	HOP

► Complete a review of the operation and efficiency of the *Community Intervention Team* Service.

Operational Plan Actions	**End Q**	**Owner**
▪ Review data collection systems and definitions in line with the development of electronic referrals to CITs.	Q1	HPPPM
▪ Produce daily electronic reports on referrals to CITs by source.	Q1	HPPPM
▪ Conduct procurement tender, evaluation and award contract for the CIT/OPAT Management Control Centre.	Q2	HPPPM

► Progress the implementation of the recommendations of the *GP Out of Hours Service Review* using existing resources.

Operational Plan Action	**End Q**	**Owner**
▪ Conclude the GP Out of Hours Service Review.	Q1	HOP
▪ Implement recommendations.	Q2	

Other 2016 Operational Plan Priority Actions	**End Q**	**Owner**
▪ Implement the recommendations from the *Review of Primary Care Island Services.*		ND
▪ Progress the Tomorrows Care for Tallaght Project.		HPPPM
▪ Establish a *Lymphoedema* Working Group to develop a model of care to include access to services and referral pathways, and review the supply and re-imbursement of compression garments.	Q1-Q3	GP & HPPPM
▪ Facilitate the transfer of appropriate *complex paediatric cases* from acute care to primary care.	Q1-Q4	HOP
▪ Progress the *Community Funded Schemes Project.*	Q1-Q4	HPPPM
Agree and implement national guidelines and protocols for the provision and management of Community funded products and services (Demand-Led Schemes) in the following areas:		
- Aids and Appliances		

- Respiratory Therapy Products - Orthotics, Prosthetics & Specialised Footwear - Incontinence Wear, Urinary, Ostomy and Bowel Care - Drugs and Medicines - Nutrition - Bandages and Dressings. This will support standardised access to and provision of community funded products and services across the country within available resources facilitate improved management of services and maximise efficiencies.		
▪ Implement paediatric waiting list initiatives in ***audiology*** services in all CHOs. ▪ Implement revised training programme for Public Health Nurses on the updated school hearing screening protocol in collaboration with Health and Wellbeing.	Q1-Q4	HPPPM
▪ Implement the recommendations of the *Civil Registration Service Review*, when agreed.	Q1-Q4	ND

Hepatitis C Treatment Programme

- ► Strengthen the management and governance structures for the treatment of Hepatitis C patients.
- ► Establish a patient registration system for patients with Hepatitis C.
- ► Ensure that learning is shared nationally in a timely manner regarding best practice.

Operational Plan Actions	End Q	Owner
▪ Establish a National Hepatitis C Treatment Programme Advisory Committee to oversee implementation of the multi annual therapeutic treatment plan for Hepatitis C in Ireland.	Q1	HPPPM
▪ Establish a Hepatitis C Clinical Advisory Group to oversee the continued prioritisation and selection of patients for all Hepatitis C treatments as per agreed clinical criteria.	Q1	HPPPM
▪ Establish current position per hospital treatment site in relation to numbers treated under the programme since commencement including HAA cardholders target treatment timelines.	Q1	HPPPM
▪ Devise a communication strategy on the application of the multi annual public health plan for the pharmaceutical treatment of Hepatitis C.	Q1	HPPPM
▪ Develop the Hepatitis C Treatment Registry to support the implementation of the multi annual public health plan.	Q1-Q4	HPPPM

Improve access to oral health and orthodontic services (OHL)

- ► Improve access to orthodontic treatment for children including those requiring orthognathic / oral surgery.

Operational Plan Actions	End Q	Owner
▪ Award procurement contracts for the provision of orthodontic services.	Q1	OHL
▪ Provide orthodontic treatment for patients waiting more than 4 years as a waiting list initiative.	Q2-Q4	OHL
▪ Develop and agree a care pathway for the provision of complex orthognathic surgery, this includes the establishment of a multi-disciplinary team for the care of these patients.	Q2	OHL

- ► Commence the process of implementation of HIQA infection control standards.

Operational Plan Actions	End Q	Owner
▪ Complete inspection of HSE dental and orthodontic services.	Q3	OHL
▪ Support the Health Protection Surveillance Centre in publishing and auditing the Guidelines for Antimicrobial Prescribing for Primary Dental Care.	Q2	OHL
▪ Develop an information programme to support HCAI/AMR targets.	Q2	OHL

▪ Commence work with Primary Care Quality and Safety to assure compliance of dental services with HIQA standards.	Q3	OHL

► Provide advice and information and onward early referral for oral healthcare for high risk children by undertaking a 'smiles' pilot programme targeting children aged between 0–3 years in one site.

Operational Plan Actions	End Q	Owner
▪ Review existing evidence and build on Fluoride and Caring for Children's Teeth (FACCT) Study data to devise appropriate intervention; the 'smiles' programme is aligned to this study.	Q2	OHL
▪ Work with the Best Health for Children Steering Group on implementation of the 'smiles' programme to high risk children.	Q3	OHL
▪ Work with colleagues in Dental Schools, commencing with Cork Dental School, on undergraduate curriculum development to support oral healthcare for high risk children.	Q4	OHL

Improve cross division service integration

► Provide an integrated response with acute services and social care services to relieve pressure in EDs, incorporating hospital admission avoidance and facilitating early discharge.

Operational Plan Action	End Q	Owner
▪ CIT Oversight and Development Group to agree priority actions across divisions to optimise use of CIT services for hospital admission avoidance and early discharge.	Q1	HPPPM
▪ Enhance GP out of hours services (reference above).	Q3	
▪ Extend the primary care minor surgery project (reference above).	Q3	
▪ Improve integrated care pathways across all CHO's for the Prevention and Management of Chronic Diseases (reference below).	Q4	

► Implement a new model of practice for the management of children with non-complex needs in primary care in collaboration with mental health and social care services.

Operational Plan Action	End Q	Owner
▪ Four demonstrator sites will be established in CHOs.	Q1	HOP

► Participate in the multi-divisional Respite Review Group (Carers Strategy) in collaboration with social care services.

Operational Plan Action	End Q	Owner
► Participate in the multi-divisional Respite Review Group (Carers Strategy) which is being established by the Social Care Division.	Q2	HOP

► Implement the *Primary Care Education, Pathways and Research in Dementia (PREPARED) Programme* through the delivery of dementia specific education to primary care teams and GPs (selected sites to be agreed in January 2016) in collaboration with social care services.

Operational Plan Actions	End Q	Owner
▪ Implement the Primary Care Education, Pathways and Research in Dementia (PREPARED) Programme through the design and delivery of dementia specific education to Primary Care Teams and GPs in collaboration with Social Care Division.	Q1-Q4	HPPPM
▪ Support the design of the education programme.	Q1	HPPM
▪ Select sites for delivery of education programme.	Q3	HPPM
▪ Deliver the education programme to PCT staff in selected sites.	Q3-Q4	HPPM

Develop and progress the priority work streams of the five integrated care programmes to improve integration, access and outcomes for patients in collaboration with Clinical Strategy and Programmes

- ► Provide structured education programmes for patients with diabetes.
- ► Implement the chronic disease demonstrator projects utilising the 2015 approved posts for respiratory, heart failure and diabetes.
- ► Progress the implementation of the Diabetes Clinical Programme making best use of the existing Integrated Care Diabetes Clinical Nurse Specialists.
- ► Progress a study of outcomes for patients with acute asthma in collaboration with Clinical Strategy and Programmes.

Operational Plan Actions	End Q	Owner
Clinical and Integrated Care Programmes ▪ Develop and progress the priority work streams of the five integrated care programmes to improve integration, access and outcomes for patients in collaboration with Clinical Strategy and Programmes. **Integrated Care for Patient Flow** ▪ Support and contribute to the establishment of the Integrated Care Programme for Patient Flow and prioritised work-streams. ▪ Support the design and phased implementation of new service delivery models and methods – non emergency service number and communication, and musculoskeletal physiotherapy services phased implementation. **Integrated Care Programme for Older Persons** ▪ Augment primary care services for older people to enable a shift from a model of acute, hospital-based episodic care to a model that reflects increased co-ordination and care planning based on the needs of the older person. ▪ Extend existing programme (in Cork and Limerick) across 4 sites (CHO 7, Tallaght Hospital; CHO 8, OLOL; CHO 4, Cork University Hospital (CUH); CHO 3 University College Hospital Limerick (UCHL). **Integrated Care Programme for the Prevention and Management of Chronic Disease** ▪ Improve integrated care pathways across all CHO's in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease for patients with: - COPD - asthma - ischaemic heart disease - diabetes. ▪ Provide structured education programmes for patients with diabetes. ▪ Implement the Chronic disease demonstrator projects; - Utilise the 2015 approved posts for respiratory, heart failure and diabetes - Support establishment of local Integrated Care Teams. ▪ Develop and recruit new clinical roles and structures to support Integrated care implementation in CHO (48 posts): - 18 additional dietitians employed - 2 per CHO: diabetic structured education programmes work and general diabetic dietetics work - support diabetes cycle of care to be implemented. - 9 additional podiatrists employed – to fill priority gaps to implement the footcare model to support the diabetes cycle of care. - 9 additional clinical nurse specialists employed - to fill priority gaps in services for diabetes. - 6 additional clinical nurse specialists to be employed to support respiratory demonstrator project. - 6 additional physiotherapists to be employed. ▪ Implement the Integrated Model of Care for Prevention and Management of Chronic Disease in identified areas.	Q1-Q4 All actions	NCAGL

▪ Support and enable the implementation of chronic disease integrated patient care pathways in each of the CHO areas. ▪ Implement the self management support strategy; support of GP and Pharmacy sessions. ▪ Release of 500 Primary Care staff for brief intervention training. ▪ Support the rollout of the National COPD Collaborative in association with the Integrated Care Programme for Prevention and Management of Chronic Disease (ICPCD). ▪ Collaborate with ICPCD and the Office of the Chief Information Officer (OCIO) in the design of chronic disease registries for use in primary, secondary and continuing care. ▪ Progress the implementation of the Diabetes Clinical Programme making best use of the existing Integrated Care Diabetes Clinical Nurse Specialists. ▪ Progress a study of outcomes for patients with acute asthma in collaboration with Clinical Strategy and Programmes. ▪ Progress the provision of a nurse led asthma information line to support patients with self management. **Integrated Care Programme for Children** ▪ Support the establishment of the Integrated Care Programme for Children and associated work-streams. **Integrated Care Programme for Maternal Care** ▪ Implement the primary care actions aligned to the National Maternity Strategy 2016-2026.		

Primary Care Reimbursement Service

► Process applications for eligibility within the agreed turnaround times.

Operational Plan Action	End Q	Owner
▪ 95% of Medical Card/GP Visit Card applications will be accurately processed within 15 days.	Q1–Q4	AND PCRS

► Maximise the use of data from other government agencies to confirm access for eligible persons.

Operational Plan Actions	End Q	Owner
▪ Replace the current system used to share data with the Department of Social Protection (Infosys) with an enhanced data sharing solution (DSP API tool).	Q3	AND PCRS
▪ Work with the Revenue Commissioners to maximise the use of available data to reduce the burden of proof on medical card holders and eliminate unnecessary reviews of existing card holders.	Q1-Q4	

► Extend the on-line medical card application system.

Operational Plan Actions	End Q	Owner
▪ Enable applicants to fully complete their application electronically.	Q4	AND
▪ Extend the document scanning solution to all work streams in the Medical Card Unit.	Q2	PCRS
▪ Further develop the medical card section of the HSE website.	Q2	

► Establish a service user panel to include representation from patients, GPs, pharmacists and other contracted service providers.

Operational Plan Actions	End Q	Owner
▪ Enhance links with key stakeholders in the medical card process.	Q2	AND
▪ Introduce a stakeholder satisfaction survey.	Q4	PCRS
▪ Build on the medical card holder survey conducted on 2015 to establish an ongoing	Q4	

process of assessing card holder satisfaction at least annually. ▪ Develop and expand the Quality Assurance function (established in 2015) to ensure: - Comprehensive review of all client correspondence. - Assurance that each letter is Irish language certified and reviewed by NALA. - Establish quality assurance clinics to troubleshoot complex applications and update Standard Operating Procedures accordingly.	 Q2 Q2 Q2	
▪ Incorporate Eircodes for all medical card applicants into the National Medical Card Unit internal processing system and in all correspondence including forms.	Q2	
▪ Enable access to new drugs and medicines in line with health policy and legislation.	Q1-Q4	

Implement the individual health identifier register

- ► Implement the plan for the roll out of individual health identifiers in 2016 in line with the *Health Identifiers Act 2014*.

Operational Plan Action	End Q	Owner
▪ Design and build the IHI register design.	Q2	HIPL
▪ Establish a Business Unit for the implementation of IHI.	Q3	HIPL

Social Inclusion

Improve health outcomes for people with addiction issues

- ► Implement the outstanding actions in the *National Drugs Strategy* (2009–2016).

Operational Plan Action	End Q	Owner
▪ Commence the HSE plan for phased increased access to buprenorphine/naloxone and buprenorphine products within the context of available resources (National Drug Strategy Action 32).	Q2	ADL
▪ Participate in development of a new National Drugs Strategy (2017 onwards) with regard to actions outlined in terms of reference of the Steering Committee.	Q2-Q4	ADL

- ► Ensure that adults deemed appropriate for treatment for substance abuse receive treatment within one calendar month (National Drug Strategy Action 32).
- ► Ensure that children deemed appropriate for treatment for substance abuse receive treatment within one week.

Operational Plan Actions	End Q	Owner
▪ Implement the Opioid Treatment Protocol to ensure that addiction services can be accessed at the lowest level of complexity and as close to the home of the service user as is practicable (arising from National Drug Strategy Action 35).	Q1-Q4	ADL
▪ Develop and expand integrated models of care, addressing needs related to mental and/or physical health-related problems, rehabilitation, and social support in order to improve the health, social reintegration and recovery of problem and dependent drug/ alcohol users, including those affected by co-morbidity.		
▪ Enhance the effectiveness of drug and alcohol treatment and rehabilitation by introducing models of care which address co-occurring conditions.	Q1-Q4	ADL

- ► Ensure that addiction services operate within the person-centred care planning processes of the *Drugs Rehabilitation Framework.*

Operational Plan Action	End Q	Owner
▪ Embed the National Drugs Rehabilitation Framework among relevant HSE Divisions, other Statutory Bodies and Voluntary/ Community Sectors to achieve integrated care management, seamless transition between services and optimal pathways to recovery for users of addiction services.	Q1-Q4	ADL

	End Q	Owner
▪ Monitor and review referrals, admissions and outcomes to HSE funded Tier 4 services; ensure that all referrals are in line with the National Drugs Rehabilitation Framework.	Q1-Q4	ADL

► Finalise the response to drug-related deaths through a *National Overdose Prevention Strategy*.

Operational Plan Action	End Q	Owner
▪ Implement the recommendations of the Naloxone Demonstration Project within available resources.	Q1-Q4	ADL

► Audit drug services in line with the Drugs Rehabilitation Framework on care planning, assessment, key working and referrals.

Operational Plan Action	End Q	Owner
▪ Ensure effective working practices among HSE Divisions, other Statutory Bodies and Voluntary/ Community Sectors, based on co-operation, avoiding duplication of efforts, securing efficient exchange of information, improving service user experiences and guaranteeing continuity of care.	Q1-Q4	ADL

► Strengthen clinical governance structures by the appointment of an Addiction Clinical Lead.

Operational Plan Actions	End Q	Owner
▪ Support the appointment of Addiction Clinical Lead.	Q1	ND
▪ Launch the HSE Clinical Guidelines for Opioid Substitution Treatment (OST) as per recommendation of the Opioid Treatment Protocol.	Q1	ADL
▪ Support the Mental Health Division in the establishment of the new Mental Health Clinical Programme for Co Morbid Mental Illness and Substance Misuse (Dual Diagnosis) and to progress the actions deriving from this programme.	Q4	ADL

Other Addiction Service Operational Plan Actions	End Q	Owner
▪ Engage with patients on their experience of primary care through service user experience surveys/listening, working with Quality and Safety and Quality Improvement Division.	Q2	ADL
▪ Develop a programme to improve the quality and safety of addiction services, working with Primary Care Quality and Safety and the National Quality Improvement Division.	Q4	ADL
▪ Apply findings of the evaluation of the Pharmacy Needle Exchange programme within available resourcing.	Q1-Q4	ADL
▪ Launch the National Guidelines for Alcohol Consumption to Reduce the Health Risk from Drinking – in partnership with Health and Wellbeing Division	Q3	ADL
▪ Participate in the European Union Reducing Alcohol Related Harm (RARHA) Project in partnership with Health and Wellbeing Division.	Q3	ADL
▪ Participate with Health and Wellbeing Division in supporting the implementation of the Hidden Harm Strategic Statement with Tusla and Drug and Alcohol Services.	Q2-Q4	ADL

Support the implementation plan to reduce homelessness

► Support the implementation plan to reduce homelessness with particular focus on health related recommendations.

Operational Plan Actions	End Q	Owner
▪ Ensure that a care and case management approach is implemented and working effectively in each CHO, with particular focus on improving the health outcomes for homeless persons.	Q1-Q4	ADL
▪ Support the development of the National Quality Standards Framework for Homeless services, due to be implemented on a pilot basis in the Dublin region, in promoting high	Q1-Q4	ADL

quality, safe and effective services to persons experiencing homelessness.		

► Ensure arrangements are in place and working effectively to ensure homeless persons have access to primary care services where required.

Operational Plan Actions	End Q	Owner
▪ Engage with the Homeless Action Teams and primary care/mental health services to ensure appropriate arrangements are in place and the needs of homeless persons are being supported in terms of improved access and take up of primary care and specialist care services.	Q1-Q4	ADL
▪ Address the key recommendations of the report "Homelessness: An Unhealthy State" on a phased basis, within the context of ongoing developments in homelessness and available resources.	Q1-Q4	ADL
▪ Work with Primary Care Quality and Safety and National Quality Improvement Division to develop a programme to improve the quality and safety of homeless services.	Q4	ADL

► Work towards ensuring that no patient is discharged into homelessness from an acute setting and ensure the provision of step-down care for homeless people with chronic and enduring needs in long-term supported accommodation in collaboration with mental health services. *(Held funding DoH Mental Health €2m of €35m)*

Operational Plan Actions	End Q	Owner
▪ Ensure that discharge protocols for homeless persons in acute hospitals and mental health facilities have been developed and are being implemented in each Hospital Group/CHO in line with the National Hospital Discharge Protocol for Homelessness (Guidance Framework).	Q2	ADL
▪ Support the provision of long-term accommodation providing care and supports to older homeless people with chronic illness, who do not need acute inpatient care.	Q2	ADL

► Ensure the provision of in-reach services to emergency accommodation settings and long-term supported accommodation for people with high support needs.

Operational Plan Action	End Q	Owner
▪ Ensure appropriate arrangements are in place within the homeless hostel network to ensure immediate access for homeless persons to primary care/mental health services.	Q1-Q4	ADL

Improve health outcomes for vulnerable groups

► Traveller and Roma health

- Provide health information and education for travellers on diabetes and cardiovascular health.

Operational Plan Action	End Q	Owner
▪ Promote, support and monitor uptake of the "*Small Changes - Big Difference*" Training Manual: Traveller Preventative Education Programme for Heart Disease and Diabetes.	Q2-Q4	SIL

- Develop a Traveller and Roma Inclusion Strategy in collaboration with clinical programmes and mental health services.
- Support an interagency initiative in two Local Authority areas – in partnership with the Local Authorities and representative groups – to improve health service delivery to the traveller community.

Operational Plan Actions	End Q	Owner
▪ Expand the Traveller Asthma Education Programme to a further 4 Traveller Health Units in collaboration with the Asthma Society of Ireland.	Q1-Q4	SIL
▪ Provide refresher training to groups trained as part of the 2014 pilot project.	Q1	SIL
▪ Conduct one year post-training evaluations with participants trained in 2015.	Q3-Q4	SIL
▪ Deliver tailored refresher training to Traveller Healthcare Workers in each region.	Q2-Q4	SIL

▪ Assist each Traveller Health Unit to develop a 3 – 5 year Action Plan based on identified priorities within their respective catchment.	Q2	SIL
▪ Review current arrangements in respect of addressing Traveller and Roma health needs in line with new CHO structures and processes.	Q2	SIL
▪ Address low uptake of vaccinations among Roma community in collaboration with HSE Public Health.	Q2	SIL
▪ Develop and implement a Roma Primary Healthcare Project in one CHO/ Traveller Health Unit.	Q3	SIL

► Domestic, Sexual and Gender based violence

- Implement the recommendations of the S*trategy on Domestic, Sexual and Gender-based Violence 2015–2020* with particular attention to vulnerable or at risk communities and support for staff in recognising and responding to victims of violence.
- Implement specific health related recommendations of the *Action Plan on Women, Peace and Security* with a focus on the listed HSE action '*Strengthen outreach to women and girls in Ireland who have been affected by conflict'*.
- Participate in the development of an Action Plan to prevent and combat human trafficking, with associated attention to reviewing and strengthening existing care and support services for persons who have been trafficked.

Operational Plan Actions	**End Q**	**Owner**
▪ Develop a shared approach with Tusla, in collaboration with service provider organisations, towards training of frontline professionals in each agency. Training should also include a focus on establishing standards, addressing quality improvement and measuring outcomes.	Q3	SIL
▪ Develop appropriate interventions in cases of domestic, sexual and gender based violence in communities with particular vulnerability, including migrants, Traveller and Roma women and people with substance misuse difficulties.	Q1-Q4	SIL

► Intercultural Health

- Develop structures and processes to provide health services under the Irish Refugee Protection programme with associated monitoring and reporting of outcomes.

Operational Plan Actions	**End Q**	**Owner**
▪ Develop a second **National Intercultural Health Strategy;** ensure a coordinated approach to addressing increasing diversity, emerging health needs of migrants, unique needs of increasing numbers of refugees and identified issues particular to people seeking asylum and support service providers in delivering responsive, culturally competent services.	Q4	SIL
▪ Develop structures and processes to provide health services under the Irish Refugee Protection programme with associated monitoring and reporting of outcomes.	Q1-Q4	SIL
▪ Address the Health Needs of people arriving in Ireland under the Refugee Resettlement Programme through pre-departure Health Screening, and addressing their health needs on arrival.	Q1-Q4	
▪ Participate on high level groups to ensure comprehensive planning and monitoring in respect of the Government Led Groups.	Q1-Q4	
▪ Establish an internal representative HSE group to support a coherent approach to putting necessary health services in place on arrival of refugee cohort, with particular reference to GP, mental health, oral health and public health nursing services.	Q1	
▪ Each CHO that has a Direct Provision or Emergency and Orientation Centre within its catchment area will report quarterly detailing emerging issues, costs incurred and other relevant updates.	Q1-Q4	SIL

▪ Monitor trends, uptake of services, impact on services, additional demands and report on same.	Q1-Q4	SIL
▪ Implement and monitor the health recommendations of the "Working Group Report to Government on Improvements to the Protection Process, including Direction Provision and Supports to Asylum Seekers", with particular reference to reviewing aspects of management of mental health issues, and provision of training to staff.	Q1-Q4	SIL
▪ Work with Primary Care Operations to implement ethnic equality monitoring across all disciplines in an agreed identified PCT (Blanchardstown), with associated reporting/ analysis of findings.	Q2-Q4	SIL
▪ Consolidate roll out of the Ethnic Identifier in a hospital setting, including roll out of online training package, and apply findings towards identified service needs.	Q1-Q4	SIL
▪ Assist CHOs in planning for the implementation of the "Report on Health Screening, Infectious Disease Assessment for Migrants", in collaboration with Public Health.	Q2-Q4	SIL
▪ Disadvantaged Communities: Roll out adapted Asthma Education programme to a community group in four sites as part of work under Health Inequalities.	Q2-Q4	SIL

Promote implementation of an interpreting model for persons who are not proficient in English or are deaf

- ▸ Provide translation facilities to assist patients not proficient in English or deaf to access and navigate health services effectively.

Operational Plan Actions	End Q	Owner
▪ Develop and maintain a database of translated health related material.	Q1-Q4	SIL
▪ Work with CHOs to map existing models of interpreting provision, including details in respect of uptake, costs and outcomes.	Q2	SIL
▪ Conduct a survey of service user experiences of using interpreting services in 2 settings.	Q2	SIL

Operational Plan Action	End Q	Owner
▪ **Map and document the nature and extent of Social Inclusion services across CHOs -** Conduct an exercise to determine the exact nature and extent of Social Inclusion services across CHO areas, with particular regard to identification of gaps, emerging issues and trends, consistency of approaches and extent of resourcing.	Q3	SIL

Palliative Care

Improve access to adult palliative care services

- ▸ Address deficits in specialist palliative care bed numbers in Kerry (15 beds).

Operational Plan Action	End Q	Owner
▪ Open a 15 bed specialist inpatient unit (Hospice) at Kerry General Hospital.	Q4	PCL

- ▸ Extend the implementation of specialist palliative care eligibility criteria to include non-cancer patients.

Operational Plan Action	End Q	Owner
▪ Develop a comprehensive communication plan to ensure services are fully aware of and implement the guideline nationally.	Q2	PCL

Improve quality within palliative care service provision

- ▸ Strengthen palliative care services through the implementation of the *National Standards for Safer Better Healthcare.*

Operational Plan Actions	End Q	Owner
▪ Establish a Quality Assurance and Improvement enabling committee for specialist palliative care services, to be followed by a Shared Learning Forum. This forum will support services to undertake self assessment, and service improvement programmes to implement the National Standards for Safer Better Healthcare.	Q1 & Q4	PCL

- Implement clinical guidelines on the management of cancer pain and the management of constipation.

Operational Plan Actions	End Q	Owner
▪ Develop an implementation plan to include the communication and dissemination of the guidelines to specialist and generalist palliative care services, including designated centres for older people.	Q1	PCL
▪ Agree and implement a multi-site demonstration project in the Dublin area.	Q2	

- Develop and implement a suite of quality improvement measures for children's palliative care services.

Operational Plan Action	End Q	Owner
▪ Work with the National Development Committee on Children's Palliative care to develop standards and national documentation to improve the provision of children's palliative care.	Q2	PCL

- Work with the Children's Hospital Group to ensure existing children's palliative care services become fully integrated with the new structures.

Operational Plan Action	End Q	Owner
▪ Engage with the Children's Hospital Group to ensure that the children's palliative care service pathways and protocols are aligned to the Clinical Programmes.	Q1	PCL

Improve access to children's palliative care services.

- Provide for a Palliative Care Consultant previously funded by Irish Hospice Foundation. *(New Funding included in Acute Services)*

Operational Plan Action	End Q	Owner
▪ Provide a Consultant Paediatrician with a Special Interest in Paediatric Palliative Care Medicine in Our Lady's Children's Hospital Crumlin.	Q3	PCL

Ensure palliative care services are effective, efficient and responsive to the needs of individuals and families

- Work with the Irish Hospice Foundation on the Design and Dignity Grants Scheme.

Operational Plan Actions	End Q	Owner
▪ Complete the minor capital projects, funded under round two of the grant scheme to improve the hospital environment for palliative care patients, their families and staff i.e. 12 projects over 9 sites to be completed e.g. family rooms, quiet spaces, mortuaries etc.	Q4	PCL
▪ Complete and publish a review project of four sites funded under the scheme.	Q4	PCL

- Work with primary care services on the *Rapid Discharge Planning Pathway* to facilitate those who wish to die at home.

Operational Plan Action	End Q	Owner
▪ Develop an agreed process that will accommodate quick access to home care packages and aids / equipment for patients returning home.	Q1	PCL

- Implement the recommendations from the *Palliative Care Support Beds Review.*

Operational Plan Action	End Q	Owner
▪ Review the recommendations and develop a plan to implement the recommendations on a phased basis. The recommendations relate to Level 2 / Support Beds aligned to Social Care.	Q3	PCL

- Implement the specialist palliative care initiative in four designated centres for older people in the North East.

Operational Plan Action	End Q	Owner
▪ Work in partnership across services to ensure residents requiring palliative care can remain at home, prevent inappropriate admissions to acute hospitals and enable people to return home as quickly as possible after a stay in hospital.	Q1-Q4	PCL

- Complete a demonstration project to develop a best practice model of palliative care for EDs.

Operational Plan Action	End Q	Owner
▪ Work in partnership with the National Clinical Programme for Emergency Medicine and the Irish Hospice Foundation to complete and disseminate the findings of the project undertaken in St. Vincent's University Hospital.	Q2	PCL

- Work with NAS to support emergency responders to manage end of life care, enabling people to be cared for at home if appropriate.

Operational Plan Action	End Q	Owner
▪ Adults: Complete a clinical practice guideline and develop a national implementation plan. ▪ Children: Complete the pilot of the Ambulance Care Directive for Children and develop national implementation plan.	Q2 Q3	PCL

Community Oncology Programme (NCCP)

Operational Plan Action	End Q	Owner
▪ Implement GP guidelines for non-melanoma skin cancer. ▪ Extend the primary care community nursing oncology programme in collaboration with the NCCP prioritising the North East, Midlands and South.	Q3	COCCP

Foster a culture that is honest, compassionate, transparent and accountable

Primary Care

Quality and Safety

Patient engagement and empowerment

- Engage with patients on their experience of primary care through listening sessions conducted in partnership with the Quality Improvement Division.
- Measure primary care service users experience within CHOs through the use of the primary care service user survey.

Operational Plan Action	End Q	Owner
▪ Engage with staff in CHOs through listening sessions and establish their views on the provision of primary care services.	Q1-Q4	Q&S

Governing for quality and safety

- Work with the Quality Improvement Division to foster accountability for quality within primary care through quality initiatives, i.e. provide support, training and advice to the primary care quality and safety committees.

Operational Plan Action	End Q	Owner
▪ Establish the Primary Care Quality and Safety Committee.	Q1	Q&S
▪ Implement the National Framework for Improving Quality in the primary care setting.	Q1-Q4	Q&S
▪ Support a quality improvement and enablement project involving training, awareness and advice.	Q2	Q&S

Open disclosure programme

- Work with the Quality Improvement Division to roll out the Open Disclosure Programme to all primary care services. (Cross reference Goal 5 operational plan actions).

Strengthening the Primary Care Accountability Framework

- Monitor performance of health services against agreed indicators for quality and safety and the Primary Care Quality Dashboard. (Cross reference Goal 5 operational plan actions).

Promoting safe services

- Ensure systems and structures are in place within primary care for reporting and monitoring serious reportable events (SREs) and other serious safety incidents.
- Ensure incidents in primary care are effectively identified, managed, reported, investigated with learning shared in line with national policy.

Operational Plan Action	End Q	Owner
▪ Ensure learning is shared on incidents through workshops during the year.	Q2-Q4	Q&S
▪ Implement effective complaints management systems in the Ombudsman's Report *Learning to get Better*.		CHOs

National Standards for Safer Better Health Care

- Support CHOs in implementing the *National Standards for Safer Better Health Care*.

Operational Plan Action	End Q	Owner
▪ Support CHOs in implementing the *National Standards for Safer Better Health Care* with a specific focus on addiction and homeless standards.	Q2-Q4	Q&S

- Establish a quality support group to promote patient safety and quality improvement programmes in primary care.

Operational Plan Action	End Q	Owner
▪ Establish a Primary Care Quality and Safety Networking and Support Group to promote patient safety and quality improvement programmes in primary care.	Q1	Q&S

Support the work of the National Clinical Effectiveness Committee

- Implement the NCEC Guidelines and Standards for Clinical Practice. (Cross reference Goal 5 operational plan actions).

Understanding patient safety incidents

- Support the roll out of the National Incident Management System (NIMS) in primary care in conjunction with Quality Assurance and Verification and the State Claims Agency.
- Develop and produce high level incident information data from NIMS.

Operational Plan Actions	End Q	Owner
▪ Work with the State Claims Agency (SCA) to produce high level incident information data from NIMS.	Q4	Q&S
▪ Engage with National Incident Management Learning Team to share learning from analysis of investigation reports.	Q4	Q&S

Audit and reviews

- Undertake audits of quality and safety in primary care, with the support of the National Quality Assurance and Verification Division, to provide assurance that standards are in line with the *National Standards for Safer Better Health Care*. (Cross reference Goal 5 operational plan actions).

Measurement and analysis of information for quality improvement: Build capacity in the use of measurement and data for quality improvement

- Work with CHOs to further develop the primary care quality dashboard to provide one mechanism for measuring quality and safety.
- Work with the Quality Improvement Division to develop a quality profile in the primary care setting.
- Promote the development of additional quality and safety indicators.

  (Cross reference Goal 5 operational plan actions).

Risk management

- Manage risk within primary care through the ongoing development of risk management processes.
- Work with other divisions to enhance the capacity and capability of staff in relation to the management of risk through education and training.

  (Cross reference Goal 5 operational plan actions).

Children First

- Provide a standard system of reporting child protection and welfare concerns to the Child and Family Agency. Reports will be tracked and monitored by the Children First Office following submission of weekly / monthly reports by assigned Designated Liaison Persons (DLPs).Names and contact details for DLPs will be available to each staff member in CHOs and hospital groups.

Operational Plan Action	End Q	Owner
▪ Implement standard systems of reporting child protection and welfare concerns to the Child and Family Agency.	Q3	CFL
▪ Circulate names and contact details for DLPs to all staff.	Q1	CFL

Primary Care Reimbursement Service

Implement the recommendations of the reform programme in PCRS

- Continue the regular engagement with primary care contractor representative organisations.

Operational Plan Actions	End Q	Owner
▪ Review and update Contractor Handbooks.	Q2	AND PCRS
▪ Enhance contractor and practice support processing.	Q2	
▪ Develop and test electronic claims processing.	Q2	
▪ Develop and test optical scanning of documents.	Q2	
▪ Enhance and develop the online Dental Treatment Service Scheme checker.	Q2	

- Review the content of itemised claims listings with primary care contractor representative organisations.

Operational Plan Actions	End Q	Owner
▪ Review and update core lists based on the outcome of Medicine Management Programme review with Clinical Programmes.	Q2	AND PCRS
▪ Review and update wound management products approved for reimbursement to align with best practice for community use.	Q3	

- Consider, in conjunction with the DoH where appropriate, further recommendations of the Clinical Advisory Group including conclusions in relation to the assessment of the burden of disease.

Operational Plan Action	End Q	Owner
▪ Implement the recommendations of the CAG reports (subject to those recommendations being approved).	Q4	AND PCRS

Develop the Community Schemes Control and Inspectorate Function in line with recommendations from the reform programme

- Develop enhanced inspection procedures.
- Increase the use of advanced data analysis to support inspection functions.

Operational Plan Actions	End Q	Owner
Primary Care Reimbursement Service		AND PCRS
Implement revised organisation structures for the PCRS Probity function as recommended in the Deloitte Prospectus Report on Governance Structures at PCRS (subject to final approval of the recommendations in the report)		
▪ Develop the Probity Function including skills in analytics; inspection and case management across the four contractor groups: - Development of data analytics to support probity assurance. - Development of an inspectorate team for each contractor group to support probity assurance.	Q1-Q4	
▪ Review and update the processes to support verification of claims with clients, compliance assurance arrangements and Community Schemes Control.	Q3	

Social Inclusion

Roll out of Brief Intervention Training for Drugs and Alcohol Services.

- Develop and distribute standardised problem alcohol and substance use screening and brief intervention SAOR (Support, Ask and Assess, Offer Assistance and Refer) toolkits to support Tier 1 and Tier 2 services.
- Publish a Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use for nurses and midwives in acute, primary and community settings.

Operational Plan Action	End Q	Owner
▪ Develop a revised Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use including review of existing best practice and stakeholder engagement.	Q2	ADL
▪ Develop and implement Screening and Brief Intervention (SBI) plans in 5 CHO areas.	Q4	ADL

Strengthen community development approaches in line with *Healthy Ireland* and other relevant initiatives

- Establish a social inclusion working group on community development, to incorporate principles in respect of addressing health inequalities, community development, community participation, social prescribing etc. with a focus on vulnerable communities. This working group will have representation from each CHO.

Operational Plan Actions	End Q	Owner
▪ Support each CHO in their engagement with the LCDCs and in the development of the LCDC Local Economic and Community Plans in each CHO area.	Q1-Q4	SIL
▪ Expand the Social Prescribing Initiative (currently in operation in Donegal) to another CHO in 2016 (area to be agreed). This will be aligned to the Framework for Implementation of Community Participation in Primary Healthcare.	Q3	SIL

Enhance Community approaches to addressing HIV/AIDS

- Collaborate with HIV Ireland and other stakeholders to further develop and enhance community approaches to addressing HIV / AIDS.

Operational Plan Actions	End Q	Owner
▪ Develop a best practice manual to support the further development of community testing nationally.	Q3	SIL
▪ Develop and Pilot a HIV, Hepatitis and STI community testing service in Area 8 (North East) within community Addiction and Homeless Services.	Q2	SIL
▪ Work with the Sexual Health and Crisis Pregnancy Programme to support 3 NGOs in the piloting of a 12 month community based rapid HIV testing initiative in non-clinical settings in Dublin, Cork and Limerick.	Q2-Q4	SIL

Hepatitis C Strategy

- Implement the recommendations of the Hepatitis C Strategy through the development of national guidelines for Hepatitis C screening and provision of updated website information.

Operational Plan Actions	End Q	Owner
▪ Health Promotion: Provide clear, consistent advice on Hepatitis C through the development of an education and awareness campaign and development of updated website information.	Q3	SIL
▪ Surveillance and Screening: Develop national guidelines for hepatitis C screening and improve information on prevalence of hepatitis C.	Q3	SIL

Palliative Care

Encourage the ongoing development of person-centred services

- Develop an integrated whole system approach to person-centred care provision.

Operational Plan Actions	End Q	Owner
▪ Undertake a stakeholder engagement exercise to support the agreement of model of care.	Q2	PCL
▪ Finalise and implement a comprehensive model of care for adult palliative care services.	Q4	PCL

- Undertake a health system performance and evaluation study from a person-centred perspective.

Operational Plan Action	End Q	Owner
▪ Support services to implement Theme 1 Person Centred Care and Support within the National Standards for Safer Better Healthcare. This will be done with the support of the Primary Care Quality and Safety Office.	Q4	PCL

- Incorporate the experiences of service users and staff to evaluate and plan services.

Operational Plan Action	End Q	Owner
▪ Adults: Work with the All Island Institute of Hospice and Palliative Care to incorporate the learning from the *Let's Talk About* survey into service plans and service delivery.	Q1-Q4	PCL

Ensure patient representation on palliative care working groups. ▪ Children: Finalise the external evaluation of the children's palliative care programme. Review the recommendations and develop an implementation plan.	Q2	PCL

- Support services to implement the *Patient Charter for Specialist Palliative Care.*

Operational Plan Action	End Q	Owner
Develop and communicate the charter in partnership with relevant stakeholders.	Q3	PCL

- Commence collection of key performance indicators with a quality focus.

Operational Plan Action	End Q	Owner
▪ Engage with inpatient units and homecare community stakeholders to pilot the metrics	Q1	PCL
▪ Pilot metrics, refine and commence collection.	Q2	PCL

- Commence the collection of patient / family satisfaction feedback.

Operational Plan Action	End Q	Owner
▪ Work in partnership with service providers and service users to agree a survey methodology and commence collection of feedback.	Q3	PCL

Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them

Primary Care

Restructure the provision of GP training

- Agree a service level agreement on the training programme for GPs.

Operational Plan Action	End Q	Owner
▪ Restructure the management and governance of GP Training.	Q1	GPTPL
▪ Increase the number of GP Trainees by 15.	Q4	

Quality and Safety

- Improve capacity in quality and safety within primary care by providing support to staff to develop clinical audit tools.

Operational Plan Action	End Q	Owner
▪ Improve capacity in quality and safety within primary care by providing support and training to staff on systems analysis investigation, incident management, risk assessment, open disclosure and clinical audit.	Q1-Q4	Q&S
▪ Develop the capacity of staff to lead and deliver quality improvement by education and training in partnership with the professional colleges. This will be progressed in collaboration with the National Quality Improvement Division.	Q4	Q&S

Implement Children First

- Promote the implementation of Children First in each CHO / hospital group.
  - Ensure each CHO / hospital group has a Children First implementation plan.
  - Ensure each CHO / hospital has a local Child Protection and Welfare Policy.
- Ensure that each staff member is aware of their social, corporate and legal responsibilities under Children First.
  - Facilitate staff (including staff of funded agencies) to undertake the Children First e-Learning programme.

- Deliver Children First Training Programmes to meet the needs of services including out of hours and at weekends if required.

Operational Plan Actions	End Q	Owner
▪ Establish a Children First National Office with a dedicated team of Training and Information Officers.	Q1	CFL
▪ Appoint DPLs in each CHO.	Q1	
▪ Commence e-reporting for submissions of all child protection reports. This will support the management of statutory requirements and will facilitate the provision of timely management information regarding all aspects of reporting including KPIs.	Q3	
▪ Develop the Children First Webpage as a resource for all primary care staff.	Q2	
▪ Ensure that all new primary care staff receive information on the HSE Child Protection and Welfare policy as part of their induction process.	Q1-Q4	

Public Health Nursing

Operational Plan Action	End Q	Owner
▪ Implement a Service Improvement Framework for Public Health Nursing/collaborative project between Office of the Nursing and Midwifery Services Director and Primary Care Division.	Q4	NL

Primary Care Reimbursement Service

Engage with and inform all team members about developments

- Develop staff skills to deliver the HR improvement initiatives from the positive workplace engagements.

Operational Plan Actions	End Q	Owner
▪ Roll out of the Staff Development Programme to all staff.	Q2	AND
▪ Conduct regular staffing briefing sessions for all staff.	Q1-Q4	PCRS

Implement organisation structures in line with the recommendations of the reform programme

- Align organisation structures and enhance team capacity as recommended.

Operational Plan Action	End Q	Owner
▪ Implement the Deloitte Prospectus Report on Governance Structures (subject to final approval of the recommendations in the report).	Q4	AND PCRS

Social Inclusion

- Provide LGBT health training for health service staff across three CHOs.

Operational Plan Action	End Q	Owner
▪ Roll out TENI (Transgender Equality Network) training to 3 CHOs.	Q2	SIL

- Provide intercultural health training to enable staff to deliver services in a culturally competent manner. This training will be targeted at staff delivering services to asylum seekers in Direct Provision and to refugees arriving under Resettlement and Relocation programmes.

Operational Plan Action	End Q	Owner
▪ Review intercultural health training.	Q2-Q4	SIL
▪ Link with services on the provision of training for staff dealing with asylum seekers and refugees.	Q3-Q4	

- Roll out of SAOR screening and brief intervention training to 300 staff for problem alcohol and substance use within Tier 1 and Tier 2 services.

Operational Plan Action	End Q	Owner
▪ Deliver 30 SAOR training sessions and complete 4 train the trainer programmes. ▪ Develop an information and education package concerning the new psychoactive substances.	Q4 Q1	ADL NCLAS

Palliative Care

Develop the capacity of healthcare professionals to better meet the needs of patients and their families

► Progress the implementation of the *Palliative Care Competence Framework*.

Operational Plan Action	End Q	Owner
▪ Establish an implementation group to work across academic, education, CPD, HR bodies and service providers to ensure the competences are incorporated into courses, job specifications and assessment processes.	Q1	PCL

► Provide training and support on the *Needs Assessment Guidance Document* and Education Module.

Operational Plan Actions	End Q	Owner
▪ Conduct an evaluation of Phase 1 training completed in 2015. ▪ Commence the training for Care Assistants.	Q2 Q3	PCL

► Implement the *Role Delineation Framework*.

Operational Plan Actions	End Q	Owner
▪ Develop a comprehensive communication plan to ensure services are fully aware of the published framework. ▪ Implement the framework across all palliative care services.	Q1 Q4	PCL

► Establish nurse prescribing within specialist palliative care.

Operational Plan Action	End Q	Owner
▪ Identify three exemplar sites to facilitate the development of nurse prescribers.	Q1	PCL

Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

Primary Care Quality and Safety

Other Operational Plan Actions	End Q	Owner
Quality and Safety **Measurement and Analysis of Information for Quality Improvement: Build capacity and capability in the system in the use of measurement and data for quality improvement**		
▪ Quality and Safety Dashboard: Work with CHOs to further develop the Primary Care Quality dashboard to provide one mechanism for providing assurance and measuring quality and safety. The dashboard will compliment the National Quality Scorecard in the NSP.	Q4	Q&S & ICT
▪ Quality Profiles: Work with NQID to develop a quality profile in a primary care setting.	Q1	Q&S
▪ Quality and Safety Indicators: promote the development of additional quality and safety indicators.	Q4	Q&S
▪ Develop a business case for the development of a Quality and Safety Information Management system for primary care.	Q2	Q&S & ICT

Policies, Procedures, Protocols and Guidelines (PPPG)	Q1	Q&S
▪ Participate in developing a HSE policy framework for PPPGs including education training and support.This will support the implementation of NCEC clinical guidelines, clinical audit and standards for clinical practice guidance.		

► Roll out of primary care ICT systems to support safe and effective provision of services. (ICT)

Operational Plan Actions	End Q	Owner
▪ Commence the implementation of ICT- enabled projects in support of improved efficiency and effectiveness across the full spectrum of service provision.	Q1	HOP
▪ Complete the rollout of electronic general referrals to all hospitals to improve communication between GPs and secondary care and reduce risk to patients.	Q4	ICT
▪ Continue deployment of Healthmail and prepare for key national systems such as those for audiology and addiction.	Q4	ICT
▪ Enhance the programme of accreditation with the ICGP, which will facilitate new developments in integrated care and universal GP cover (under 6s and under 12s, asthma and diabetes cycles of care).	Q4	ICT
▪ Develop solutions for ePrescribing in the community to support the eHealth agenda and provide an essential building block towards delivery of the summary care record.	Q4	ICT

Primary Care Reimbursement Service

Assist DoH and DPER in the implementation of the Drugs Cost Strategy

► Implement relevant actions arising from the finalised strategy.

Operational Plan Action	End Q	Owner
▪ Participate in and support the new IPHA Agreement on the Supply of Medicines to the Health Services.	Q4	AND PCRS

Progress the centralised administration of the Drugs Payment and the Long Term Illness Schemes

► Plan and schedule the migration to centralised administration of the scheme (subject to approval of the business case setting out the resources and other supports required for implementation).

Operational Plan Action	End Q	Owner
▪ Design, develop and implement the necessary systems, processes and supports to host the Drugs Payment Scheme and the Long terms Illness Scheme at PCRS.	Q1-Q4	AND PCRS

Support the work of the Medicines Management Programme (MMP) to improve quality and safety and cost effective prescribing behaviours

► Provide data and analysis as required by the programme.

Operational Plan Action	End Q	Owner
▪ Design, develop and implement reports to support the work of the Medicines Management Programme.	Q1-Q4	AND PCRS

Other Operational Plan Actions Primary Care Reimbursement Service	End Q	Owner
▪ Implement strategic projects to support organisational and divisional priorities	Q4	AND PCRS
▪ Progress the project to transition the current HR record management system and payroll to SAP HR and Payroll (in accordance with corporate plans).		
▪ Utilise HSE Shared Services capacity for administrative support services (e.g. Payroll and Pension Administration and Vendor Management).	Q4	
▪ Implement Phase 2 of SEPA project to reduce the numbers of cheques being issued	Q1-Q4	

Balance Scorecard - Quality and Access Indicators of Performance

Quality and Access Indicators of Performance

Quality	Expected Activity / Target 2016
Primary Care	
Service User Experience	*System-wide*
• Complaints	
• % of PCTs by CHO that can evidence service user involvement.	100%
Safe Care	
• Serious Reportable Events	*System-wide*
• Safety Incident Reporting	
Healthcare Associated Infections: Medication Management	
• Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	< 21.7
Effective Care	
Community Intervention Teams (number of referrals)	**24,202**
• Admission Avoidance (includes OPAT)	914
• Hospital Avoidance	12,932
• Early discharge (includes OPAT)	6,360
• Unscheduled referrals from community sources	3,996
Health Amendment Act: **Services to persons with state acquired Hepatitis C**	
• Number of patients who were reviewed	798
Primary Care Reimbursement Service	
Effective Care	
Medical Cards	
• % of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	90%
• % of Medical Card / GP Visit Card applications which are accurately processed by national medical card unit staff	95%
Social Inclusion	
Effective Care	
Traveller Health	
• No. of people who received health information on type 2 diabetes and cardiovascular health	3,470
Homeless Services	
• % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	85%
Palliative Care	
Effective Care	
• % of patients triaged within 1 working day of referral	90%
• % of patients with a multi-disciplinary care plan documented within 5 working days of initial	90%

Quality	Expected Activity / Target 2016
review	

Access	Expected Activity / Target 2016
Primary Care	
GP Activity	
• No. of contacts with GP Out of Hours service	964,770
Nursing	
• No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	0
Speech and Language Therapy	
• % on waiting list for assessment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 52 weeks	100%
Physiotherapy and Occupational Therapy	
• % of new patients seen for assessment within 12 weeks	70%
• % on waiting list for assessment ≤ 52 weeks	100%
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology	
Podiatry	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	75%
Ophthalmology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Audiology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Dietetics	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	70%
Psychology	
• % on waiting list for treatment ≤ 52 weeks	100%
• % on waiting list for treatment ≤ 12 weeks	60%
Oral Health	
• % of new patients who commenced treatment within 3 months of assessment	80%
Orthodontics	
• % of referrals seen for assessment within 6 months	75%
• Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	< 5%
Primary Care Reimbursement Service	
Medical Cards	
• % of completed Medical Card / GP Visit Card applications processed within 15 days	95%
• No. of persons covered by Medical Cards as at 31st December	1,675,767
• No. of persons covered by GP Visit Cards as at 31st December	485,192*

Access	Expected Activity / Target 2016
Social Inclusion	
Substance Misuse	
• % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	100%
• % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	100%
• No. of clients in receipt of opioid substitution treatment (outside prisons)	9,515
• Average waiting time from referral to assessment for opioid substitution treatment	14 days
• Average waiting time from opioid substitution assessment to exit from waiting list or treatment commenced	28 days
Needle Exchange	
• No. of unique individuals attending pharmacy needle exchange	1,731
Palliative Care	
• Access to specialist inpatient bed within 7 days	98%
• Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	95%
• No. of patients in receipt of specialist palliative care in the community	3,309
• No. of children in the care of the children's outreach nursing team / specialist palliative care team	370

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Appendix 1: Financial Tables

2016 CHO Net Expenditure Allocations

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Area 1					
Primary Care	59.9	19.2	79.1	-1.6	77.5
Social Inclusion	.3	1.9	2.2	.0	2.2
Palliative Care	4.7	1.6	6.3	-.5	5.8
Core Services	**64.9**	**22.7**	**87.6**	**-2.1**	**85.6**
Local DLS	.0	21.0	21.0	.0	21.0
Total	**64.9**	**43.7**	**108.6**	**-2.1**	**106.6**
Area 2					
Primary Care	56.3	24.8	81.1	-2.1	79.0
Social Inclusion	.1	6.0	6.1	.0	6.1
Palliative Care	1.5	3.7	5.2	.0	5.2
Core Services	**57.9**	**34.5**	**92.4**	**-2.1**	**90.3**
Local DLS	.0	21.4	21.4	.0	21.4
Total	**57.9**	**55.9**	**113.8**	**-2.1**	**111.7**
Area 3					
Primary Care	36.2	17.9	54.1	-1.5	52.6
Social Inclusion	1.9	6.4	8.3	-.2	8.1
Palliative Care	.0	11.6	11.6	.0	11.6
Core Services	**38.1**	**35.9**	**74.0**	**-1.7**	**72.3**
Local DLS	.0	11.7	11.7	.0	11.7
Total	**38.1**	**47.7**	**85.7**	**-1.7**	**84.0**
Area 4					
Primary Care	71.5	32.9	104.4	-10.2	94.2
Social Inclusion	2.3	13.6	16.0	.0	16.0
Palliative Care	.6	7.7	8.4	-.2	8.1
Core Services	**74.5**	**54.3**	**128.7**	**-10.4**	**118.3**
Local DLS	.0	28.5	28.5	.0	28.5
Total	**74.5**	**82.8**	**157.2**	**-10.4**	**146.8**
Cork Dental					
Primary Care	1.5	.6	2.1	-.4	1.8
Social Inclusion	.0	.0	.0	.0	.0
Palliative Care	.0	.0	.0	.0	.0
Core Services	**1.5**	**.6**	**2.1**	**-.4**	**1.8**
Local DLS	.0	.0	.0	.0	.0
Total	**1.5**	**.6**	**2.1**	**-.4**	**1.8**
CHO	**Pay**	**Non Pay**	**Gross Budget**	**Income**	**Net Budget**

	€m	€m	€m	€m	€m
Primary Care	73.0	33.5	106.5	-10.5	96.0
Social Inclusion	2.3	13.6	16.0	.0	16.0
Palliative Care	.6	7.7	8.4	-.2	8.1
Core Services	**76.0**	**54.9**	**130.8**	**-10.8**	**120.1**
Local DLS	.0	28.5	28.5	.0	28.5
Total	**76.0**	**83.4**	**159.4**	**-10.8**	**148.6**
Area 5					
Primary Care	54.5	23.3	77.8	-3.3	74.5
Social Inclusion	1.2	6.4	7.7	.0	7.7
Palliative Care	.2	1.1	1.3	.0	1.3
Core Services	**56.0**	**30.8**	**86.8**	**-3.3**	**83.5**
Local DLS	.0	18.2	18.2	.0	18.2
Total	**56.0**	**49.0**	**105.0**	**-3.3**	**101.7**
Area 6					
Primary Care	39.0	14.6	53.6	-4.5	49.1
Social Inclusion	.5	2.0	2.6	.0	2.6
Palliative Care	.3	.4	.7	.0	.7
Core Services	**39.8**	**17.0**	**56.8**	**-4.5**	**52.3**
Local DLS	.0	18.3	18.3	.0	18.3
Total	**39.8**	**35.3**	**75.0**	**-4.5**	**70.5**
Dublin Dental					
Primary Care	5.2	1.7	6.9	-1.4	5.5
Social Inclusion	.0	.0	.0	.0	.0
Palliative Care	.0	.0	.0	.0	.0
Core Services	**5.2**	**1.7**	**6.9**	**-1.4**	**5.5**
Local DLS	.0	.0	.0	.0	.0
Total	**5.2**	**1.7**	**6.9**	**-1.4**	**5.5**
Total Area 6 (Incl. Dublin Dental)					
Primary Care	44.2	16.3	60.5	-5.9	54.6
Social Inclusion	.5	2.0	2.6	.0	2.6
Palliative Care	.3	.4	.7	.0	.7
Core Services	**45.0**	**18.7**	**63.7**	**-5.9**	**57.8**
Local DLS	.0	18.3	18.3	.0	18.3
Total	**45.0**	**37.0**	**82.0**	**-5.9**	**76.1**

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Primary Care	54.0	25.0	79.0	-.3	78.7
Social Inclusion	17.7	28.1	45.8	-.1	45.7
Palliative Care	2.3	.5	2.9	.0	2.8
Core Services	**74.1**	**53.6**	**127.6**	**-.4**	**127.2**
Local DLS	.0	46.3	46.3	.0	46.3
Total	**74.1**	**99.9**	**173.9**	**-.4**	**173.5**
OLH					
Primary Care	.0	.0	.0	.0	.0
Social Inclusion	.0	.0	.0	.0	.0
Palliative Care	23.2	5.5	28.7	-8.2	20.5
Core Services	**23.2**	**5.5**	**28.7**	**-8.2**	**20.5**
Local DLS	.0	.0	.0	.0	.0
Total	**23.2**	**5.5**	**28.7**	**-8.2**	**20.5**
Total Area 7 (Incl. OLH)					
Primary Care	54.0	25.0	79.0	-.3	78.7
Social Inclusion	17.7	28.1	45.8	-.1	45.7
Palliative Care	25.6	6.0	31.6	-8.3	23.3
Core Services	**97.3**	**59.1**	**156.4**	**-8.6**	**147.7**
Local DLS	.0	46.3	46.3	.0	46.3
Total	**97.3**	**105.3**	**202.6**	**-8.6**	**194.0**
Area 8					
Primary Care	76.8	36.0	112.9	-2.5	110.4
Social Inclusion	1.7	2.1	3.7	.0	3.7
Palliative Care	4.7	1.1	5.8	-.5	5.3
Core Services	**83.2**	**39.1**	**122.4**	**-3.0**	**119.4**
Local DLS	.0	26.4	26.4	.0	26.4
Total	**83.2**	**65.5**	**148.8**	**-3.0**	**145.8**
Area 9					
Primary Care	51.8	27.1	78.9	-.1	78.8
Social Inclusion	11.5	23.0	34.5	-.2	34.3
Palliative Care	.0	10.5	10.5	.0	10.5
Core Services	**63.2**	**60.7**	**123.9**	**-.3**	**123.6**
Local DLS	.0	50.8	50.8	.0	50.8
Total	**63.2**	**111.5**	**174.7**	**-.3**	**174.4**
Other Primary Care Services (Note 1)					
Primary Care	11.2	51.1	62.3	-.1	62.3
Social Inclusion	.2	.5	.7	.0	.7
Palliative Care	.0	1.0	1.0	.0	1.0
Core Services	**11.4**	**52.6**	**64.1**	**-.1**	**64.4**
Local DLS	.0	.0	.0	.0	.0
Total	**11.4**	**53.0**	**64.1**	**-.1**	**64.4**
PCRS	16.4	2,545.2	2,561.6	-144.5	2,417.1
Total	**16.4**	**2,545.2**	**2,561.6**	**-144.5**	**2,417.1**

CHO	Pay	Non Pay	Gross Budget	Income	Net Budget
	€m	€m	€m	€m	€m
Overall Totals					
Primary Care	518.0	274.2	792.2	-27.7	764.4
Social Inclusion	37.5	90.2	127.6	-.6	127.1
Palliative Care	37.6	44.6	82.2	-9.5	72.8
Core Services Total	**593.0**	**409.0**	**1,002.0**	**-37.8**	**964.2**
Local DLS	.0	242.6	242.6	.0	242.6
PCRS	16.4	2,545.2	2,561.6	-144.5	2,417.1
Total	**609.4**	**3,196.8**	**3,806.2**	**-182.2**	**3,624.0**

Note 1: Other primary care services include regional services and national services.

2016 PCRS Schemes Budget

Scheme/ Payment Category	Allocation 2016 €m
GP Fees and Allowances	528.1
Drug Target Refund	.3
GMS Pharmacy Claims	796.4
DPS Pharmacy Claims	59.2
LTI Pharmacy Claims	196.1
EEA Pharmacy Claims	1.2
Dental Treatment Services	67.3
High Tech Drugs/Medicines	569.1
Methadone Treatment	20.6
Health Amendment Act 1996	1.7
Community Ophthalmic Services	31.3
Hardship Arrangements	15.6
Oncology Drugs Medicines	18.5
OPAT	8.1
OPIT	2.9
Orphans Drugs Medicines	11.0
HEP C Drugs Medicines	30.0
A.D.H.D.	10.0
Other Hospital Drugs	9.0
Administration	33.7
Technical Services/HSE Reg Stationery	6.9
Total Payments	**2,417.1**

Appendix 2: HR Information

Primary Care Division – Staff Numbers by CHO (WTEs)

Primary Care	Medical/ Dental	Nursing	Health & Social Care Professionals	Management / Admin	General Support Staff	Patient & Client Care	Total	Projected Outturn Dec 2015
CHO 1	78	285	276	306	47	79	**1,072**	1,079
CHO 2	95	282	293	276	36	72	**1,054**	1,061
CHO 3	77	182	151	249	48	67	**774**	779
CHO 4	135	334	287	259	20	90	**1,124**	1,133
CHO 5	78	244	219	197	26	51	**815**	821
CHO 6	56	175	212	194	32	82	**752**	757
CHO 7	112	493	352	305	145	262	**1,669**	1,681
CHO 8	216	372	325	435	27	137	**1,512**	1,524
CHO 9	115	310	307	250	54	113	**1,148**	1,157
Other	1		10	361	3		**375**	378
Total Primary Care Division staff numbers by CHO	**962**	**2,677**	**2,433**	**2,832**	**438**	**953**	**10,294**	**10,370**

Primary Care Section 38

HSE S38	WTE Dec 14	WTE Sep 15	Projected Outturn Dec 2015
HSE	9,469	9,633	9,705
Section 38	634	661	665
Total Primary Care	**10,103**	**10,294**	**10,370**

Primary Care	WTE Dec 14	WTE Sep 15	Projected Outturn Dec 2015
CHO Area 1	1,069	1,072	1,079
CHO Area 2	1,030	1,054	1,061
CHO Area 3	782	774	779
HSE	1,046	1,037	1,045
Section 38	86	87	88
CHO Area 4	1,131	1,124	1,133
CHO Area 5	820	815	821
HSE	661	663	668
Section 38	83	89	89
CHO Area 6	744	752	758
HSE	1,175	1,183	1,192
Section 38	466	486	488
CHO Area 7	1,641	1,669	1,681
CHO Area 8	1,508	1,512	1,524
CHO Area 9	1,097	1,148	1,157
Other	281	375	378
Total	**10,103**	**10,294**	**10,370**

Appendix 3 – Performance Indicator Suite

Primary Care

Primary Care				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Community Intervention Teams (no. of referrals)	M	**26,355**	**18,600**	**24,202**
Admission avoidance (includes OPAT)		1,196	651	914
Hospital Avoidance	M	14,134	10,788	12,932
Early discharge (includes OPAT)	M	6,375	3,980	6,360
Unscheduled referrals from community sources	M	4,650	3,181	3,996
Health Amendment Act: **Services to persons with state acquired Hepatitis C** No. of patients who were reviewed	Q	820	22	798
Healthcare Associated Infections: Medication Management Consumption of antibiotics in community settings (defined daily doses per 1,000 population)		< 21.7	25.7	< 21.7
Service User Experience % of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	Q	New PI 2016	New PI 2016	100%
GP Activity No. of contacts with GP Out of Hours Service	M	959,455	964,770	964,770
Nursing No. of new patients accepted on the caseload and waiting to be seen over 12 weeks	M	New PI 2016	New PI 2016	0
Physiotherapy % of new patients seen for assessment within 12 weeks	M	80%	83%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
Occupational Therapy % of new patients seen for assessment within 12 weeks	M	80%	76%	70%
% on waiting list for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
Speech and Language Therapy % on waiting lists for assessment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
Podiatry, Ophthalmology, Audiology, Dietetics and Psychology **Podiatry** % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI	New PI	75%

Primary Care				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
		2016	2016	
Ophthalmology % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting lists for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Audiology % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Dietetics % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment less ≤ 12 weeks	M	New PI 2016	New PI 2016	70%
Psychology % on waiting list for treatment ≤ 52 weeks	M	New PI 2016	New PI 2016	100%
% on waiting list for treatment ≤ 12 weeks	M	New PI 2016	New PI 2016	60%
Oral Health % of new patients care who commenced treatment within 3 months of assessment	M	New PI 2016	New PI 2016	80%
Orthodontics % of referrals seen for assessment within 6 months	Q	75%	74%	75%
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	Q	< 5%	8%	< 5%

Note: All waiting list targets reflect end of year target.

Primary Care Reimbursement Service				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
% of completed Medical Card / GP Visit Card applications processed within the 15 days	M	90%	90%	95%
% of Medical Card / GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	M	90%	90%	90%
% of Medical Card / GP Visit Card applications which are accurately processed by national medical card unit staff	M	New PI 2016	New PI 2016	95%

Primary Care Reimbursement Service				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
No. of persons covered by Medical Cards as at 31st December	M	1,722,395	1,725,767	1,675,767
No. of persons covered by GP Visit Cards as at 31st December	M	412,588	435,785	485,192*

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Social Inclusion				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Substance Misuse % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	Q	100%	97%	100%
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	Q	100%	89%	100%
No. of clients in receipt of opioid substitution treatment (outside prisons)	M	9,400	9,413	9,515
Average waiting time from referral to assessment for Opioid Substitution Treatment	M	New PI 2016	New PI 2016	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	M	New PI 2016	New PI 2016	28 days
Needle Exchange No. of unique individuals attending pharmacy needle exchange	Q	1,200	1,731	1,731
Homeless Services % of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	Q	85%	72%	85%
Traveller Health No. of people who received health information on type 2 diabetes and cardiovascular health	Q	3,470	2,228	3,470

Palliative Care				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Inpatient Units – Waiting Times Access to specialist inpatient bed within 7 days	M	98%	98%	98%
Access to specialist palliative care services in the community provided within 7 days (home, nursing home, non-acute hospital)	M	95%	87%	95%
No. of patients in receipt of specialist palliative care in the community	M	3,248	3,178	3,309
No. of children in the care of the children's outreach nursing team / specialist palliative care team	M	320	359	370

Palliative Care				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
% patients triaged within 1 working day of referral	M	New PI 2016	New PI 2016	90%
% of patients with a multi-disciplinary care plan documented within 5 working days of initial review	M	New PI 2016	New PI 2016	90%

System-Wide				
Indicator	**Reporting Frequency**	**NSP 2015 Expected Activity / Target**	**Projected Outturn 2015**	**Expected Activity / Target 2016**
Budget Management including savings **Net Expenditure variance from plan (within budget)** Pay – Direct / Agency / Overtime	M	≤ 0%	To be reported in Annual Financial Statements 2015	0.33%
Non-pay	M	≤0%		0.33%
Income	M	≤ 0%		0.33%
Capital Capital expenditure versus expenditure profile	Q	New PI 2016	New PI 2016	100%
Audit % of internal audit recommendations implemented by due date	Q	New PI 2016	New PI 2016	75%
% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received	Q	New PI 2016	New PI 2016	95%
Service Arrangements / Annual Compliance Statement % of number of Service Arrangements signed	M	100%	100%	100%
% of the monetary value of Service Arrangements signed	M	100%	100%	100%
% of Annual Compliance Statements signed	A	100%	100%	100%
HR % absence rates by staff category	M	3.5%	4.19%	≤ 3.5%
% variation from funded staffing thresholds	M	New PI 2016	To be reported in Annual Report 2015	≤ 0.5%
Health and Safety No. of calls that were received by the National Health and Safety Helpdesk	Q	New PI 2016	New PI 2016	15% increase
Service User Experience % of complaints investigated within 30 working days of being acknowledged by the complaints officer	M	75%	75%	75%

System-Wide				
Indicator	Reporting Frequency	NSP 2015 Expected Activity / Target	Projected Outturn 2015	Expected Activity / Target 2016
Serious Reportable Events % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)	M	New PI 2016	New PI 2016	99%
% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer	M	90%	62%	90%
Safety Incident reporting % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group / CHO	Q	New PI 2016	New PI 2016	90%
% of claims received by State Claims Agency that were not reported previously as an incident	A	New PI 2016	New PI 2016	To be set in 2016

Primary Care – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016											
								Community Healthcare Organisations									
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
Community Intervention Teams (number of referrals)				26,355	18,600	24,202		0	900	4,713	1,350	3060	1,200	6,941	1,140	4,898
Admission Avoidance (includes OPAT)	NSP	Quality	M	1,196	651	914	CHO	0	36	164	108	139	77	141	57	192
Hospital Avoidance	NSP	Quality	M	14,134	10,788	12,932	CHO	0	234	2,598	435	1994	816	4,922	275	1,658
Early discharge (includes OPAT)	NSP	Quality	M	6,375	3,980	6,360	CHO	0	540	935	275	847	253	1,878	694	938
Unscheduled referrals from community sources	NSP	Quality	M	4,650	3,181	3,996	CHO	0	90	1,016	532	80	54	0	114	2,110
Outpatient parenteral Antimicrobial Therapy OPAT Re-admission rate %	DOP	Access /Activity	MQ2	New PI 2016	New PI 2016	≤5%	HG		≤5%	≤5%	≤5%	≤5%	≤5%	≤5%	≤5%	≤5%
Community Intervention Teams Activity (by referral source)				26,355	18,600	24,202	CHO	0	900	4,713	1,350	3060	1,200	6,941	1140	4,898
ED / Hospital wards / Units	DOP	Access /Activity	M	17,038	11,272	13,956	CHO	0	504	2,509	392	1,408	646	5,274	740	2,483
GP Referral	DOP	Access /Activity	M	6,029	4,073	6,386	CHO	0	324	795	352	1,288	449	1,055	259	1,864
Community Referral	DOP	Access /Activity	M	1,455	1,823	2,226	CHO	0	0	1,216	470	0	0	211	50	279
OPAT Referral	DOP	Access /Activity	M	1,833	1,432	1,634	CHO	0	72	193	136	364	105	401	91	272
GP Out of Hours																
No. of contacts with GP Out of Hours Service	NSP	Access /Activity	M	959,455	964,770	964,770	National									
Tobacco Control																
% of primary care staff to undertake brief intervention training for smoking cessation	DOP	Quality	Q	New 2016	New 2016	5%	CHO	5%	5%	5%	5%	5%	5%	5%	5%	5%
Physiotherapy																
No of patient referrals	DOP	Activity	M	184,596	192,884	193,677	CHO	25,157	20,877	15,802	28,818	24,029	12,215	22,237	27,207	17,335
No of patients seen for a first time assessment	DOP	Activity	M	159,260	158,262	160,017	CHO	21,228	15,884	12,062	26,412	20,911	10,049	16,886	23,059	13,526
No of patients treated in the reporting month (monthly target)	DOP	Activity	M	34,993	35,291	36,430	CHO	4,721	4,288	2,305	5,646	4,868	2,174	4,171	5,324	2,933

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No of face to face contacts/visits	DOP	Activity	M	770,878	767,109	775,864	CHO	116,183	84,366	50,877	114,348	103,297	49,304	85,229	109,972	62,288
Total No. of physiotherapy patients on the assessment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	28,527	CHO	3,313	4,497	3,294	2,877	3,232	1,484	2,791	3,776	3,263
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	80%	83% Data Gap	70%	CHO	70%	70%	70%	70%	70%	70%	70%	70%	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%	95%	95%	95%	95%	95%	95%	95%	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
Occupational Therapy																
No of patient referrals	DOP	Activity	M	85,030	88,162	89,989	CHO	11,698	6,888	7,926	8,984	10,308	5,979	13,286	14,114	10,806
No of new patients seen for a first assessment	DOP	Activity	M	83,004	84,983	86,499	CHO	10,306	6,754	7,450	9,620	9,311	6,530	14,611	12,739	9,178
No of patients treated (direct and indirect) monthly target	DOP	Activity	M	19,811	20,070	20,291	CHO	2,706	1,924	1,474	2,074	1,815	1,274	2,835	3,436	2,753
Total No. of occupational therapy patients on the assessment waiting list at the end of the reporting period **	DOP	Access	M	New PI 2016	New PI 2016	19,932	CHO	1,161	1,958	874	3,754	3,226	900	2,329	3,543	2,187

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of occupational therapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% of new patients seen for assessment within 12 weeks	NSP	Access	M	80%	76% Data Gaps	70%	CHO	70%	70%	70%	70%	70%	70%	70%	70%	70%
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for assessment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%	95%	95%	95%	95%	95%	95%	95%	95%
% on waiting lists for assessment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	80%
Orthodontics																
No. of patients receiving active treatment at the end of the reporting period	DOP	Access	Q	21,050	16,887	16,887	National/ former region									
% of referrals seen for assessment within 6 months	NSP	Access	Q	75%	74%	75%	National/ former region									
% on waiting list for assessment ≤ 12 months	DOP	Access	Q	100%	99.8%	100%	National/ former region									
% of patients on the treatment waiting list less than 2 years	DOP	Access	Q	75%	60%	75%	National/ former region									
% of patients on treatment waiting list less than 4 years (grade 4 and 5)	DOP	Access	Q	95%	92%	95%	National/ former region									

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016											
								Community Healthcare Organisations									
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of patients on the assessment waiting list at the end of the reporting period	DOP	Access	Q	6,165	5,966	5,966	National/ former region									
No. of patients on the treatment waiting list – grade 4 –at the end of the reporting period	DOP	Access /Activity	Q	9,444	9,912	9,912	National/ former region									
No. of patients on the treatment waiting list – grade 5 –at the end of the reporting period	DOP	Access /Activity	Q	7,562	8,194	8,194	National/ former region									
Reduce the proportion of patients on the treatment waiting list longer than 4 years (grade IV and V)	NSP	Access	Q	<5%	8%	<5%	National/ former region									
Oral Health (Primary Dental Care and Orthodontics)																
No. of new patients attending for Scheduled Assessment	DOP	Access /Activity	M	No Target 2015	Unavailable	Unavailable	CHO	7,500 (data gaps)	Unavailable	Unavailable	15938	10,554 (data gaps)	8950	Unavailable	Unavailable	Unavailable
No. of new patients attending for Unscheduled Assessment	DOP	Access /Activity	M	No Target 2015	Unavailable	Unavailable	CHO	4,071 (data gaps)	Unavailable	Unavailable	9406	4,420 (data gaps)	4245	Unavailable	Unavailable	Unavailable
% of new patients who commenced treatment within 3 months of assessment	NSP	Access	M	No Target 2015	Not Available	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	
Healthcare Associated Infections: Medication Management							CHO									
Consumption of antibiotics in community settings (defined daily doses per 1,000 population)	NSP	Quality		<21.7	25.7	<21.7	National									
Primary Care – Psychology																
No. of patient referrals	DOP	Activity	M	New	12,250	12,261	CHO	1,443	1,312	416	1,096	1,403	1,179	1,467	2,589	1,356
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,601	2,626	CHO	630	260	118	219	262	226	194	591	126
New patients seen	DOP	Activity	M	No Target 2015	9,387	9,367	CHO	1,449	1,147	190	614	880	879	1,368	2,229	611
Total No. of psychology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	6,028	CHO	882	702	422	911	727	542	609	1,114	119
No. of psychology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of psychology patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%	60%	60%	60%	60%	60%	60%	60%	60%
Primary Care – Podiatry																
No. of patient referrals	DOP	Activity	M	New	10,689	11,589	CHO	2,407	2,010	1,305	1,303	220	No direct service	No direct service	4,344	No direct service
Existing patients seen in the month	DOP	Activity	M	No Target 2015	5,095	5,210	CHO	1,456	981	570	1,580	60	No direct service	No direct service	563	No direct service
New patients seen	DOP	Activity	M	No Target 2015	7,279	8,887	CHO	1,987	3,100	752	1,056	307	No direct service	No direct service	1,685	No direct service
Total No. of podiatry patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	3,186	CHO	819	522	488	766	22	No direct service	No direct service	569	No direct service
No. of podiatry patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of podiatry patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%	95%	95%	95%	95%	95%	95%	95%	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	75%	CHO	75%	75%	75%	75%	75%	75%	75%	75%	75%
No of patients with Diabetic Active Foot Disease treated in the reporting month	DOP	Quality	M Q3	New PI 2016	New PI 2016	133	CHO	32	28	11	40	2	0	0	20	0
No. of treatments for Diabetic Active Foot Disease in the reporting month	DOP	Access /Activity	M Q3	New PI 2016	New PI 2016	532	CHO	128	112	44	160	8	0	0	80	0
Primary Care – Ophthalmology																
No. of patient referrals	DOP	Activity	M	New	22,261	26,913	CHO	6,147	2,613	2,407	4,436	6,810	1,054	0	1,000 (Louth)	2,446
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,818	13,807	CHO	1,770	610	509	unavailable	10,044	189	0	250 (Louth)	435
New patients seen	DOP	Activity	M	No Target 2015	10,091	16,524	CHO	4,620	1800	1,806	Unavailable	5,504	751	0	800 (Louth)	1,243
Total No. of ophthalmology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	14,267	CHO	2,478	553 (June to Oct data)	1,833	3,484	781	2,397		598 (Louth Oct data only)	2,143
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%	60%	60%	60%	60%	60%	60%	60%	60%
Primary Care – Audiology																
No. of patient referrals	DOP	Activity	M	No Target 2015	18,317	18,317	CHO	1,951	2,849	1,189	2,261	2,037	Service included in CHO9	3,100	1,868	3,062
Existing patients seen in the month	DOP	Activity	M	No Target 2015	2,822	2,850	CHO	499	304	215	439	365	Service included in CHO9	331	263	434
New patients seen	DOP	Activity	M	No Target 2015	16,645	16,459	CHO	1,629	1,636	1,390	4,387	2,325	Service included in CHO9	1,840	1,491	1,761
Total No. of audiology patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New PI 2016	13,870	CHO	1,894	2,550	803	1,344	1,150	Service included in CHO9	2,036	3,269	824
No. of audiology patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016											
								Community Healthcare Organisations									
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of audiology patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	80%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	60%	CHO	60%	60%	60%	60%	60%	60%	60%	60%	60%
Primary Care – Dietetics																
No. of patient referrals	DOP	Activity	M	No Target 2015	25,138 (data gap)	27,858	CHO	3,624	2,720	2,026	7,012	2,811	2,082	2,613	3,022	1,948
Existing patients seen in the month	DOP	Activity	M	No Target 2015	3,393 (data gap)	5,209	CHO	589	1,816	109	1,038	457	415	220	413	152
New patients seen	DOP	Activity	M	No Target 2015	19,281 (data gap)	21,707	CHO	3,335	1,208	975	5,440	2,569	2,018	1,767	3,141	1,254
Total No. of dietetics patients on the treatment waiting list at the end of the reporting period *	DOP	Access	M	New PI 2016	New 2016	5,479	CHO	1,061	554 (June to Oct. data)	427	704	669	195	486	1,023	360
No. of dietetics patients on the treatment waiting list at the end of the reporting period 0-12 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period 12 weeks ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period 26 weeks ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
								Community Healthcare Organisations								
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO	1	2	3	4	5	6	7	8	9
No. of dietetics patients on the treatment waiting list at the end of the reporting period 39 weeks ≤ 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
No. of dietetics patients on the treatment waiting list at the end of the reporting period > 52 weeks	DOP	Access	M	New PI 2016	New PI 2016	No target	CHO	No target	No target	No target	No target	No target	No target	No target	No target	No target
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting lists for treatment ≤ 39 weeks	DOP	Access	M	New PI 2016	New PI 2016	95%	CHO	95%	95%	95%	95%	95%	95%	95%	95%	95%
% on waiting lists for treatment ≤ 26 weeks	DOP	Access	M	New PI 2016	New PI 2016	85%	CHO	85%	85%	85%	85%	85%	85%	85%	85%	85%
% on waiting lists for treatment ≤ 12 weeks	NSP	Access	M	New PI 2016	New PI 2016	70%	CHO	70%	70%	70%	70%	70%	70%	70%	70%	70%
Primary Care – Nursing																
No. of patient referrals	DOP	Activity	M	No Target 2015	150,768	159,694	CHO	8,351 (Data gap)	18,417	17,796	84,403	Unavailable	7,809	1,702 (Data gap)	Unavailable	21,216
Existing patients seen in the month	DOP	Activity	M	No Target 2015	63,724	64,660	CHO	3,857 (Data gap)	5,341	21,934	26,441	Unavailable	1,482	1,800 (Data gap)	Unavailable	3,805
New patients seen	DOP	Activity	M	No Target 2015	115,785	123,024	CHO	10,960 (Data gap)	17,185	16,509	49,450	Unavailable	5,948	1,884 (Data gap)	Unavailable	21,088
Number of new patients accepted on the caseload and waiting to be seen over 12 weeks	NSP	Access	M	New 2016	New 2016	0	CHO	0	0	0	0	0	0	0	0	0
Primary Care – Speech and Language Therapy***																
No. of patient referrals	DOP	Activity	M	No Target 2015	50,863	50,863	CHO	6,140	4,373	4,062	6,739	4,905	3,333	5,769	7,918	7,624
Existing patients seen in the month	DOP	Activity	M Q2	New 2016	New PI 2016	New PI 2016	CHO	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016
New patients seen for initial assessment	DOP	Activity	M	No Target 2015	41,083	41,083	CHO	4,569	3,891	3,381	6,324	4,450	1,862	4,045	6,414	6,147
Total No. of speech and language patients waiting initial assessment at end of the	DOP	Access	M	New 2016	New PI 2016	13,050	CHO	963	658	832	1,566	1,109	504	3,057	2,223	2,138

Key Performance Indicators Service Planning 2016 KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	KPIs 2015 2015 National Target / Expected Activity	2015 Projected outturn	KPIs 2016 2016 National Target / Expected Activity	Reported at National/ CHO	Community Healthcare Organisations 1	2	3	4	5	6	7	8	9
reporting period ****																
Total No. of speech and language patients waiting initial therapy at end of the reporting period ****	DOP	Access	M	New 2016	New PI 2016	8,279	CHO	61	668	393	1,205	2,400	429	1,060	1,121	942
% on waiting list for assessment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% on waiting list for treatment ≤ to 52 weeks	NSP	Access	M	New PI 2016	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Amendment Act - Services to persons with state acquired Hepatitis C																
No. of patient who were reviewed.	NSP	Quality	Q	820	22	798	National	50	70	65	96	88	65	180	63	121

Note: All waiting list targets reflect end of year target.
***Monthly average based on April – Oct 2015 submitted data.**
**** Monthly average based on July – Oct 2015 submitted data.**
***** Speech and Language Therapy Data includes all non – acute activity across the care groups.**
****** SLT Monthly average based on Jan – Oct. 2015 submitted data**

Quality and Patient Safety – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016				KPIs 2015		KPIs 2016										
KPI Title	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Freq-uency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	1	2	3	4	5	6	7	8	9
Quality and Patient Safety																
Service User Experience																
% ratio of compliments to complaints by CHO	DOP	Quality	Q	New PI 2016	New PI 2016	New PI 2016	CHO	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016
% of complaints investigated within 30 working days of being acknowledged by the complaints officer (mandatory)	NSP	Quality	M	System Wide	New PI 2016	75%	CHO	75%	75%	75%	75%	75%	75%	75%	75%	75%
Service User Involvement																
% of PCTs by CHO, that can evidence service user involvement as required by Action 19 of the Primary Care Strategy – A New Direction (2001)	NSP	Quality	Q Q3	System wide	New PI 2016	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
Serious Reportable Events																
% of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer (mandatory) and entered on the National Incident Management System (NIMS)*	NSP	Quality	M	System wide	New PI 2016	99%	CHO	99%	99%	99%	99%	99%	99%	99%	99%	99%
% of investigations completed within 120 days of event occurrence)	NSP	Quality	M	System wide	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
Safety Incidence Reporting																
% of **Safety** Incidents being entered on the National Incident Management System (NIMS) within 30 days of occurrence	NSP	Quality	Q	System wide	New PI 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% of claims received by State Claims Agency that were not reported previously as an incident	NSP	Quality	A	System wide	New PI 2016	New PI 2016	CHO	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016	New PI 2016

*** All incidents including SREs are to be reported on NIMS. Until IIMS has been formally stood down, all SREs must also be reported onto the Incident Information Management System (IIMS)**

PCRS – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016				KPIs 2015		
KPI Title	Reported against NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity
Medical Cards/GP Visit Cards						
No. of persons covered by Medical Cards as at 31st December	NSP	Access	M	1,722,395	1,725,767	1,675,767
No. persons covered by GP Visit Cards as at 31st December	NSP	Access	M	412,588	435,785	485,192*
% of completed Medical / GP Visit Card applications processed within the 15 day turnaround	NSP	Access	M	90%	90%	95%
% of Medical Card/GP Visit Card applications, assigned for Medical Officer review, processed within 5 days	NSP	Quality	M	90%	90%	90%
% of Medical Card / GP Visit Card application which are accurately processed by National Medical Card Unit staff	NSP	Quality	M	New Metric	New Metric	95%
% of applications for Medical Cards / GP Visit Cards that are processed from end to end without the need for additional information	DOP	Quality	M	New Metric	New Metric	60%
Long Term Illness						
No. of claims	DOP	Access	M	1,120,068	1,824,463	2,125,507
No. of line items	DOP	Access	M	3,942,639	6,495,305	7,555,211
Drug Payment Scheme	DOP					
No. of claims	DOP	Access	M	2,396,604	2,184,413	2,177,935
No. of line items	DOP	Access	M	7,985,416	7,159,454	7,113,927
GMS						
No. of prescriptions	DOP	Access	M	18,696,633	18,908,657	17,780,183
No. of line items	DOP	Access	M	57,727,106	57,438,152	54,229,556
No. of claims - special items of service	DOP	Access	M	943,897	1,005,543	999,158
No. of claims - special type of consultations	DOP	Access	M	1,149,957	1,167,312	1,164,844
HiTech						
No. of claims	DOP	Access	M	520,857	550,483	533,824
DTSS						
No. of treatments (above the line)	DOP	Access	M	1,356,483	1,248,819	1,207,639
No. of treatments (below the line)	DOP	Access	M	70,379	66,192	65,315
No. of patients who have received treatment (above the line)	DOP	Access	M	628,611	584,104	567,728
No. of patients who have received treatment (below the line)	DOP	Access	M	67,907	63,806	63,000
Community Ophthalmic Scheme						
No. of treatments	DOP	Access		848,747	844,798	832,933
(a) Adult	DOP	Access	M	767,068	758,601	747,849
(b) Children	DOP	Access	M	81,679	86,197	85,084

*Target does not include Universal GP Visit Cards for children aged 6 to 11 years

Social Inclusion – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations								
								1	2	3	4	5	6	7	8	9
Total no. of clients in receipt of opioid substitution treatment (outside prisons)	NSP	Access	M 1 Mth in Arrears	9,400	9,413	9,515	CHO	85	125	260	405	395	985	3,740	565	2,955
No. of clients in opioid substitution treatment in Clinics	DOP	Access	M 1 Mth in arrears	5,400	5,392	5,470	CHO	0	45	125	310	215	520	2,170	230	1,855
No. of clients in opioid substitution treatment with level 2 GP's	DOP	Access	M 1 Mth in arrears	2,000	1,995	1,975	CHO	50	0	40	5	0	295	1,855	180	550
No. of clients in opioid substitution treatment with level 1 GP's	DOP	Access	M 1 Mth in Arrears	2,000	1,999	2,080	CHO	35	80	95	90	180	170	725	155	550
No. of clients transferred from clinics to level 1 GP's	DOP	Access	M 1 Mth in Arrears	300	238	300	CHO	0	26	14	27	60	8	61	45	59
No. of clients transferred from level 2 GP's	DOP	Access	M 1 Mth in Arrears	100	115	134	CHO	0	0	10	0	0	20	50	9	45
No. of clients transferred from level 2 to level 1 GPs)	DOP	Access	M 1 Mth in Arrears	120	94	119	CHO	10	0	0	0	7	17	50	18	17
Total no. of new clients in receipt of opioid substitution treatment (outside prisons)	DOP	Access	M 1 Mth in Arrears	500	588	617	CHO	20	20	30	97	70	55	170	45	110
Total no. of new clients in receipt of opioid substitution treatment (clinics)	DOP	Access	M 1 Mth in Arrears	400	482	498	CHO	0	20	30	95	70	27	151	15	90
Total no. of new clients in receipt of opioid substitution treatment (level 2 GP)	DOP	Access	M 1 Mth in Arrears	100	88	119	CHO	20	0	0	2	0	28	19	30	20
Average waiting time from referral to assessment for Opioid Substitution Treatment (days)	NSP	Access	M 1 Mth in Arrears	New 2016	New 2016	14 days	CHO	14 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days
Average waiting time from Opioid Substitution assessment to exit from waiting list or treatment commenced	NSP	Access	M 1 Mth in Arrears	New 2016	New 2016	28 days	CHO	28 days	28 days	28 days	28 days	28 days	28 days	28 days	28 days	28 days
Number of Pharmacies providing of opioid substitution treatment	DOP	Access	M 1 Mth in Arrears	630	635	653	CHO	34	44	43	66	67	65	133	94	107

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016											
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations								
								1	2	3	4	5	6	7	8	9
Number of people obtaining opioid substitution treatment from Pharmacies	DOP	Access	M 1 Mth in Arrears	6,430	6,421	6,463	CHO	97	123	251	372	430	630	2,110	625	1,825
No. of substance misusers who present for treatment	DOP	Access	Q 1 Q in arrears	1,274 per quarter	5,860 per annum	6,972	CHO	724	308	208	1244	1596	308	872	996	716
No. of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	797 per quarter	4,260 per annum	4,864	CHO	368	228	164	696	1176	308	820	540	564
% of substance misusers who present for treatment who receive an assessment within 2 weeks	DOP	Quality	Q 1 Mth in Arrears	100%	71%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of substance misusers (over 18 years) for whom treatment has commenced following assessment	DOP	Quality	Q 1 Mth in Arrears	1,124 per quarter	4.658 per annum	5,584	CHO	584	256	164	972	1,536	296	468	968	340
No. of substance misusers (over 18) for whom treatment has commenced within one calendar month following assessment	DOP	Quality	Q 1 Mth in Arrears	1,100 per quarter	4590 per annum	5,024	CHO	580	256	132	972	1520	296	468	460	340
% of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	NSP	Access	Q 1 Mth in Arrears	100%	97%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of substance misusers (under 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Mth in Arrears	32 per quarter	302 per annum.	268	CHO	36	16	0	24	44	0	124	8	16
No. of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1 Mth in Arrears	30 per quarter	176 per annum	260	CHO	32	16	0	20	44	0	124	8	16
% of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	NSP	Access	Q 1 Mth in Arrears	100%	89%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations								
								1	2	3	4	5	6	7	8	9
% of substance misusers (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	79%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of substance misusers (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	84%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of substance misusers (under 18 years) for whom treatment has commenced	DOP	Access	Q 1 Qtr in Arrears	32 per quarter	302 per annum.	268	CHO	36	16	0	24	44	0	124	8	16
% of substance misusers (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	88%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of substance misusers (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	88%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of problem alcohol users who present for treatment	DOP	Access	Q 1 Qtr in Arrears	699 per quarter	3,530 per annum	3540	CHO	548	36	16	724	920	240	400	536	120
No. of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	414 per quarter	2,240 per annum	2,344	CHO	272	36	12	392	684	240	400	248	60
% of problem alcohol users who present for treatment who receive an assessment within 2 weeks	DOP	Access	Q 1 Qtr in Arrears	100%	59%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of problem alcohol users (over 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Qtr in Arrears	636 per quarter	3,296 per annum	3228	CHO	464	28	12	592	908	240	380	524	80

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations								
								1	2	3	4	5	6	7	8	9
No. of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	Q 1 Qtr in Arrears	635 per quarter	3,262 per annum	3228	CHO	464	28	12	592	908	240	380	524	80
% of problem alcohol users (over 18 years) for whom treatment has commenced within one calendar month following assessment	DOP	Access	Q 1 Qtr in Arrears	100%	99%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of problem alcohol users (under 18 years) for whom treatment has commenced following assessment	DOP	Access	Q 1 Qtr in Arrears	5 per quarter	38 per annum	56	CHO	8	0	0	4	8	0	20	0	16
No. of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1 Qtr in Arrears	5 per quarter	32 per annum	56	CHO	8	0	0	4	8	0	20	0	16
% of problem alcohol users (under 18 years) for whom treatment has commenced within one week following assessment	DOP	Access	Q 1Qtr in Arrears	100%	57%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of problem alcohol users (over 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	75%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of problem alcohol users (over 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	86%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of problem alcohol users (under 18 years) for whom treatment has commenced who have an assigned key worker	DOP	Quality	Q 1 Qtr in Arrears	100%	86%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016											
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations									
								1	2	3	4	5	6	7	8	9
% of problem alcohol users (under 18 years) for whom treatment has commenced who have a written care plan	DOP	Quality	Q 1 Qtr in Arrears	100%	71%	100%	CHO	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. of tier 1 and tier 2 staff trained in SAOR Screening and Brief Intervention for problem alcohol and substance use	DOP	Quality	Q 1 Qtr in Arrears	300	244	300	CHO	30	30	20	100	30	0	40	30	20
No. of pharmacies recruited to provide Needle Exchange Programme	DOP	Quality	TRI M 1 Qtr in Arrears	129	132	119	CHO	12	16	13	21	24	0	0	33	0
No. of unique individuals attending pharmacy needle exchange	NSP	Access	TRI M 1 Qtr in Arrears	1,200	1,731	1,731	CHO	58	129	314	393	372	0	0	465	0
No. of pharmacy needle exchange packs provided	DOP	Access	TRI M 1 Qtr in Arrears	3,200	3,628	3,433	CHO	124	318	527	975	670	0	0	819	0
Average No. of needle / syringe packs per person	DOP	Quality	TRI M 1 Qtr in Arrears	15	16	16	CHO	16	16	16	16	16	0	0	16	0
No. and % of needle / syringe packs returned	DOP	Quality	TRI M 1 Qtr in Arrears	930 (30%)	930 (30%)	1,032 (30%)	CHO	38 (30%)	96 (30%)	158 (30%)	293 (30%)	201 (30%)	0	0	246 (30%)	0
No. and % of individual service users admitted to homeless emergency accommodation hostels/ who have medical cards	DOP	Quality	Q	75%	1046 (71%)	1108 (75%)	CHO	68 (75%)	62 (75%)	182 (75%)	420 (75%)	120 (75%)	11 (75%)	98 (75%)	68 (75%)	79 (75%)
No and % of service users admitted during the quarter who did not have a valid medical card on admission and who were assisted by Hostel staff to acquire a medical card during the quarter.	DOP	Quality	Q	90%	324 (75%)	302 (70%)	CHO	7 (70%)	15 (70%)	31 (70%)	159 (70%)	31 (70%)	3 (70%)	25 (70%)	20 (70%)	11 (70%)

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016											
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National / CHO	Community Healthcare Organisations									
								1	2	3	4	5	6	7	8	9
% of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	NSP	Quality	Q	85%	72%	85%	CHO	85%	85%	85%	85%	85%	85%	85%	85%	85%
% of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed and are being supported to manage their physical / general health, mental health and addiction issues as part of their care/support plan	DOP	Quality	Q	80%	80%	80%	CHO	80%	80%	80%	80%	80%	80%	80%	80%	80%
Number of people who received health information on type 2 diabetes and cardiovascular health	NSP	Quality	Q	3,470 20% of the population in each Traveller Health Unit	2,228	3,470	CHO	245	695	350	320	395	130	475	585	275
Number of people who received awareness and participated in positive mental health initiatives	DOP	Quality	Q	3,470 20% of the population in each Traveller Health Unit	3,108	3470	CHO	245	695	350	320	395	130	475	585	275

Palliative Care – Full Metrics/KPI Suite (All metrics highlighted in yellow background are those that are included in the Balance Scorecard)

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
Inpatient Palliative Care Services																
Access to specialist inpatient bed within 7 days (during the reporting month)	NSP	Access	M	98%	98%	98%	CHO	98%	98%	98%	98%	98%	98%	98%	98%	98%
Access to specialist palliative care inpatient bed from 8 to14 days (during the reporting month)	DOP	Access	M	New metric 2016	New metric 2016	New metric 2016	CHO	2%	2%	2%	2%	2%	2%	2%	2%	2%
Total number of referrals for specialist inpatient Palliative care services received	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
Total number of referrals deemed appropriate for admission - cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
Total number of referrals deemed appropriate for admission - non cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
No. of patients in receipt of treatment in specialist palliative care inpatient units (during the reporting month)	DOP	Access /Activity	M	445	429	474	CHO	41	55	70	97	13	31	82	0	85
No. of new patients seen or admitted to the specialist palliative care service (monthly cumulative)	DOP	Access /Activity	M	2,752	2,633	2,877	CHO	270	304	400	616	111	170	496	0	510
No. of admissions to specialist palliative care inpatient units (monthly cumulative)	DOP	Access /Activity	M	3,177	3,403	3,310	CHO	311	350	460	708	128	196	570	0	587

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
Community Palliative Care Services																
Access to specialist palliative care services in the community provided within 7 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	NSP	Access	M	95%	87%	95%	CHO	95%	95%	95%	95%	95%	95%	95%	95%	95%
Access to specialist palliative care services in the community provided to patients in their place of residence 8 to 14 days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	DOP	Access	M	New metric 2016	New metric 2016	New metric 2016	CHO	3%	3%	3%	3%	3%	3%	3%	3%	3%
Access to specialist palliative care services in the community provided to patients in their place of residence 15+ days (Home, Nursing Home, Non Acute hospital) (during the reporting month)	DOP	Access	M	New metric 2016	New metric 2016	New metric 2016	CHO	2%	2%	2%	2%	2%	2%	2%	2%	2%
Total number of referrals received for specialist Palliative care services in the normal place of residence	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
Total number of referrals deemed appropriate for services - cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
Total number of referrals deemed appropriate for services - non cancer	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
No. of patients in receipt of specialist palliative care in the community (monthly cumulative)	NSP	Access /Activity	M	3,248	3,178	3,309	CHO	413	409	386	508	464	249	308	275	297
No. of new patients seen or admitted to specialist palliative care services in the community	DOP	Access /Activity	M	8,907	9,089	9,353	CHO	577	1,116	887	1,548	1,040	777	941	1,543	944

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016											
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
No. of patients in receipt of specialist palliative day care services (during the reporting month)	DOP	Access /Activity	M	349	301	349	CHO	14	29	36	116	0	33	42	0	79
No. of new patients in receipt of specialist palliative day care services (monthly cumulative)	DOP	Access	M	962	1003	985	CHO	48	54	129	375	2	100	92	0	185
No. of patients in receipt of care in designated palliative care support beds (during the reporting month)	DOP	Access /Activity	M	165	142	165	CHO	16	4	19	31	33	7	40	15	0
Children's Palliative Care Services																
No. of children in the care of the children's outreach nursing team / specialist palliative care team	NSP	Access	M	320	359	370	CHO	31	19	24	25	33	11	140	41	46
No. of children in the care of the children's outreach nursing team / specialist palliative care team (Acute setting)	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	0	0	0	0	0	0	115	0	0
No. of children in the care of the children's outreach nursing team / specialist palliative care team (community)	DOP	Access /Activity	M	n/a	n/a	New metric 2016	CHO	31	19	24	25	33	11	25	41	46
No. of new children in the care of the children's outreach nursing team / specialist palliative care team	DOP	Access /Activity	M	229	190	190	CHO	18	11	14	14	19	6	59	23	26
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Acute settings)	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	0	0	0	0	0	0	48	0	0
No. of new children in the care of the children's outreach nursing team / specialist palliative care team (Community)	DOP	Access /Activity	M	New metric 2016	New metric 2016	New metric 2016	CHO	18	11	14	14	19	6	11	23	26

Key Performance Indicators Service Planning 2016	NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	KPIs 2015		KPIs 2016										
KPI Title				2015 National Target / Expected Activity	2015 Projected outturn	2016 National Target / Expected Activity	Reported at National/ CHO / HG Level	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
Total number of new referrals for inpatient services seen by the specialist palliative care team	DOP	Access /Activity	M	n/a	486	Expected activity to be determined	CHO	Baseline to be determined								
Specialist palliative care services provided in the acute setting for new patients and re referral within 2 days	DOP	Quality	M	n/a	93%	Target to be determined	CHO	Baseline to be determined								
Bereavement Services																
Total number of family units who received bereavement services	DOP	Access /Activity	M	n/a	621	621	CHO	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric	New metric
% patients triaged within 1 working day of referral (acute service)	NSP	Quality	M 2016 Q4 Reporting	New metric 2016	New metric 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%
% patients with a multidisciplinary care plan documented within 5 working days of initial review	NSP	Quality	M 2016 Q4 Reporting	New metric 2016	New metric 2016	90%	CHO	90%	90%	90%	90%	90%	90%	90%	90%	90%

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that were completed in 2014/2015 but not operational, projects due to be completed and operational in 2016 and also projects due to be completed in 2016 but not operational until 2017

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
PRIMARY CARE									
CHO 1: Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan									
Derrybeg/Bunbeg, Co. Donegal	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
CHO 2: Galway, Roscommon, Mayo									
Castlebar, Co. Mayo	Primary Care Centre, by lease agreement.	Q4 2016	Q4 2016	0	0	0.00	0.00	0	0.00
CHO 3: Clare, Limerick, North Tipperary/East Limerick									
Windmill Court, Garryowen, Limerick City	Primary Care Centre, by lease agreement.	Q4 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Borrisokane, Co. Tipperary	Extension of primary care facility.	Q4 2016	Q4 2016	0	0	0.28	0.46	0	0.00
CHO 4: Kerry, North Cork, North Lee, South Lee, West Cork									
Charleville, Co Cork	Primary Care Centre, by lease agreement (includes a mental health primary care centre).	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
St. Finbarr's Hospital, Cork	Audiology services, ground floor, block 2.	Q2 2016	Q3 2016	0	0	0.80	1.50	0	0.00
Ballyheigue, Co. Kerry	Primary Care Centre, refurbishment of existing health centre.	Q1 2016	Q2 2016	0	0	0.10	0.14	0	0.00
CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, Wexford									
Tipperary Town	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
CHO 6: Wicklow, Dun Laoghaire, Dublin South East									
Carnew, South Wicklow	Primary Care Centre, by lease agreement.	Q1 2016	Q2 2016	0	0	0.00	0.00	0	0.00
CHO 7: Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West,									
Kilnamanagh/Tymon, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0.00	0.00	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
Springfield, Tallaght, Dublin	Primary Care Centre, by lease agreement.	Q3 2016	Q4 2016	0	0	0.00	0.00	0	0.00
Tus Nua, Kildare Town	Primary Care Centre, by lease agreement.	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
Celbridge, Co. Kildare	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Blessington, Co. Wicklow	Primary Care Centre, by lease agreement.	Q2 2016	Q2 2016	0	0	0.00	0.00	0	0.00
CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath									
Ballymahon, Co. Longford	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Mullingar, Co. Westmeath	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Kells, Co. Meath	Primary Care Centre, by lease agreement.	Q4 2015	Q1 2016	0	0	0.00	0.00	0	0.00
Tullamore, Co. Offaly	Refurbishment of vacated original hospital (Scott's) buildings to replace rented accommodation in the Tullamore area. A wide range of community health services will be provided from this building.	Q4 2016	Q1 2017	0	0	2.00	14.73	0	0.00
CHO 9: Dublin North, Dublin North Central, Dublin North West									
Corduff, Co. Dublin	Primary Care Centre, to be developed on HSE owned site.	Q1 2016	Q2 2016	0	0	2.58	7.36	0	0.00
Blanchardstown, Co. Dublin	Refurbishment of Roselawn Health Centre to complete the provision of primary care services in the Corduff/Blanchardstown network.	Q4 2016	Q4 2016	0	0	0.25	0.25	0	0.00
PRIMARY CARE *(contd.)*									
Balbriggan, Co. Dublin	Primary Care Centre, by lease agreement.	Q4 2016	Q1 2017	0	0	0.00	0.00	0	0.00
Grangegorman, Dublin	Primary Care Centre, to be developed on site in Grangegorman.	Q3 2016	Q4 2016	0	0	6.50	12.00	0	0.00
	Relocation of Eve Holdings to Grangegorman Villas (1-5).	Q4 2016	Q4 2016	0	0	0.25	0.75	0	0.00
St. Ita's Hospital, Portrane	Upgrade and refurbishment of 123 Block. This will	Q2 2016	Q2 2016	0	0	2.00	4.30	0	0.00

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2016 Implications	
						2016	Total	WTE	Rev Costs €m
	facilitate the provision of Coolock Primary Care Centre, a European Institute of Innovation and Technology Centre and accommodate services currently in rented accommodation and accommodate staff currently in Coolock Health Centre.								

Accountability Framework

Introduction

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

The Primary Care Division recognises the critical importance of good governance and of continually enhancing its accountability arrangements. During 2015, the HSE strengthened its overall accountability arrangements and put in place a new **Accountability Framework.** This enhanced governance and accountability framework was implemented by the Primary Care Division and made explicit the responsibilities of all managers, including primary care managers, to deliver the targets set out in the National Service Plan and the Primary Care Division Operational Plan. The Accountability Framework describes in detail the means by which the HSE, and in particular Hospital Groups and Community Healthcare Organisations, was held to account in 2015.

2015 was the first year of operation of the new Accountability Framework. The Framework has been updated for 2016 to ensure its operation, effectiveness and application best meets the evolving needs of the organisation and drives overall performance improvement. A formal review of the Framework was commissioned and completed in 2015, focusing on the operation of the Framework during its first year of operation. Proposed recommendations for further enhancement from the review will be implemented early in 2016.

Accountability Levels

There are 5 main levels covered by the Accountability Framework. These are the accountability of the:

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

Accountability Suite (Plans, Agreements and Reports)

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

A key feature of the Accountability Framework was the introduction in 2015 of formal Performance Agreements. During 2016 the monitoring and management of the NSP and Operational Plans will be strengthened through the Performance Agreements which will explicitly link accountability for the delivery of the HSE's plans to managers at each level of the organisation. These Agreements were put in place as follows:

- The National Director Performance Agreement between the Director General and each National Director for services.
- The Hospital Group CEO Performance Agreement between the National Director Acute Hospitals and each Hospital Group CEO.

- A single CHO Chief Officer Performance Agreement (covering all community service Divisions) between the four National Directors for Primary Care, Social Care, Mental Health and Health and Wellbeing and each of the CHO Chief Officers.

Accountability Processes

The Executive Management Committee for Community Healthcare, comprising of the four National Directors (i.e. Primary Care, Social Care, Mental Health and Health and Wellbeing) was established in 2015 and will continue in its current form in 2016. During 2015 the National Director for Social Care was appointed by the Director General to chair the committee. These arrangements will remain in place in 2016.

Accountability Processes

During 2015, the National Performance Oversight Group (NPOG) was established (subgroup of the Directorate). This remit of this group is underpinned by the Accountability Framework and is the principal planning and performance assurance governance group within the HSE. The National Director for the Primary Care Division has monthly engagements with this group and provides reports, commentary, plans (including developmental and/corrective measures plans) to this group on behalf of Divisional service/projects/issues.

The main outputs from the NPOG include:

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

Escalation, Interventions and Sanctions

One of the key elements of the strengthened Accountability Framework is the requirements for Managers at each level to ensure that any issues of underperformance are identified and addressed at the level where they occur. Where there are issues of persistent underperformance (in any quadrant of the Balance Scorecard) the HSE, or Division, implements a formal Performance Escalation, Support and Intervention Process as part of the Accountability Framework. The process includes:

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

The National Director for the Primary Care Division has agreed the escalation thresholds for the targets set out in the Primary Care Division Balance Scorecard.