Galway University Hospitals

Ospidéil na h-Ollscoile Gaillimh

UNIVERSITY HOSPITAL GALWAY
MERLIN PARK UNIVERSITY HOSPITAL

SERVIRE CUM CARITATE HUMILITATE ET PURITATE

Galway and Roscommon University Hospitals Group

Service Plan 2013

28 February, 2013

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Introduction – Group CEO

Mr Bill Maher

Context

The National Service Plan 2013 (NSP 2013), approved by the Minister on 09 January 2013, sets out the type and volume of services to be delivered by the Health Sector in 2013 and is informed by the Department of Health's *Statement of Strategy 2011 – 2014* and *Future Health, a Strategic Framework for Reform of the Health Service 2012 – 2015*, both of which set out the Government's priorities for the health services.

The Group is committed to supporting the *Programme for Government* change agenda which will bring about significant changes to the way health services are managed and delivered in 2013 and beyond.

This Group Service Plan builds on the firm foundations laid in 2012 in terms of service delivery, reducing waiting times, establishing sound governance arrangements and improving patient quality.

Reforming Our Health Services

In November 2012, the Minister for Health published *Future Health,* the framework for health reform. This framework, based on Government commitments in its *Programme for Government*, outlines the main healthcare reforms that will be introduced in the coming years as key building blocks for the introduction of Universal Health Insurance in 2016.

Future Health seeks to support innovative ways of care delivery and in particular integrated care pathways. All this must be achieved under the most stringent fiscal constraints experienced for decades and cognisant of health trends and drivers of change such as:

- Increased activity
- Demographic and societal change
- New medical technologies, health informatics and telemedicine
- Rising expectations and demands
- Spiralling costs of healthcare provision
- Growing external scrutiny

The health services and our Group continue to experience very significant budgetary challenges alongside increased demands for services. We also face the challenge of reducing costs while at the same time improving outcomes for our patients, and reducing access times.

We will continue to introduce models of care across all our services which treat patients at the lowest level of complexity and provide services at the least possible unit cost based on best practice where possible, and to quality standards set by HIQA.

Group's Service Objectives for 2013

The primary focus in 2012 was to establish the governance foundations to address our immediate operational challenges and set out a strategy to realise the Group's full potential. Initial governance arrangements have been developed internally with the establishment of a Group Executive Council, Group Management Team and a Clinical Directors Forum with agreed governance and reporting model.

At the heart of this governance is our Clinical Directorate Structure and we will further develop this in 2013.

The key priorities for the Group in 2012 were to continue to improve the quality of care provided while enhancing accessibility to hospital services and improving the morale of our staff.

These priorities were set in the context of reducing our cost base and improving our overall financial performance. They were also set in the context of a growing demand for health services generally and for hospital services in particular, as well as the loss of key personnel arising from the Pension Protected Retirement Scheme.

The Group was successful in achieving its key priorities in 2012, including significant progress in maximisation of its resources through better integration, significant improvement in trolley waits, achieving stringent Patient Target List (PTL) targets, establishing governance arrangements, real engagement with Clinical Care Programmes and integrating the new group of hospitals.

2013 Service Objectives

For 2013 the Group will continue to develop its governance structures including a fully functional Board of Directors and an appropriate Governance Framework. We will also hold a number of board meetings in public, providing real local accountability to the public we serve.

We will incorporate new hospital additions into the Group as recommended by the Professor Higgins report within our corporate clinical governance model.

We will deliver the following level of patient activity (based on the existing hospitals within the Group):

Group Activity	Target
Inpatients	50,953
Day Cases	90,377
ED Presentations	89,784
Births	5,441
Outpatients	291,532
Urgent Care Centre	5,440

- Delivery of services will be managed across the Group of hospitals maximising integration options at all times. We will take cognisance of national targets in terms of inpatient and outpatient waiting list targets as follows:

Scheduled Activity	Target
Inpatient / Day Case	No adult waiting longer than 8 months for an elective procedure
Outpatient	No person waiting longer than 52 weeks for an appointment
Paediatric	No child waiting longer than 20 weeks for an elective procedure
GI Endoscopy	No person waiting longer than 13 weeks for procedure

- We will also meet the access targets set out for unscheduled care as follows:
  - 95% of all attendees at ED will be discharged or admitted within 6 hours of registration.
  - All patients admitted through the ED within 9 hours of registration will be discharged or admitted.

- 95% of all new medical patients attending the Acute Medical Unit (AMU) are to spend less than 6 hours from ED registration to AMU departure.

- HIQA standards are of paramount importance and will underpin our service delivery to deliver patient centred care.

- We will also reflect the implementation of the National Clinical Programmes in all of our hospitals and the service efficiencies derived from the programmes.

- Service provision will be delivered by a dedicated work force fully committed to provide a world class health service to the public.

- The Group will also manage its financial resources and ensure that resources are used effectively, efficiently and competitively.

- We will continue to monitor our performance internally through our appropriate performance management tools and we will aim for a GREEN rating in CompStat across all hospitals.

- We will continue to push for autonomy for the Group particularly in the areas of recruitment and procurement as these are fundamental in meeting quality and safety standards as well as efficiency and financial stability.

- We will support Government reform and changes to the service delivery model for the former HSE West region.

- We will commence implementation of our ICT strategy and implement ICT solutions that are cost effective and service efficient looking for opportunities to partner with the private sector, where appropriate, to improve service and delivery value for money.

- The Group will publish its Strategy 2012-2016 and commence implementation of the key objectives.

- We will develop a succession plan for governance continuity through our Future Leadership Programme.

- We will continue to develop our communications strategy and engage with all key partners and key stakeholders, particularly our staff across the Group and all the patients we serve.

- We will develop our learning and development strategy to maximise our work force and ensure development of our staff.

Other service plan objectives include:

- Implementing a quality and safety management system.
- Developing nursing and midwifery services within the Group.
- Implementing directorate priorities and KPIs – see Appendix 2.
- Progressing governance of the Cancer Strategy Group.
- Embedding the clinical audit programme.
- Designing branding for Group.
- Establishing international partners.
- Establishing a Foundation to maximise charitable donations and support capital developments.

Finance – Group CFO

Mr Maurice Power

Introduction

The NSP 2013 sought to address legacy issues and give each budget holder a realistic budget for 2013 in the context of service levels in 2012. As a result, the Group is starting 2013 in an improved financial position with an increase of €20.9m in our budget. This is a very positive result for the Group albeit it still leaves us with a financial challenge of approximately €26m to ensure that as a Group we manage to remain within budget in 2013. This will require a continued strong focus on cost control throughout the organisation, the achievement of value for money (VFM) and our ability to maximise our income streams.

Summary of the Group Financial Position 2013

The 2013 budget for the Group is €318.5m. This is a net increase of €20.9m on the 2012 budget. The increase follows a budget realignment process undertaken by HSE as part of the Service Plan 2013 planning stage to assign more realistic budgets to the Hospital Sector. However while the increase is very welcome, it still results in the Group facing a significant financial challenge for 2013 in the order of €26m including the 2013 cost pressures identified.

Part of the €26m challenge will be achieved by looking at other sources of funding for non-revenue item expenditure, for example procurement of medical equipment, the introduction of legislation to allow hospitals to invoice private patients accommodated in public beds and the sourcing of additional funding, (for example, to help deliver our challenging access targets).

The balance of approximately €16m will require the implementation of cost containment measures across the Group to address the deficit gap and ensure we break-even by year end. We do not underestimate the challenge and it will require detailed realistic cost containment plans that can be performance managed on a monthly basis to ensure delivery of the planned saving targets. Our Clinical Directorates will be key to achieving this.

2013 Finance Objectives

For 2013 the key objectives for Group Finance will be:

- Deliver Group financial break-even position.
- Implement ABC system and Electronic Claims Management System throughout the Group.
- Progress the procurement of financial systems including HR, payroll, approvals process and materials management.
- Secure procurement and recruitment control.
- Carry out financial due diligence on potential additional hospitals to join the Group.
- Secure revised bed designation arrangements for Group.
- Continue to promote cost containment culture within the Group.
- Establish Group finance function and Group audit function (as part of our corporate governance).
- Review and implement strong, robust internal control mechanisms for the Group.
- Develop a Group wide casemix strategy.
- Establish Group Finance Committee chaired by a Non-Executive Director to further improve accountability.

Group Financial Projections 2013

	€m
Annual Budget 2012	€297.6m
Annual Budget 2013	€318.5m
Net Increase	+€20.9m
2013 Forecast (including cost pressures) Expenditure	€344.5m
Forecast Gap on Budget	-€26m
Measures	
Income from legislation	€7m
Deferral of Medical Equipment procurement	€4.0m
Cost Containment Measures	€15m

Cost Containment

Cost containment requires a reduction of 5% on the 2013 expected expenditure to ensure a break-even position having allowed for income legislation, budget and deferral of medical equipment.

The Group will address the delivery of cost containment plans through a combination of measures agreed with the Clinical Directorates and the individual hospitals' management, as well as a number of Group-wide procurement measures. The primary objective will be to deliver on plans which minimises the impact on front line services. The identification of cost containment measures will take into account the nationally agreed cost containment proposals and locally driven proposals. It is important to note that to remain within the funding level will be a significant challenge particularly as this is the fourth year that we are required to implement cost containment measures and the significant cost savings, income generation opportunities already introduced further reduce our ability to go further.

Measures for implementation include:

National Cost Containment:

- Reduction in Non-Consultant Hospital Doctor (NCHD) overtime.
- Pre-retirement incentive schemes.
- Career breaks incentive.
- Consultant rest days – reduction in pay.
- Nursing graduates – reducing pay.
- Employment control Figure - reducing headcount where possible.
- Procurement (medical and surgical, laboratories, x-ray).

Local Cost Containment:

- **Target specific reduction areas**
  Each hospital will have costs that are specific to their hospital. Local plans will be developed to identify some savings across these expenditure items. Examples are grants and rental payments.

- **Catering/Cleaning**
  We are in the process of tendering for our catering and cleaning services across the Group. The priority will be to ensure best value in terms of service provision with a reduced contractual price. Potential savings will be to the latter part of the year.

- **Drugs Control Expenditure**
  A control monitoring process will be put in place to track expenditure by drug type, specialty and hospital to ensure that we remain within budget. A system of tracking cancer drug costs is in place so that we can potentially access additional funding from NCCP for increase levels of expenditure relating to certain drugs.

- **Rosters savings**
  A review is taking place of nursing rosters to address inefficiencies and identify skill mix requirements. The review is commencing in March 2013 with external support from the Office of the Nursing and Midwifery Services Director (ONMSD). A review of NCHD rosters is also in progress with objective to streamline rosters and ensure compliance with the European Working Time Directive (EWTD).

- **Premia savings**
  While there has been significant reduction in premia payments there is still scope to review further. Savings will be generated from the rosters' review outlined above plus additional scope in other staff category pay areas.

- **Contractual savings**
  The Group has negotiated a number of contract price reductions during 2012 that will have a full-year effect in 2013. We have also a senior procurement specialist working with the Group for 2013 and a significant piece of work will be to review product prices across the hospitals to ensure that the most competitive price per product is secured. Consumables groups will be working in each Directorate to review consumable volumes and prices with objective to rationalise usage and reduce price.

- **Agency savings**

  One of the national targets in 2012 was to reduce agency expenditure by over 50%. We achieved a 32% reduction. We intend to remove use of agency in all areas except where we have no other alternative due to shortage of suitably qualified personnel. Where possible we will recruit employees rather than use agency.

  There are a number of large scale initiatives taking place in the Group that will have cost savings if implemented this year. These include the procurement of an electronic document imaging system, implementation of a debt management system and a number of outsourcing options. They will also contribute to savings required under Whole Time Equivalent (WTE) ceiling targets. However it is more likely that the success of these initiatives will have a savings impact from 2014 onwards.

Information Technology

Introduction

In 2012 the Group undertook a review of ICT to support effective delivery and interoperability of ICT across the Group. The outcome of the review is a proposed strategy to transform the current ICT service to support the achievement of the Group service objectives. This is a significant undertaking and one which will require additional capacity, capability and significant funding. We intend to progress the agreed strategy in 2013.

Operational Plan

For 2013 we will deliver on the strategy to support patient care and corporate efficiency by:

- Development of a common master patient index.
- Development of electronic patient record solution across the group and progress to procurement stage.
- Review ICT structures across the Group.
- Development of web-based performance management platform.
- Development of a group intranet.
- Moving Portiuncula into the Group network (domain move – infrastructure project).
- Rollout new systems including endoscopy reporting, medical device track and trace systems, blood tracking systems – all at early stages of implementation planning.
- Rollout systems into priority areas – as per ICT strategy including bed management, ED and theatre management and agree consolidation of discharge summary systems.
- Extension of the Group patient correspondence systems to Roscommon and Portiuncula.
- Development of telephony strategy and procure Group-wide system (working with national ICT).
- Enhancement of infrastructure in 2013 including replacing older equipment – PCs, servers across Group.
- Delivery will be governed and managed through the ICT steering group.

Medical Services and Quality and Safety – Group Clinical Director

Dr Pat Nash

Introduction

My focus for 2013 is to consolidate and further develop the clinical governance structure across the organisation, developing and supporting the Clinical Directorates as the core management units in our organisation. Integral to good clinical governance is prioritisation of quality and patient safety across our hospitals. The National Clinical Programmes and the HIQA standards will be the driving forces for this. Balancing the competing demands between unscheduled and scheduled care will remain a priority during the year, whilst maintaining our focus on delivering a high quality and safe service for all patients.

Medical Manpower

In 2012 there was significant progress made in the development of our Medical Manpower Strategy including:

- Additional sessions worked by surgeons and anaesthesia to target long waiters in surgery and meet the SDU targets.
- Reorganisation of on-call rotas in Medicine between Merlin Park and UHG. This improved medical care to patients and reduced associated risk for emergency medical admissions as well as increasing throughput and reduced average length of stay.
- Revised NCHD rotas between Merlin Park and UHG cross cover provided by Medical Registrar out of hours to orthopaedic patient on the Merlin Park site. This reduced overtime payments and reduced working hours for NCHDs.
- On call rotas have been reviewed in Anaesthesia, Paediatrics and Medicine to provide better cover and reduced working hours for NCHDs.

For 2013:

- Development of a business case and the implementation of the ICU Programme between GUH and Portiuncula which will be implemented early 2013. This will provide enhanced anaesthesia cover to ICU in Portiuncula by GUH Consultants and improve patient safety.

- Plastic surgery - new additional clinics and day surgery in Roscommon maximising its role as a level 2 hospital.

- Further work was initiated on compliance levels for EWTD amongst NCHDs.

- Additional work will take place to implement compliant rosters for staff in UHG particularly with Medical Registrars.

- On the Roscommon and Portiuncula sites we will reconfigure rosters to ensure efficient service delivery.

- For 2013, rotations have been developed between UHG, Roscommon and Portiuncula to make posts more attractive on the smaller sites. In addition, certain posts are been evaluated and where possible we may convert some SHO posts to intern posts. This will lead to quality improvements and also meet the need for additional posts for the increased number of graduates.

  Note - ongoing problems in relation to recruitment of NCHDs will continue in the areas of Emergency Medicine, Paediatrics, Obstetrics and Gynaecology. In addition to these areas the smaller sites can also experience recruitment issues in General Medicine and Surgery. We will minimise the problem by joint recruitment and the provision of rotations between the Group hospitals.

Improving Quality and Delivering Safe Services

The development, rollout and go-live of a quality and safety new processes and upgraded system is scheduled to be completed in March 2013. A full education and roll out programme will be provided to ensure staff have an understanding of the new processes, the roles and responsibilities, and the upgraded Q-Pulse system.

Following go-live, the new processes shall be supported by ongoing education and training across the hospital sites. This shall include a support desk (telephone and email) for quality and safety related queries, as well as the Q-Pulse system.

A real-time comprehensive monitoring system shall ensure the system is being utilised appropriately and that the information is providing effective benefits to all line managers, staff and ultimately the patients. This monitoring system shall allow for both automated, and manual, escalation of incidents and events where required.

Comprehensive monthly reports shall be developed and provided on all activities, incidents, timeframes, classification analysis, trends and risks in relation to quality and safety events. The provisions of this information shall be a key support to the operations of the Directorates and the newly formed Patient Safety Committee.

We must deliver services that are safe and are evidence-based and meet regulatory requirements and healthcare standards. This can be achieved with the continued development of National Clinical Programmes and implementation of the National Standards for Safer Better Healthcare (HIQA).

We need to address other quality issues such as the monitoring and reduction of Hospital Acquired / Staph Aureus Blood Stream Infection Rates, Emergency Readmission Rates, Rates of Day Surgery and Day of Surgery Admission, and Average Length of Stay (ALOS).

Audit of waiting times for access to safe stroke thrombolysis, waiting times for access to interventional cardiology for ST elevation myocardial infarction (STEMI) and non-STEMI cases and 5 year survival rates for breast, colorectal, prostate and cervical cancer are all areas which provide evidence of quality service.

In admissions we will develop specialty specific admissions projects to redesign pathways, reduce waiting lists, improve efficiency, support earlier discharges, and reduce ALOS and ED pressures.

In bed management we will develop a Group bed model through procurement of system solution and process reengineering. We will reduce length of stay and increase elective admissions, moving to a model of protected beds. We will streamline patients' pathway using expected date of discharge (EDD).

Cancer Care

Galway University Hospitals is one of the eight designated cancer services in the delivery of a comprehensive National Cancer Control Programme (NCCP) and incorporates the diagnostic therapeutic and palliative care teams as well as translational research, clinical trials and biobanking.

We will continue to progress the governance of the Group's Cancer Strategy Group and the primary objectives for 2013 are:

- Development of a set of KPIs for each cancer specialty group.
- Improvement in patient experience by continuing to develop effective cancer care pathways.
- Improvement in patient flow in oncology.
- Support the roll out of the National Colorectal Programme.
- Continue to support the transfer of major cancer surgeries into designated cancer centres (rectal, prostate, GI).
- Continue to deliver rapid access diagnostic clinics.
- Continue to work with NCCP and clinicians to develop cancer services and capacity alongside existing Group service pressures and development of GUH as a centre of excellence.
- Implement the National Plan for Radiation Oncology (NPRO) capital programme and the associated enabling works.

Nursing and Midwifery Services – Group Director of Nursing and Midwifery

Ms Colette Cowan

Introduction

Nursing and Midwifery are committed to achieving the objectives of the Group's Service Plan 2013. We are the leaders that drive the standards for quality of patient care and patient experience. We want to deliver the best service that staff are proud to deliver, where the essence of care is valued and where staff want to work in our Group. Our objectives will be achieved through our key priorities and key performance indicators.

2013 Nursing and Midwifery Service Objectives

The primary focus for 2013 for Nursing and Midwifery is to continue to provide a patient-centred service that meets the expectations of our service users.

The Group nursing structure will be further defined to address strategic and operational governance with assigned authority and accountability on specific areas of quality, safety, infection prevention and control and patient experience. The nursing directorate will deliver on targets that will be underpinned by the Standards for Better Safer Healthcare and work towards the Group achieving licensing. Our Nursing Strategy will identify the manpower plan for the Group.

Priorities:

- The formal transition to a Group and Board will allow autonomy to the Group Director of Nursing and Midwifery (DoNM) to manage the nursing budget efficiently, recruit and manage the largest workforce in the Group and deliver on performance metrics that meet the national and Group targets. The Group DoNM will have one overall budget, headcount and WTE for the hospitals.

- Patient safety is paramount to the Group. Nursing and Midwifery are the direct providers of care who give assurance to the Board and executive management team. A senior nurse role will be established to lead on the patient safety agenda and coordinate the delivery of the Better Safer Health Care Standards

through the Directorate structures including devolved responsibility to the front line.

- The Group DoNM will further review Senior Nurse Managers' roles and progress a business case to establish a Director of Midwifery for Maternity Hospitals.
- Our priority is to deliver further on scheduled and unscheduled Care in achieving zero waits on trolleys, waiting lists targets and Outpatient Department (OPD) waiting list achievements through cross site access for patients, sharing of the nursing resource to provide sessions across the hospitals and recruitment of staff to a Group-wide remit.
- Continue to support and deliver on National Clinical Programmes.
- To address cost containment and address the cost of agency and overtime, a Group wide review will be commenced to review skill mix and dependency levels at ward level to measure and support conversion of some nursing posts to Health care assistants.
- Further develop the Advanced Nurse Practitioner role to support scheduled Care and unscheduled care, particularly in the Emergency Department.
- Progress the development of Midwifery-led units and Advanced Midwife Practitioners.
- Roll out PRactical Obstetric Multi-Professional Training (PROMPT) training on Obstetric emergencies and treatment.
- Support implementation of ICT to include COMPSTAT, MAXIMS and Q-Pulse.
- Progress the implementation of an electronic patient record.
- Progress the education of nurses to deliver on new services i.e. Nurse Endoscopists to deliver on colorectal screening.
- Review of education programmes in collaboration with NUI Galway and deliver module based programmes that incorporate fundamentals of nursing care and acute medicine modules.
- Progress the development of a professorial post in nursing that incorporates a culture of research and audit practice within nursing.
- Progress a PhD course on nurse practice to re-establish the role of the nurse and refocus on the value and importance of the generalist nurse.

Operational Challenges
- Group Chief Operating Officer

Mr Tony Canavan

Introduction

2013 presents us with some unique operational challenges. The context for these challenges is that we have received a significant uplift in our allocation for 2013 versus 2012. That being said we are still an estimated €26m short of where we need to be in order to break even. The context for these operational challenges is also the upward trend in patient activity across almost all service areas in each of the Group hospitals. We have set ourselves stringent access targets in the key areas of trolley waits, the inpatient / day case waiting list, access to diagnostic services and access to outpatient service. We must achieve these targets while also continuing to keep pace with the growth in demand for services that we saw in 2012 and while we also deliver on our financial obligations.

Activity Plan

Group Targets for Patient Activity

	Inpatients	Day Cases	Outpatients	ED presentations	Births	UCC patients
GUH	37,720	75,158	230,849	66,895	3,382	-
PHB	11,335	9,126	45,275	22,889	2,059	-
RH	1,898	6,093	15,408	-	-	5,440
GROUP	50,953	90,377	291,532	89,784	5,441	5,440

We will manage the agreed service level activity through the development of individual hospital service plans with a strong focus on Group integration. We will review service provision on each site and where appropriate reconfigure services within our overall bed base. We will continue with the establishment of a Group integration funding mechanism for 2013.

Scheduled Care

Having achieved the 9 month Patient Target List (PTL) target in 2012, the challenge for the Group is to maintain this target and achieve a further reduction to the 2013 national target of 8 month waiting time target for scheduled care, 20 week target for paediatric care and 13 week target for regular GI endoscopy procedures.

We will also meet the national targets set for trolley waits, ED and Diagnostics. We must also focus on limiting cancellations, access to the required diagnostics and consistent experience across the patient pathway.

An important requirement will be to ensure that demand and capacity for Unscheduled care are in balance with the reduction and eventual elimination of back-logs for Scheduled care patients. We will embed the practice of discharge planning on admission and promote estimated date of discharge (EDD).

SharePoint will be used as the reporting tool to support the achievement of waiting list targets. The data generated will facilitate short and long-term decisions about managing patient flows and capacity. We must also enable the current scheduled care booking system to effectively manage peak activity while maintaining efficiency over time.

The Group's current outpatient waiting list stands at approximately 38,000 with long waits in some specialities. These long waits are unacceptable and inconsistent with the ethos of the Group. The Group's position is similar to that across the country and the outpatient waiting list is a priority KPI for 2013.

The Group has started to make progress regarding the outpatient waiting list in a number of specialities:

- A high level action plan has been developed to address key areas.
- A five point plan is now in place to focus on initiatives such as converting review capacity to new capacity, ongoing validation, and reducing the "Do Not Attend" or DNA rate to target areas with long waiters.

This is a major challenge for the organisation and will be our primary focus in 2013.

Unscheduled Care

While we have achieved significant progress in meeting the national targets there is still room for improvement in reducing waiting times and to meet the target that 95% of patients are seen within 6 hours.

An Unscheduled Care Steering Group has been established to oversee its implementation. We now have better information on the flows of patients which will allow us to plan towards delivering zero 9 hour waits and 95% 6 hour waits in line with national targets.

In the absence of any clear national solution and given the ongoing patient safety risks we aim to implement an IT system for the Emergency Departments in the Group.

Estates Strategy

Our aim is to ensure that healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. Our work plan for developments on each of our sites in 2013 will ensure that developments are carried out in a planned, effective, efficient and progressive manner and in line with Development Control Plans and support both the delivery of existing and new services as well as addressing key infrastructural deficits.

We will develop an Estates 2013 work plan for the Group to include:

- Development of endoscopy services across the Group through commissioning of the Central Scope Decontamination Unit, progression of the new Endoscopy Unit in Roscommon Hospital and the refurbishment/reconfiguration of existing facilities across all hospitals. We will progress upgrade of Endoscopy Suite in Portiuncula to address infrastructural deficits and ensure that it meets quality standards / Joint Advisory Group on GI Endoscopy (JAG) compliance.
- Implementation of the National Clinical Programmes - supported through identified accommodation, reconfigurations across the sites to improve facilities in the Emergency Department, outpatients and rehab services.
- Progress the new interim ward block on UHG site and decanting of service to support.
- Work in partnership with NUI Galway to progress Clinical Research Facility building project.
- Progress enabling works for the National Plan for Radiation Oncology project.
- Implement infrastructural programme for Merlin Park in line with future service delivery strategy for the campus.
- Development of mobility plan for UHG site.
- Development of Group Estates function.
- Continuation of infrastructural upgrades across the sites to address any electrical, infection control, medical gases and fire issues.
- Continuation of funding submissions for minor capital projects, medical equipment and once-off minor building work projects.
- We will progress the Development Control Plan for Portiuncula Hospital to address infrastructural deficits.

Human Resources
- Group Director of Human Resources

Mr John Shaughnessy

Introduction

Following a period of significant staffing challenges since 2009, we are entering 2013 with a leaner and more efficient workforce. We are certainly doing more with less and that will continue to be the theme for the foreseeable future. We can take confidence from the fact that we have delivered more patient services year on year with fewer staff and less money to spend. We have done this partly because staff attendances at work have improved and because teamwork has become more central to our daily efforts. It is testament to the professionalism and dedication of our staff that we are now being held up as an example to the health services of how change can and does work.

Over the past year, the Group has created a robust governance model and there has been consolidation of services in an effort to reduce duplication – for example, the management of the four hospitals has been distilled to a small team, there is one human resources service for the Group, medical recruitment is centralised and the Clinical Directorate structure has evolved to include all of the constituent hospitals.

Employment Control Framework Challenge

Group WTE Position

The Group is operating within its ceiling; the Group has a current ceiling of 3980 Whole Time Equivalents (WTEs) as of December 2012 and is currently operating at 3951 WTEs which is 105 fewer WTEs (2.59%) when compared to January 2012.

Headcount reductions

Between May 2009 and October 2012 the Group lost 394 WTEs (9.11%). This is to be viewed in the context of increasing activity levels:

> The Group is 8% over the national inpatient discharges National Service Plan (NSP) 2012 target; 9% over the NSP day case rate target; and 24% over the emergency admissions target.

With 4,000 posts to be taken out of the health service and 131 WTEs identified for this Group, this year's reduction in staffing will be challenging in the context of the depletion of staff to date with corresponding increases in service delivery. Natural turnover will not bring about an appreciable reduction in headcount.

We will continue to focus on any duplication of services, inefficiencies, consolidation and development of shared services, rosters, skill-mix and staffing levels through our Public Service Agreement (PSA) Working Group which is tasked with identifying and progressing all possible efficiencies.

Possible productivity increases are more likely to be viable when the performance management process is rolled out across the Group. The engagement process with the unions has commenced. We are seeking an increase in our ceiling through the redistribution of posts from corporate and non-front line operations to the front line service providers.

WTE by Department of Health category, by hospital and by Group December 2012

DoH Category	GUH	RCH	PHB	Group
Nursing	1,164	99	271	1,535
General Support Staff	270	61	71	403
HSCP	405	20	60	486
Management/ Admin	482	54	108	644
Medical/ Dental	482	31	82	596
Other Patient and Client Care	210	10	51	273
Other	11	0	0	0
Grand Total	**3,027**	**278**	**646**	**3,951**

Staff absenteeism

Management of absenteeism will be a key focus for 2013 as we aim to achieve a position of < 3.5% across the Group. We continue to focus on all measures to address attendance rates more effectively, taking a multi-faceted approach to tackling absenteeism, focusing on maximising attendance, providing supportive structures for staff and addressing any inappropriate use of sick leave schemes.
Across the Group we are making progress and in 2012 the absence rate has dropped from 5.16% to 4.69% (under the national average) – effectively a 9.11% drop. We have an Attendance Management Plan, a task force to manage nursing attendance and trend analysis reports, while we consistently deliver ongoing training to staff and managers alike.

There is an emphasis on communicating the 'reduce absenteeism' message regularly and there is auditing of compliance with the policy. Detailed management reports (including league tables) are issued monthly and the disciplinary procedure is invoked where appropriate. Use of the Occupational Health and Employee Support services are

promoted and an emphasis is placed on the responsibility of all staff to render regular and effective service through making attendance management a standing item on all staff meeting agendas.

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2012
GUH	5.30%	4.92%	4.43%	4.50%	4.51%	4.37%	4.64%	4.31%	3.85%	4.57%	4.72%	4.42%	4.54%
PHB	4.59%	4.88%	5.75%	3.73%	4.93%	3.94%	3.92%	4.48%	4.23%	5.42%	4.23%	4.60%	4.59%
RCH	5.00%	5.95%	5.51%	4.77%	7.54%	7.33%	6.27%	6.48%	7.66%	8.59%	8.31%	6.95%	6.70%
Group	5.16%	4.99%	4.65%	4.36%	4.75%	4.50%	4.64%	4.49%	4.18%	4.99%	4.89%	4.69%	4.69%

Recruitment plans

The Clinical Directorate management teams filter all applications for posts. In turn, they forward applications to the Employment Control Committee (ECC) which was established in March 2012 to ensure compliance with Employment Control Framework considerations. Only half of the applications received to date have been approved by the ECC. This robust process enables all recruitment decisions for the Group to be made with service and finance priorities in mind. All of the Group Management Team sit on the ECC.

Reduced spend on overtime and agency

The Group recognises that a reduced spend on overtime and agency will be critical in delivering overall pay reductions necessary in 2013. Significant gains have been made in the area of agency staff usage with a 66% reduction in agency hours (September 2012 to January 2013) since an additional control mechanism was introduced. Our service units have been assigned targets to meet with respect to this and will be required to strictly adhere to allocated budgets for overtime and agency. The graduate nurse initiative is also being targeted as a means to eliminate nursing agency costs.

We are also focusing on reductions in overtime throughout 2013 with all service areas receiving targets for savings which will be reviewed regularly throughout the year.

For 2013, HR plans include:

- Evaluate and implement roster efficiency possibilities.
- Implement performance management.
- Increase flexibility among the staff body.
- Manage reduced staffing and skill loss effectively.
- Improve staff support programmes.
- Improve management skills at the front line.
- Pursue PSA initiatives across the Group.

Appendices

1. Clinical Directorate Priorities

Directorate	Priority	Timeframe
Radiology  Dr R. McLoughlin Clinical Director	▪ Provide timely access to imaging for all patients in the Group. ▪ Realise adequate staff levels. ▪ Continue our staff training and education programme. ▪ Formulate Directorate equipment replacement strategy. ▪ Maximise diagnostic imaging capacity across the Group. ▪ Consolidate and integrate RIS/PACS across the Group. ▪ Deliver savings supporting the Group financial break-even plan. ▪ Reduce Directorate risks. ▪ Develop the Interventional Radiology service.	Q3 Q4 Q3 Q2 Q4 Q4 Q4 Q4 Q4
Women and Children  Dr G. Gaffney Clinical Director	▪ Implement a new appointment system for antenatal scans. ▪ Increase number of post-natal women availing of early discharge home service. ▪ Develop a pregnancy day services ▪ Achieve a waiting time of 4 weeks for Gynaecological oncology cases. ▪ Develop ambulatory gynaecology services for pre-menopausal women. ▪ Develop post of liaison Paediatric Nurse for children with long term illnesses. ▪ Develop Day services. ▪ Secure diabetic support for Maternity and Paediatric OPD clinics. ▪ Cost Containment.	Q4 Q2 Q4 Q2 Q2 Q1 ECC Q1

Laboratory  Dr D. Griffin Clinical Director	▪ Tender for and installation of blood gas analysers. ▪ Electronic cross-matching. ▪ Plan Group-wide Blood Transfusion Service. ▪ Progress to tender for Blood Sciences Project. ▪ Histopathology - achieve acceptable turnaround times for all specimens. ▪ Progress cost-per-test to establish Relative Value Units. ▪ Plan for Group-wide clinical governance. ▪ Ensure a stable Laboratory Information System platform across the Group. ▪ Review service level agreements with external agencies.	Q1-3 Q1-3 Q4 Q1-2 Q1-3 Q1 Q2 Q1-4 Q1-4
Theatre, Anaesthetics and Critical Care (TACC)  Dr P. Naughton Clinical Director	▪ Recruit theatre staff ▪ Plan theatre access in line with current resources. ▪ Recruit Critical Care Unit staff. ▪ Audit. ▪ Pre-operative/admission/assessment services: – 5 sessions per week by June – 10 sessions per week by end of year. ▪ Chronic pain programme – pain management programme x 2 per year. ANP post x 2 across the Group. First programme to be delivered by June. Implement in line with current resources. ▪ Cost containment/theatre consumables. ▪ Implementation of the Surgical and Anaesthesia National Programme. ▪ Critical Care Clinical National Programme development ▪ Theatre Information Management. ▪ Restore bed capacity in ICU in first quarter, with full capacity by year end ▪ Theatre Admission Lounge – full development. ▪ Enhanced Anaesthesia commitment to X-ray Paediatric MRI Service. ▪ Maximise theatre/ICU/HDU capacity across the Group.	Q2 Ongoing WIP Q4 Q1 Q4 Q1 Ongoing WIP Ongoing WIP Q1 Ongoing Q4 WIP Q1 Ongoing WIP

Surgical  Mr K. Sweeney Clinical Director	▪ Scheduled Care: maximise availability of theatre sessions through recruitment of theatre nursing staff. ▪ Unscheduled Care: no patient waiting >24 hours for surgery ▪ Pre-assessment Clinic: 85% of all patients will be pre-operatively assessed. ▪ Audit: all mortality and morbidity data to be collected centrally. ▪ TPOT: establish the Productive Operating Theatre (TPOT) across the Group ▪ Inpatient waiting list management: to move from a 9 month PTL target to an 8 month PTL target. ▪ Outpatient waiting list management: to review outpatient department processes and waiting lists in line with national targets of 12 Months. ▪ Reconfiguration of the Surgical Day Ward: structural reconfiguration. Extension of working day for greater throughput. Reallocation of Endoscopy. ▪ Increase the number of patients through for cost effectiveness and improved scheduling. ▪ Distribution of Surgery: appropriate distribution of complex and non complex surgery across the Group. ▪ Maximising surgical capacity within the Group.	Q4 Q4 Q2 Q3 Q1 Q3 Q4 Q1 Q1 Q3 Q4
Medical  Dr D. Reddan Clinical Director	▪ Consolidate Directorate structure and performance management culture as follows: – Specialty based KPI's. – Data access. – Integration across Group. ▪ Reduction in trolley counts in ED. ▪ Improve patient flow through the Acute Medical Unit. ▪ Optimise patient flow ▪ Implement the Acute Medicine Programme. ▪ Implement the Emergency Medicine Programme. ▪ Implement the Endoscopy Strategy. ▪ Maintain a focus on other National Clinical Care Programmes. ▪ Target OPD waiting times greater than 1 year. ▪ Review of medical outpatient services across the Group. ▪ Cost containment. ▪ Maximise capacity across group. ▪ Recruit / replace priority staff for the Directorate	Ongoing Ongoing Q1 Q2 Ongoing Ongoing Q2 Ongoing Ongoing Ongoing Ongoing Ongoing Q1 Ongoing

2. Hospital Priorities

Galway University Hospitals

Ms Ann Cosgrove
General Manager

	Priority	Timeframe
Scheduled Care	▪ Implement Productive Theatre and Ward.	Q2
	▪ Inpatients and day cases - achieve 8 month target.	Q3
	▪ Outpatients - achieve 12 month target.	Q4
Unscheduled Care	▪ Discharge Planning on Admission. ▪ Implement estimated date of discharge (EDD).	Q1
	▪ Reduce patient experience time; time waiting to be admitted from ED. ▪ Improve communication and collaboration with PCCC.	Q2
	▪ Reduction ED trolleys. ▪ Develop Ambulatory Emergency Services.	Q3
Patient Care	▪ Progress ICT solutions for EDM, Bed Management and ED.	Q2
Cancer Strategy	▪ Define KPI set for Each Cancer Specialty. ▪ Improve patient flow. ▪ Implement Colorectal Screening Programme.	Q1
	▪ Produce Group Cancer Strategy.	Q2
	▪ Develop clinical pathways.	Q4
AMP	▪ Implement early warning scores. ▪ Integrate Short Stay Unit and Acute Medical Unit.	Q1
	▪ Reconfigure Consultant call structures.	Q4
Clinical Programmes	▪ Recruit Palliative Care Consultant. ▪ Recruit Rehab Consultant. ▪ Care of the elderly (COTE) implementation.	Q4
	▪ Progress appointment of EMP consultant. ▪ Reconfigure ED. ▪ Implement ED system.	Q1
Surgical and Anaesthetic Programme	▪ Increase the number of patients through Theatre Access Lounge. ▪ Deliver more day surgery. ▪ Increase day of surgery admission rates.	Q2
	▪ Target no cancellation of elective patients. ▪ Target no patient waiting > 24 hours for surgery. ▪ Target 85% of patients pre operatively assessed. ▪ Reconfigure structures. ▪ Extension of working day for greater throughput.	Q4

2. Hospital Priorities

Roscommon County Hospital

Ms Elaine Prendergast
General Manager

Priority	Timeframe
▪ Review of hospital specialities.	Q1
▪ Put SLA in place for GUH consultants.	Q2
▪ Validate OPD Lists.	Q2
▪ Increase number of OPD clinics.	During 2013
▪ Set up central OPD appointments.	Q3
▪ Support bi-directional flow of patients between level 2, 3 and 4 hospitals within the group.	Q4
▪ Ensure the delivery of high quality and safe services in line with the National Standards for Safer Better Healthcare.	By end of 2013
▪ Progress rollout of Q-Pulse system for policy and procedures, incident and complaint management to embed a continuous quality improvement culture within the new group governance structures.	Q2
▪ To work with PHB and NUI Galway to establish Medical Academy on the PHB site for Portiuncula/Roscommon in January.	Q1

2. Hospital Priorities

Portiuncula Hospital Ballinasloe

Ms Chris Kane
A/General Manager

	Priority	Timeframe
NEWS (National Early Warning Score System)	▪ Roll out of the early warning score in the first quarter 2013.	Q1
Reduce OPD Waiting Times	▪ Appointment of additional Consultant Dermatologist with sessional commitment to PHB to assist in addressing waiting list. Validation exercises to be undertaken particularly in orthopaedics, urology.	Q1 - Q2
ED targets	▪ Trajectory plan in place to ensure 95% compliance with the 6 hour target by April 2013.	Q2
AMAU targets	▪ Increase our same day admission rate from 7% to 12% within the first quarter of the Acute Medical Assessment Unit (AMAU) being established with a view to increasing further by year end.	Q2-Q4
Improve average length of stay (ALOS)	▪ Introduction of designated beds, pre- assessment models and AMAU and increased access to same day diagnostics to reduce ALOS in line with clinical programme targets.	Q4
Reduce Absenteeism	▪ Focused attendance management with a target reduction in each staff category to meet the national 3.5% target.	Q1 – Q4
Scheduled Care	▪ Review demand capacity with resources and theatre schedule to ensure that we maximise use of theatres, beds, staffing and ensure that we meet targets.	Q2
DNA rates	▪ Work with specialties to reduce number of patients who do not attend to 8% by end of 2013.	Q4
Employment	▪ To operate within the established ceiling and ensure resources utilised efficiently and effectively.	Q1 - Q4
Diagnostics	▪ Meet KPIs in relation to waiting times for access to CT, MRI and ultrasound.	
Hand Hygiene	▪ Achieve 90% hand hygiene compliance.	Q3 - Q4
Breastfeeding	▪ Audit the ten steps to successful breastfeeding.	Q3
Infection Control	▪ Reduce incidence of HCAI MRSA rates and ensure that there is support from the Group in terms of Microbiology advice.	Q1 - Q4

3. Performance Activity Indicators by Hospital

Galway University Hospitals

	Performance Activity and Indicators	Target 2013	Indicate achievability against target as appropriate G = Green A = Amber R = Red
	Day of Procedure Admission ▪ % of elective inpatients who had principal procedure conducted on day of admission	75%	A
	▪ % of elective surgical inpatients who had principal procedure conducted on day of admission	85%	A
	Re-Admission ▪ % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge ▪ % of surgical re admissions to the same hospitals to the same hospital within 30 days of discharge	9.6% <3%	A
	Time to Surgery % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	95%	A
	Stroke Care ▪ % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis ▪ % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	9% 50%	A
	ACS % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	70%	A
	Emergency Care Waiting Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	A
	% of all attendees at ED who are discharged or admitted within 9 hours of registration	100%	A
	Acute Medicine Programme Percentage of all new medical patients attending the acute medical unit (AMAU) who spend less than 6 hours from ED registration to AMU departure.	95%	A
	Elective Waiting Time ▪ Number of adults waiting more than 8 months for an elective procedure ▪ Number of children waiting more than 20 weeks for an	0 0	G

	elective procedure		
	Outpatients Number of people waiting longer than 52 weeks for OPD appointment	0	G
	ALOS ▪ Medical patient average length of stay ▪ Surgical patient average length of stay ▪ ALOS for all inpatient discharges and deaths ▪ ALOS for all inpatient discharges and deaths excluding LOS over 30 days	5.8 4.5% reduction 5.6 4.5	A
	Colonoscopy / Gastrointestinal Service ▪ Number of people waiting more than four weeks for an urgent colonoscopy ▪ Number of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	0 0	G
	Delayed Discharges ▪ Reduction in delayed discharges	10% reduction	A
Finance	Variance against Budget: Income and Expenditure	≤ 0%	A
	Variance against Budget: Income Collection	≤ 0%	A
	Variance against Budget: Pay	≤ 0%	A
	Variance against Budget: Non Pay	≤ 0%	A
	Variance against Budget: Revenue and Capital Vote	≤ 0%	A
HR	Variance from approved WTE ceiling	≤ 0%	A
	Absenteeism rates	3.5%	A

3. Performance Activity Indicators by Hospital

Roscommon County Hospital

	Performance Activity and Indicators	Target 2013	Indicate achievability against target as appropriate G = Green A = Amber R = Red
	Day of Procedure Admission ▪ % of elective inpatients who had principal procedure conducted on day of admission	75%	G
	▪ % of elective surgical inpatients who had principal procedure conducted on day of admissio	85%	G
	Re-Admission ▪ % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge ▪ % of Surgical re-admission to the same hospital within 30 days of discharge	9.6% <3%	G
	Urgent Care Waiting Time % of all attendees at UCC who are discharged or admitted within 6 hours of registration	95%	G
	Acute Medicine Programme Percentage of all new medical patients attending the acute medical unit (AMAU) who spend less than 6 hours from ED registration to AMU departure	95%	G
	Elective Waiting Time ▪ Number of adults waiting more than 8 months for an elective procedure ▪ Number of children waiting more than 20 weeks for an elective procedure	0 0	G
	Outpatients Number of people waiting longer than 52 weeks for OPD appointment	0	A
	ALOS ▪ Medical patient average length of stay ▪ Surgical patient average length of stay ▪ ALOS for all inpatient discharges and deaths ▪ ALOS for all inpatient discharges and deaths excluding LOS over 30 days	5.8 4.5% reduction 5.6 4.5	A
	Colonoscopy / Gastrointestinal Service		G

	▪ Number of people waiting more than four weeks for an **urgent** colonoscopy ▪ Number of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	0 0	
	Delayed Discharges ▪ Reduction in bed days lost through delayed discharges	10% reduction	A
Finance	Variance against Budget: Income and Expenditure	≤ 0%	A
	Variance against Budget: Income Collection	≤ 0%	A
	Variance against Budget: Pay	≤ 0%	G
	Variance against Budget: Non Pay	≤ 0%	G
	Variance against Budget: Revenue and Capital Vote	≤ 0%	G
HR	Variance from approved WTE ceiling	≤ 0%	G
	Absenteeism rates	3.5%	A

3. Performance Activity Indicators by Hospital

Portiuncula Hospital Ballinasloe

	Performance Activity and Indicators	Target 2013	Indicate **achievability** against target as appropriate G = Green A = Amber R = Red
	Day of Procedure Admission ▪ % of elective inpatients who had principal procedure conducted on day of admission	75%	A
	▪ % of elective surgical inpatients who had principal procedure conducted on day of admission	85%	A
	Re-Admission ▪ % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge ▪ % of surgical readmissions to the same hospital within 30 days of discharge	9.6% <3%	A
	Stroke Care ▪ % of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis ▪ % of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.	9% 50%	A
	Emergency Care Waiting Time % of all attendees at ED who are discharged or admitted within 6 hours of registration	95%	G
	% off all attendees at ED who are discharged or admitted within 9 hours of registration	100%	A
	Acute Medicine Programme Percentage of all new medical patients attending the acute medical unit (AMAU) who spend less than 6 hours from ED registration to AMU departure	95%	A - Once AMAU is established Q2 2013
	Elective Waiting Time ▪ Number of adults waiting more than 8 months for an elective procedure ▪ Number of children waiting more than 20 weeks for an elective procedure	0 0	G
	Outpatients Number of people waiting longer than 52 weeks for OPD	0	G

	appointment		
	ALOS ▪ Medical patient average length of stay ▪ Surgical patient average length of stay ▪ ALOS for all inpatient discharges and deaths ▪ ALOS for all inpatient discharges and deaths excluding LOS over 30 days	 5.8 4.5% reduction 5.6 4.5	A
	Colonoscopy / Gastrointestinal Service ▪ No. of people waiting more than four weeks for an urgent colonoscopy ▪ No of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	 0 0	G
	Delayed Discharges ▪ Reduction in bed delays lost through delayed discharges	10% reduction	A
Finance	Variance against Budget: Income and Expenditure	≤ 0%	A
	Variance against Budget: Income Collection	≤ 0%	A
	Variance against Budget: Pay	≤ 0%	A
	Variance against Budget: Non Pay	≤ 0%	A
	Variance against Budget: Revenue and Capital Vote	≤ 0%	A
HR	Variance from approved WTE ceiling	≤ 0%	G
	Absenteeism rates	3.5%	A