South East Community Healthcare - Operations Plan 2019

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

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Foreword from the Chief Officer

I am pleased to present our South East Community Healthcare Delivery Plan for 2019.

South East Community Healthcare is responsible for providing community health and social care services to a population of 510,333 within the South Eastern counties of Waterford, Wexford, South Tipperary, Carlow and Kilkenny. We are committed to ensuring that services delivered in the South East are of high quality safe care, with equitable access and distribution within the resources available.

This South East Community Healthcare Delivery Plan 2019 sets out the type and volume of health and personal social services to be provided in community settings in the South East during 2019 within the funding available. It also includes developmental actions that will be undertaken in 2019 to continue to improve and expand upon service delivery. Our plan incorporates priorities as set out in the HSE National Service Plan 2019 and the HSE National Community Operations Plan and our own local strategic priorities.

Within this plan, our services are outlined within the care groups of Primary Care, Health and Wellbeing, Older Persons, Disability, and Mental Health. These services will be delivered using an integrated approach to provide a sustainable, high quality safe and effective healthcare that meets the needs of our population. Integration between our care groups, as well as with our partners such as acute hospitals and voluntary organisations, will continue to be the main foundation block to deliver service user centred care.

While this Delivery Plan sets out how services will be provided over the coming year within our catchment area for each of our key care-groups, South East Community Healthcare will continue to apply a multi-year approach to planning key service improvements for our community.

A key priority for 2019 will be to maintain appropriate capacity in our services. South East Community Healthcare continues to deliver services in a challenging environment of population growth, increasing demand for our services, increased public expectation, an ageing population, and a rise in Governance and Compliance obligations. Meeting the health needs of our population within the funding available will present an on-going and significant management challenge during 2019.

Our dedicated teams will continue to promote and implement service improvement and innovation opportunities throughout our services during 2019 and will strive to foster a culture that can continuously improve the quality of healthcare for our service users.

The Sláintecare Report (2017) and Sláintecare Implementation Strategy (2018) signal a new direction for the delivery of health and social care services in Ireland. South East Community Healthcare welcomes the focus on moving to a community-led model, which can provide

local populations with access to a comprehensive range of non-acute services at every stage of their lives. This can enable our healthcare system to provide care closer to home for patients and service users, to be more responsive to needs and deliver better outcomes, with a strong focus on prevention and population health improvement.

An important feature of the delivery of safer services is that of governance and accountability, and our teams will be working to key performance indicators as set out in this plan. The delivery of the plan will be underpinned by the HSE Accountability Framework and through the ongoing strengthening of governance arrangements.

Key service priorities for South East Community Healthcare in 2019 will include:

- Continued implementation of our Healthy Ireland Plan with a sustained focus on achieving the high level goals of Healthy Ireland and improving the health and wellbeing of our population.
- Reducing inequalities in health and improving outcomes for the most vulnerable in our area, and enhancing participation of socially excluded groups and communities in health services.
- Continue to build on success of our Community Intervention Teams to facilitate increased volume of complex hospital avoidance and early discharge cases across Carlow/Kilkenny, South Tipperary and Waterford.
- Develop an overarching service improvement initiative to address the needs of children and young people including promotion, prevention, early intervention, primary, disability and mental health services. We will develop a service improvement plan that addresses the needs of children and young people across the care spectrum and in particular implement the *National Policy on* Access to Services for Children and Young People with Disability and Developmental Delay within available resources.
- Continue to improve quality, safety, access and responsiveness of primary care services to support the decisive shift of services to primary care.
- Continue with the implementation structures for local action plans within our Mental Health Services aligned to *National Connecting for Life* implementation framework with the objective of reducing suicide rates in our community.
- Continued development of a recovery focused community mental health service will be an ongoing priority for during 2019. This work will be supported by the implementation of the *Service Reform Fund Project* and roll out of *Advancing Recovery Initiatives*. South East Community Healthcare will also work with the Department of Housing, Planning and Local Government regarding the implementation of the *National Housing Strategy* as it relates to South East Community Healthcare residential services.
- Our Mental Health Service will continue with the implementation of the '*Best Practice Guidance Framework*' to ensure better governance in planning and measuring improvement, and identifying and addressing gaps. Work commenced in our approved centres in 2018 and this framework will roll out to other service areas in 2019.
- Progress implementation of *Time to Move on from Congregated Settings* by supporting a further 38 people with disabilities to transition to homes in the community in 2019.

- Progress implementation of *New Directions* national policy on the provision of day services for people with disabilities and strengthen the quality of day service provision throughout the South East.
- The implementation of the new HSE Incident Management Framework will provide a consistent and effective response to the management of incidents and support those affected by the incident.
- Continue to further develop and implement the *Integrated Care Programmes for Older Persons* (ICPOP) in conjunction with our acute hospital partners.
- Completion of new state of the art Regional Specialist Inpatient Unit & Day Service in Palliative Medicine at University Hospital Waterford in line with the implementation of HSE Palliative Care Services Three Year Development Framework (2017 – 2019).
- Continue to develop our workforce to ensure the delivery of a person-centred social care model of service.
- The single Funding Model of Home Support commenced in 2018 will be further embedded in 2019 with a particular focus on strengthening governance, management capability, quality, and reliability.
- Implement the health actions, identified as a priority in 2019, in *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016 and Housing First National Implementation Plan, 2018 - 2021*, in order to provide the most appropriate Primary Care, specialist addiction, and mental health services for homeless people.

I wish to thank our staff for their hard work and commitment to ensuring that quality social care, mental health and primary care services are delivered to the people of the South East. Their support and dedication is deeply appreciated and is making a real difference to the lives of those that depend on us in counties Carlow, Kilkenny, South Tipperary, Waterford and Wexford.

Kate Killeen-White
Chief Officer
South East Community Healthcare

Section 1 Introduction

1. Introduction

Our Delivery Plan has been prepared in response to HSE National Service Plan 2019 and the funding allocation and associated requirements and conditions set out in the Department of Health's Letter of Determination. It sets out community healthcare services to be provided in County Waterford, Wexford, South Tipperary, Carlow and Kilkenny by type and volume within the funding resources provided to the area for 2019.

It is recognised that 2019 will be another challenging year for healthcare delivery in Ireland. South East Community Healthcare continues to deliver services in an environment where the population is growing, the number of people seeking to access services is higher than before and where public expectations for quality of services continue to increase. Balancing demands and needs within the funding available will be an on-going and significant management challenge in 2019 and may impact on the successful delivery of this plan.

We are determined to address these challenges through a constant focus on improvement and innovation. As a Community Health Organisation (CHO) we will continue to work in close partnership with service users and their families, always seeking opportunities to improve the service user experience of care in the south east, and support staff in the delivery of these services.

During 2019, we will continue all efforts towards enhancing the health of our population and enabling everyone to optimise their own health and wellbeing. Our CHO will prioritise initiatives that can prevent and reduce ill health; improve access to our services; and maximize all opportunities to further improve integration of healthcare delivery in our area. This plan places strong emphasis on achieving further improvement in integrated care across our community services and between Community Healthcare and Acute Hospitals.

We will continue to prioritise chronic disease management through 2019 with almost three quarters of all deaths in Ireland due to three chronic diseases: cancer, cardiovascular disease, and respiratory disease.

Our Population

According to the 2016 Census, the total population of our catchment area is 510,333 people, a net increase of 12,755 (+2.6%) since the previous Census in 2011. The greatest increases were in the older age groups with 74,302 people now aged 65 years and older. This age group has grown by 11,481 since 2011 Census. The greatest decreases in

population groups were in the younger age groups, particularly those aged 25-34 years (-11,447). *Source: CSO preliminary census 2016 and census 2011*

Life Expectancy and Health Status

The Department of Health in Ireland: Key Trends, 2018 shows that life expectancy in Ireland has increased by almost two and a half years since 2006, with male life expectancy consistently higher than the EU average throughout the last decade.

Much of this increase in life expectancy is due to significant reductions in major causes of death such as circulatory system diseases and cancer. This decrease is particularly strong for mortality rates from stroke (-39%), breast cancer (-16%), suicide (-26%) and pneumonia (-39%). The overall mortality rate has reduced by 14.9% since 2008.

Life expectancy in the South East is similar to national figures with women at just over 83 years and men at 79.3. The greatest gain in life expectancy has been achieved in the older age groups, particularly those aged 65-74 (+7,501) reflecting decreasing mortality rates from major diseases.

Healthy Childhood

Although our national birth rates are decreasing our child population aged 0-17 years, is above the EU average (Ireland 26% and EU is 18.8%) (Department of Health and Children and Youth Affairs 2014). The variation in our age profile presents challenges in responding to health needs and will require our service planning to reflect different population health needs.

Within the South East our aim is to ensure children living in the South East experience a healthy childhood. Challenges to achieving our aim are highlighted in the 2018, Child Health Profiles and include the following:

Infant Mortality Rates

Waterford County had one of the highest infant mortality rates in the country in 2017 (6.0/1,000 vs 2.8/1,000 nationally).

The 5 year standardised child mortality rate (2013-17) in Carlow was the highest in the country (5.0/100,000 vs 2.7/100,000 nationally). This compares with their neighbouring County Kilkenny which had one of the lowest child mortality rates in 2017 and 5 year standardised child mortality rates (2013-17) in the country (0.8/100,000 vs 2.4/100,000 nationally and 1.5/100,000 vs 2.7/100,000 nationally).

Carlow had lowest proportion of low birth-weight births in the country (3.1% vs 5.5% nationally).

Immunisation Rates

We know the importance of immunisation for children and our community medical doctors, registered public health nurses and administrative staff who are continuously working to support an increase in uptake rates in South East Community Healthcare. We are aware of the challenges that staff face and although progress has been made, we still have a way to go in achieving national targets.

- In 2017 Carlow/Kilkenny (95.7%), Tipperary South (96.2%) and Wexford (95.1%) met the 6-in-1 vaccination at the 24 month national target. However, all areas in South East Community Healthcare had higher uptake rates than the national average by 24 months.
- In 2017 none of our areas in South East Community Healthcare met the 95% uptake target for the MMR vaccination at 24 months, although it was very close in Carlow/Kilkenny (94.3%). However, all areas in South East Community Healthcare had higher uptake rates in 2017 than the national average.
- In 2017 Carlow/Kilkenny had one of the highest uptake rates in the country for the MMR in Junior Infants (95.2%). This was the only area in South East Community Healthcare to meet the national target.
- In 2016/2017 Wexford had one of the lowest uptake rate of the HPV vaccination in in the country (41.6% vs 51.0% nationally). However, the update rate of the HPV vaccination by girls in Carlow/Kilkenny and Waterford was higher than the national uptake rate.

Breastfeeding

In 2017, the rate of breastfeeding on discharge from hospital was significantly below the national average in Carlow, Tipperary, and Wexford (55.1%, 49.9%, 50.8%, respectively vs 59.9% nationally).

Chronic Disease

We know that the major chronic diseases; diabetes, cardiovascular and respiratory disease will increase by 20% -30% in the next five years. Chronic disease accounts for 76% of deaths, 80% of GP consultations, 40% of admissions, 75% of bed days and 55% of hospital expenditure in Ireland.

Heart disease and diabetes can deprive people of up to 8 years of life and 19 years of a healthy life.

108,738 is the estimated amount of people living within the South East with a chronic condition.

People living with a chronic condition such as diabetes, asthma, COPD or heart disease manage their medicines, their behaviours and their emotions every day. *Self-Management Support* aims to help and support the population to manage their chronic conditions better.

In January 2019, we launched our South East Directory of Services and Programmes for Adults with Diabetes, Heart Conditions, Stroke, COPD and Asthma.

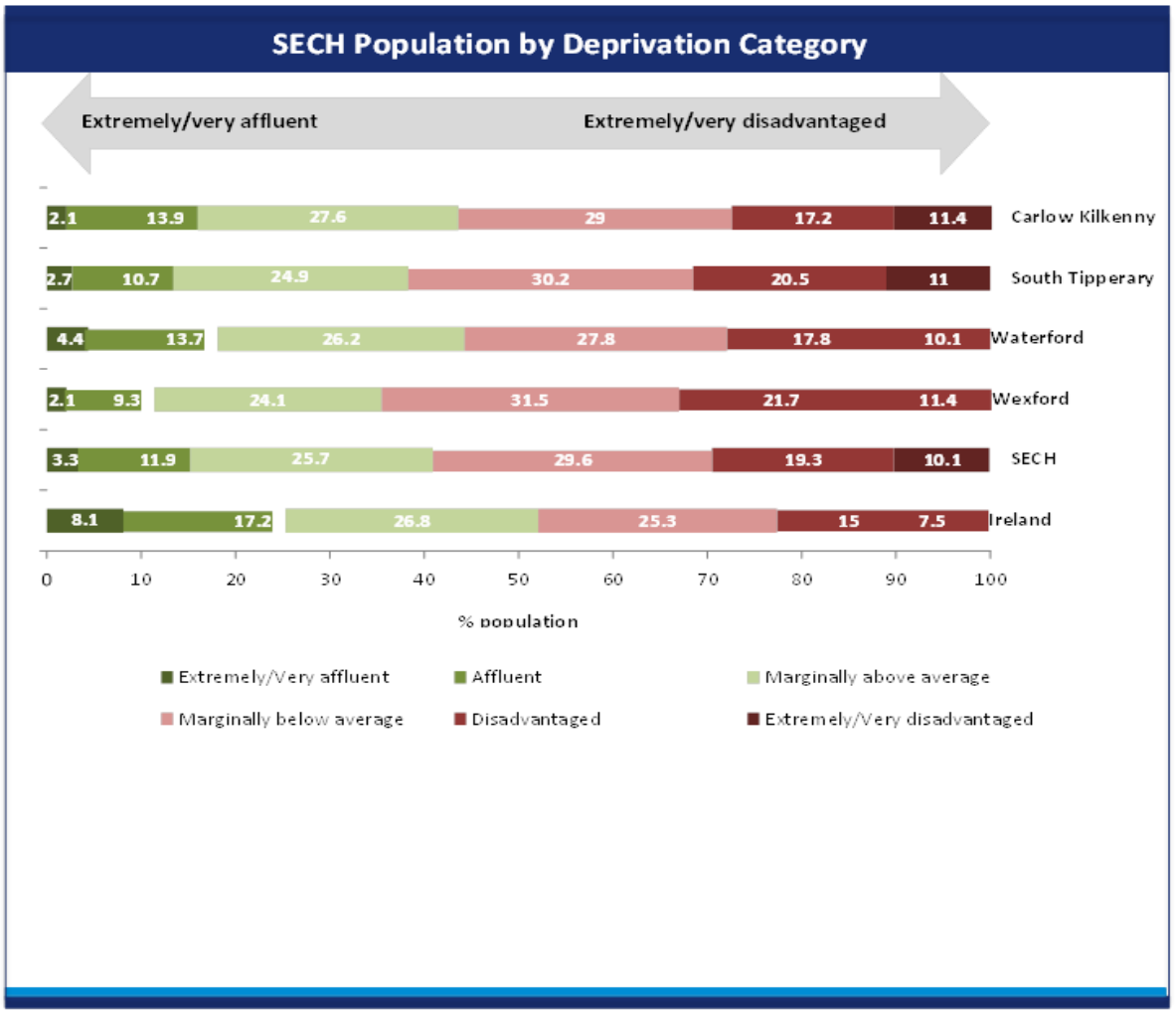
Making Every Contact Count

Making Every Contact Count is central to healthcare reform. It is based upon the up-skilling of all front line staff to use a behavioural change model to support those they are in contact with to eat well, get active, rethink their drinking and quit smoking. In 2019, we will be implementing Making Every Contact Count in five learning sites across the South East.

Health Inequalities

It is well established that there is a strong link between poverty, socio-economic status and health.

As the following table shows, each county in the South East and South East Community Healthcare as a whole has a higher proportion of population categorised as disadvantaged to some extent, and a smaller proportion categorised as 'affluent' to 'extremely affluent' than national averages. As shown below, Wexford has the highest level of disadvantage in South East Community Healthcare.



Refugees and Asylum Seekers

South East Community Healthcare has five Direct Provision Centres (DPC) for asylum seekers within its geographic remit; two in Waterford City, two in Tramore, Co Waterford and one in Carrick-on-Suir, Co. Tipperary. The total number of asylum seekers residing in the South East can be greater than 500 people at any one time, each with varying health needs.

There is also an Emergency Reception and Orientation Centre (EROC) in Clonea, Co. Waterford for up to 120 Programme Refugees.

In addition to these, refugee resettlement programmes are now in place in Waterford, Wexford, Carlow and Kilkenny for those that have been granted refugee status.

In order to support the health needs of these groups, we provide an “In-reach Primary Healthcare Model of care”. We developed this initially from our learning in providing healthcare education and support within the EROC.

This model includes a Health Education Toolkit which includes translated materials regarding health orientation (information and access), Healthy Eating / Diet, Information about Exercise, Over the Counter Medication, Self Care (colds and flu etc) based on "Under the Weather.ie" and trauma information and education.

Homelessness

Across Community Healthcare there is strong commitment to improving the quality of care and improvement of homelessness services. This includes work being undertaken by frontline teams and larger developments and improvement programmes at group, organisation and system level. Improving quality is everybody's business and to achieve real and sustained improvements we must find new and better ways to achieve the outcomes that will best meet patient needs. Community Healthcare is committed to providing care that is person centred, effective, and safe and which leads to better health and wellbeing. Section 2 of this plan details the specific actions that will be taken to progress our clinical and service quality improvement strategy.

Travellers and Roma

A similar percentage of the population in the South East are Travellers (0.7%) compared to the National average (0.7%). Nearly four thousand (3,728) live in South East Community Healthcare, which is approximately 12% of the national Traveller population (30,987). The Traveller population has a shorter life expectancy than the general population, over 11 years shorter for Traveller women and 15 years shorter for Traveller men (Traveller Report 2014). Worryingly, this leads to a mortality rate far greater than the general population (three times greater for Traveller women and four times greater for Traveller men). Our two Traveller Health Projects in County Wexford will be part of Making Every Contact Count Learning Sites in 2019.

Reform and Transformation

Sláintecare Report (2017) and Sláintecare Implementation Strategy (2018) signal a new direction for the delivery of health and social care services in Ireland and offers a framework within which the HSE will focus on transforming health services over the coming decade.
South East Community Healthcare will welcome this focus on moving to a community-led model as an opportunity to enable our healthcare system to provide care closer to home for patients and service users, and to be more responsive to needs and deliver better outcomes, with a strong focus on prevention and population health improvement.

South East Community Healthcare is committed to the principle of transferring care from acute and congregated settings, to more appropriate community and home-based settings.

Our aim over time is to maximise all available opportunities to meet the vast majority of the population's health and social care needs in local settings. This goal is reflected throughout our plan and includes initiatives which support collaboration and integrated working across professions, acute and primary and community service settings and across all localities.

Portfolio Management Office (PMO)

The PMO provides a consistent and best practice approach to project and programme management. It works to ensure that all change is appropriately planned and implemented in a managed and systematic way and that South East Community Healthcare resources and expertise are aligned to service delivery priorities and that these priorities are delivered in defined and measurable ways.

At project level it strives to ensure a consistent and best practice project management approach, providing an environment where projects can be run successfully. At programme level it emphasises the co-ordinating and prioritising of resources across projects and managing links between the projects. It ensures that a group of related projects are managed in a co-ordinated manner to obtain benefits and control not available from managing them individually.

The aim of our PMO is to support and accelerate the realisation of service improvement reforms through the delivery of local and national initiatives as set out in our Delivery and Operational Plan for 2019 and through the realisation of the intent of *CHO Report (Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group', published in October 2014), the SláinteCare Report (2017), and the SláinteCare Implementation Strategy (2018)*. The PMO within South East Community Healthcare will support this body of work throughout 2019.

The main functions of the PMO are:

Methodology: Act as a central point for the approved project methodology, lessons learned and best practice to enable successful delivery of programme and project work to agreed time, cost and quality requirements.

Governance: Drive and oversee health service improvement at a local level on behalf of the Project Sponsor and ensure that the Portfolio Steering Group, project working groups and project teams have the appropriate information to make necessary change decisions.

Integration: Connect programmes and projects across the HSE; identify interdependencies and risks; network and promote the programme efforts throughout the health system.

Delivery Support: Assist project teams to deliver on an agreed scope of work by providing advice, suggestions and developing required team competencies.

Oversight and Traceability: Collate and report programme and project status reports; manage project documentation, including risk registers, schedules, incident logs, benefits plan etc., monitor and review programme and project performance.

Risks to the delivery of Operational Plan 2019

South East Community Healthcare is committed to ensuring best possible healthcare outcomes are achieved for our service users, within the resources available to us. Meeting the health needs of our population within the funding available will present an on-going and significant management challenge during 2019. As mentioned in my Foreword, we continue to operate in a challenging environment of population growth, increasing demand for our services, increased public expectation, an ageing population, and a rise in Governance and Compliance obligations.

There are a number of risks to the successful delivery of our 2019 Plan and particular focus will be required to mitigate risk in the following areas:

- Potential additional demand for services beyond funded levels. This will be impacted by multiple factors including population growth and key demographic changes such as ageing population, increased numbers of people living with a disability, and increase in incidence of chronic disease.
- Meeting the regulatory requirements in public long-stay residential care facilities and the disability sector which must be responded to within the limits of the revenue and capital funding available.
- Level of changing needs and requirement for emergency placements in Disability Services and Mental Health.
- Responding to additional service pressures which will arise during the winter period in relation to hospital, community and primary care services.
- Requirement to provide complex paediatric discharges within Primary Care.
- Impact of Brexit.
- Progressing at scale and pace the required transformation agenda, in the context of resources available.
- Responding to unplanned and unforeseen events (e.g. adverse weather / other environmental events), in the absence of a contingency fund in 2019.
- Responding adequately within available funding to support delivery of key service developments and expansion in community services.
- Complying with the General Data Protection Regulation requirements.
- Effectively managing our workforce, including recruitment and retention of a highly skilled and qualified workforce, delivering a reduction in overtime and the use of agency personnel and staying within our pay budget.
- Control over pay and staff numbers while seeking to deliver on key service delivery targets and achieve compliance with our regulatory requirements.
- Supporting information driven health care within the limitations of our clinical, business information, financial and HR information systems.

Every effort will be made to mitigate these risks through 2019. Our dedicated teams and staff will continue to work towards maximising all resources to ensure provision of high quality, safe and effective services to our population.

Section 2 Clinical Quality Patient Safety

Background

Quality Patient Safety is a key priority for South East Community Healthcare. Over the last two years we have re-configured our Quality Patient Safety (QPS) team and appointed a QPS Manager; 2 additional QPS advisors, administrative support and a Health and Safety Officer. We have developed a Regional QPS team from which we have assigned QPS advisors to act as a support to each of our care groups.

There has also been significant change at National QPS level resulting in the formation of the single National Community Healthcare Quality and Patient Safety Office in 2018.

2018 saw the development and launch of the National Incident Management Framework and the prioritisation of Open Disclosure following the publication of the Scally report (2018) and the enactment of Part 4 of the Civil Liability Bill.

Throughout these changes and developments, the following core elements have been and continue to be the foundation stone of Quality Patient Safety within South East Community Healthcare:

- Governance
- Reporting
- Learning
- Compliance

During 2018, we worked with National Quality Improvement Division to review the organisational structure and governance of QPS within South East Community Healthcare. The report and recommendations from this review included an options appraisal to give greater oversight and assurance to the Chief Officer. In 2019, we will be working to implement these recommendations.

Priorities and Actions

In 2019, we will continue to build on the work which commenced in 2018 and the requirements of Sláintecare, Compliance and the Patient Safety Strategy.

The following areas are identified as priority:

The implementation of the Incident Management Framework within South East Community Healthcare will be a target project with a project team commencing in January 2019. Open Disclosure will be implemented in South East Community Healthcare in line with the recommendations from the Scally Report 2018. A sub group of the project team will identify a strategy for training in Open Disclosure for the year. It is hoped that After Action Reviews will become a standard tool for South East Community Healthcare and the early identification of persons to be trained in 2019 is paramount.
The assessment of primary care services against Safer Better Healthcare will be a continuous process and will include the completion of patient surveys.

In order to improve the Quality of data and reporting of incidents onto the National Incident Management System (NIMS), South East Community Healthcare will prioritise the time delay between incident and reporting with a view to finding a workable solution to meet the Key performance Indicator of all incidents being reported to NIMS within < 30 days.

The completion of review pages for all Grade 1 incidents will also be a targeted Key Performance measure.

QPS will support the national development of the Patient Safety Strategy, in particularly in the area of Falls, Pressure wounds and Infection Prevention Control.

Priority	Priority Action	Timeline	Lead
Incident Management Framework	• A Working Project Group will be formed which will oversee the roll out of and compliance with Incident Management Framework across the South East Community Healthcare	By the end of Q4 2019	Head of Health &Wellbeing/ QPS Manager
Open Disclosure	• Working group will be formed to oversee the rollout of the revised open disclosure policy and identify training needs and develop the training plan for 2019/2020.	By the end of Q4 2019	QPS Manager/Open Disclosure Lead
Reporting NIMS	• To prioritise the time delay between incident and reporting • The completion of review pages for all Grade 1 Incidents	Q1 – Q4 Q1 – Q4	QPS Manager QPS Advisors
After Action Review (AAR)	• After Action Review will become a standard tool for South East Community Healthcare. To achieve this a critical	Q4 2019	Heads of Service/QPS Manager

	mass of AAR facilitators to be in place across the entire geographical area		
Safer Better Healthcare	• The continued assessment of Primary Care services against the Safer Better Healthcare. • Continued involvement and active participation in the National Safer Better Healthcare Forums. • Patient Surveys feedback	Q1 – Q4 Q1 – Q4 Q1	QPS Advisor Primary Care
Development of QPS Structures	• To fill the vacant QPS advisor post • Implement the QPS model developments as agreed by the Chief Officer. • Identify training and knowledge needs through the use of the Knowledge and skills guide.	Q1 2019	QPS Manager Head of Health and Wellbeing QPS Manager
Falls Group	• The continued development of A Falls Group across the South East Community Healthcare to discuss incidents and learning from those incidents	Q1 – Q4	QPS Advisor Social Care
Safer Medicines Programme	• Extension of the HSE medication safety work into our residential, home care and out-patient settings.	Q1 – Q4	All heads of staff
Healthcare Associated Infections (HCAI)	• Examine our HCAI structures and resources to ensure prioritisation of infection prevention control across all service areas	Q4	Head of Health and Wellbeing
Management and Reduction of Violence, Harassment and Aggression within the workplace	• Release of staff for the appropriate level of training in Management and Reduction of violence, harassment and aggression within the workplace. • Prioritisation of services based on risk	Q1 – Q4 Q1 – Q4	All Heads of Service
Pressure Ulcers	• Implementation of the recommendations from the Review of Pressure Ulcers in Mental Health Services • Sharing of the learning from this review across the South East Community Healthcare	Q1 – Q4	All Heads of Service QPS Manager
Policies	• Agree and establish a cross divisional document control system for all regional policies	Q3	Head of Service/QPS Manager

Health and Safety

South East Community Healthcare is committed to putting in place a Health and Safety Management System that is compliant with the Safety, Health and Welfare at Work Act 2005 and associated legislations. The Management of Occupational Safety, Health and Wellbeing are vital to the continuous development of our service by protecting the most valuable asset of South East Community Healthcare, our employees.

Health and Safety key delivery priorities for 2019 are:

- Support and advise local management on establishing a robust system of Health and Safety Governance in South East Community Healthcare.
- Provide advice and assistance to managers and employees on health and safety related issues and improve their Health and Safety Knowledge.
- Working in partnership with HSE National Health and Safety Function (NHSF) and the States Claims Agency to allow better use of resources.
- Work with local Health and Safety Governance Committees to provide advice and assistance with Health and Safety issues that arise.
- Promote the NHSF safety Web-pages and promotional campaigns.
- Collect and analyse National Key Performance Indicators (KPI's) on a quarterly basis for South East Community Healthcare.
- Communicate all Health and Safety Policies and assist with implementation locally.
- Drive and promote local awareness of mandatory training. Communicate the need for training and promote supports available both locally and nationally.
- Assist locally with the preparation for the Level 1 Audit tool.

Our 2019 priorities are included below and will be delivered through planned general inspections, investigation of NIMS forms; advice and visits to premises, follow-up revisits to check implementations and improvements, attending local governance meetings, and presentations.

Priority	Priority Action	Timeline	Lead
Health and Safety Statement	• Finalise South East Community Healthcare's Health and Safety Statement.	Q2	Health & Safety Officer
Health and Safety Audits	• Pilot of two sites with NHSF • Support disciplines and the NHSF in preparing for and the carrying out of Health and Safety Level 1 Audits across the South East Community Healthcare	Q4 2018 Q2 – Q4	NHSF/ H&Safety Officer Health & Safety Officer
Dangerous Goods Safety Advisor (DGSA)	• Activate the DGSA contract across South East Community Healthcare • Complete approximately 13 onsite Dangerous Goods Audits • Complete the DGSA Annual Report	Q2 Q2 – Q4 Q4	H&S Officer H&S Officer DGSA
Work Positive Tool	• Launch the Work Positive Tool pilot in South East Community Healthcare • Support the implementation of the Work Positive Tool Pilot	Q1 Q1 – Q4	Head of Health and Wellbeing Health and Safety Officer
Performance Indicators	• Collate the National Occupational Health and Safety KPIs for South East Community Healthcare on a quarterly basis. • Support care groups to examine incident trends and agree a targeted intervention plan • Work with colleagues nationally to create a metadata to help managers when completing the National Occupational Health and Safety KPIs. Create guidance and support to encourage good returns.	Q2 – Q4 Q3	All Heads of Service H&S Officer H&S Officer
Presentations/Training	• Complete occupational health and safety awareness presentation to management and staff in South East Community Healthcare	Q2 – Q4	H&S Officer

Patient and Service User Engagement

Partnering with patients, service users and families to learn from their experience is an essential component in enabling improvements in care and ensuring a quality, effective and

safe service that is responsive to the needs of patients and service users. They will need to be central to the design, planning and commissioning of services.

During 2019, South East Community Healthcare will continue to develop Your Voice Matters (Patient Narrative Project) to enable patient experiences to be captured innovatively by the HSE and to support the implementation of local service improvement initiatives.

This work to date has included stakeholder engagement and collection of patient experiences (466 to date). This will be collated and used to promote service improvement activities, build local capacity, and develop processes for engagement with and use of service user experience and narratives.

Section 3 Health & Wellbeing

Population

A fundamental goal of our health service is to support the health and wellbeing of our population within the South East. *Sláintecare* recognises the importance of supporting people to look after and protect their own health and wellbeing. *Healthy Ireland* is the national strategy for improved health and wellbeing. It was developed in response to a number of significant public health challenges, including significant projected increases in levels of preventable chronic disease and growing heath inequalities. It articulates four central goals for improved health and wellbeing:

- Increasing the proportion of Irish people who are healthy at all stages of life
- Reducing health inequalities
- Protecting the public from threats to health and wellbeing
- Creating an environment where every sector of society can play its part.

Healthy Ireland within the health services identifies three priority areas for the HSE:

- Health Service Reform – our greatest opportunity
- Reducing the burden of Chronic Disease – our greatest challenge
- Improving staff health and wellbeing – our greatest asset

Healthy Ireland asserts that population health and wellbeing is critical for our social, economic and cultural progress, and our overall quality of life. It recognises the requirement for a 'whole of Government' approach to addressing the social determinants and predictors of health and wellbeing, many of which fall outside the health sector, e.g. housing, transportation, education, workplaces and environment along with an individual's socio-economic status.

We know that giving the same service to everyone does not mean that everyone will have the same positive health outcomes. We need to ensure that our services are matched to each individual's own health needs and that our health assessments take account of all factors that can impact on health.

Healthy Ireland also provides for an inclusive, partnership approach to improve population health and wellbeing by shifting our emphasis to prevention, and to empowering individuals and communities by supporting them to take more responsibility for their health and wellbeing.

There are many positive trends visible within our health service: life expectancy is increasing; mortality rates are declining; and survival rates from conditions such as heart disease, stroke and cancer are improving. Despite these encouraging developments, we know changing lifestyles, chronic disease patterns and ageing population trends are altering our population's healthcare needs. To address these challenges we will continue to prioritise high quality evidence based prevention, early intervention and health protection strategies to help reduce demand on our health and social care services thereby ensuring a sustainable health system for future generations.

Our Health and Wellbeing Services are dedicated to improving health across the region with a commitment to:

- Implement year one of our South East Community Healthcare Healthy Ireland Implementation plan 2019-2022
- Support implementation of Making Every Contact Count (MECC) across the region and in particular within identified learning sites
- Work with Local Community Development Committee's (LCDC's) and Children and Young People's Services (CYPSC) to implement county based Healthy Ireland plans, to reduce smoking prevalence of young people in out-of-school settings and to work towards making health everyone's business
- Work with the community and voluntary sector to increase healthy eating and active living
- Development of a Self-Management Support Regional Action Plan
- Increase uptake of flu vaccination
- Pilot social prescribing model in Waterford
- Enhance the health and wellbeing of staff within the health services
- Provide leadership in regional emergency planning functions
- Develop and implement a work programme for the prevention and control of Healthcare Associated Infections (HCAI's)

Services Provided

Population health is about supporting all those who reside in the South East to stay healthy and well by focusing on prevention, protection, and health promotion and improvement including the following:

- Local implementation of the National Policy Priority Programmes for tobacco, alcohol, healthy eating, active living, sexual health and crisis pregnancy and child health expertise, strategic advice and direction to address known preventable

lifestyle risk factors by designing and developing evidence based best practice policies, programmes and initiatives.

- Health Promotion and Improvement which provides a range of education and training programmes focused primarily on building the capacity of staff across the health service and in key external bodies who are ideally placed to positively influence health behaviour. Health and wellbeing services work with people across a variety of settings in the community, in hospitals, in schools and in workplaces.
- Public health services which protect our population from threats to their health and wellbeing through the design and oversight of national immunisation and vaccination programmes and actions for the prevention and control of infectious diseases.
- National screening services which provide population-based screening programmes for BreastCheck, CervicalCheck, BowelScreen and Diabetic RetinaScreen.

Issues and Opportunities

Our demographic profile is changing and is placing substantial pressure on our health and social care services. Demand for healthcare services will increase by between 20% and 30% in the next ten years. Unhealthy lifestyle choices such as those related to diet, exercise, smoking and alcohol use are all driving demand for health services and resulting in an increased level of chronic disease amongst our population.

Building upon *Sláintecar*e and HSE structural reforms and enablers create greater capacity within the organisation to lead and deliver upon the health and wellbeing reform agenda. The development and implementation of comprehensive *Healthy Ireland* plans in CHO's and Hospital Groups will deliver upon the health and wellbeing reform agenda locally, improving the health and wellbeing of the South East population by reducing the burden of chronic disease and also improving staff health and wellbeing. The transition of Health Promotion and Improvement to CHO's will significantly augment existing health and wellbeing resources supporting accelerated embedding and integration of health and wellbeing across services locally.

A detailed national framework has been developed which outlines how to progress implementation of Self-Management Support for chronic diseases. Through the implementation of the Making Every Contact Count (MECC) Programme, and the Self-Management Support Framework, chronic disease prevention and management will be an integral and routine part of clinical care by all healthcare professionals enabling them to capitalise on the opportunities that occur every day to support individuals to make healthier lifestyle choices.

Priorities 2019

- Improve the health and wellbeing of the population by reducing the burden of chronic disease.
- Build upon *Sláintecare* and HSE structural reforms and enablers to create greater capacity within the organisation to lead and deliver upon the health and wellbeing reform agenda.
- Early Years Intervention including the National Healthy Childhood and Nurture Infant Health and Wellbeing Programmes.
- Protect our population from threats to health and wellbeing through infectious disease control, immunisation, and environmental health services.
- Improve staff health and wellbeing.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
South East Community Healthcare's Healthy Ireland Plan	• Launch South East Community Healthcare's Healthy Ireland (HI) plan. • Commence year 1 of the implementation of South East Community Healthcare HI Plan to deliver actions and embed prevention, early detection and self-management support among their staff and the communities they serve	Jan 2019 Q1- Q4	HoHWB HoHWB
Chronic disease prevention & Self-management support (SMS)	• Establish local governance structure for Self- Management Support	Q1	HWB Primary Care
Self-Management Support	• Continue the implementation of Living Well with a Chronic Condition: Framework for Self-Management Support and support for the integrated chronic disease programme.	Q1- Q4	Self-Management Support Co-ordinator
Self-Management Support	• Increase the provision of access to Chronic Disease SMS Programme	Q1- Q4	Self-Management Support Co-ordinator

	(CDSMP) within the South East		
Self-Management Support	• Finalise the mapping for Self-Management Support within the South East & the development of a directory of services/supports	Q1	Self-Management Support Co-ordinator
Self-Management Support	• Develop a South East Plan for Self-Management Support	Q2	Self-Management Support Co-ordinator
Self-Management Support	• Ensure Self-Management Support materials are kept up to date and are displayed in public facing areas	Ongoing	Self-Management Support Co-ordinator
Self-Management Support	• Support the development of a patient guide to Self-Management Support	Q3	Self-Management Support Co-ordinator
Self-Management Support	• Work to support the increase in provision and access to Self-Management supports such as: Pulmonary Rehabilitation and Cardio Rehabilitation	Q4	Self-Management Support Co-ordinator
Self-Management Support	• Develop the Peer Support Groups in each county within the South East	Q1-Q4	Self-Management Support Co-ordinator
Structured Patient Education	• Work with dietetic services to improve access and uptake of structured patient education programmes for patients with Type 2 Diabetes in the community	Q1-Q4	Self-Management Support Co-ordinator HoHWB Primary Care
MECC	• Implementation of Making Every Contact Count across the following learning sites: Carrick-on-Suir Health Centre; Regional Podiatry Service; Wexford Traveller Health Project; Residential Learning Disability Services in South Tipperary & the Dept of Psychiatry in Waterford	Q1 – Q4	Heads of Services/ HoHWB/ HP&I
MECC	• Evaluate the MECC learning sites	Q4	HoHWB
Alcohol	• Promote and support the *askaboutalcohol* campaign to increase awareness of the risks associated with alcohol intake.	Ongoing	HoHWB
Alcohol	• Support Alcohol and Substance misuse policy development with all secondary and third level colleges	Ongoing	Primary Care Social Inclusion
Alcohol	• Challenge social norms and myths		

	relating to alcohol harm by providing evidence based information on health impacts and social & psychological impacts on families and Children	Q4	HoHWB
Alcohol	• Provide tailored prevention and early intervention programmes via drug education officers and community based drug initiative workers	Ongoing	Primary Care Social Inclusion
Healthy Childhood	• Support the implementation of the Framework for the National Healthy Childhood Programme, including the Nurture – Infant Health & Wellbeing Programme	Ongoing	Heads of Service Child health lead primary care
Healthy Childhood	• Map the availability of parenting courses in South East Community Healthcare and provide an overview of parenting courses available in South East Community Healthcare	Q2	HoWB
Healthy Childhood	• Support South East Community Healthcare initiatives such as Lift the Lip; Snuggles Stories; books for babies	Ongoing	HWB
Healthy Childhood	• Where possible, facilitate staff to complete the relevant training in child health modules such as - Children First Training - Breastfeeding training - Nutrition blended e-learning training (as part of nurture programme) - Multi-level training to promote Infant Mental Health (as part of the Nurture Programme) - Substance Misuse & Pregnancy training programme being co-developed with NMPDU/RCNME and Substance Misuse	Q4	Heads of Service
Healthy Childhood	• Support the implementation of the HSE Breastfeeding Implementation Plan	Q4	Primary Care HWB
Healthy Childhood	• Support the roll out child mental health pathway poster in partnership with CYPSC.	Q4	In Partnership with CYPSC
Healthy Childhood	• Support Schools to develop health and wellbeing plans and provide health and wellbeing training to	Q1 – Q4	HP & I

	teachers on a range of nationally agreed topics		
Tobacco Free	• Continue to Implement the Regional Tobacco Free Positive Messaging Initiatives across the South East Community Healthcare and in partnership with youth organisations and the 5 LCDC's across the South East Region.	Q1- Q4	HWB with LCDC's
Tobacco Free	• Support staff to quit and stay quit and continue to provide subsidised Nicotine Replacement Therapy for HSE staff who wish to QUIT	Ongoing	HWB
Tobacco Free	• Ensure that QUIT support resources will be displayed in all appropriate South East Community Healthcare sites	Ongoing	Heads of Service
Tobacco Free	• Support National communication campaigns	Ongoing	HWB
Tobacco Free	• Support the delivery of smoking cessation interventions particularly targeting high risk groups	Ongoing	HWB
Tobacco Free	• Support the implementation and monitoring of Tobacco Free Campus Policy across all sites and services	Ongoing	All HOS
Healthy Eating Active Living	• Support the delivery of Community Nutrition and Cookery Programmes across the South East Community Healthcare in partnership with the community and voluntary organisations and LCDC's and CYPSC	Q1- Q4	HWB HP&I
Healthy Eating Active Living	• Link with county GAA Health and Wellbeing Committees to support the rollout of the Healthy Club Programme	Q3	HWB HP&I
Healthy Eating Active Living	• Support Implementation of HSE Vending policy across the Health Services	Q1- Q4	Heads of Service
Healthy Eating Active Living	• Support the implementation of Healthy Weight for Children Prevention Programme	Q4	HWB Primary Care HP&I
Healthy Eating	• Continue to support the delivery of	Ongoing	HOS

Active Living	the START Campaign		
Healthy Eating Active Living	• Work in collaboration with Local Sports Partnerships to increase public participation in physical activity	Q1- Q4	HWB HP&I
Mental Health and Wellbeing	• Continue to support the roll out of the "Little things campaign"	Ongoing	HWB All HOS
Mental Health and Wellbeing	• Pilot in South East Community Healthcare 'Minding your Well Being' – pilot study being carried out nationally & evaluation by IT Carlow	Q4	HP&I
Mental Health and Wellbeing	• Roll out Introduction to Youth Mental Health & Minding Youth Mental Health	Q4	HP&I
Mental Health and Wellbeing	• Support social prescribing project in Waterford	Ongoing	HWB HP&I
Mental Health and Wellbeing	• Continue to support interagency mental wellbeing groups/committees to deliver specific wellbeing initiatives such as the "Music in Mind refugee Programme" "Mind your Mental Health" 'Traveller Wellbeing Check-In Tool' and 'It's your Choice 'Programme	Ongoing	Social Inclusion
Positive Aging	• Support the delivery of Age with Confidence, Taking Stock	Q4	HP&I
Positive Aging	• Support the work of Age Friendly Programmes in each of the counties within the South East	Q4	HWB HP&I
Positive Aging	• Support the Understand Dementia Campaign within the South East	Q4	All HOS HP&I
Positive Aging	• Review regional guidelines for the management of malnutrition in line with the new national guidelines once developed.	When developed	Community Dieticians
Positive Aging	• Continue the South East QPS Falls Cross Care Group Initiative	Ongoing	All Heads of Service
Regional Flu	• Promote and increase the uptake of the Flu Vaccine amongst residents in our Long-term Care facilities and HSE staff	Flu Season	All HOS
Positive Sexual Health	• Disseminate the Good Practice poster from the South East Positive Sexual Health Seminar held in Nov 2018	Q2	HWB
Positive Sexual Health	• Support implementation of evidenced informed sexual health	On-going	HWB HP&I Social

	training programmes		Inclusion
Positive Sexual Health	• Work in partnership with HSE colleagues, statutory and voluntary bodies to support local/regional sexual health	On-going	HWB HP&I Social Inclusion
Positive Sexual Health	• Implement process to ensure that all staff are aware of the available free sexual health resources and training opportunities (Condom distribution service, Health promotion material, HSE & HSE funded training) and encourage uptake	Q4	HWB HP&I Social Inclusion
Partnership Working	• Continue to work in partnership with the 5 LCDC's and 5 CYPSC in the South East	Ongoing	HoHW HP&I
Emergency Planning	• Finalise the South East Community Healthcare emergency plan	Q1	HoHWB
	• Continue to support Local Authorities in the development of community resilience across the South East	Ongoing	HoHWB
	• Participate in the feasibility study to develop resilience desks in the South East	Q1	HoHWB
Immunisation	• Continue to promote and support the uptake of childhood vaccinations within the South East	Ongoing	HoHWB Primary Care
Screening Programmes	• Continue to identify and work with the National Cancer Control Programme to target the promotion of the uptake of screening services in areas which are low within the South East	Ongoing	HoHWB Primary care
Staff health and Wellbeing	• Continue to support the enhancement of Staff health and wellbeing through the development of Healthy Ireland in the workplace group	Ongoing	HWB
Staff health and Wellbeing	• Continue to support staff health and wellbeing initiatives including mindfulness and yoga within the workplace	Ongoing	HWB
Staff health and Wellbeing	• Continue to support COOK It for staff across the South East	Ongoing	HWB
Staff health and Wellbeing	• Support the Reclaim Your Lunch Campaign for staff	Ongoing	Heads of Service
Staff health and	• Support the provision of *'Resilience*	Q4	HP&I/HR

Wellbeing	*in the Workplace*' workshops		
Staff health and Wellbeing	• Support the piloting of Work Positive Tool in South East Community Healthcare	Q1- Q4	HoHWB HR, all HOS
Staff health and Wellbeing	• Continue to support healthy eating and active living for staff such as Steps to Health and Love Life Love Walking	Ongoing	HoHWB
Staff health & Wellbeing	• Continue to progress a culture of person centeredness in South East Community Healthcare	Ongoing	HWB
Staff health & Wellbeing	• Continue to roll out the Smarter Travel pilot initiative in Kilkenny	Ongoing	HWB

Section 4 Primary Care Services

Services Provided

In 2019, Primary Care will provide clear leadership and deliver on our statutory commitments and work to progress and implement, as appropriate, the key priorities and actions as set out in the National Service Plan for 2019.

The core objective of Primary Care services in the South East is to achieve a more balanced health service by ensuring that the vast majority of service users and service users 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 service users' needs;
- 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), community network services, community schemes and social inclusion. Reference to Primary Care throughout this plan includes reference to all of these services. The Primary Care Team is the starting point for service delivery, consisting of general practice, community nursing, physiotherapy, occupational therapy and speech and language therapy, serving a population of approximately 7,000 to 10,000 people. Community network services include audiology, ophthalmology, dietetics, podiatry, psychology and oral health services. Other Primary Care services include GP out of hours, diagnostic services and community intervention teams (CITs) and children supported at home by way of paediatric home care packages.

Enhanced Primary Care is a key element of the overall Health Reform programme to ensure a sustainable health service. In 2019, South East Community Healthcare will continue to enhance core Primary Care services and develop innovative initiatives to respond to the presenting needs of its population. We will respond to key initiatives planned under Sláintecare to further develop services in the region with the overall aim of improving health outcomes of the population in the South East. Acknowledging the direct impact that poverty and social exclusion have on the health and wellbeing of our population, a key aspect of service development will be the focused provision of social inclusion services to improve health outcomes for those who are most vulnerable in our community. The Role of Social Inclusion Services is:

- To improve access to mainstream and targeted health services for people from disadvantaged groups;

- To reduce inequalities in health;
- We also aim to enhance the participation of socially excluded groups and communities in health services.

Issues and Opportunities

Demographic changes including an increased birth rate and ageing population are leading to greater numbers of patients presenting to Primary Care services in the South East and a change in the profile of care needs in our population. In particular, there is a notable increase in demand for services for age related chronic conditions. The demand for GP services, community nursing services and therapy services is at an all-time high. The changing socio-demographic profile in the South East in recent years has also led to increasing demand for Social Inclusion services; particularly substance misuse services, homelessness services and services to refugees, which are often beyond funded levels.

Infrastructural challenges

It is internationally recognised that the strategic repositioning of Primary Care at the core of health service provision is critical to meet the escalating demand on health services and ensure appropriate care provision for the changing profile of care needs presenting as a result of population ageing and its associated increase in chronic condition prevalence. Accessible, comprehensive, continuous, and co-ordinated Primary Care is central to better serving the needs of our population.

Deficits in ICT, in particular digital information systems, continue to pose a significant challenge to coordinated, integrated Primary Care service delivery in the South East. The absence of ICT solutions to service user management and related clinical time lost will continue to impact on service efficiency in 2019.

Resource Constraints

While striving to provide the highest quality of Primary Care service provision, a key challenge for 2019 will be the capacity to maintain existing levels of service in a number of key areas against the backdrop of increasing demand and system and resource constraints.

Overall reductions in funded levels of primary care activity inevitably have implications on provision of community demand-led schemes, although this can be partially mitigated on the assumption that certain developments will have implementation time delays.

The ongoing control of pay and staff numbers will impact on performance in 2019. In particular, accessing waiting times for occupational therapy, ophthalmology, audiology, dietetics, podiatry, psychology will present challenges.

Maintaining complex paediatric home Care packages to funded levels in the context of increasing demand and earlier discharge from acute services will be a particular challenge.

Enhanced Care Opportunities

Development of Primary Care Centres continues to enhance the operation of PCTs and network services in the South East and the planned role out of an agreed, modernised contract for the provision of General Practice services will enable a more structured approach to chronic condition management with potential to improve care outcomes for a significant proportion of our population. GP access to diagnostic (ultrasound) services remains a key capacity deficit in supporting the decisive healthcare policy shift to Primary Care. The phased roll out of community diagnostics has commenced in certain geographic areas of greatest need in the South East with further roll out planned, increasing potential for efficiencies in Primary Care in 2019.

Priorities 2019

- Improve quality, safety, access and responsiveness of Primary Care services and implement learning sites in South East Community Healthcare in line with *SláinteCare*.
- Improve access for Primary Care Therapy services with a focus on addressing patients waiting over 52 weeks.
- Improving GP access to diagnostics will be aided by the provision of community diagnostic provision in Primary Care locations in 2019.
- Continue to build on success of Community Intervention Teams (CITs) by providing treatment for in excess of 6,468 referrals across Carlow/Kilkenny, South Tipperary and Waterford. Strengthen the focus on hospital admission avoidance and early discharge from acute hospital settings.
- Deliver Healthy Ireland actions as appropriate to Primary Care.
- Further develop effective care pathways between acute and Primary Care services with a focus on integrating care for chronic conditions.
- Progress the implementation of the national Healthy Childhood and Nurture programmes and provide packages of care for children discharged from hospital with complex medical conditions to funded levels.
- Improve access to mainstream and targeted health services for people from disadvantaged groups and reduce inequalities in health and enhance the participation of socially excluded groups and communities in health services.
- Termination of Pregnancy - Develop termination of pregnancy services in line with the vision of *SláinteCare* to ensure access in community settings through Primary Care providers.

- Antimicrobial Resistance and Infection Prevention and Control - Improve the management of antimicrobial resistance and infection prevention and control in our services within our community.
- Ensure treatment is offered to patients with hepatitis C in line with the National Hepatitis C Treatment Programme goal of eliminating hepatitis C by 2026.
- The development and implementation of a Primary Care Patient Management System to facilitate referrals between primary care teams and networks, and specialist and acute care, improve communication and support integrated patient care is a key priority.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
Community Intervention Teams (CITs)	Continue to build on the success of the Community Intervention Teams (CIT's) in South East Community Healthcare • Strengthen the focus on admission avoidance and early supported discharge through the CIT Governance Group • Develop appropriate care pathways accounting for clinical need in the local care context • Treating over 6,500 referrals across the CHO in 2019 • Support hospitals in increasing the proportion of service users who are taught to self-administer compounded IV antibiotics SOPAT	Ongoing Q3 Q4	Primary Care Development Officers
Community Diagnostics	Deliver GP access to Community Diagnostics • Expand GP access to ultrasound in Our Lady's Health Campus, Cashel and to x-ray in Carlow/Kilkenny and Cashel • Strengthen the referral pathway to the new GP access to ultrasound facility in Carlow	Ongoing	Primary Care Development Officers
Physiotherapy	Deliver high quality Physiotherapy Services, responsive to clinical need of the population. • Deliver evidence based physiotherapy programmes across South East Community Healthcare including: - 8 Chronic Low Back Pain group education sessions in Carlow/Kilkenny. - a 6 week Multiple Sclerosis fatigue management education programme in South Tipperary	Ongoing Q1- Q4	Physiotherapy Managers

	and 2 'Getting the Balance Right' groups in Cashel - 6 Parkinson's Disease Aerobic and Balance Training sessions in Cashel - 6 Stroke Aerobic and Balance training Sessions in Cashel - bone health education programmes in Wexford - roll out back care programme in Wexford Town Sector - roll out knee and shoulder group rehab session to CHN locations in New Ross, Enniscorthy and Gorey • Continued development of Knee Class with University Hospital Waterford. • Review and update the balance and falls programme in Carlow/Kilkenny in collaboration with St. Luke's Hospital and Older Person's services • Implement Frailty Assessment in 6 Primary Care Teams in Carlow and South Kilkenny • Implement the Integrated Care Programme for Older People (ICPOP) in South Tipperary and commence and review physiotherapy direct referral to the Waterford Integrated Programme for Older People (WICOP) "falls and blackout" clinic. • Audit compliance of South East Community Healthcare Primary Care musculoskeletal assessment • Review feasibility of extending physiotherapy led orthotic clinics to paediatric clients with non complex needs in Wexford and commence process of improved management of paediatric service users transitioning to adult primary care service in relation to ongoing orthotic needs and monitoring in Waterford	Q2- Q3 Q3 Q2 – Q4 Q1 – Q2 Q2 Q2	
Primary Care Psychology	Deliver high quality Psychology services, responsive to identified clinical need of the population. • Optimise the contribution to service delivery of Assistant Psychologists through continuing to facilitate the agreed education and training programme across	Ongoing	Psychology Managers

	South East Community Healthcare • Implement the Stepped Care Model in Carlow/Kilkenny and South Tipperary and pilot clinics with Assistant Psychologists for children on the waiting list with non-complex needs in South Tipperary/Wexford and Waterford in line with the Stepped Care Model • Develop assessment and intervention pathways in South Tipperary and develop consultation, assessment and intervention pathways in Carlow/Kilkenny • Roll out workshops and group based services to meet the needs of children and families on the waiting list in Carlow, Kilkenny, Wexford and Waterford • In collaboration with Social Care deliver 2 behaviour management group workshops for parents in South Tipperary • Implement and evaluate the Solihull Approach Parenting Programme in Carlow/Kilkenny • Roll out a community-based bibliotherapy initiative, in collaboration with local libraries in Carlow/Kilkenny • Support promotion of 'Psychological Well-Being in Adolescence' by delivering an Exam Stress workshop in secondary schools in Carlow/Kilkenny • Establish consultation with service users regarding service development in Carlow/Kilkenny and implement on-going evaluation of the service in Carlow/Kilkenny • Facilitate training placements for psychologists on recognised university programmes Wexford/Waterford • Roll-out individual supervision of psychologists as a quality initiative in Wexford/Waterford • Development of a suite of policies, procedures, protocols & guidelines (PPPG) for Psychology Department Wexford/Waterford		

Speech and Language	Deliver high quality Speech and Language Therapy services in line with the National Model • Implement the National Primary Care Speech and Language Therapy Model of Care in South East Community Healthcare • Deliver SLT Programmes across South East Community Healthcare: o New Concept Development (vocabulary) groups for young children o Hanen 'Talkability' Parent Training Programmes, in South Tipperary, Waterford and Wexford. o 'Tipp Tiny Talkers' Parent Advice Sessions o Development Language Disorder awareness training with teachers in South Tipperary - Lamh/Baby Lamh in Wexford and Waterford - Run dysphagia information sessions for families, nursing and care staff in Wexford and Waterford • In collaboration with South Tipperary General Hospital and Social Care, implement new Dysphagia Standard Induction Protocol for new staff • Implement Parent Advice Pathways in Carlow/Kilkenny as piloted in 2018 • Develop and trial a paediatric speech fluency pathway and a speech sound pathway in Carlow/Kilkenny • Develop a FEDS pilot program with Occupational Therapy and dietetics to be held on a quarterly basis to address the needs of Primary Care Service Users and review content of FEDS awareness training sessions for nursing and care staff in line with satisfaction survey results in Carlow/Kilkenny • Progress parent training and coaching programs for: - children (0-6 years) with language delay referred through the Primary Care Service in Waterford and	Ongoing Q2- Q4 Q1- Q4 Q1- Q4 Q1- Q4 Q3- Q4 Q1 Q4	SLT Managers

	Wexford - children (5-18 years) with social communication delay and/or disorder referred through the Primary Care Service Waterford and Wexford • Deliver SLT training sessions for PHNs, library information sessions and targeted teacher training in Waterford and Wexford • Deliver evidence based pilot intervention groups for children with suspected Developmental Language Disorder (DLD) • Implement Narrative Skills group for older children with language disorder (1 x 5 week programme) • Implement Group Therapy Plan in Primary Care for children with a variety of speech deficits • Develop information programmes for families with acquired and progressive communication disorders and information sessions for clients and their families with acquired and progressive swallowing difficulties (dysphagia) • Re-Launch of Aphasia Café in Waterford	Q1 – Q4 Q4 Q4 Q4 Q3- Q4 Q4	
Occupational Therapy	Deliver high quality Occupational Therapy Services, responsive to identified population need. • Roll out adult outpatient clinics in all networks and provide dedicated 'long waiters' clinics to address the needs of the population in more timely manner and sustain reduction in waiting lists • Expand the fatigue management group programme for clients with cardiac and neurological conditions (Multiple Sclerosis, Motor Neuron Disease and arthritic conditions) • Implement Frailty Assessment in Primary Care Teams for over 75's in Carlow/Kilkenny and support the integrated pathway for Frailty in collaboration with Wexford General Hospital • Support the Integrated Care Programme for Older Persons (ICPOP) by providing a timely service to enable Older Persons to	Ongoing Q1 – Q4 Q1 – Q4 Q1 – Q4 Q1 – Q4	Occupational Therapist Managers

	live well in Carlow/Kilkenny and South Tipperary and the roll out of two Well Elderly Groups in Waterford • Review of service audits and ongoing follow up on agreed actions by OT staff Wexford	Q1- Q4	
Oral Health	Deliver high quality Oral Health Services, responsive to identified population need • Support the implementation of targeted screening for areas that do not have access for 11-13 year olds to ensure national equity within available resources • Provide treatment for 11-13 year old children in prioritising public dental health i.e. fissure sealants within available resources • Support the implementation of the Clinical Governance Framework for oral health services, within a timeframe agreed for completion of infection control standards • National Dental Computerised Patient Recording System SOEL Health – Implementation and continued training of staff in South East Community Healthcare • Continuation of Lift the Lip programme in partnership with Public Health Nurses in Waterford and Wexford • Shared Learning – The ongoing and expanding programme of clinical audit will continue through 2019.	Ongoing Q2 Q1– Q3 Q1- Q4 Q1- Q4 Q1- Q4 Q1- Q4	Principal Dental Surgeons
Orthodontic Department	Deliver high quality Orthodontic Department Services that respond to identified population need. • Reduce waiting times for orthodontic assessment with equity across South East Community Healthcare • Reduce the proportion of grade 4 and 5 service users on the treatment waiting list	Ongoing Q4 Q4	Consultant Orthodontist
Ophthalmology	Deliver high quality Ophthalmology Services that respond to identified need • Further roll out of the recommendations of the Primary Care Eye Services Review Group in Wexford • Training of staff in use of recently acquired Occular Computer Tomography (OCT) machine for treatment of patients	Ongoing Q4 Q2	Ophthalmic Manager

	with age related macular degeneration vascular pathology • Establishment of satellite eye clinic with University Hospital Waterford • Continuation of Eye Nurse training module for PHNs • Continue eye health promotion by Wexford Ophthalmologist and including a focus on smoking cessation with adult patients	Q2 Q3 Q3	
Chronic Disease	Deliver high quality chronic condition care in South East Community Healthcare by implementing nationally agreed Models of Care, responding to the identified need of the population. • Participate as an initial site for rollout of Making Every Contact Count, working in collaboration with Health and Wellbeing to support actions in relation to tobacco, alcohol, healthy eating, active living and positive ageing and wellbeing • Support the implementation of the Diabetes National Clinical Programme by: - Delivering 20 dietetic-led structured patient education (SPE) programmes across the CHO - Continue to expand the number of GP practices participating in the Diabetes Integrated Care Programme in Carlow/Kilkenny to 16 and 17 practices in South Tipperary - Delivering diabetes education to health care professionals within South Tipperary - Collaborate with St. Luke's Hospital Kilkenny to continue to develop integrated care pathways - Follow the delivery of the Model of Care for the Diabetic Foot according to the revised document due to be launched in 2019 - Continue to develop podiatry support to the travelling community and manage foot health problems relating to chronic conditions such as Diabetes as part of the multidisciplinary team - Further development of Primary Care	Ongoing Q1 – Q4 Q1 – Q4	Primary Care Development Officers and Integrated Care Clinicians

	Paediatric Diabetic Clinics - Develop, support and work collaboratively with GP practices, Public Health Nursing, UHW and other health professionals by providing education on foot health needs of service users with Diabetes and those with active foot disease as required in Waterford - Provide education to health professions in relation to diabetes/chronic diseases and the impact on foot health and further develop relationships with health professionals working directly with those with additional issues, the homeless, refugees, asylum seeker and travellers and Roma communities to improve foot health related outcomes for those most vulnerable • Support the implementation of the National Clinical Programme for Heart Failure - Recruit new GP practices in Carlow/Kilkenny area in accessing the Heart Failure Integrated Care Programme and utilising the Heart Failure Virtual Consultation/heart failure outreach clinic for specialist advice - Establish a Heart Failure Peer Support group for Carlow/Kilkenny - Continue data collection on Heart Failure population looking at prevalence and service gaps in diagnosis and treatments - Create links to collaborate with Community Intervention Team (C.I.T) and community palliative care - Enhance dietician services in Waterford/Wexford • Support the implementation of the National Respiratory Clinical Programme - Plan the relocation of chronic disease management clinics from the acute setting to the new primary care centres - Increase provision of respiratory education sessions across South	Q1 – Q4 Q1 – Q4	

	East Community Healthcare - Expand provision of targeted pulmonary rehabilitation programmes - Enhance respiratory physiotherapy service in Wexford - Increase GP participation in the Respiratory Integrated care programme in Carlow/Kilkenny - Initiate musculoskeletal (MSK) clinics in Waterford City Primary Care		

Community Dietetics	Deliver a high quality Dietetic Service, responding to identified population needs.
	• Implement recommendations from dietetic model of service delivery
	• Support completion of Scientific Recommendations for Healthy Eating Guidelines for Toddlers and Preschoolers
	• Healthy Eating & Active Living Programme:
	  • Support the development of National Community Nutrition/Cooking Programme content and development of model of delivery in South East Community Healthcare
	  • Deliver train the trainer sessions on new National Community Nutrition/Cooking Programme for teachers, health professionals and community workers
	  • Support tutors trained to deliver programmes across South East Community Healthcare
	• In partnership with Waterford and Carlow Institutes of Technology, support Waterford Men's Sheds to roll out Community Nutrition/Cooking Programme – deliver one training session to tutors and provide ongoing support to tutors in delivering programmes
	• Deliver eight group weight management programmes across PCTs in Clonmel, Tipperary Town, Waterford, Dungarvan, Enniscorthy, Gorey, Carlow and Kilkenny
	• Deliver dietetic assessment and therapy
		Ongoing
		Q1 – Q4
		Q1
		Q2- Q4
		Q2
		Q2- Q4
		Q1- Q4
			Dietician Manager

	services in PCTs across South East Community Healthcare • Progress development of dietetic service in Waterford and South Tipperary in liaison with the Integrated Care Programme for Older People, to deliver pilot dietetics workshop as part of Occupational Therapy-led Well Elderly Clinic in Waterford • Deliver training to PCT members on community funded schemes service improvement – nutrition support in Clonmel, Tipperary Town, Waterford, Dungarvan, Enniscorthy, Gorey, Carlow and Kilkenny, for quality improvement	Q2- Q4 Q1- Q4	Occupational therapy manager and Dietician manager
Public Health Nursing	Deliver high quality Public Health Nursing Service, responsive to identified population need. • Develop an integrated care team approach to discharge planning in collaboration with St. Luke's Hospital Kilkenny (SLHK). • Deliver 17 nurse led Leg Ulcer Assessment and Wound Management clinics per week across South East Community Healthcare • Deliver 13 weekly Enuresis and Encopresis clinic and increase service provision for nocturnal enuresis; toilet training; constipation and soiling for all children in the Waterford area • Rollout of ASQ (Ages and Stages Questionnaire) for all 21-24 month developmental assessments as part of the National Healthy Childhood Programme in South East Community Healthcare • Rollout of National Healthy Childhood Programme – blended learning for all Public Health Nurses (PHN) in South East Community Healthcare • Rollout of Traveller Health Chronic Conditions Programme Pack, in response to the recommendations in the Traveller Health Unit South East Strategic Plan 2015-2020. • Lift the Lip initiative to continue in 2019 in partnership with Oral Health Waterford	Ongoing Q1- Q4 Q1- Q4 Q1- Q4 Q1- Q4 Q1- Q4 Q1- Q4 Q4	Director of Nursing

	and Wexford • Snuggle Stories to continue in 2019 in Waterford • Wexford PHN Department to deliver Books 4 Babies Universal Programme to all children who are receiving their 7-9 month developmental assessment. • Ongoing updating and management of the dementia project www.understandingtogether.ie. Work will commence with the Health & Wellbeing division to develop Bunclody as a Dementia Friendly Town. • Development of Older Persons Chart in South East Community Healthcare • Further develop integrated discharged planning with Wexford General incorporating Patient Flow and Discharge Planning • Provide face to face training to support seven online modules on infant nutrition/child health (blended learning), in Carlow/Kilkenny, South Tipperary, Waterford and Wexford	Q1-Q4 Q2-Q4 Q3 Q3 Q1- Q4 Q1- Q4	
Nurture and Healthy Childhood Programmes	Develop implementation plan to progress the delivery of the Healthy Childhood and Nurture programmes in South East Community Healthcare: • Provision of Public Health Nursing Services that are responsive to local child health needs • Increase childhood immunisation and associated boosters and promote the update of HPV etc in older age children • Ensure that 98% of newborn babies are visited by a PHN within 72 hours of discharge from maternity services • Ensure 95% of children have had child development screening on time or before reaching 10 months of age • In line with the HSE Breastfeeding Action Plan 2016-2021 increase the percentage of babies breastfed at the first PHN visit and at 3 month PHN developmental check to meet KPI's in South East	Ongoing Q1 –Q4 Q1- Q4 Q1- Q4 Q1- Q4 Q1- Q2	DPHNs and HoS PC

	Community Healthcare • Development of weaning Clinics with initial input from Dieticians Waterford • Roll out of the BOAT Tool to all breastfeeding mothers in Wexford • Introduction of Lactation Consultant Clinics	 Q1- Q4 Q1- Q4 Q1- Q4	
Quality and Patient Safety	Improving the management of antimicrobial resistance and infection prevention and control in our services and within our community.	Ongoing	HoS PC
Primary Care	Progress the implementation of Services in Primary Care • Update the current Primary Care Team – Clinical Team Meeting (CTM) guidelines • Improvement of Information for Service Users in Primary Care • Develop Patient Information Leaflets for both new Primary Care Centres – Waterford City and Dungarvan illustrating the services provided on site in both centres • Provide information in both primary care centres on Your Service Your Say and the Complaints Procedure to members of the public in all awaiting areas • Cervical Screen Support – Liaison Officer for South East Community Healthcare will continue to provide support to the 221 + Group. Providing access for these patients in a timely manner on the following: - Support will be provided under the packages of supports to assist both psychology and financially as required - The Liaison Officer will continue to link in with the other cervical screening support offices via weekly teleconference and attend meetings as required until a formal process is put in place nationally • Deliver awareness raising sessions on	Ongoing Q1 – Q3 Q1 – Q3 Q1 – Q4 Q2 – Q3 Q1 – Q4	Primary Care Lead

	Elder Abuse to attendees at Day Care Centres in the Carrick on Suir, Slieveardagh and Cashel areas	Q1- Q4	
Primary Care Social Work	• In collaboration with Primary Care Psychology, continue to progress the Infant Mental Health Study Group in order to promote early intervention work with relevant client group	Ongoing	Primary Care Social Workers
Clinical Nurse Specialists Mental Health	• Primary Care Clinical Nurse Specialists in Mental Health will provide early intervention, assessment and as appropriate psychotherapeutic interventions for service users between 16 and 65 yrs • Strengthen the relationship between Primary and Secondary Care through monthly Secondary Care Mental Health Service multi-disciplinary team meetings • Deliver a monthly (demand-led) Primary Care mental well-being information clinic in Clonmel • In collaboration with the senior medical social worker maternity services, South Tipperary General Hospital, develop and deliver 2 Mellow Bumps offers support to pregnant women with additional social care needs	Ongoing	CNS MH Lead

Social Inclusion Services

Services Provided

HSE Social inclusion works across a range of statutory services in partnership with the community and voluntary sectors, to improve access to health services for disadvantaged groups. Improving health outcomes for the most vulnerable in society is the key focus of Social Inclusion services. This includes provision of targeted interventions for people from marginalised groups who experience health inequalities, have difficulties accessing services and present with multiple, complex health and support needs. Various studies have illustrated that homeless, Traveller and migrant populations face greater health care needs than the general population. Primary Care has a major role to play in relation to the health of people with addictions or those who are homeless, and in delivering on commitments such as the Refugee Relocation Programme. Vulnerable people and communities include Travellers and Roma, asylum seekers, refugees and lesbian, gay, bisexual, transgender and intersex service users.

Issues and Opportunities

Ensuring that we improve service user outcomes for those most vulnerable in society is a key priority. Capacity to meet government commitments as set out in the Refugee Protection Programme / EU Relocation and Resettlement Programme, *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016, Housing First National Implementation Plan 2018-2021* and the National Drug Strategy: *Reducing Harm, Supporting Recovery – A health led response to drug and alcohol use in Ireland 2017-2025* will support more effective social inclusion.

Priorities and Actions

- Improve health outcomes for the most vulnerable in society including those with addiction issues, the homeless, refugees, asylum seekers and Traveller and Roma communities.
- Implement the health actions, identified as a priority in 2019, in *Rebuilding Ireland Action Plan for Housing and Homelessness, 2016 and Housing First National Implementation Plan, 2018 - 2021*, in order to provide the most appropriate Primary Care and specialist addiction / mental health services for homeless people.
- Improve access to Primary Care services for refugees in emergency reception and orientation centres / resettlement phase, with a focus on chronic disease management, increasing access to mental health supports and addressing the oral health needs of children and adults.
- Provide targeted interventions as a means of reducing health inequalities in the Traveller and Roma communities, with a focus on improving mental health and reducing the rate of suicide.

- Implement agreed HSE assigned actions under the *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021* within existing resources.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
Refugees, Asylum Seekers & Roma	• Further development of South East Regional Intercultural Health structures for both funded agencies and the Intercultural Peer Health Workers network.	Q1 – Q4	Roma Health Lead & ICH Refugee & Asylum Seeker Lead
	• Support the development of annual health work plans for target groups that are aligned to relevant health policies, frameworks and standards as well as the new National Intercultural Health Strategy and the Strategic Plans for Intercultural Health in the South East	Q1 – Q2	Roma Health Lead & ICH Refugee & Asylum Seeker Lead
	• Through the Regional structures provide interactive workshops on relevant health policies, strategies, frameworks and standards and their relevance to planning health work and measuring health outcomes.	Q1- Q4	Roma Health Lead & ICH Refugee & Asylum Seeker Lead
	• Develop the South East Community Healthcare Intercultural Heath Training as an online tool for staff in partnership with national Social Inclusion Office.	Q1- Q4	Roma Health Lead & ICH Refugee & Asylum Seeker Lead
	• Launch South East Community Healthcare Vulnerable Migrant Health Research.	Q3 – Q4	CH Refugee Asylum Seeker Lead
	• Further develop the Primary Healthcare In-reach Project in Clonea EROC. Support dental and Mental Health Services to develop service and supports aligned to the Project Model.	Q1- Q4	CH Refugee Asylum Seeker Lead
	• Promote the health and wellbeing of the Roma Population through the Roma Health Advocacy Projects in Wexford and Waterford and their work in implementing relevant actions in the National Traveller and Roma Inclusion Strategy (2017-2021)	Q1- Q4	Roma Health Lead
	• Provide targeted interventions as a means of reducing health inequalities in the Roma Communities	Q1- Q4	Roma Health Lead
LGBTI Health	• Further develop the regional LGBTI Health Steering Group.	Q1 – Q4	LGBTI Health Lead

	• Support TENI to develop the Adult Module of Gender Identity Skills Training (GIST) and deliver this and GIST in South East Community Healthcare for health service staff. • Deliver LGB Awareness Training for staff. • Develop the South East Community Healthcare LGB Awareness Training • Model as a Train the Trainer Initiative. • Support LGB Ireland to develop an online version of LGB Awareness training.	Q1- Q4 Q1 – Q4 Q1 - Q4 Q3 – Q4 Q1 - Q4	LGBTI Health Lead LGBTI Health Lead& HP&I Sexual Health Lead
Improve health outcomes for the most vulnerable in society including those with addiction issues, the homeless, refugees, asylum seekers and Traveller and Roma communities			
Addiction Services			
Enhance Governance Structures in Substance Misuse Services	• Employment of Assistant Director of Nursing	Q3 - Q4	General Manager
	• Expand availability of naloxone training and distribution within the substance Misuse Service	Q1 - Q4	Substance Misuse Lead
	• Continue to work with Primary Care and Mental Health services to ensure the needs of service users are being supported in terms of improved access and uptake of mainstream services	Q1- Q4	Substance Misuse Lead
National Drugs Rehabilitation Framework	• To continue a programme of training and information provision to staff within the HSE and partner agencies, to support quality service provision across the continuum of care, to include SAOR training, naloxone/overdose prevention training. • To ensure high quality services are provided equitably across the region, which are needs-led, timely and accessible, and which support individual rehabilitation • Expand mental health services for people with substance misuse problems presenting in acute hospitals through the provision of a mental health nurse to provide interventions in hospital and referral pathways to community based addiction services as necessary • To provide effective harm reduction services which are accessible throughout South East Community Healthcare region including needle and syringe programmes, blood borne virus screening, vaccination; as per national Hepatitis C Screening Guidelines 2016 and also in line with the national Hepatitis C treatment programme. • Implementation of the actions from the "Reducing Harm, Supporting Recovery (2017-	Q1 - Q4 Q1 - Q4 Q3 - Q4 Q1 - Q4 Q1 - Q4	Substance Misuse Lead Substance Misuse Lead Substance Misuse Lead Substance Misuse Lead Substance Misuse Lead

	2025). • Continue to provide and improve access to treatment and rehabilitation services for adults and children, with a particular focus on under 18's within the Substance Misuse Service. • Improve health outcomes for pregnant women engaged in substance misuse and their babies through enhanced interagency working between Substance Misuse and Maternity Service through the provision of a community based Alcohol & Drug Liaison Midwife.	Q1 - Q4 Q3 - Q4	Substance Misuse Lead Substance Misuse Lead
	• Continue to implement the *National Standards for Safer Better Health Care* in Primary Care Substance Misuse Services. • Improve service user outcomes and experience of Substance Misuse Services through Service User Involvement. • Strengthen the capacity of Services to address complex needs of service users by establishing a Care and Case Management group with key stakeholders in each county.	Q1 - Q4 Q1 - Q4 Q1 - Q4	Substance Misuse Lead Substance Misuse Lead Substance Misuse Lead / Regional Rehab Coordinator/ Homeless Lead
	• Continue the Partnership with the Recovery College through the development of co-production training.	Q1 - Q4	Substance Misuse Lead
Provide Traveller Cultural Awareness / competency to Health Service Executive frontline staff	Based on the recommendations of the WIT Evaluation the Traveller Health Coordinator will: • Enhance the training provided by the Traveller Health Projects • Organise the upskilling of existing Traveller Health Workers and train new Travellers as trainers in the new programme • Facilitate the updating of the training manual to a durable, user friendly toolkit to support the roll out of the Traveller Cultural Awareness Trainers when rolling out training. • Work with primary care and other HSE departments to develop targets for Traveller Cultural Competency training. • Work with partners and HSE land to produce an e-learning module	Q1 - Q4	Traveller Health Coordinator
Traveller Health Projects meet their KPI Targets	Traveller Health Coordinator will • ensure that the Section 39 Traveller Health funded organisations will meet their KPI targets and report in a timely manner • Will support the Section 39 Traveller Health funded organisations to do so.	Q1 - Q4	Traveller Health Coordinator
To develop TMHLN Role in line with best practice	• The TMHLN will implement the recommendation of the formal evaluation of the post by Trinity	Q1 - Q4	Traveller Health

guidelines available	College to inform best practice and positive outcomes for Traveller Mental Health going forward through the Traveller Mental Health Carlow Kilkenny Subgroup of the THU. • The TMHLN will attend relevant training and implement learning and recommendations to support positive mental health where possible. • Continue to work with Primary Care and Mental Health services to ensure the needs of travellers are being supported in terms of improved access and uptake of mainstream services		Coordinator
Ensure Connecting for life training is rolled out for Traveller Health Project Staff	• Support the initiatives developed within the South East Community Healthcare Traveller Health Unit on Mental Health and Wellbeing (incorporating 'little Things') and collaborate with the Regional Suicide Office and the new Mental Health Service Co-ordinator for Traveller	Q1 - Q4	RLNTH
To feed into the learning on the ground from this area on Traveller Health at a local/regional/National level	• The RLNTH will continue to link with other agencies and underpin her work to regional/national strategies	Q1 - Q4	RLNTH
Promote the uptake of Vaccinations at every life stage including the Childhood vaccinations, HPV and seasonal flu vaccinations in the Southeast	• The Traveller Health Liaison Nurse will support the Traveller Health Projects to continue to outreach to Traveller to raise Travellers awareness of the childhood vaccination programme through using the information cards from the Travellers Health Chronic Conditions Programme.	Q1 - Q4	RLNTH
Coordination of Chronic Conditions Advisory	• The Traveller Health Liaison Nurse will continue to coordinate the Chronic Conditions Advisory Group to oversee advice and support the roll out of the Chronic Conditions Sub Group.	Q1 - Q4	RLNTH
Homeless Rebuilding Ireland Strategy: Continued implementation of the HSE Actions	• To continue to work in partnership with the Homeless Action Teams in each local authority area within South East Community Healthcare to ensure they continue to increase their capacity to meet the complex and diverse health and social care needs of homeless people, particularity those with mental health and addiction problems. • In partnership with the Lead Local Authority, to support and facilitate the re-configuration of current Housing First projects into a Regional Housing First Model ensuring standardisation of practice in line with the fidelity of Housing First Principals. This includes the development	Q1 - Q4 Q1- Q4	Regional Rehab Coordinator/ Homeless Lead Regional Rehab Coordinator/ Homeless Lead

	of a Housing First project in South Tipperary and increase capacity throughout the region through Service Reform Funding. • As part of the Service Reform Funding for Housing First, HSE-Social Inclusion to employ a Senior Psychologist to provide psychological support and interventions as part of the wrap around service provision for the complexities of Housing First service users. • Continue to work with Primary Care and Mental Health services to ensure the needs of homeless persons are being supported in terms of improved access and uptake of mainstream services	Q1 – Q4 Q1 – Q4	Regional Rehab Coordinator/ Homeless Lead Regional Rehab Coordinator/ Homeless Lead
Homeless	National Drugs Strategy – continue implementation of the actions related to Care & Case Management • Further implementation of the National Drugs Rehabilitation Framework across Social Inclusion in the South East Community Healthcare. • Continue to work with and support HSE Care Groups in provision of wrap around health and social care services for homeless persons through integrated shared care plans as per the National Protocols.	Q1 – Q4	Regional Rehab Coordinator/ Homeless Lead
Homeless	Quality Standards • Continue engaging with key stakeholders regarding the implementation of the National Quality Standards for Homeless Services aligned with the National Standards for Safer Better Healthcare • To provide support to Homeless Services in building their capacities to implement quality improvement plans and monitor same.	Q1 – Q4	Regional Rehab Coordinator/ Homeless Lead
Homeless	• To continue to support increased capacity, confidence and competency of staff within homeless/ substance misuse services in managing challenging behaviour of complex cases accessing services. • Provide MAPA Train the Trainer event for homeless/substance misuse services to ensure each service has a dedicate MAPA Trainer & Champion to support staff skill in managing potential aggression/violence in the workplace. • Trained trainers will then commence training homeless/substance misuse services staff in MAPA and support implementation of MAPA within these services	Q1 – Q4 Q1 Q2 - Q4	Regional Rehab Coordinator/ Homeless Lead Regional Rehab Coordinator/ Homeless & Substance Misuse Leads
Homeless	• Improve the health outcome for people experiencing or at risk of homelessness	Q1 – Q4	Reg Rehab Coordinator/ Homeless Lead

Section 5 Mental Health Services

Population

The South East Community Healthcare Mental Health Services encompasses the counties of Carlow, Kilkenny, South Tipperary, Waterford and Wexford**.** South East Community Healthcare is the 2nd most deprived region in the country (behind the border region); Wexford County and Waterford City are respectively remanded 3rd and 6th in the most deprived areas of the country based on the Pobal HP Relative Deprivation Score, 2011 (Wexford Socio-Economic Baseline Report, April 2015).

Services Provided

In general terms, specialist mental health services are provided to serve a particular group within the population, based on their stage of life. Child and Adolescent Mental Health services (CAMHs) serve young people aged up to 18 years, general adult services for those aged 18 to 64 years and psychiatry of later life provides services for those over 65 years. Services are provided in a number of different settings including; Community based service user clinics, acute day services (day hospitals), the individual's own home, inpatient facilities. Within South East Community Healthcare, there are 6 approved centres including two acute adult units, and four Psychiatry of Later Life units. Community Mental Health Services are delivered by a range of community mental health multi-disciplinary teams using a sectorised population based approach in line with *Vision for Change*. Services for people with enduring mental health illness are provided at day centres, community day services and a range of low, medium and high support community residences.

South East Community Healthcare Mental Health Services as the statutory service provider will continue to work with our voluntary partners to ensure the meaningful involvement of the service user in the design and delivery of our mental health service. This will be supported by our on-going engagement with a variety of stakeholders including the ongoing development of area forums to ensure that service users have a voice. In addition, the ongoing development of *Advanced Recovery Ireland* and the *Recovery College* will continue.

In 2019, the role of Area Lead for Mental Health Engagement, in addition to the Peer Support Worker initiative, will continue to build on the representation of the views of Service Users, family members and carers towards the ongoing development of a recovery based mental health service.

The Senior Management Team in South East Community Healthcare Mental Health Services remains committed to the continued delivery of a high quality service user focused safe

service. The focus for 2019 will be on the ongoing review of overall Service Delivery, the Model of Care and the provision of a safe and effective service in accordance with service priorities and key performance indicators.

Issues and Opportunities

Opportunities

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

- Strengthen the Mental Health Service governance arrangements to ensure effective use of human, financial and infrastructural resources.
- Continue with the implementation structures for local action plans within South East Community Healthcare Mental Health Services aligned to *National Connecting for Life* implementation framework with the objective of reducing suicide rates in our community.
- The development of a recovery focused community mental health service will continue to be an ongoing priority for South East Community Healthcare Mental Health Services in 2019. This work will be supported by the implementation of the *Service Reform Fund Project/Advancing Recovery Initiatives/Recovery College*. In addition to this South East Community Healthcare Mental Health Services will work with the Department of Housing, Planning and Local Government regarding the implementation of the "National Housing Strategy" as it relates to the South East Community Healthcare residential services.
- South East Community Healthcare Mental Health Service will continue with the implementation of the '*Best Practice Guidance Framework'* to ensure better governance in planning and measuring improvements, identifying and addressing gaps. This work commenced in the approved centres i.e. Department of Psychiatry – Waterford and Kilkenny in 2018 and this framework will roll out to other service areas in 2019.
- The development of local Area Forums commenced in 2018 and this work will continue in 2019 to ensure that service users have a voice in the delivery and design of the Mental Health Services
- Training for staff relating to the Mental Health Commission judgement support framework will continue in 2019. Training will also commence for staff, further to the requirements of the new Mental Health Commission Centralised Information System.
- The appointment of an additional Psychiatry of Old Age Consultant Psychiatrist in Carlow/Kilkenny will assist in addressing the challenge presented by the

demographic pressures which has seen an increase in the number of referrals to Psychiatry of Old Age services.

Issues

Challenges for 2019 in Mental Health Services include:

- The capacity to recruit and retain a highly-skilled and qualified workforce, particularly in high-demand health and social care professional/medical and nursing clinical staff.
- Lack of Acute Inpatient beds commensurate to meet the clinical needs of the population and the resultant difficulties created by over occupancy .
- Access to appropriate inpatient CAMHs beds/units and out of hours service.
- Continued demographic pressures and increasing demand for services will be over and above the capacities of the planned staffing/resource levels thus impacting on the ability to deliver services.
- Lack of single health care record (HCR) across South East Community Healthcare Mental Health Services continues to pose risk to the optimum management of service user's care. Ways of overcoming this challenge are being explored in advance of the optimum solution of provision of E-record.
- Lack of specialised workforce due to pending retirements in the nursing division which impacts on our ability to comply with statutory requirements due to shortage of nursing.
- Lack of capital infrastructure to support the delivery to a Mental Health Service across the area.
- Delayed discharges from Acute Units for service users who require ongoing management in specialist supported accommodation.
- Financial Risks – in order to maintain existing levels of service, net expenditure in Mental Health Services is projected to increase, with the main cost drivers:
    - Medical and Nursing Agency due to ongoing recruitment difficulties ;
    - Revenue and Capital costs arising from legislation/regulation to achieve compliance ;
    - Delayed Discharges from Acute Units for Service Users who require ongoing management in specialist supported accommodation ;
    - Demographic increase with corresponding increased service pressures.

Priorities 2019

The vision for South East Community Healthcare Mental Health Services is to support service users to achieve their optimal mental health through the following key priorities:

- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.
- Design integrated, evidence based and recovery focussed Mental Health Services.

- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.
- Enable the provision of mental health services by highly trained and engaged staff
- To review the infrastructure requirements of South East Community Healthcare Mental Health Service and plan for the future.

South East Community Healthcare Mental Health Service works with primary care, acute hospitals, services for older people, services for people with disabilities, and with a wide range of non-health sector partners.

South East Community Healthcare Mental Health Services

Carlow/Kilkenny & South Tipperary Mental Health Services			
Service	**No. Provided**	**Service**	**No. Provided**
No. of Adult Acute In Service user Beds	44	Psychiatry of Old Age	
General Adult		**POA Acute Inpatient Beds**	
No. of non acute beds for adults	60	Number of Day Hospitals	0
No. of Day Hospitals	4	No. of Community Mental Health Teams	2
No. of Community Mental Health Teams	8	Number of Day Centres	0
Number of Day Centres	9	**Specialist Mental Health Services**	
No. of High Support Community Residences	12	No. of Rehab and Recovery Teams	2
No. of Low and Medium support Community Residences	12 (11 low and 1 medium)	No. of Liaison Psychiatry Teams	1
CAMHS		No. of MHID Teams	0
Number of Inpatient Beds	0	Other	2 Crisis Houses
No. of Day Hospitals	0		
No. of Community Mental Health Teams	4		

Waterford/Wexford Mental Health Services			
Service	**No. Provided**	**Service**	**No. Provided**
No. of Adult Acute In Service user Beds	44	**Psychiatry of Old Age**	
General Adult		POA Acute Inpatient Beds	
No. of non acute beds for adults	55	Number of Day Hospitals	0
No. of Day Hospitals	5	No. of Community Mental Health Teams	3
No. of Community Mental Health Teams	5	Number of Day Centres	0
Number of Day Centres	3	**Specialist Mental Health Services**	
No. of High Support Community Residences	9	No. of Rehab and Recovery Teams	2

No. of Low and Medium support Community Residences	16 (1 low and 4 medium)	No. of Liaison Psychiatry Teams	0
CAMHS		No. of MHID Teams	0
Number of In Service user Beds	0	Other	1 Respite house
No. of Day Hospitals	0		
No. of Community Mental Health Teams	3		

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
Promoting Mental Health of the population with other services and agencies including reducing the loss of life by suicide	• Continue with the implementation structures for local Action Plans within South East Community Healthcare Mental Health Services aligned to national Connecting For Life (CFL) implementation frameworks	Q1 – Q4	General Manager/Regional Suicide Support Officer
	• Within available resources, The Regional Suicide Office will deliver a range of training interventions from basic suicide awareness to skills based programmes. Options available include: esuicideTALK, safeTALK, Applied Suicide Intervention Skills Training (ASIST), Understanding Self Harm and Skills Training on Risk Assessment for Self Injury (STORM). The Resource Office for Suicide Prevention (ROSP) will work with the National Office for Suicide Prevention on the roll out of the new National Training Strategy.	Q1 – Q4	General Manager/Regional Suicide Support Officer
	• Mental Health will continue to work with Primary Care regarding the development and implementation of the assistant psychology service	Q1 – Q4	Service Manager/Psychology Manager
	• South East Community Healthcare will work with the National Youth Mental Health Taskforce to implement agreed actions.	Q4	Head of Service/General Manager/ECD
Design Integrated Evidence Based and Recovery Focused Mental Health Services	• Continuation of training of clinicians in Behavioural Family Therapy (BFT) and the development of the standard operational procedure to support the work of the Behavioural Family Therapist.	Q2	Head of Service/General Manager/ECD

	• Continue to roll out the Qbtech ADHD computerised assessment tool in accordance with available resources	Q3	Service Manager
	• The development of a recovery focused community mental health service will be an ongoing priority for South East Community Healthcare Mental Health Services in 2019. This work will be supported by the implementation of the Service Reform Fund Project/Initiatives and will inform the completion of the National Recovery Framework. The Advancing Recovery Initiatives will continue to roll out in 2019 and following significant progress in 2018, the further development of the Recovery College will continue to be a priority in relation to the development of a recovery focus.	Q1 – Q4	General Manager
	• South East Community Healthcare will continue to work with Cork Kerry Community Healthcare to operationalise the HSE Standard Operating Procedure to optimise timely access to in-patient beds	Q1 – Q4	Head of Service/ECD
	• Continue the development of the adult mental health team with the appointment of a MHID consultant.	Q1 –Q4	Head of Service/Executive Clinical Director
Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements	• Expand out of hours responses for General Adult MHS through the development of the 7/7 day hospitals and appointment of agreed new staffing in Waterford	Q1 –Q4	Area Director of Nursing/Executive Clinical Director /Service Manager
	• Develop a brief and subsequent business case to support the development of an inpatient unit and a day hospital for CAMHS in South East Community Healthcare	Q1 –Q4	Head of Service/ Executive Clinical Director.
	• Implement the HSE Incident Management Framework 2018	Q1 – Q4	Head of Service/ECD/General Manager/Area Directors of Nursing
	• Continue the implementation of the HSE “Best Practice Guidance Framework” for Mental Health Services including	Q1 – Q4	Head of Service/ ECD/General Manager/Area

	development and delivery of training and reporting for Quality Surveillance		Directors of Nursing
	• Support compliance through monitoring of services, in collaboration with the Mental health Commission, in order to achieve statutory requirements	Q1 – Q4	Executive Clinical Director/Clinical Directors/Head of Service/General Manager/Area Directors of Nursing
	• Continue the development of the Community Mental Health Team's CAMHs, General Adult and Psychiatry of Later Life Services in accordance with approved new development money/resources	Q1 – Q4	Executive Clinical Director/Head of Service/General Manager
Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services	• Improve mental health engagement in the design and delivery of services through the further development of forums in South East Community Healthcare, in conjunction with service users, family members and carers.	Q1-Q4	General Manager/Service Managers/MH Engagement Lead
	• Develop a standardised approach to inclusion of service users in care planning and promoting enhanced self-management for service users in line with the recommendations of the National Recovery Framework.	Q1 – Q4	General Manager/Service Managers/MH Engagement Lead
	• Develop a plan of implementation of the mental health engagement standards to ensure a consistent national model of engagement by service users and carers.	Q1- Q4	General Manager/Service Managers/MH Engagement Lead
	• Implement the recently developed CAMHs advocacy model	Q1 – Q4	General Manager/Service Managers
	• Continue Roll out for all Staff Recovery Principle Training	Q1 – Q4	General Manager
	• Inclusion of Service User representative on Quality and Patient Safety Committee within the approved centres	Q1 – Q4	General Manager/Service Manager/MH Engagement Lead
Enable the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure	• Develop and implement Workforce Plans for all Disciplines	Q1 – Q4	Head of Service /Executive Clinical Director/General Manager
	• Progress implementation of the	Q1 – Q4	Area Directors of Nursing/Service

	postgraduate nursing programme, develop postgraduate non nursing programmes and appoint agreed increased undergraduate nursing numbers to address critical staffing challenges in mental Health nursing		Managers
	• Commence the design and implementation of additional quality and performance indicators in mental health service aligned to increased/new services	Q1 – Q4	Head Of Service/Executive Clinical Director/General Manager
	• Participate in the development of a HSE-wide programme for the implementation of the assisted decision-making legislation in mental health services delivery	Q1 – Q4	Head Of Service/Executive Clinical Director/General Manager
	• Roll out the agreed minor capital fund to enhance facilities and infrastructure. Progress plans for major capital development requirement e.g. Replacement of Acute Psychiatric Units	Q1 – Q4	Head Of Service/Executive Clinical Director/General Manager
	• Standardise and move towards more equitable resource allocation models based on a revised costing model for mental health in line with a Vision for Change and continue the mental health multi-year approach to budgeting	Q1 – Q4	Head Of Service/Executive Clinical Director/General Manager
	• Through the performance management process, seek to ensure that current resources are utilised in an effective manner which maximises outcomes for service users.	Q1 – Q4	Head Of Service/Executive Clinical Director/General Manager

Section 6 Disability Services

Population

The rate of disability has risen in Ireland over the last number of years with 13.5% of the population now reporting at least one disability since 2011 (Census 2016). The rate of reported disability has risen to 5.9% for those aged 0 to 14 years and 9.3% for those aged 15 to 24 years. This has led to an increased demand across all services for children and young people. In addition the rate of those aged 65 years and over with a reported disability has risen to 9.5% since 2011. People are living longer and adults with intellectual disability have age-related illnesses and conditions. In addition, more people with a disability have more complex needs. Of people reporting with a disability, the number of people aged 35 years and over with moderate, severe and profound intellectual disability has increased from 28.5% in 1974 to 49.3% in 2016 (NIDD, 2016).

This change in demographics, increased life expectancy and changing needs for those with both a physical and sensory disability, and an intellectual disability has led to a significant increase in the need for disability services across all settings. This includes day supports, residential and respite services, personal assistant and home support services.

Services Provided

In South East Community Healthcare, there are HSE residential units in South Tipperary, Wexford and Kilkenny, however, the majority of residential places and all respite and day services are provided through voluntary and private providers. There are three Section 38 Agencies and over thirty-five Section 39 Residential Agencies. We will work in partnership with our voluntary and private providers to provide agreed levels of service to this service user group.

In 2019, South East Community Healthcare will continue to deliver social care supports and services to people with a disability across the spectrum of day, respite, residential and home support provision. The financial resources made available to South East Community Healthcare will present as a challenge owing to financial pressures across Disability Services.

Issues and Opportunities

Disability services have a significant programme of reform underway which is informing a new model of service provision. *Transforming Lives* sets out the recommendations of the

Value for Money and Policy Review of Disability Services in Ireland, 2012. It provides the framework for the implementation of:

- Time to Move on from Congregated Settings – A Strategy for Community Inclusion in respect of residential centres to support the transition of people from institutional settings to community-based living.
- New Directions Programme is improving day services and supports and aims to meet the needs of school leavers and those graduating from rehabilitative training.

Implementation of these programmes will enable South East Community Healthcare to maximise the use of existing resources and develop sustainable models of service provision with positive outcomes for service users, delivering best value for money and moving towards an inclusive model of community-based services and supports.

A significant underlying challenge relates to the unmet need for residential and respite care, which exists in our services. There is a significant demand for unplanned residential places to respond to the most urgent cases on our waiting list.

At the same time, Disability Services are working to comply with the national standards for residential care as regulated by HIQA and to maintain registration for all our residential centres.

Priorities and Actions

Value Improvement Actions

- Achieve the required value improvement actions through monitoring of service for Older Persons Services.

Safeguarding

- Implement the revised HSE Safeguarding Policy when approved.

Disability Act 2005 – including assessment of need

- Reduce the waiting times for assessment of need under the *Disability Act 2005* through the provision of 15 additional posts.
- Once agreed nationally implement a Standard Operation Procedure for the Assessment of Need.
- Conclude the recruitment of 11 Children's Disability Network Posts and implement Progressing Disability Services for Children and Young People.

Residential Services

- Progress implementation of *Time to Move on from Congregated Settings* with a further 15 people with disabilities supported to transition to homes in the community in 2019. This is subject to funding.
- Provide an additional 9 new emergency residential placements.
- Continue with the ongoing review of residential placements in line with service improvement.

Respite Services

- Continue to provide 461 people with disabilities, quarterly, with centre-based respite and alternative innovative models of day respite.
    - 13,722 amount of bed nights delivered to 461 amount of people.
    - 1,405 day only respite sessions accessed by people with a disability.

Day Services and Supports

- Progress implementation of *New Directions* national policy on the provision of day services for people with disabilities and strengthen the quality of day service provision throughout South East Community Healthcare.
- Continue to provide adult day services and supports to adults with physical and sensory disabilities, intellectual disability and autism in South East Community Healthcare.
- Provide additional day service supports for approximately 264 school leavers (SL) and those graduating from rehabilitative training (RT) programmes in 2019 that require a HSE funded day service.
- Continue to implement the interim standards for *New Directions* through the EASI (Evaluation, Action and Service Improvement) process commenced in 2018.

PA and Home Support

- Continue to deliver home support and PA hours to almost 2,000 people with disabilities.
- Provide 564,883 home support and PA hours to alleviate the demand for emergency residential places. This is above the 2018 target due to under reporting in 2018.

Autism Spectrum Disorder Review

- Implement the recommendations arising from the 'Review of the Health Services for Individuals with Autism Spectrum Disorder', carried out in 2017.

Personal Budgets Demonstration Project

- Roll-out a demonstrator project in South East Community Healthcare in line with the recommendations "Towards personalised budgets for people with a disability in Ireland".

Joint HSE and Tusla Interagency Protocol

- Continue to support operational roll out of the Joint HSE and Tusla Interagency Protocol, including internal supporting protocols for CAMHS, Primary Care and Disability through the dedicated joint workshop sessions.

Children's Ombudsman (ref: Molly's Case)

- Fully implement recommendations arising from the Children's Ombudsman report on the Molly's Case.

Service Arrangements

- Review Part 1 and Part 2 of the service arrangements for section 38 and section 39 service providers and private providers taking account of the recommendations from the independent review group set up to examine the role of voluntary organisations in publicly funded health services.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
South East Community Healthcare Social Care will promote health and well-being within care-groups	• In particular, social care will meet the MECC targets and will facilitate staff to complete the relevant training.	Q4	GM Disability Services
Provision of and access to day services	• Provide additional day service supports for approximately 264 school leavers (SL) and those graduating from rehabilitative training (RT) programmes in 2019 that require a HSE funded day service • Provide updated data regarding all individuals requiring a HSE funded day service in 2019 • Advise on the accommodation requirements for new day service entrants 2019. • Coordinate the completion of profile assessments within South East	Q3 Q2 Q2 Q2	Disability Managers and GM for Disability

	Community Healthcare of all identified SL's & RT exits requiring HSE funded adult day services in 2019 and submit same to Disability Social Care. • Identify existing capacity within current services that can accommodate new SL's & RT exits without additional funding. • When notified of the resource being allocated to meet the needs of school leavers, prepare and deliver appropriate service responses with the provider during April and May 2019 so that families can be communicated with before the end of May 2019. • Participate in the validation of the school leaver funding process for 2019. • Update and Maintain current Occupational Guidance Service Database	Q2 Q2 Q3 Q3	
Assisted Decision Making	• Promote independence of persons with a disability through: • Working in partnership with advocacy services thus ensuring the voice of a person with a disability is heard • Provision of briefing sessions on Assisted Decision Making (Capacity) Act 2015 • Prepare an action plan for implementation of Assisted Decision Making (Capacity) legislation.	Q4	HOS-SC and GM – Disability Services
Home Support	• Ensure that the Home Support Service is fit for purpose so that it reduces the need for high cost emergency residential care. • Deliver 564,883 home support and PA hours to children and adults • Within existing resources the level and type of support provided is outcome based for the profile of the individual • Target area for 2019 is to review the home support services provided to children aged 8-16 with a high functioning autism across the South East Community Healthcare. • Development of Framework of operating enhanced support as an alternative to residential placements	End of Q3 End of Q4 Q2-Q3 End of Q4	General Manager Disability Services Disability Service Managers GM and Disability Service Managers

Home Sharing Project Funded by SRF	• Development of a home sharing model of support across the South East Community Healthcare in collaboration with the section 38/39 agencies as per plan agreed with Service Reform fund.	End of Q4	General Manager Disability Services
Management of Residential Care including Emergency Places	• In 2019 through the Residential Supports Executive Management Committee and the profile information of the DSMAT continue to discuss and agree economies of scale in managing emergency placements. • Implement new actions as outlined in the revised Residential Support Executive Management framework Version 2 and Guidance for Community Support including New Directions (2019) • Establish the Resource Allocation Group as outlined in the revised Residential Framework (2019)	Q1-Q4 Q1 Q1	GM Disability Services GM Disability Services HOS
Emergency and Support Placements	• Provide new emergency and support placements as per the agreed governance process and within the funding allocated.	Q1-Q4	HOS Social Care
Respite Services	• Participate on the National Taskforce Oversight Respite Committee • Carry out a review of respite provision in South East Community Healthcare area to inform the development of standard operating protocol for the provision of respite across the South East Community Healthcare area to ensure quality and equity of service and reducing the reliance on emergency residential placements • Establish South East Respite allocation Committee • Agree within the HSE and section 38/39 providers and implement a Standard Operating Protocol for the provision of Respite services • Continue with the provision of respite services across the South East Community Healthcare.	Q1-Q4 Q2 – Q4 Q2 – Q4 Q2 – Q4 Q1 – Q4	Disability GM
Implement Quality & Safety Initiatives	• Continue with representation at the Social Care Quality and Safety Committee.	Q1-Q4	HOS Social Care and GM Disability Services

	• Review and analyse incidents (numbers, types, trends) • Ensure the recommendations of any serious investigations are implemented and learning shared to include SRE's/serious incident investigations • Review and analyse complaints (numbers, types, trends) • Provide an active integrated Disabilities Risk Register.		
Finalise a Framework for Disability Services	• Finalise a Framework for Disability Services to improve the operational delivery of social care services for people with a disability. • The above framework will be finalised with a focus on ensuring that recommendations emanating from varying reports are implemented in full.	Q4	
Enhance Governance for Service Arrangements	• Further develop enhanced monitoring of service arrangements to ensure that resources are appropriately recorded and deployed • Service Level Arrangements to be finalised and signed as appropriate by 28th February 2019	Q1-Q4 Q1	GM Disability Services GM Disability Services
	• Grant Aid Agreements to be finalised and signed as appropriate by 28th February 2019	Q1	GM Disability Services
Implement Revised Safe Guarding and Protection Policy	• Implement the new safeguarding and protection policy • 848 staff will be trained in 2019 in the Safeguarding Policy • Safeguarding Committee will deliver on the priority of spreading general awareness of safeguarding throughout the wider community	Q1-Q4 Q1-Q4 Q1-Q4	PSW PSW PSW
Recruitment and Retention of Staff within Disability Service to deliver the service in a safe and appropriate manner	• Continue to work with HR to expedite recruitment of all existing vacancies within disability Service. • Continue to reduce the over reliance on agency • Ensure that staff working within the disability service understand and have clarity on their role, have the time and the resources to carry out their roles	Q2 Q1-Q4	HOS Social Care and HR , GM Disability

New Directions School Leavers/RT Process	• New Funding identified of €224,000 to be utilised to support the implementation of New Directions and the School Leaver process in South East Community Healthcare. This funding is specifically allocated to address the following:- - Referrals and Guidance - Profiling and Placement - Data Collection and Validation. - Structure and initiatives to advance Interim Standards for New Directions • Develop and Implement a South East Community Healthcare plan in agreement with National Office including the necessary recruitment business case to ensure that *New Directions* develops in a standardised and consistent manner.	Q1 Q1 – Q4	HOS General Manager Disability Service
Progress implementation of the national policy for reform of the disability services Transforming Lives – the programme for implementing the Value for Money and Policy Review of Disability Services in Ireland, 2012.	• Review and reconfigure available staff to work on the development of the NASS and identify any gaps that may impede databases being populated appropriately such as to provide up to date and accurate information for planning purposes. • Continue to participate in the joint housing steering groups with local authorities	Q2 Q1-Q4	Disability GM Disability GM
Implement time to move on from congregated settings	• Support the transfer of 15 service users from institutional settings to community based settings. This is subject to funding. • Work with providers to develop clear, time appropriate action plans to identify how service providers will transition residents from congregated settings into the community in line with policy.	Q4 Q4	Disability Managers and General Manger for Disability Services
HIQA Compliance	• Social Care in the South East will strengthen working relations with disability providers and will support providers to rank and prioritise quality improvement initiatives within services as such demands arise and having regard to available resources. The outcome of such ranking will ensure that highest risk areas are addressed	Q3	General Manager – Disability Services

	as a matter of priority.		
Progress Disability Services for Children and Young People (0-18s) Programme	• Support the implementation of National Policy on Access to Services for Children with a Disability or Developmental Delay in collaboration with Primary Care with children's disability network teams as they are established. • Further progress towards reconfiguration of 13 (0-18) Service Teams and support the implementation of the programme. To achieve this, South East Community Healthcare is establishing a Cross Sectoral Children's Services Forum to deliver an integrated approach to reconfiguration. • Implement the National Access Policy in collaboration with primary care to ensure one clear pathway of access for all children with a disability into their local services. • Set up a joint Primary Care/Social Care implementation plan for the NAP • Evaluate the effectiveness of the national policy on access to services for children with a disability or developmental delay in collaboration with primary care • Implement the new procedures in relation to the Assessment of Need under the Disability Act	Q1-Q4 Q1-Q4 Q1-Q4	Head of Social Care GM Disability Services & Project Manager Head of Social Care & Head of Primary Care
Centralisation of the Assessment of Need Office	• Commence reassignment of the backlog stage 1 applications (143) across the South East Community Healthcare • Scope the project plan for a centralised application system within the South East Community Healthcare subject to available resources	End of Q4 Q1-Q4	GM Disability Services/Project Manager, Progressing Disability Services
Continuation of implementation of Joint TUSLA-HSE protocol	• Continue with implementation of the joint protocol as agreed with TUSLA. Embed the terms of reference and develop procedures and pathways for engagement and escalation • As part of implementing the joint protocol, South East Community Healthcare social care will undertake an assessment of need of children with a moderate to high level of disability currently within foster care within the South East	Q1-Q4	Head of Social Care & General Manager Disability Services

Participate in roll out of the Neuro-Rehabilitation Strategy	• Identify resource available within South East Community Healthcare that can be aligned to the implementation of the Neuro-Rehabilitation Strategy	Q4	Disability GM

Section 7 Older Persons & Palliative Care Services

Population

The biggest increase in Ireland's population is within the older age groups. The 2016 Census showed a significant increase of 18.3% in the population of those aged 65 years and older in South East Community Healthcare compared to 2011. Over the same time period the number of people aged 85 and over in South East Community Healthcare increased by 14%.

This increase in the older persons' population is welcome; it is an acknowledgment of improved health and greater longevity. It brings opportunities as well as presenting the challenge to ensure that health and social care services can be delivered at adequate levels, in an integrated manner to meet or support the needs of older people. It is also important to acknowledge the role of carers in the context of their support to older people.

The table illustrates the population of those aged 65 years and older in South East Community Healthcare.

Area	Aged 65-69	Aged 70-74	Aged 75-79	Aged 80-84	Aged 85+	Total
Carlow Kilkenny	6218	4798	3333	2340	2028	18717
South Tipperary	4727	3640	2636	1881	1544	14428
Waterford	6285	4990	3540	2464	1893	19172
Wexford	7265	5791	4151	2693	2085	21985
TOTAL	24,495	19,219	13,660	9,378	7,550	74,302

Services Provided

Older persons' services are delivered through a community-based approach, supporting older people to live in their own homes and communities and, when needed, high quality residential care will also be provided. A wide range of services are provided including home supports, short stay and long stay residential care, transitional care and day care, through HSE direct provision and through voluntary and private providers.

Issues and Opportunities

South East Community Healthcare Older Persons Services will continue to further develop and implement the Integrated Care Programmes for Older Persons (ICPOP) in Carlow/Kilkenny, South Tipperary, Waterford and Wexford in 2019.

In conjunction with HSE Estates, South East Community Healthcare Older Persons Services will continue to engage in the advancement of the Community Nursing Units Public Private Partnership Project.

Priorities and Actions

Value Improvement Actions

- Achieve the required value improvement actions through monitoring of service for Older Persons Services.

Home Support

- The single Funding Model of Home Support commenced in 2018 will be further embedded in 2019 with a particular focus on strengthening governance, management capability, quality, and reliability.
- The revised 2018 contract for HSE Home Support staff will be implemented in 2019.
- Provide home support of 1.95 million hours to an average of 6115 people, at any one time.

NHSS/Residential and HSE Public Units

- Continue to provide Nursing Home Support Scheme funding to 520 long term public and private residential places in 2019.
- Continue to implement a national target wait time of no greater than 4 weeks for funding approval.
- Support the reconfiguration of local NHSS offices in line with the national plan to develop 4 regional offices.
- Continue the implementation of the 2016-2021 Capital Plan for public residential units with colleagues in HSE Estates and the National PPP Office to ensure maximum regulatory compliance of our built environment by the critical regulatory date of 2021.
- The use of Transitional Care Funding as an enabler to hospital discharge for those who are indicated as requiring long stay care and those requiring post acute convalescence on their journey home will be maximised with an envisaged benefit of up to 42 people per week.

Dementia

- Continue to support people with dementia through the memory technology resource rooms in 7 sites in the South East.

- Provide 2 day training to home support staff in dementia specifically to HSCAs working with people with dementia.
- Implement the learnings and outcomes from the HSE / Genio-supported dementia specific initiatives which focus on personalised and flexible approaches to care.

Day Care and Community Supports

- Continue to provide HSE day care services to support older people.
- Continue to provide a broad range of other community and voluntary services including, meals on wheels, social satellite services, befriending services etc. to older people in South East Community Healthcare through section 39 grants.
- Continue to progress development of a telephone contact befriending service.
- Provide support to existing supported care home services to maintain existing services in accordance with HIQA regulations using additional funding allocated at the end of 2018.

Safeguarding

- Implement the revised HSE Safeguarding Policy when approved.

Integrated Care Programme for Older Persons

- Continue to support and develop the Integrated Care Programmes for Older Persons (ICPOP) in Carlow/Kilkenny, South Tipperary, Waterford and Wexford in 2019.
- Develop and foster working relationships with the Age Friendly Alliances in each county.

Falls Prevention and Bone Health

- Progress the AFFINITY and Bone Health programme across all services in developing an integrated approach to the prevention and management of falls.
- Falls working group established on preventing falls in residential units.

Single Assessment Tool

- Implementation of the Single Assessment Tool (SAT) will continue as a focus with recognised implementation challenges.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
Home Support	• Deliver 1.95 million home support hours in South East Community Healthcare.	Q1-Q4	GM Older Persons Services
	• Deliver Home Support to 6115 older people in South East Community Healthcare at any time to enable them to return to, or remain at home for as long as appropriate to their needs.	Q1-Q4	GM Older Persons Services
	• Continue to provide dedicated home supports and transitional care to acute hospitals as part of the winter measures. (40 additional packages for South East Community Healthcare as part of the Winter Plan)	Q1-Q4	GM Older Persons Services
	• Commence audit reviews of home support services to ensure standardised practices are in place.	Q1-Q4	GM Older Persons Services
	• Implement the single funding model for home support services and improve quality of service through review and audit	Q1-Q4	GM Older Persons Services
Nursing Homes Support Scheme	• Continue to support the Nursing Homes Support Scheme	Q1-Q4	GM Older Persons Services
	• Continue to implement a national target wait time of no greater than 4 weeks for funding approval	Q1-Q4	GM Older Persons Services
Residential Services	• Ensure effective implementation of recommendations arising from HIQA inspections in designated centres.	Q1-Q4	GM Older Persons Services
	• Continue implementation of Capital Plan for public residential units with colleagues in HSE Estates and the National PPP Office to ensure HIQA compliance	Q1- Q4	GM Older Persons Services
	• Aim for an occupancy target of 90% in short stay beds	End of Q4	GM Older Persons Services
Dementia	• Continue to communicate key messages of the Understand Together campaign	Q1-Q4	GM Older Persons Services
	• On-going delivery of Intensive Homecare Packages for People with Dementia	Q1-Q4	GM Older Persons Services

	• Continue a process for the design and delivery of personalised intensive homecare packages to people with dementia in: - Waterford - South Tipperary	Q1-Q4	GM Older Persons Services
	• Support ongoing education across the community and acute settings including workshops/online modules and educational awareness programmes	Q1–Q4	GM Older Persons Services
	• Continue to support memory clinics across South East Community Healthcare	Q1-Q4	GM Older Persons Services
	• Continue to support the Memory Technology Resource Rooms (MTRRs) in the 7 sites across South East Community Healthcare	Q1–Q4	GM Older Persons Services
	• Train 8 trainers to roll out 2 day training in dementia care specifically to HSCAs working with people with dementia.	Q1–Q4	GM Older Persons Services
	• Train 100 HSCAs working with people with dementia	Q1-Q4	GM Older Persons Services
Day Care and Community Supports	• Continue to provide HSE day care services to support older people.	Q1-Q4	GM Older Persons Services
	• Continue to provide a broad range of other community and voluntary services including, meals on wheels, social satellite services, befriending services etc. to older people in South East Community Healthcare through section 39 grants.	Q1-Q4	GM Older Persons Services
Integrated Care Programme for Older Persons (ICPOP)	• Continue to support and develop the four ICPOP programmes	Q1- Q4	GM Older Persons Services
Falls Prevention and Bone Health	• Continue to progress the actions of the Falls Working Group across HSE residential units in order to minimise and reduce falls	Q1-Q4	GM Older Persons Services
National Carers' Strategy 2012	• Continue to consult with the Older Persons Councils/Age Friendly County programme in the continued development of carer's supports.	Q1-Q4	GM Older Persons Services
Quality and Safety	• Conduct Quality & Safety walk arounds in each of the HSE Residential Units	Q1-Q4	GM Older Persons

			Services
	• Continue to support Residents Councils, Family Forums, Service User Panels.	Q1-Q4	GM Older Persons Services
	• Continue to review and analyse incidents (numbers, types, trends)	Q1-Q4	GM Older Persons Services
	• Ensure that the recommendations of any serious investigations are implemented and learning shared to include SRE's/serious incident investigations	Q1-Q4	GM Older Persons Services
	• Continue to review and analysis of complaints (numbers, types, trends)	Q1-Q4	GM Older Persons Services
	• Maintain an active Older Persons Services Risk Register	Q1-Q4	GM Older Persons Services
	• Older Persons Services Quality and Safety Committee will continue to ensure that recommendations from incident investigations, reviews, inspection reports and other sources of best practice are implemented and audited for effectiveness across the care group	Q1-Q4	GM Older Persons Services
	• Review the trends from the collation of HIQA Notification Forms submitted by HSE provided-services	Q1-Q4	GM Older Persons Services
Single Assessment Tool (SAT)	• Progress implementation of SAT for assessment of care needs for older people seeking access to community care and long stay residential care.	Q1-Q4	GM Older Persons Services
Service Arrangements	• Service Arrangements to be finalised and signed appropriate by 28th February 2019	Q2	GM Older Persons Services
	• Grant Aid Agreements to be finalised and signed as appropriate by 28th February 2019	Q2	GM Older Persons Services
Safeguarding	• Implement the new safeguarding and protection policy • 848 staff will be trained in 2019 in the Safeguarding Policy • Safeguarding Committee will deliver on the priority of spreading general awareness of safeguarding throughout the wider community	Q1-Q4 Q1-Q4 Q1-Q4	PSW PSW PSW

Palliative Care Services

Palliative Care Services Provided

The aim of palliative care is to enhance quality of life for patients suffering from life-limiting conditions and, wherever possible, to positively influence the course of illness with a focus on the prevention and relief of suffering by means of assessing and treating pain and other physical, psychosocial or spiritual problems. Palliative Care also extends support to families to help them cope with their family member's illness and their own experience of grief and loss.

Demand for palliative care services is growing as the population ages and rates of invasive cancers and other chronic life limiting conditions such as heart disease, respiratory conditions and dementia continue to rise. It is estimated that 50% of deaths from non-cancer conditions, such as heart disease, respiratory disease, cerebrovascular disease and dementia can benefit from palliative care support.

Palliative Care in Southeast Community Healthcare is currently provided by consultant led specialist teams, both acute and community, in each county of Waterford, Wexford, Carlow, Kilkenny and South Tipperary. These teams consist of Consultants in Palliative Medicine, Non Consultant Hospital Doctors, Clinical Nurse Specialists and Occupational Therapists. This specialist service aims to provide supports in a place of the service user's choice whenever clinically possible. At any one time approximately 400 Service Users access Community Specialist Palliative Care Services across the South East.

Issues and Opportunities

Commissioning of our new Regional Specialist Palliative Care Centre at University Hospital Waterford provides significant scope to drive a fully integrated approach to the delivery of Consultant Led Specialist Palliative Services across Acute/In-Service user/Community Nursing Units/Service users Homes. Clear clinical and operational governance arrangements across *Specialist Palliative Care Units* and existing *Community Specialist Palliative Care Nursing Services* are now required to optimise the palliative care services model in the South East. Implementation of Standards for *Safer Better HealthCare* within Community Specialist Palliative Care Services throughout the South East also provides opportunity for service improvement. While national policy indicates that all Palliative Care Service should be funded by the state, service provision in the South East continues to be challenged by complex service funding arrangements whereby statutory funding to Voluntary Hospice Movements currently stands at 35%.

Priorities

- Expand the provision of Consultant led specialist palliative care services in the South East in 2019 optimising an integrated service model approach.
- Commence the implementation of the National Clinical Programme for Palliative Care, *Model of Care*
- Continue the implementation of the *Palliative Care Services – Three Year Development Framework 2017-2019*.
- Continue to partner local voluntary organisations to improve access to quality care in the community.

Implementing Priorities in 2019

Priority	Priority Action	Timeline	Lead
Opening of Regional Inpatient Specialist Palliative Care Unit	• Complete commissioning of building by end of Q2 2019 • Develop Recruitment plan for Unit. • Waterford Community Specialist Palliative care team (SPCT) to commence operating from building • Phased opening of inpatient unit beds to commence in Q4 2019. • Develop and implement an agreement between South East Community Healthcare and University Hospital Waterford in relation to corporate and clinical governance of shared services for the unit.	Q2 Q2 Q3 Q4 Q1 – Q3	Primary Care General Manager Waterford/Wexford
Governance structure for Community Specialist Palliative Care Teams across South East Community Healthcare	• Engage with Hospice committees/ movements to integrate Clinical Nurse Specialist and Clinical Nurse Managers 3 into the regional Nursing governance structure for Specialist Palliative Care services	Q2 - 4	Primary Care Director of Nursing, General Manager Waterford/Wexford.
Development of Regional Palliative Care partnership forum between HSE and Hospice movements / committees	• Secure appropriate membership of forum to include Hospice Movements/ Committees/ Service User/ HSE to advise on the ethos and operations of the Specialist Palliative Care Service	Q3-Q4	Primary Care Director of Nursing, General Manager Waterford/Wexford
Implement Palliative Care Outcomes Collaboration (PCOC) documentation, assessment tools and data collection as the method to drive ongoing quality improvement.	• Commence implementation of PCOC by Waterford Specialist Palliative Care Team (SPCT) and assess suitability to implement PCOC for IPU	Q1- Q4	Primary Care Waterford PCOC steering committee

Commence streamlining of PPPGs and documentation across 4 Community Specialist Palliative Care Teams	• Develop and implement a Regional Medication Management Procedure • Standardise medication management documentation used in the home throughout SPC in South East Community Healthcare	Q2 - Q3	Primary Care Director of Nursing

Section 8 Workforce

Workforce

Workforce Position

Government policy on public service numbers and costs (pay and non-pay) is focused on ensuring that the health workforce operates within the approved pay budgets and WTE level. South East Community Healthcare (SECH) manages a WTE of 5,231wte (Statutory and Voluntary December 2018 figure – Source – Health Service Personnel Census).

South East Community Healthcare (SECH)	WTE December 2018
Overall	5,231
HSE (SECH)	4,171
Section 38s (Voluntary Agencies)	1,060

Health Services People Strategy 2019-2024

The health sector's workforce is at the core of the delivery of healthcare services working across and within all care settings in communities, hospitals and healthcare offices. Building on progress made to date; the health service will continue to nurture, support and develop a workforce that is caring, dedicated to excellence, welcomes change and innovation, embraces leadership and teamwork, fosters inclusiveness and diversity and maintains continuous professional development and learning. The People Strategy 2019-2024 has been developed in recognition of the vital role our workforce plays in delivering safer better healthcare. This strategy placed emphasis on Leadership, Talent Capability enabling people and culture change and a key tenet underpinning its implementation is the commitment to engage, develop, value and support the workforce and deliver the Sláintecare vision.

Recruiting and retaining motivated staff remains of paramount importance in the continued delivery of health services to an increasing and changing demographic population. The challenges in relation to the ongoing recruitment and retention of staff is even more significant in the context of the Health Reform Programme which will require significant

change management, organisation re-design and organisational development support in order to become a reality.

2019 Key Priorities for Human Resources:

- Subject to available resources South East Community Healthcare will continue developing the HR operating model by building on the work to date undertaken with PwC and the Heads of HR across the 9 CHOs with regard to national discussions on CHO implementation and the implementation of SláinteCare.
- A key priority for South East Community Healthcare is the implementation of the National Integrated Staff Records & Pay Programme (NiSRP) in South East Community Healthcare.
- Continue to support and contribute to the further development of staff engagement as a core organisational priority and as a foundation for improved performance. A series of workshops will be arranged with staff in Q2 on the Staff Survey 2018 to feedback on the results and to identify and explore actions with managers and staff to address the findings. Staff health and wellbeing will be a key focus in 2019 in progressing the engagement agenda.
- Work in collaboration with colleagues in Heath and Well Being and Health and Safety in ensuring that support and assistance is provided during the roll out of the pilot WorkPositiveCI survey in Q1 of 2019 with a view to commencing implementation of action plans in relation to Work Positive across all services in 2019.
- Work with Health Business Services (HBS) to attract, recruit and retain staff.
- Continued commitment to Public Service Stability Agreement 2018-2020 including support for the work of the Public Service Pay Commission and implementation of recommendations where relevant.
- Implementation of Consultant Contract 2008 Settlement Agreement and consultant contract compliance arrangements.
- On-going implementation of WRC nursing and midwifery recruitment and retention agreement and ED agreement.
- In conjunction with Learning, Education and Talent Development (LETD) develop and provide relevant training across all disciplines and grades within South East Community Healthcare.

- Implementation of *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning*.
- Implementation of the *Strategic Review of Medical Training and Career Structure* (MacCraith Report).

Pay and Staffing Strategy 2018 and Funded Workforce Plans

The 2019 Pay and Staffing Strategy is a continuation of the paybill strategy which has been in place for a number of years and is central to continued compliance with allocated WTE and expenditure budgets. 2019 will be extremely challenging given the WTE employment limits and budgetary situation. Pay expenditure, which is made up of direct employment costs, overtime and agency, will continue to be robustly monitored, managed and controlled to ensure compliance with allocated pay budgets and WTE employment limits.

A key objective in 2019 will be to focus on reducing and controlling pay costs, including agency and overtime, and implementation of cost containment plans. This is in addition to maximising the performance and productivity of the health workforce. An assessment of agency use to determine scope for its reduction will be undertaken in Q1 and Q2 across all Care Groups and plans will be agreed to address the findings.

- Operate strictly within allocated pay frameworks, while ensuring that services are maintained to the maximum extent and that the service priorities determined by Government are addressed.
- Comply strictly with public sector pay policy and public sector appointments.
- Continue to robustly manage Attendance Management in line with the provisions of the relevant HSE policies and procedures.

Leadership, Education, Talent and Development

In consultation with Leadership, Education, Talent and Development (LETD) South East Community Healthcare will continue to support staff development to ensure an appropriate qualified and developed workforce who can deliver our organisational goals whilst developing their talent and capability thus aiding staff retention. In consultation with LETD we will provide a leadership, education and development plan for South East Community

Healthcare to build capacity of staff in the South East to meet the organisational requirements. The LED priorities in respect of 2019 will be agreed with LETD and will in part be contingent on available funding.

Enhancing Nursing Services

Strategic leadership and workforce development is supported by education and training, safe clinical evidence-based practice, a consistent and standardised approach, avoidance of duplication of effort while supporting legal and regulatory requirements at all levels. Key priorities in 2019 include:

- Strengthen the capacity of nurses and teams to meet the healthcare and wellbeing needs of the population through collaboration on policy, regulatory, professional and education matters, leadership, professional development, educational sponsorship, workforce planning, role expansion, effective communication, informatics and professional support.
- Support and progress initiatives, including the roll-out of the Framework for Staffing and Skill Mix for Nursing (phase 1 and 2);
- Support nurses to participate in programmes to prepare for advanced practitioner roles.
- Support nurses in education programmes

Health and Social Care Professions

Health and Social Care Professions (HSCP) refer to 25 groups of professionals who provide services which impact on the health, wellbeing and quality of life of people. The HSCP workforce includes therapists, social workers, psychologists, orthoptists, audiologists and dieticians among others. The services in which they work include community and primary care, mental health, older persons', disability and residential services and acute hospitals. Key priorities in 2019 include:

- Support National HSCP Office to implement the priority actions outlined in the *HSCP Education and Development Strategy 2016-2019*, within South East Community Healthcare
- Support managers to strengthen and support evidence-based HSCP practice.

Workforce Planning

The DoH published a *National Strategic Framework for Health Workforce Planning – Working Together for Health* in 2017, providing an integrated, dynamic and multi-disciplinary approach to workforce planning at all levels of the health service. We will work with National HR on the implementation of the strategic framework as it applies to our CHO and to further the workforce planning goals in the revised People Strategy.

European Working Time Directive

South East Community Healthcare is committed to maintaining and progressing continued compliance with the requirements of the European Working Time Act for both non-consultant hospital doctors (NCHDs) and staff in the social care sector. Key indicators of performance agreed with the European Commission include a maximum 24 hour shift, maximum average 48 hour week; 30 minute breaks every six hours, 11 hour daily rest / equivalent compensatory rest and 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest. Performance in relation to the measures is monitored on a regular basis.

HR System / Human Resource Professional Services

A key priority for 2019 is the implementation of the National Integrated Staff Records and Pay Programme (NiSRP) within South East Community Healthcare.

- NiSRP will modernise the way South East Community Healthcare connects with staff, improving access for them to their staff record and pay details via online employee and manager self-service.
- The potential benefits of full implementation of NiSRP include
    - Single Staff Records technical system that will give full coverage of all South East Community Healthcare service staff related data.
    - Single payroll technical platform linked to the staff records system which will give full costs for staff internal and agency hour by hour leading to better workforce analysis and planning.
    - Full staff service history from a current date which will improve pension services into the future.

- A direct link between on line time returns and payroll will eliminate the amount of time spent checking and validating manual returns.
- Employee & Manager Self Service will make the staff records service more accessible and help ensure the information on file is more accurate. Staff will be able to check their record to ensure it is accurate and complete and arrange to have it changed if necessary.

National Workplace Investigations Unit

South East Community Healthcare will continue to work with the National Workplace Investigations Unit to improve the investigations process in our CHO and ensure that suitable nominees attend the training provided.

People's Needs Defining Change - Health Services Change Guide

People's Needs Defining Change is the policy framework and agreed approach to change signed off by HSE Leadership and the Joint Information and Consultation Forum representing the trade unions. It presents the overarching Change Framework that connects and enables a whole system approach to delivering change across the system and is a key foundation for delivering the people and culture change required to implement Sláintecare and Public Sector Reform. The Change Guide complements all of the other service, quality and culture change programmes that are currently making progress towards the delivery of person-centred care, underpinned by our values of Care, Compassion, Trust and Learning and can be applied at all levels to support managers and staff to mobilise and implement change. Building this capacity will enable and support staff to work with and embrace change as an enabler of better outcomes for service users, families, citizens and local communities. The guide is available on *www.hse.ie/changeguide*

Wellbeing and Engagement

South East Community Healthcare will continue to work with Health & Wellbeing, Occupational Health, EAP and Health & Safety in ensuring all staff can avail of the full range of support services. Appropriate case management will be supported which will assist in preventing illness

or injury at work. South East Community Healthcare will continue to build on initiatives commenced in the 2018 in relation to:

- Providing opportunities for staff and managers to build capacity and resilience at individual, team and organisational level
- Growing and develop leadership skills among all our staff, through coaching, personal development and training.
- Supporting the implementation of the findings from staff surveys and consultation workshops / events related to staff health & wellbeing
- Supporting and leading out as appropriate on behalf of South East Community Healthcare on recommendations from key pieces of work underway in HSE e.g. WorkPositiveCI, Cultural Survey and Staff Survey etc.
- Mapping, maintain and disseminate information in relation to services, supports and activities available to staff
- To work in partnership with our colleagues, locally and nationally in developing a sustainable supportive culture in our organisation.

Code of Conduct for Health and Social Service Providers

South East Community Healthcare will ensure adherence to Supporting a Culture of Safety, Quality and Kindness: A Code of Conduct for Health and Social Service Providers 2018. This will ensure the safety of those accessing services whilst supporting our staff in providing safe services.

Risks

There are staffing risks that may impact on the capacity of South East Community Healthcare to achieve the ambitions set out in this Plan. The constraints that will apply arising from the need to remain within WTE and affordability limits will put pressure on the capacity of the system to deliver safer health and social care services with the resources that are available.

The impact of the constrained recruitment environment over the last decade has resulted in an ageing workforce profile. This is likely to continue to be the reality for the immediate future and brings with it potential risks for staff given the complex and diverse operating environment.

Section 9 Finance & Value Improvement Programme

Summary

South East Community Healthcare was assigned a budget of **€474.62m in 2019** which is a €10.42m / 2.1% year on year budget reduction versus the 2018 closing budget of **€485.04m**. This budget is required to cover services to be delivered through the year including the impacts of -

- National pay agreements (primarily public sector-wide).
- Increases in drugs and other clinical non-pay costs including health technology innovations.
- Inflation-related price increases
- Full year cost of services commenced in 2018
- Additional service activity to meet demographic pressures.

South East Community Healthcare - 2019		Pay	Non Pay	Gross Budget	Income	Net Budget
Division	Care Group	€m	€m	€m	€m	€m
Primary Care	Primary Care Direct	56.53	29.66	86.20	-1.42	**84.78**
	Social Inclusion	2.92	6.22	9.15	0.00	**9.14**
	Palliative Care	0.18	1.25	1.44	0.00	**1.44**
	Local Demand Led	0.00	18.53	18.53	0.00	**18.53**
	CHO 5 Corp, PMO & QPS	0.87	0.04	0.91	0.00	**0.91**
Primary Care Total		**60.51**	**55.71**	**116.22**	**-1.42**	**114.80**
Mental Health		83.52	17.51	101.03	-1.98	**99.05**
Mental Health Care Total		**83.52**	**17.51**	**101.03**	**-1.98**	**99.05**
Social Care	Disability	23.76	156.34	180.10	-0.44	**179.66**
	Older Persons	84.78	35.40	120.18	-39.06	**81.12**
Social Care Total		**108.54**	**191.74**	**300.28**	**-39.50**	**260.77**
CHO 5 Total		**252.57**	**264.96**	**517.53**	**-42.91**	**474.62**

Financial challenge 2019

A best estimate of the Financial Challenge for 2019 is €22.3m before national coverage. Nationally, the HSE have adopted a range of actions / initiatives to address the financial challenge in 2019 and the key measures that will be adopted in the South East include but are not limited to -

- Procurement – Reduction in costs via contracting
- Overhead and other non-pay efficiencies
- Agency/Overtime conversion
- Vacancy control i.e. prioritisation of frontline staff replacement within pay budgets
- Vacancy control community voluntary organisations
- Disability – Department of Health to agree HIQA compliance phased investment programme 2019 to 2021 – provision limited to €2.6m for 2019
- High cost community residential care including external placements – centralised procurement and co-ordination
- Reconfigure the overall bed stock to a more sustainable level giving rise to a possible reduction in bed numbers

In addition to the range of specific actions / initiatives listed above, and following review at leadership team level, the HSE will seek, notwithstanding the delivery and other risks already being managed within the plan, to secure additional savings by further evaluation of potential opportunities in the following areas:

- Reduction in absenteeism rates in addition to measures already assumed
- Further stock and logistics efficiencies
- Reduction in low value / no value care
- Further prioritisation of staff travel
- Additional modernisation and prioritisation of training and development
- Community income

Risks to Operational Service Areas resulting from 2019 Funding Position

South East Community Healthcare has modelled the expected level of activity that the 2019 funding will cover and identified service areas where the HSE is expected to address service demands beyond its funding envelope. It has looked at what cost savings can be made and has also assessed the costs that cannot be avoided or are fixed. In the case of some services, given that the HSE is the statutory provider of last resort and the realities around the relatively fixed nature of certain costs, there is often pressure to respond to need even if this exceeds the available funding level.

Disabilities - Funding Challenge of €11m and impacts are –

- Emergency Residential Placements - An inability to provide for Emergency Residential Placements resulting in risk to vulnerable adults and children. These arise due to safeguarding, health and safety concerns etc
- Inability to meet legal requirements and unmet need
- Home Support and PA Service – Non-recycling of hours will result in lack of service for a significant number of vulnerable adults and children with disabilities across the South East.
- Transport of Service Users

- Assessment of Need
- Decongregation – plans will be delayed as a result of funding shortage
- Section 38 and 39 Agencies may see their funding curtailed

Older Persons – Funding Challenge of €3.2m (before national coverage) and key impacts are -

- Inadequate provision of home support which will lead to increased waiting lists, failure to assist acute hospitals discharges, risks to vulnerable adults, safeguarding and health and safety risks.
- Reconfiguration and potential closure of beds which will result in failure to assist acute hospital discharges.

Primary Care (excluding Demand Led) – Funding Challenge of €1.3m (before national coverage) and key impacts are –

- Aids and Appliances: This continues to be the main area of deficit in Primary Care. Spend is driven by the increasing pressure from Acute Services to facilitate hospital avoidance and early discharges. A curtailment on spend will significantly impact on discharges from the acute hospital sector and the ability to maintain service users within their own home.
- Therapies:
    - Due to the lack of additional funding and the curtailment of the employment of agency the already lengthy waiting times for all therapies across all Southeast Primary Care will continue to increase.
    - Lack of approval to backfill critical front line maternity leaves will impact on placements for UCC students which heretofore were accommodated.
- Psychology: Due to the lack of additional funding and the curtailment of the employment of agency will impact on waiting times and the availability to see clients within the Primary Care Setting.
- Orthodontics: Currently there is an extremely challenging position in relation to the provision of orthodontics with wait times of up to 4 years.
- Paediatric Home Care Packages: The provision of comprehensive Paediatric Home Care Packages will be a major challenge in 2019. For the safe provision of clinical services, it is not feasible to directly curtail this service.
- Social Inclusion – Interpreter expenses: South East Primary Care have seen a significant increase in the requirement for interpreter services. In 2018 there was a significant deficit and it is expected that this will increase further in 2019 with the allocation of additional refugees and asylum seekers.
- Palliative Care: The lack of funding for the new palliative care unit at University Hospital Waterford will mean that the unit cannot open in line with previous targets.

The dedicated Project Manager Post will not be appointed which will impact on the preparation for opening.

- Maintenance: There has been significant control of costs in the areas of building maintenance, decorating and furnishings to the extent that many facilities are in need of refurbishment and if continued will not comply with required standards.

Mental Health - Funding Challenge of €6.7m (before Time Related Savings and funded developments) and key impacts are –

- Reduced capacity to recruit and retain a highly-skilled and qualified workforce, particularly in high-demand health and social care professional/medical and nursing clinical staff.
- Lack of Acute Inpatient beds to meet the clinical needs of the population and the resultant difficulties created by over occupancy
- Timely access to appropriate inpatient CAMHs beds/units and out of hours service.
- Continued demographic pressures and increasing demand for services will be over and above the capacities of the planned staffing/resource levels thus impacting on the ability to deliver services.
- Lack of adequate infrastructure to support the delivery of services across the area.
- Delayed discharges from Acute Units for service users who require ongoing management in specialist supported accommodation
- Lack of increased resources (clinical and nonclinical) to comply with regulations.

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Health & Well Being - key impacts of funding challenge are –

- Insufficient investment in chronic disease programmes
- Threats to general population health and wellbeing through lack of infectious disease control, immunisation, and environmental health services.
- Impact on HSE staff health and wellbeing

Value Improvement Programme

The Value Improvement Programme (VIP) commenced in 2018 responding to the requirements laid out in NSP2018 to support services and corporate units in realising cash savings, improvements in efficiency and service effectiveness. Value Improvement for NSP2019 will be a more balanced approach across the four aims at the core of the programme, population health, patient experience, per capita cost and staff experience.

VIP is a multi-year programme, reaching beyond what could be perceived as purely cost saving measures and will deliver on all four aims. The key underpinning principle of the Programme is that value does not come at the expense of service quantum or quality.

Indeed, the goal is to improve quality and quantum by driving efficiency and effectiveness equally.

The National VIP Team will assist project teams in identifying the value improvement opportunities, verifying their validity and measuring and reporting the value gained.

Finance – Supporting Service Delivery

Finance provides strategic and operational financial support, direction and advice to services within the HSE to achieve the organisational goals of providing high quality, integrated health and personal social services. The objectives of the finance team are to support the HSE to secure and account for the maximum appropriate investment in health and social care and to support our services to deliver and demonstrate value for money in the widest sense of that phrase (including safe, effective and efficient services).

Finance Department Priorities for 2019

- Prepare for the implementation of a single national financial and procurement system (IFMS) by standardising and streamlining finance processes
- Improve reporting and budgeting capacity by repointing of the existing Finance Staff Resources to focus on specific Care Groups
- Review of Skill Mix in Residential Units and implementation of recommendations
- Improve controls and compliance
- Pay Bill Management – working with HR and the Service Divisions on the continued development of an integrated strategy in respect of recruitment, agency conversion and workforce planning in 2019.
- Continued development of Corporate Procurement Compliance Plan as part of the National Compliance Improvement Programme (CIP).

Appendices

KPI Targets (CHO 5) South East Community Healthcare

KPI's Primary Care

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Community Diagnostics (Privately Provided Service)								
No. of ultrasound referrals accepted		Access and Integration	M	20,278	23,290		CHO	No Service
No. of ultrasound examinations undertaken		Access and Integration	M	20,278	24,168		CHO	No Service
Community Intervention Teams Referrals by referral category				**38,180**	**43,084**	**45,432**		**6,468**
Admission Avoidance (includes OPAT)	NSP	Quality and Safety	M	1,186	609	1,380	CHO	288
Hospital Avoidance	NSP	Quality and Safety	M	28,417	34,090	33,180	CHO	5,076
Early discharge (includes OPAT)	NSP	Quality and Safety	M	5,997	5,200	7,068	CHO	1,104
Unscheduled referrals from community	NSP	Quality and	M	2,580	3,185	3,804	CHO	0

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
sources		Safety						
Outpatient Parenteral Antimicrobial Therapy (OPAT) Re-admission rate %	OP	Access and Integration	M	≤5%	4.5%	≤5%	HG	≤5%
Community Intervention Teams Referrals by referral source				**38,180**	**43,084**	**45,432**	**CHO**	**6,468**
ED / Hospital wards / Units	OP	Access and Integration	M	25,104	29,719	29,736	CHO	3,948
GP Referral	OP	Access and Integration	M	8,938	9,621	11,148	CHO	2,160
Community Referral	OP	Access and Integration	M	2,484	2,723	2,760	CHO	0
OPAT Referral	OP	Access and Integration	M	1,654	1,021	1,788	CHO	360
GP Out of Hours								
No. of contacts with GP Out of Hours Service	NSP	Access and Integration	M	1,105,151	1,039,496	1,147,496	National	
Physiotherapy								
No. of physiotherapy patient referrals	OP	Access and Integration	M	197,299	199,236	199,236	CHO	25,776
No. of physiotherapy patients seen for a first time assessment	OP	Access and Integration	M	162,554	160,488	162,549	CHO	24,570
No. of physiotherapy patients treated in the reporting month (monthly target)	OP	Access and Integration	M	34,927	34,605	34,926	CHO	5,232
No. of physiotherapy service face to face contacts/visits	OP	Access and Integration	M	726,724	709,764	709,764	CHO	95,076

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Total no. of physiotherapy patients on the assessment waiting list at the end of the reporting period	OP	Access and Integration	M	35,429	34,023	34,023	CHO	4,718
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	21,437	No target	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	7,051	No target	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	2,439	No target	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	1,340	No target	CHO	No target
No. of physiotherapy patients on the assessment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	1,756	No target	CHO	No target
% of new physiotherapy patients seen for assessment within 12 weeks	NSP	Access and Integration	M	80%	81%	81%	CHO	81%
% of physiotherapy patients on waiting list for assessment ≤ 26 weeks	OP	Access and Integration	M	80%	84%	84%	CHO	84%
% of physiotherapy patients on waiting list for assessment ≤ 39 weeks	OP	Access and Integration	M	89%	91%	91%	CHO	91%

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
% of physiotherapy patients on waiting list for assessment ≤ to 52 weeks	NSP	Access and Integration	M	93%	95%	95%	CHO	95%
Occupational Therapy								
No. of occupational therapy service user referrals	OP	Access and Integration	M	90,961	94,800	94,800	CHO	11,292
No. of new occupational therapy service users seen for a first assessment	OP	Access and Integration	M	90,700	91,740	94,678	CHO	10,489
No. of occupational therapy service users treated (direct and indirect) monthly target	OP	Access and Integration	M	20,513	21,803	21,803	CHO	2,398
Total no. of occupational therapy service users on the assessment waiting list at the end of the reporting period	OP	Access and Integration	M	30,258	31,220	31,220	CHO	5,246
No. of occupational therapy service users on the assessment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	9,877	No target	CHO	No target
No. of occupational therapy service users on the assessment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	6,858	No target	CHO	No target
No. of occupational therapy service users on the assessment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	4,108	No target	CHO	No target
No. of occupational therapy service users on the assessment waiting list at the end of	OP	Access and Integration	M	No target	3,005	No target	CHO	No target

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
the reporting period >39 weeks but ≤ 52 weeks								
No. of occupational therapy service users on the assessment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	7,372	No target	CHO	No target
% of new occupational therapy service users seen for assessment within 12 weeks	NSP	Access and Integration	M	68%	65%	68%	CHO	68%
% of occupational therapy service users on waiting list for assessment ≤ 26 weeks	OP	Access and Integration	M	54%	54%	54%	CHO	54%
% of occupational therapy service users on waiting list for assessment ≤ 39 weeks	OP	Access and Integration	M	67%	67%	67%	CHO	67%
% of occupational therapy service users on waiting list for assessment ≤ to 52 weeks	NSP	Access and Integration	M	85%	76%	85%	CHO	85%
Primary Care – Speech and Language Therapy								
No. of speech and language therapy patient referrals	OP	Access and Integration	M	51,763	50,892	50,892	CHO	5,208
Existing speech and language therapy patients seen in the month	OP	Access and Integration	M	19,515	19,621	19,514	CHO	2,515
New speech and language therapy patients seen for initial assessment	OP	Access and Integration	M	45,631	42,432	45,635	CHO	4,695
Total no. of speech and language therapy patients waiting initial assessment at end of the reporting period	OP	Access and Integration	M	13,359	14,236	14,236	CHO	1,585

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Total no. of speech and language therapy patients waiting initial therapy at end of the reporting period	OP	Access and Integration	M	8,008	7,939	7,939	CHO	1,694
% of speech and language therapy patients on waiting list for assessment ≤ to 52 weeks	NSP	Access and Integration	M	100%	96%	100%	CHO	100%
% of speech and language therapy patients on waiting list for treatment ≤ to 52 weeks	NSP	Access and Integration	M	100%	93%	100%	CHO	100%
Primary Care – Speech and Language Therapy Service Improvement Initiative								
New speech and language therapy patients seen for initial assessment	OP	Access and Integration	M	5,659	3,882	3,882	CHO	581
No. of speech and language therapy initial therapy appointments	OP	Access and Integration	M	18,940	16,956	16,956	CHO	4,554
No. of speech and language therapy further therapy appointments	OP	Access and Integration	M	21,732	20,062	20,062	CHO	1,669
Primary Care – Podiatry Updated 18/1/19								
No. of podiatry patient referrals	OP	Access and Integration	M	10,749	11,184	11,184	CHO	816
Existing podiatry patients seen in the month	OP	Access and Integration	M	5,656	6,187	6,187	CHO	255
New podiatry patients seen	OP	Access and Integration	M	6,339	8,856	8,856	CHO	444

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Total no. of podiatry patients on the treatment waiting list at the end of the reporting period	OP	Access and Integration	M	4,145	3,654	3,654	CHO	626
No. of podiatry patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	1,182	No target	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	716	No target	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	462	No target	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	385	No target	CHO	No target
No. of podiatry patients on the treatment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	909	No target	CHO	No target
% of podiatry patients on waiting list for treatment ≤ 12 weeks	NSP	Access and Integration	M	26%	32%	32%	CHO	32%
% of podiatry patients on waiting list for treatment ≤ 26 weeks	OP	Access and Integration	M	43%	52%	52%	CHO	52%
% of podiatry patients on waiting list for treatment ≤ 39 weeks	OP	Access and Integration	M	61%	65%	65%	CHO	65%
% of podiatry patients on waiting list for treatment ≤ to 52 weeks	NSP	Access and Integration	M	77%	75%	77%	CHO	77%

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
No. of patients with diabetic active foot disease treated in the reporting month	OP	Quality and Safety	M	502	552	566	CHO	53
No. of treatment contacts for diabetic active foot disease in the reporting month	OP	Access and Integration	M	878	1,077	1,113	CHO	69
Primary Care – Ophthalmology								
No. of ophthalmology patient referrals	OP	Access and Integration	M	28,286	24,888	24,888	CHO	4,344
Existing ophthalmology patients seen in the month	OP	Access and Integration	M	5,923	6,080	6,080	CHO	1,151
New ophthalmology patients seen	OP	Access and Integration	M	25,314	26,232	26,232	CHO	7,584
Total no. of ophthalmology patients on the treatment waiting list at the end of the reporting period	OP	Access and Integration	M	20,748	20,203	20,203	CHO	1,380
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	4,599	No target	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	3,128	No target	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	2,271	No target	CHO	No target

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	1,826	No target	CHO	No target
No. of ophthalmology patients on the treatment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	8,379	No target	CHO	No target
% of ophthalmology patients on waiting list for treatment ≤ 12 weeks	NSP	Access and Integration	M	26%	23%	26%	CHO	26%
% of ophthalmology patients on waiting list for treatment ≤ 26 weeks	OP	Access and Integration	M	46%	38%	46%	CHO	46%
% of ophthalmology patients on waiting list for treatment ≤ 39 weeks	OP	Access and Integration	M	58%	49%	58%	CHO	58%
% of ophthalmology patients on waiting list for treatment ≤ 52 weeks	NSP	Access and Integration	M	66%	59%	66%	CHO	66%
Primary Care – Audiology								
No. of audiology patient referrals	OP	Access and Integration	M	21,139	20,256	20,256	CHO	2,928
Existing audiology patients seen in the month	OP	Access and Integration	M	2,899	2,849	2,899	CHO	237
New audiology patients seen	OP	Access and Integration	M	17,765	16,512	17,760	CHO	2,080
Total no. of audiology patients on the treatment waiting list at the end of the reporting period	OP	Access and Integration	M	14,693	15,088	15,088	CHO	2,387

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
No. of audiology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	5,763	No target	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	3,267	No target	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	2,265	No target	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	1,801	No target	CHO	No target
No. of audiology patients on the treatment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	1,992	No target	CHO	No target
% of audiology patients on waiting list for treatment ≤ 12 weeks	NSP	Access and Integration	M	41%	38%	41%	CHO	41%
% of audiology patients on waiting list for treatment ≤ 26 weeks	OP	Access and Integration	M	64%	60%	64%	CHO	64%
% of audiology patients on waiting list for treatment ≤ 39 weeks	OP	Access and Integration	M	78%	75%	78%	CHO	78%
% of audiology patients on waiting list for treatment ≤ to 52 weeks	NSP	Access and Integration	M	88%	87%	88%	CHO	88%
National Newborn Hearing Screening Programme								

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Total no. and % of eligible babies whose screening was complete by four weeks	OP	Access and Integration	Q, 1 Qtr in Arrears	~~64,027~~ TBA >95%			National. CHO number baseline to be established in 2018	>95%
No. of babies identified with ~~primary~~ permanent childhood hearing impairment referred to audiology services from the screening programme	OP	Access and Integration	Q, 1 Qtr in Arrears	~~90~~ TBA			CHO	~~9~~ TBA
No. and % of babies from screening programme identified with a hearing loss by six months of age	OP	Quality and Safety	Q, 1 Qtr in Arrears	~~71~~ TBA ≥80%			CHO	~~7~~ TBA ≥80%
Primary Care – Dietetics								
No. of dietetic patient referrals	OP	Access and Integration	M	34,015	34,788	34,788	CHO	2,904
Existing dietetic patients seen in the month	OP	Access and Integration	M	3,459	3,349	3,459	CHO	357
New dietetic patients seen	OP	Access and Integration	M	21,873	23,028	21,874	CHO	2,461
Total no. of dietetic patients on the treatment waiting list at the end of the	OP	Access and Integration	M	14,241	16,085	16,085	CHO	2,235

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
reporting period								
No. of dietetic patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	5,464	No target	CHO	No target
No. of dietetic patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	2,945	No target	CHO	No target
No. of dietetic patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	1,598	No target	CHO	No target
No. of dietetic patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	1,225	No target	CHO	No target
No. of dietetic patients on the treatment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	4,853	No target	CHO	No target
% of dietetic patients on waiting list for treatment ≤ 12 weeks	NSP	Access and Integration	M	37%	34%	37%	CHO	37%
% of dietetic patients on waiting list for treatment ≤ 26 weeks	OP	Access and Integration	M	59%	52%	59%	CHO	59%
% of dietetic patients on waiting list for treatment ≤ 39 weeks	OP	Access and Integration	M	71%	62%	71%	CHO	71%
% of dietetic patients on waiting list for treatment ≤ to 52 weeks	NSP	Access and Integration	M	79%	70%	79%	CHO	79%

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
Primary Care – Psychology								
No. of psychology patient referrals	OP	Access and Integration	M	12,480	12,948	12,948	CHO	1,536
Existing psychology patients seen in the month	OP	Access and Integration	M	2,240	2,550	2,550	CHO	201
New psychology patients seen	OP	Access and Integration	M	13,144	10,884	10,884	CHO	1,824
Total no. of psychology patients on the treatment waiting list at the end of the reporting period	OP	Access and Integration	M	7,868	7,919	7,919	CHO	1,016
No. of psychology patients on the treatment waiting list at the end of the reporting period 0 - ≤ 12 weeks	OP	Access and Integration	M	No target	2,168	No target	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >12 weeks - ≤ 26 weeks	OP	Access and Integration	M	No target	1,735	No target	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >26 weeks but ≤ 39 weeks	OP	Access and Integration	M	No target	1,168	No target	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period >39 weeks but ≤ 52 weeks	OP	Access and Integration	M	No target	875	No target	CHO	No target
No. of psychology patients on the treatment waiting list at the end of the reporting period > 52 weeks	OP	Access and Integration	M	No target	1,973	No target	CHO	No target

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
% of psychology patients on waiting list for treatment ≤ 12 weeks	NSP	Access and Integration	M	36%	27%	36%	CHO	36%
% of psychology patients on waiting list for treatment ≤ 26 weeks	OP	Access and Integration	M	48%	49%	49%	CHO	49%
% of psychology patients on waiting list for treatment ≤ 39 weeks	OP	Access and Integration	M	62%	64%	64%	CHO	64%
% of psychology patients on waiting list for treatment ≤ to 52 weeks	NSP	Access and Integration	M	81%	75%	81%	CHO	81%
Primary Care – Nursing								
No. of nursing patient referrals	OP	Access and Integration	M	139,184	140,832	140,832	CHO	11,232
Existing nursing patients seen in the month	OP	Access and Integration	M I Mth in Arrears	52,063	49,436	52,063	CHO	4,706
New nursing patients seen	OP	Access and Integration	M I Mth in Arrears	118,849	134,916	118,849	CHO	2,533
% of new patients accepted onto the nursing caseload and seen within 12 weeks	NSP	Access and Integration	M I Mth in Arrears	96%	99%	100%	CHO	100%
Child Health								
% of children reaching 10 months within the reporting period who have had child development health screening on time or	NSP	Quality and Safety	M I Mth in Arrears	95%	93%	95%	CHO	95%

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
before reaching 10 months of age								
% of newborn babies visited by a PHN within 72 hours of discharge from maternity services	NSP	Quality and Safety	Q	98%	96%	98%	CHO	98%
% of babies breastfed (exclusively and not exclusively) at first PHN visit	NSP	Quality and Safety	Q 1 Qtr in Arrears	58%	56%	58%	CHO	58%
% of babies breastfed exclusively at first PHN visit	NSP	Quality and Safety	Q 1 Qtr in Arrears	48%	40%	48%	CHO	48%
% of babies breastfed (exclusively and not exclusively) at three month PHN visit	NSP	Quality and Safety	Q 1 Qtr in Arrears	40%	40%	40%	CHO	40%
% of babies breastfed exclusively at three month PHN visit	NSP	Quality and Safety	Q 1 Qtr in Arrears	30%	30%	30%	CHO	30%
Oral Health Primary Dental Care								
No. of new oral health patients in target groups attending for scheduled assessment	OP	Access and Integration	M	131,386	139,152	~~139,152~~ 162,336	CHO	20,820
No. of new oral health patients attending for unscheduled assessment	OP	Access and Integration	M	62,081	64,812	64,812	CHO	7,968
% of new oral health patients who commenced treatment within three months of scheduled oral health assessment	NSP	Access and Integration	M	92%	90%	90%	CHO	90%
Orthodontics								

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
No. of orthodontic patients receiving active treatment at the end of the reporting period	OP	Access and Integration	Q	16,431	18,000	18,000	National/ former region	
No. and % of orthodontic patients seen for assessment within 6 months	NSP	Access and Integration	Q	2,483 46%	2,406 45%	~~2,459~~ 2,406 46%	National/ former region	
% of orthodontic patients on the waiting list for assessment ≤ 12 months	OP	Access and Integration	Q	100%	95%	100%	National/ former region	
% of orthodontic patients on the treatment waiting list ≤ two years	OP	Access and Integration	Q	75%	58%	75%	National/ former region	
% of orthodontic patients (grades 4 and 5) on treatment waiting list less than four years	OP	Access and Integration	Q	99%	94%	99%	National/ former region	
No. of orthodontic patients on the assessment waiting list at the end of the reporting period	OP	Access and Integration	Q	7,199	8,722	8,722	National/ former region	
No. of orthodontic patients (grade 4) on the treatment waiting list at the end of the reporting period	OP	Access and Integration	Q	9,566	9,432	9,432	National/ former region	
No. of orthodontic patients (grade 5) on the treatment waiting list at the end of the reporting period	OP	Access and Integration	Q	8,369	8,426	8,426	National/ former region	

Key Performance Indicators Service Planning 2019				2018	2018	2019		2019 Expected Activity / Target
KPI Title	**NSP/ OP**	**Performance Area**	**Reporting Period**	**2018 National Target / Expected Activity**	**2018 Projected outturn**	**2019 National Target / Expected Activity**	**Reported at National/ CHO / HG**	**CHO 5**
~~Reduce the proportion of orthodontic patients (grades 4 and 5) on the treatment waiting list waiting longer than four years~~ % of orthodontic patients (grades 4 and 5) on the treatment waiting list longer than four years	NSP	Access and Integration	Q	<1%	6%	<6%	National/ former region	
Services to persons with Hepatitis C								
No. of Health Amendment Act 1996 cardholders who were reviewed REMOVE SHADING NO LONGER NSP	OP	Quality and Safety	Q	459	119	340	National	45

KPI Social Inclusion

Performance Activity / KPI (Wording as per NSP/OP)	Target/EA Full Year	CHO 5
Number of pharmacies recruited to provide a Pharmacy Needle Exchange Programme	95	15
No of unique individuals attending the Pharmacy Needle Exchange Programme	1,650	324
No. of pharmacy needle exchange packs provided as per the Pharmacy Needle Exchange Programme	No Target	
Number of clean needles provided each month as per the Pharmacy Needle Exchange Programme	22,559	4,759
Average no. of clean needles (and accompanying injecting paraphenilia per unique individual each month	14	14
No. of needle / syringe packs returned as per the Pharmacy Needle Exchange Programme	643	130
% of needle / syringe packs returned as per the Pharmacy Needle Exchange Programme	41%	41%

KPI's Palliative Care

Palliative Care	Target/EA Full Year	CHO 5
Access to specialist inpatient bed within seven days during the reporting year	98%	98%
No. accessing specialist inpatient bed within seven days (during the reporting year)	3,809	68
% of patients triaged within one working day of referral (Inpatient Unit)	90%	90%
Access to specialist palliative care services in the community provided within seven days (normal place of residence)	90%	90%
% of patients triaged within one working day of referral (Community)	95%	95%
No. of patients who received specialist palliative care treatment in their normal place of residence in the month	3,405	422
No. of children in the care of the Clinical Nurse Co-ordinator for Children with Life Limiting Conditions (children's outreach nurse)	280	30
No. of children in the care of the acute specialist paediatric palliative care team (during the reporting month)	97	

KPI's Mental Health

Key Performance Indicators 2019 Service Planning KPI Title	Reported against NSP	KPI Type Access/ Quality /Access Activity	Report Frequency	2019 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO5
% of accepted referrals / re-referrals offered first appointment within 12 weeks by General Adult Community Mental Health Team	NSP	Quality	M	90%	CHO	90%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by General Adult Community Mental Health Team	NSP	Quality	M	75%	CHO	75%
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	NSP	Access /Activity	M	< 22%	CHO	< 22%
% of accepted referrals / re-referrals offered first appointment within 12 weeks by Psychiatry of Later Life Community Mental Health Teams	NSP	Quality	M	98%	CHO	98%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Psychiatry of Later Life Community Mental Health Teams	NSP	Quality	M	95%	CHO	95%

%. of new (including re-referred) Later Life Psychiatry Team cases offered appointment and DNA in the current month	NSP	Access /Activity	M	< 3%	CHO	< 3%
Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units.	NSP	Quality	M	75%	National	N/A
Percentage of Bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of Bed days used by children in mental health acute inpatient units	NSP	Quality	M	95%	CHO	95%
% of accepted referrals / re-referrals offered first appointment within 12 weeks by Child and Adolescent Community Mental Health Teams	NSP	Quality	M	78%	CHO	78%
% of accepted referrals / re-referrals offered first appointment and seen within 12 weeks by Child and Adolescent Community Mental Health Teams	NSP	Quality	M	72%	CHO	72%
%. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	NSP	NSP	M	< 10%	CHO	< 10%
% of accepted referrals / re-referrals offered first appointment and seen within 12 months by Child and Adolescent Community Mental Health Teams excluding DNAs	NSP	NSP	M	95%	CHO	95%
% of urgent referrals to Child and Adolescent Mental Health Teams responded to within three working days	NSP	NSP	M	New KPI 2019	CHO	New KPI 2019
No. of adult referrals seen by mental health services	NSP Vol	Access /Activity	M	28,716	CHO	3,465
No. of admissions to adult acute inpatient units	NSP Vol	Access /Activity	Q in arrears	12,148	CHO	1,244

No. of Psychiatry of Later Life referrals seen by mental health services	NSP Vol	Access /Activity	M	8,896	CHO	1,210
No. of CAMHs referrals received by mental health services	NSP Vol	Access /Activity	M	18,128	CHO	1,867
No. of CAMHs referrals seen by mental health services	NSP Vol	Access /Activity	M	10,833	CHO	897
Total No. to be seen for a first appointment at the end of each month.	OP	Access /Activity	M	2,498	CHO	155
Total No. to be seen 0-3 months	OP	Access /Activity	M	1,142	CHO	91
Total No. on waiting list for a first appointment waiting > 3 months	OP	Access /Activity	M	1,356	CHO	64
Total No. on waiting list for a first appointment waiting > 12 months	OP	Access /Activity	M	0	CHO	0
No. of admissions to adult acute inpatient units	OP	Access /Activity	Q in arrears	12,148	CHO	1,244
Median length of stay	OP	Access /Activity	Q in arrears	11	CHO	11
Rate of admissions to adult acute inpatient units per 100,000 population in mental health catchment area	OP	Access /Activity	Q in arrears	62.9	CHO	64.8
First admission rates to adult acute units (that is, first ever admission), per 100,000 population in mental health catchment area	OP	Access /Activity	Q in arrears	23.0	CHO	24.0
Acute re-admissions as % of admissions	OP	Access /Activity	Q in arrears	63%	CHO	63%
Inpatient re-admission rates to adult acute units per 100,000 population in mental health catchment area	OP	Access /Activity	Q in arrears	39.9	CHO	40.8
No. of adult acute inpatient beds per 100,000 population in the mental health catchment area	OP	Access /Activity	Q in arrears	21.3	CHO	18.3
No. of adult involuntary admissions	OP	Access /Activity	Q in arrears	1,918	CHO	202

Rate of adult involuntary admissions per 100,000 population in mental health catchment area	OP	Access /Activity	Q in arrears	9.9	CHO	10.5
Number of General Adult Community Mental Health Teams	OP	Access	M	114 (119 returns)	CHO	11
Number of referrals (including re-referred)received by General Adult Community Mental Health Teams	OP	Access /Activity	M	43,819	CHO	4,870
Number of Referrals (including re-referred) accepted by General Adult Community Mental Health Teams	OP	Access /Activity	M	39,437	CHO	4,383
No. of new (including re-referred) General Adult Community Mental Health Team cases offered first appointment for the current month (seen and DNA below)	OP	Access /Activity	M	35,035	CHO	4,228
No. of new (including re-referred) General Adult Community Mental Health Team cases seen in the current month	OP	Access /Activity	M	28,716	CHO	3,465
No. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	OP	Access /Activity	M	6,319	CHO	763
%. of new (including re-referred) General Adult Community Mental Health Team cases offered appointment and DNA in the current month	OP	Access /Activity	M	< 22%	CHO	< 22%
Number of cases closed/discharged by General Adult Community Mental Health Teams	OP	Access /Activity	M	27,606	CHO	3,068
Number of Psychiatry of Later Life Community Mental Health Teams	OP	Access	M	31	CHO	5
Number of referrals (including re-referred)received by Psychiatry of Later Life Mental Health Teams	OP	Access /Activity	M	12,455	CHO	1,444

Number of Referrals (including re-referred) accepted by Psychiatry of Later Life Community Mental Health Teams	OP	Access /Activity	M	11,211	CHO	1,300
No. of new (including re-referred) Later Life Psychiatry Team cases offered first appointment for the current month (seen and DNA below)	OP	Access /Activity	M	9,163	CHO	1,246
No. of new (including re-referred) Later Life Psychiatry Team cases seen in the current month	OP	Access /Activity	M	8,896	CHO	1,210
No. of new (including re-referred) Later Life Psychiatry cases offered appointment and DNA in the current month	OP	Access /Activity	M	267	CHO	36
Number of cases closed/discharged by Later Life Psychiatry Community Mental Health Teams	OP	Access /Activity	M	8,969	CHO	1,040
No. of child and adolescent Community Mental Health Teams	OP	Access	M	70	CHO	7
No. of child and adolescent Day Hospital Teams	OP	Access	M	4	CHO	0
No. of Paediatric Liaison Teams	OP	Access	M	3	CHO	0
No. of child / adolescent admissions to HSE child and adolescent mental health inpatient units	OP	Access /Activity	M	296	CHO	N/A
No. of children / adolescents admitted to adult HSE mental health inpatient units	OP	Access /Activity	M	30	National	N/A
i). <16 years	OP	Access /Activity	M	0	National	N/A
ii). <17 years	OP	Access /Activity	M	0	National	N/A
iii). <18 years	OP	Access /Activity	M	30	National	N/A

No. of child / adolescent referrals (including re-referred) received by mental health services	OP	Access /Activity	M	18,128	CHO	1,867
No. of child / adolescent referrals (including re-referred) accepted by mental health services	OP	Access /Activity	M	13,069	CHO	1,343
No. of new (including re-referred) CAMHs Team cases offered first appointment for the current month (seen and DNA below)	OP	Access /Activity	M	11,919	CHO	987
No. of new (including re-referred) child/adolescent referrals seen in the current month	OP	Access /Activity	M	10,833	CHO	897
No. of new (including re-referred) child/adolescent referrals offered appointment and DNA in the current month	OP	Access /Activity	M	1,086	CHO	90
No. of cases closed / discharged by CAMHS service	OP	Access /Activity	M	10,454	CHO	1,074
Total No. to be seen for a first appointment by expected wait time at the end of each month.	OP	Access /Activity	M	2,498	CHO	155
i) 0-3 months	OP	Access /Activity	M	1,142	CHO	91
ii). 3-6 months	OP	Access /Activity	M	550	CHO	33
iii). 6-9 months	OP	Access /Activity	M	454	CHO	20
iv). 9-12 months	OP	Access /Activity	M	352	CHO	11
v). > 12 months	OP	Access /Activity	M	0	CHO	0
12-15 months	OP	Access /Activity	M	0	CHO	0
15-18 months	OP	Access /Activity	M	0	CHO	0

> 18 months	OP	Access /Activity	M	0	CHO	0
18-21 months	OP	Access /Activity	M	0	CHO	0
21-24 months	OP	Access /Activity	M	0	CHO	0
24-27 months	OP	Access /Activity	M	0	CHO	0
27-30 months	OP	Access /Activity	M	0	CHO	0
30-33 months	OP	Access /Activity	M	0	CHO	0
33-36 months	OP	Access /Activity	M	0	CHO	0
36-39 months	OP	Access /Activity	M	0	CHO	0
39-42 months	OP	Access /Activity	M	0	CHO	0
42-45 months	OP	Access /Activity	M	0	CHO	0
45-48 months	OP	Access /Activity	M	0	CHO	0
>48 months	OP	Access /Activity	M	0	CHO	0

KPI's Disability Services

Performance Activity / KPI (Wording as per NSP/OP)	Target/EA Full Year	CHO 5
Safeguarding: (combined KPI's with Older Persons Service) % of Preliminary Screenings for adults aged 65 years and over with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	100%	100%
Safeguarding: (combined KPI's with Older Persons Service) % of Preliminary Screenings for adults under 65 years with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	100%	100%
% compliance with regulations following HIQA inspection of Disability Residential Services	80%	
No. of requests for assessments of need received for children	5,065	265
% of child assessments completed within the timelines as provided for in the regulations	100%	100%
% of school leavers and Rehabilitation Training (RT) graduates who have been provided with a placement	100%	100%
% of Children's Disability Network Teams established	100%	100%
No. of Children's disability Network Teams established	80	No target ~~25~~
No. of residential places for people with a disability	8,568	886
No. of new emergency places provided to people with a Disability	90	
Facilitate the movement of people from congregated to community settings	160	15
No of people with a disability in receipt of work/work-like activity services (ID/Autism and Physical and sensory disability)	2,513	446
No. of people (all disabilities) in receipt of Rehabilitative Training (RT)	2,282	287

No. of people with a disability in receipt of other day services (excl. RT and work/ Work-like activities (adult) (ID / Autism and Physical and sensory disability)	22,272	3,483
No of day only respite sessions accessed by people with a disability(ID/Autism and Physical and Sensory Disability)	32622	1,405
No of people with a disability in receipt of respite services (ID/Autism and Physical and Sensory Disability)	6,559	461
No. of overnights (with or without day respite) accessed by people with a disability(ID/Autism and Physical and Sensory Disability)	182,506	13,722
Number of PA Service hours delivered to adults with a physical and / or sensory disability	1,630,000	178,593
No. of adults with a physical and / or sensory disability in receipt of a PA service	2,535	406
No. of Home Support Service Hours delivered to people with a disability (ID/Autism and Physical and Sensory Disability)	3,080,000	386,290
No of people with a disability in receipt of Home Support Services (ID/Autism and Physical and Sensory Disability)	8,094	904
Percentage of "Transforming Lives" priorities Implemented	100%	Retired
Percentage of Service improvement priorities implemented	100%	Retired
% of CHOs who have established a Residents' Council / Family Forum / Service User Panel or equivalent for Disability Services	100%	Retired
% of CHO quality and safety committees in place with responsibilities to include governance of the quality and Safety of HSE provided disability Services who have met in this reporting month	100%	Retired

KPI's Older Persons Services

Performance Activity / KPI (Wording as per NSP/OP)	Target/EA Full Year	CHO 5
Quality		
% of CHOs who have established a Residents' Council / Family Forum / Service User Panel or equivalent for Services for Older People		
% of compliance with Regulations following HIQA inspection of HSE direct-provided Older Persons Residential Services	80%	N/A
% of CHO Quality and Safety Committees with responsibilities to include governance of the quality and safety of Older Persons' Services who have met in this reporting month		
Safeguarding		
% of Preliminary Screenings for adults aged 65 years and over with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	100%	100%
% of Preliminary Screenings for adults under 65 years with an outcome of reasonable grounds for concern that are submitted to the Safeguarding and Protection Teams accompanied by an interim Safeguarding Plan.	100%	100%
Deliver on Service Improvement Priorities		
Deliver on Service Improvement Priorities: %of Service improvement priorities implemented		
Home Support		
No. of Home Support hours provided (excluding provision of hours from Intensive Home Care Packages (IHCPs))	17,900,000	1,950,000
No. of people in receipt of Home Support (excluding provision from Intensive Home Care Packages(IHCPs)) - each person counted once only	53,182	6,115
Intensive Home Care Packages		
Total No. of persons in receipt of an Intensive Home Care Package (IHCP)	235	N/A
% of clients in receipt of an IHCP with a Key Worker Assigned	100%	100%
No. of Home Support hours provided from Intensive Home Care Packages	360,000	N/A
NHSS		

No. of persons funded under NHSS in long term residential care during the reporting month	23,042	N/A
% of clients with NHSS who are in receipt of Ancillary State Support	13.5%	N/A
% of clients who have Common Summary Assessment Report (CSARs) processed within 6 weeks	90%	N/A
Public Beds		
No. of NHSS Beds in Public Long Stay Units	4,900	511
No. of Short Stay Beds in Public Long Stay Units	1,850	229
% Occupancy of Short Stay Beds to commence Q3 2019	90%	90%
% of population over 65 years in NHSS funded Beds (based on 2016 Census figures)	≤3.5%	N/A
Transitional Care Beds		
No. of Persons at any given time being supported through transitional care in alternative care settings	1,160	N/A
No. of Persons in acute hospitals approved for transitional care to move to alternative care settings	10,980	N/A
Single Assessment Tool (SAT)		
No. of People seeking service who have been assessed using the Single Assessment Tool(SAT)(commencing Q4)	300	N/A

KPI's Health & Wellbeing

Key Performance Indicators Service Planning 2018 KPI Title	Reported against NSP / DOP	KPI Type Access/ Quality /Access Activity	Report Frequency	2019 National Target / Expected Activity	Reported at National / CHO / HG Level	CHO5 HG5
No. of smokers who received face to face or telephone intensive cessation support from a cessation counsellor	NSP	Access /Activity	Q-1Q	11,500	CHO/HG/ Nat Quitline	
No. of smokers who are receiving online cessation support services	NSP		Q	??	National	
% of smokers on cessation programmes who were quit at four weeks	NSP	Access /Activity	Q-1Q	45%	National	
No. of unique runners completing a 5k park run	DOP	Quality	M	220,946	CHO/LHO	

No. of people attending a HSE funded structured community based healthy cooking programme	DOP	Access /Activity	Q	4,400	CHO	
No. of people who have completed a structured patient education programme for type 2 diabetes	NSP	Access /Activity	M	4,190	CHO	345
% children aged 12 months who have received 3 doses Diphtheria (D3), Pertussis (P3), Tetanus (T3) vaccine Haemophilus influenza type b (Hib3) Polio (Polio3) hepatitis B (HepB3) (6 in 1)	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% children at 12 months of age who have received two doses of the Pneumococcal Conjugate vaccine (PCV2)	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% children at 12 months of age who have received 1 dose of the Meningococcal group C vaccine (MenC1)	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%

% children at 12 months of age who have received two doses of the Meningococcal group B vaccine (MenB2)	DOP		Q-1Q	95%	LHO/CHO	95%
% children at 12 months of age who have received two doses of Rotavirus vaccine (Rota2)	DOP		Q-1Q	95%	LHO/CHO	95%
% children aged 24 months who have received 3 doses Diphtheria (D3), Pertussis (P3), Tetanus (T3) vaccine, Haemophilus influenza type b (Hib3), Polio (Polio3), hepatitis B (HepB3) (6 in 1)	NSP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% children aged 24 months who have received 2 doses Meningococcal C (MenC2) vaccine	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% children aged 24 months who have received 1 dose Haemophilus influenza type B (Hib) vaccine	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% children aged 24 months who have received 3 doses Pneumococcal Conjugate (PCV3) vaccine	DOP	Access /Activity	Q-1Q	95%	LHO/CHO	95%

% children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine	NSP	Access /Activity	Q-1Q	95%	LHO/CHO	95%
% of children aged 24 months who have received three doses of the Meningococcal group B vaccine (MenB3)	DOP		Q-1Q	95%	LHO/CHO	95%
% of children aged 24 months who have received two doses of the Rotavirus vaccine (Rota2)	DOP		Q-1Q	95%	LHO/CHO	95%
% children in junior infants who have received 1 dose 4-in-1 vaccine (Diphtheria, Tetanus, Polio, Pertussis)	DOP	Access /Activity	A	95%	LHO/CHO	95%
% children in junior infants who have received 1 dose Measles, Mumps, Rubella (MMR) vaccine	DOP	Access /Activity	A	95%	LHO/CHO	95%
% first year students who have received 1 dose Tetanus, low dose Diphtheria, Acellular Pertussis (Tdap) vaccine	DOP	Access /Activity	A	95%	LHO/CHO	95%
% of first year girls who have received two doses of HPV Vaccine	NSP	Access /Activity	A	85%	LHO/CHO	85%

% of first year students who have received one dose meningococcal C (MenC) vaccine	DOP	Access /Activity	A	95%	LHO/CHO	95%
% of health care workers who have received seasonal Flu vaccine in the 2018-2019 influenza season (acute hospitals)	NSP	Access /Activity	A	60%	National / HG	60%
% of health care workers who have received seasonal Flu vaccine in the 2018-2019 influenza season (long term care facilities in the community)	NSP	Access /Activity	A	60%	National /CHO/LHO	60%
% uptake in Flu vaccine for those aged 65 and older with a medical card or GP visit card	NSP	Access /Activity	A	75%	LHO/CHO	75%
No. of infectious disease (ID) outbreaks notified under the national ID reporting schedule	NSP	Access /Activity	Q	500	National	
No. of individual outbreak associated cases of infectious disease (ID) notified under the national ID reporting schedule	DOP	Access /Activity	Q	5090	National	

% of identified TB contacts, for whom screening was indicated, who were screened.	DOP	Quality	Q-1Q	>/=80%	National	
No. of frontline Staff to complete the eLearning Making Every Contact Count Training in brief intervention	NSP	Workforce	Q	1,425	National	
No. of frontline Staff to complete the Face to Face Module of the Makine Every Contact Count Training in brief intervention	NSP	Workforce	Q	284	National	