Grúpa Ospidéal
Oirthear na hÉireann

Ireland East Hospital Group (IEHG)

Operational Plan 2019

Seirbhís Sláinte Níos Fearr á Forbairt

Building a Better Health Service

Goal 1 Promote health and wellbeing as part of everything we do so that people will be healthier

Goal 2 Provide fair, equitable and timely access to quality, safe health services that people need

Goal 3 Foster a culture that is honest, compassionate, transparent and accountable

Goal 4 Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them

Goal 5 Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

DRAFT

Published March 2019

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Foreword from the Chief Executive Officer

2019 heralds a year of opportunities and challenges for the Ireland East Hospital Group. IEHG welcomes the implementation of the Sláintecare programme and we are keen to engage with the programme to progress our plans for integrated care. 2019 also indicates uncertainty for the future of the Ireland East Hospital Group. We are progressing the delivery of services against the uncertainty associated with changes arising from national policy plans for the Development of Regional Integrated Care Organisations (RICOs). More important than structures, a key success factor is building and maintaining effective partnerships and relationships with internal and external key stakeholders across the Group and with UCD. Investment in these relationships has been pivotal to improved patient services in the Ireland East Hospital Group and we are anxious to continue to build upon these service improvements particularly in integration and standardisation of clinical services and cross site working.

The targeted reduction in elective surgery required to address the unavoidable growth in unscheduled care demands risks increasing waiting times for patients requiring admission for planned procedures. We will engage with the NTPF to mitigate any increase in waiting lists/times. The impact of any planned reduction in activity will be closely monitored during the year and consequences escalated as necessary.

Throughout the year the IEHG will continue to deliver its programme of transformational change and service improvement though our use of Lean methodology. We will build upon the improvement work already undertaken across Frailty, Ophthalmology, Unscheduled Care, Cancer and Theatre Optimisation. In 2019, we look forward to delivering service improvements in our ophthalmology and scheduled care programmes.

In line with our key strategic objective to become a fully Academic Health Science System by 2020, we have identified key service themes which reflect our combined national and international strengths and ambitions in research, clinical practice and education. The themes are: Cancer, Genomics and Women's Health/Paediatrics/Adolescents. These services have been restructured into Clinical Academic Directorates (CADs) and will be charged with delivering high quality care, educating and training healthcare professionals, embedding research into the system and translating those research benefits into patient benefits. During the year we will also deliver CADs in Neurosciences and Cardiovascular. We have also prioritised the establishment of an Ophthalmology Institute to oversee the structure and delivery of ophthalmology services across the Group. The IEHG Research Programme will be operational in 2019 and will build on the strengths of the UCD Clinical Research Centre to further enhance the quality and oversight of research activity across the IEHG network and to establish clear governance framework for all IEHG research to ensure both local hospital and central leadership have oversight of research activity

This year we will complete and submit both our proposal for the national Trauma Strategy (A Trauma System for Ireland:) and our plan to develop a stand-alone elective surgical hospital in greater Dublin.

Our Operational Plan 2019 is subject to the range of assumptions and risks already outlined in the HSE Service Plan. The risks primarily relate to our ability to deliver the volume of activity identified in SP19 within the allocated funding and to the absence contingency funding. It is disappointing that none of the clinical service priorities identified for the Group in 2019 have been funded. This will impact our ability to address some of the significant challenges within the group such as expansion of critical care capacity, increase our neonatal nursing staff, improving access to clinics as well as the supporting the establishment of a sustainable dermatology service in the Midlands. Additional challenges can be anticipated to address the ongoing increasing drug costs and to ensure compliance with the new Falsified Medicines Directive most of which have to be accommodated within existing resources

We will keep these and other risks under on-going review to ensure that they are mitigated as far as possible and escalated as required.

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Mary Day
Chief Executive Officer

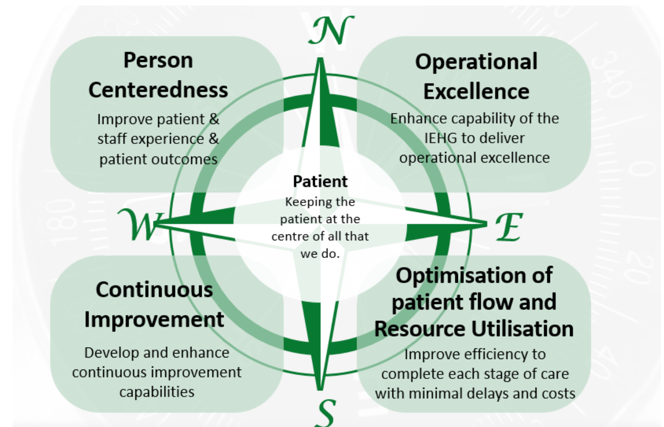
Date: 28th February 2019

1. Ireland East Hospital Group

The Ireland East Hospital Group, together with our academic partner University College Dublin, aims be a national leader in healthcare delivery, with a strong international reputation, improving the quality of healthcare and patient outcomes through education, training, research and innovation for the 1.1 million people we serve.

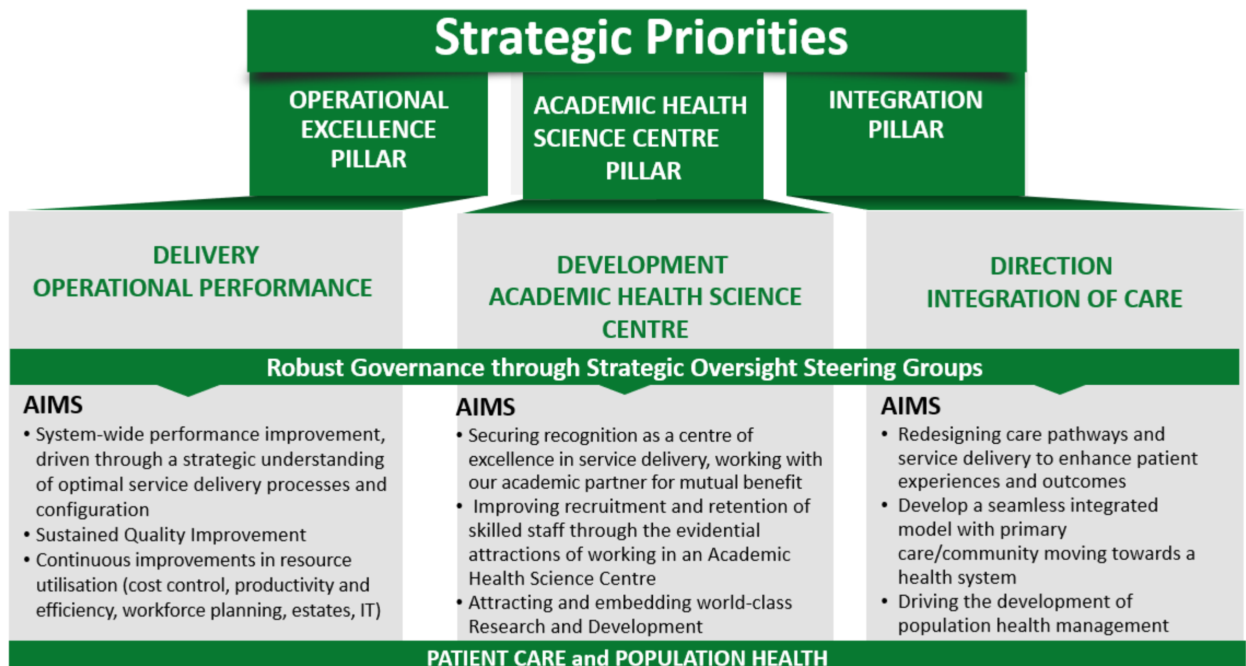
Our mission is to deliver improved healthcare outcomes through:

- Provision of patient-centred care
- Ongoing audit and evaluation
- Access to world-class education, training, research and innovation through our partnership with UCD, leading to the delivery of innovative, evidence-based healthcare
- Application of a Lean management system in order to build a strategic and management model for operational excellence and continuous improvement



The IEHG has developed a Strategic Framework Programme under a three-pillar structure which focuses on the Goals of:

- **Delivery**: Operational Excellence underpinned by a Lean Management Framework.
- **Direction**: Integrated Health System underpinned by a Population health approach
- **Development**: of an Academic Health Science Centre



The Ireland East Hospital Group (IEHG) is Ireland's largest Hospital Group with UCD as the academic partner. Serving a population of 1.1m the Group overlaps with 4 Community Health Organisations (CHOs), employs just over 11,770 staff and has gross expenditure of over €1bn. IEHG is an emerging organisation of 11 hospitals, six voluntary and five statutory, and has a unique profile of local services and focused tertiary and quaternary services.

The six voluntary hospitals are for the purposes of the Health Act 2004 funded by the HSE as five Section 38 agencies (St. Michael's Hospital (SMH) and St. Vincent's University Hospital (SVUH) are part of one legal entity). Two voluntary hospitals (National Maternity Hospital (NMH) and Royal Victoria Eye and Ear Hospital) are constituted by legislation or charter. The Mater Misericordiae Hospital (MMUH) and the St. Vincent's Healthcare Group (SVHG) are companies incorporated under the Companies Act 2014 and are also registered charities.

This presents some unique challenges for our Group as each entity has its own corporate governance arrangements, and legal obligations. The current arrangement whereby the Hospital Groups have been established on an administrative basis gives rise to challenges, primarily around accountability and governance and primary legislation is required to mitigate these risks.

The Group Chief Executive has delegated authority to manage Hospitals within the Group under the Health Act 2004. Independent public hospitals ('voluntary hospitals') are funded by through Section 38 of the Health Act 2004 pursuant to authority delegated from the Director-General of the Health Service and this authority is operated through the Service Arrangement. Within the architecture of the health service and subject to rules and regulations applicable to Section 38 agencies, the Board of governors or directors of voluntary hospitals are legally responsible for service delivery.

The Group CEO is accountable for the Group's planning and performance in line with the Performance and Accountability Framework of the HSE. Targets and performance criteria adopted in the HSE Service Plan are monitored regularly through this framework.

IEHG at a glance

329,287
Inpatient/ Day case

730,138
Outpatient

317,311
People seen in ED

Our Academic Partner

11,693
Total WTE

2 Hospitals have JCI accreditation

2,042
Inpatient Beds

534
Day Beds

306
Maternity Beds

Theatre capacity

46.6
Open

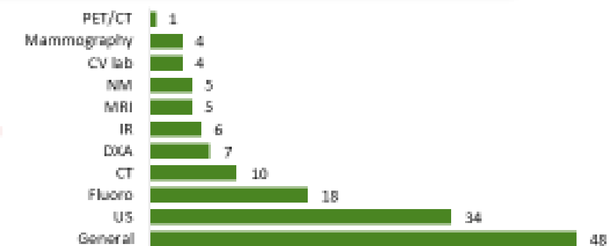
National Transplant Centres surgeries completed:

56 Livers | **18** hearts | **27** lungs | **5** pancreas

Strong integration platform with GPs across the Group

Diagnostic Stock

142

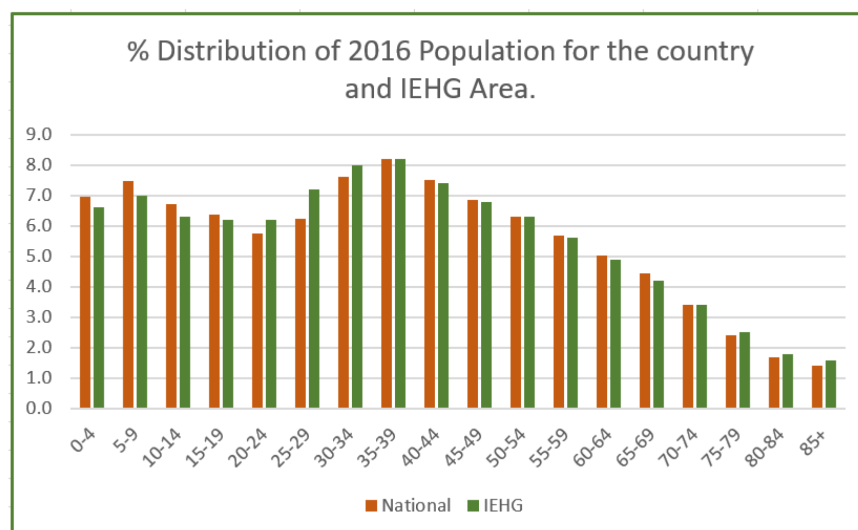


2. Our Population

The Ireland East Hospital Group serves a population of just over 1.1 million people as evidenced by the 2016 census. This constitutes just over one fifth of the national population at the time of the census. It is notable from the figures available that, in certain age brackets, the group serves nearly a quarter of the populations, namely in the 20's to 30's and also in the over 80's.

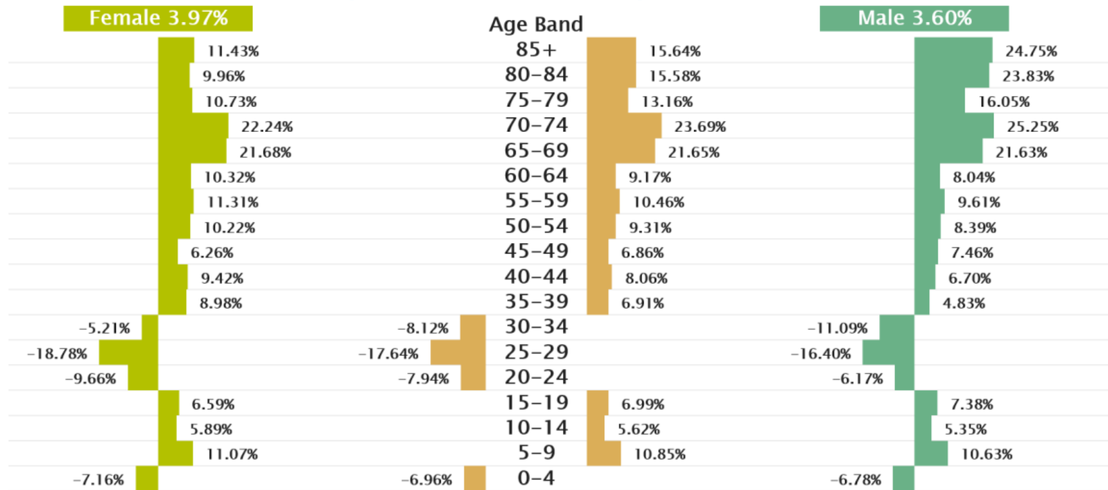
Similar to the wider health care system IEHG struggles to manage the increasing demands for services within a fixed budget allocation while maintaining and improving standards and quality of patient care.

An ageing population, patient/public expectations, advent of new technologies, increasing chronic illness, potential industrial unrest and limited bed capacity all increase the demands upon our hospitals. These factors coupled with increasing population and an increase in chronic diseases result in ongoing challenges providing timely access for patients requiring both elective and emergency care.



Comparing against the 2011 census it is evident that in the 5 years there has been a 3.8% increase in the population. This is broken down in age and gender as shown in the figure below. There are major increases in the population numbers over 65 and as evidenced above the IEHG serves the largest proportion of this segment of the population compared to the other hospital groups.

The over 65's represents 13% of the Group's total population but accounts for **37% of the inpatient discharges in 2017**. This growing demographic sector represents one of the key determinants in service delivery across the group.



Population Health Management

IEHG will continue to engage with the HSE Health Atlas Division to map our IEHG population by area of residence, GP, their demographics, age, ethnicity and deprivation indices. This data will guide service delivery and targeted funding in collaboration with our community partners.

In order to improve health outcome across the population we plan to introduce a Population Health Management (PHM) initiative to improve health outcomes particularly for those with long term chronic conditions. PHM seeks to improve health outcomes across a population by identifying and monitoring individual patients and target cost and clinically effective programmes. The programme brings together clinical, financial and operational data from across the system to provide actionable analytics to improve efficiency and patient care.

Using a Population Health Management Assessment Tool developed by IBM Watson we will be reviewing the readiness of our existing clinical services to deliver more integrated care. The areas under review include governance, clinical pathway and systems, as well as finance and contracting data and analytics. This advanced PMH can provide real-time and predictive insights to clinicians and administrators to allow us to better identify and address gaps in care within our patient's population.

3. Reform and Transformation

Integrated care, also known as integrated health and seamless care, is a worldwide trend in health care reforms and new organisational arrangements focusing on more coordinated and integrated forms of care provision. Integrated care puts the person/patient at the centre of the service, not the organisation.

Similar to healthcare systems worldwide, IEHG is on a journey to better manage our population of over 1 million patients. For the past three years we have been leading the integration of care across our hospitals and adjoining CHOs. This is underway both internally through the Service Improvement Team and externally through greater engagement with the Community Health Offices and General Practitioners (GPs).

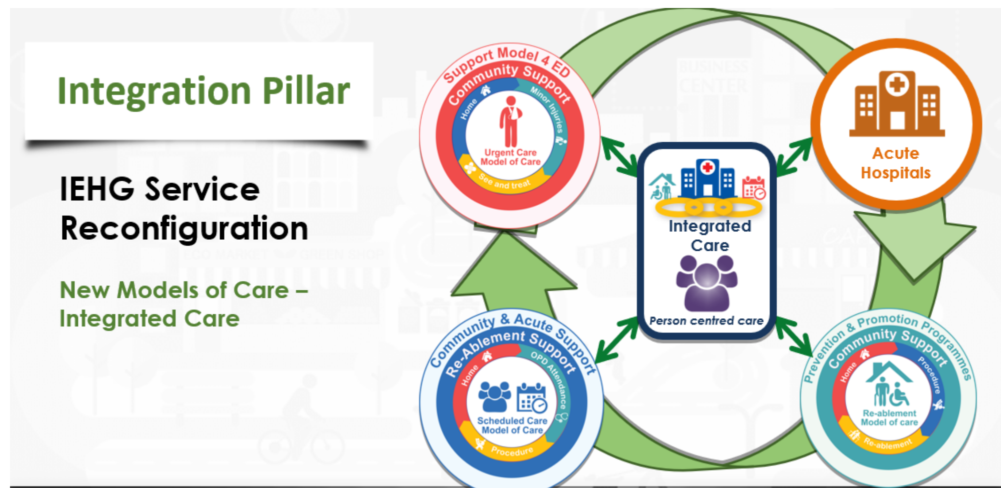
The redesign programme currently underway within the Group will continue in 2019. This programme will result in the realignment of clinical services across the 11 hospitals to ensure appropriate response to the rapidly changing shift in the design and performance of our current systems of care. To succeed, collaboration with a wide range of internal and external partners is a prerequisite, thereby facilitating an integrated approach and response to changes in technology, patient demands and service delivery.

A clinically led engagement process, which challenges the way services are currently designed and delivered is underway. A number of proactive Service Review and Working Group forums have been established to focus on improving the patient's experience and outcomes of care in agreed specialities. Several initiatives and working group work-flows are underway and will continue in 2019 This includes work flows relating to orthopaedics, ophthalmology, critical care, pharmacy services, venous thromboembolism (VTE), weight management, vascular services, diagnostics, neurology, paediatric and neonatal services. The work streams underway captures all activity and looks at enhancing high quality safe care while exploring potential for service innovation and aligned to the value improvement programme.

The work to improve clinical links between Our Lady's Hospital Navan (OLHN) and the Mater Misericordiae University Hospital (MMUH) and St Columcille's Hospital (SCH) with St Vincent's University Hospital (SVUH) will continue to ensure the provision of appropriate patient services to meet local population needs. Working groups have been established within both of these programmes to ensure patient safety and a high quality of care is delivered in the most appropriate setting in a timely, effective and efficient manner.

During 2018, we restructured our Community Integration Framework and set up regular business meetings between IEHG and our community partners. We are currently developing pathways to develop a range of integrated projects across primary and community services in community ophthalmology, virtual clinics for heart failure, community management of Hepatitis C, frailty initiatives and a winter preparedness to minimise admissions. These projects, along

with the establishment of Local Integrated Care Committees between GPs and acute hospitals in St Luke's General Hospital Carlow/Kilkenny, Our Lady's Hospital, Navan and St Columcille's are initiatives which we intend to further rollout during 2019.



The Heart Failure Virtual Clinic (St Vincent's and St Michaels Hospitals) continue to deliver better care in the community, improved outcomes (reduced referrals to ED/AMAU and OPD), reduced costs and greater satisfaction among GP providers in providing this model of care. With the support of Sláintecare we are anxious to scale up these projects and expand access for patients. Similarly, IEHG has developed a proposal for an integrated care programme for Hepatitis C shared between the community and hospital sectors. We are progressing this initiative to consolidate the benefits already identified in the Eurocare project.

During 2019 IEHG will progress the establishment of an Ophthalmology/Eye Institute to meet the increased demand for ophthalmology services. Integration with the community is central to addressing ophthalmology challenges within the Group. Establishing this programme to encompass hospital and community services is aimed at improving the quality of the service and expanding access to address adult and paediatric waiting list challenges. Reorganisation of services to this magnitude will be supported by a focus on key enablers including but not limited to informatics and data, primary / community care, health systems research, innovation and healthcare improvement. Our plans are strategically aligned to Sláintecare goals and we have submitted proposals to Sláintecare to progress these programmes.

The IEHG has also commissioned a study with UCD to assess '*Enhancing access to and integration of care – a longitudinal study* (the GP-Link Study). This research programme is led by the UCD School of Medicine, and the General Practice & Primary Care Research Network. The aim of the network is to enhance patient care, treatment outcomes and therefore population health, by conducting multidisciplinary programmes of research in general practice and primary care to inform future service planning, and their subsequent delivery and evaluation. During 2019 we will undertake a 'demonstration project' (i.e. feasibility study of a complex intervention) to enhance access to / integration of care at participating practices. The demonstrator project will relate to medical readmissions. This study will inform healthcare policy on promote access to and integration of primary and secondary care.

4. Quality and Safety

The quality of care within the Group will focus on patient safety, effectiveness of care and patient experience and the measurable elements within these domains.

The Ireland East Hospital Group will produce an annual Quality Account, a report demonstrating the quality of services delivered and improvements made within the Group to achieved delivery of consistent, high quality care to meet the needs of the population. The account will provide information on how we measure how well we are doing and how we continuously improve the services provided. The report will provide information on how we respond to checks made by regulators like HIQA, modelled on the Care Quality Commission (CQC) NHS.

The development of robust governance systems across the group will be tracked and monitored through this report to ensure that the infrastructure to enable development and sustainability of quality driven services is supported and embedded.

Aligned to national QPS priorities 2019, the group is actively engaged in implementing tactile solutions to advance the culture of patient safety and continuous improvement across the Group by:

- Strengthening clinical leadership and engagement in the development and deployment of a quality strategy
- Due diligence of capacity and capability to deliver safe care enabling reengineering of existing structures to enhance and develop robust integrated clinical and cooperate governance.
- Improving patient and service user engagement to ensure that the priorities of patients and service users inform service planning which is designed around their needs, enhancing patient safety and improving overall patient experience.

Priorities and Actions

Patient Safety:

- Empower staff to improve safety through across the Group and integrated services through the:
  - Development of robust clinical and cooperate governance structures across the Group
  - Improve overall response to safety incidents (reporting and investigation) by developing capacity and capability across the Group to support the implementation of the HSE Integrated Incident Management Framework
  - Development of structures to embed a proactive approach to address safety risks proactive.
  - Develop sources of patients safety data, data management and capacity and capability in relation to data analysis to support decision making in relation to quality and safety of services provided across the Group.
  - Support and implementation of initiatives to reduce harm

Health Care Associated Infections (HCAI):

- Ensure governance structures are in place in each hospital to drive improvement and monitor compliance with targets for HCAIs / AMR (antimicrobial resistance) with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms.
- Support a programme of work to control antimicrobial resistance (including Carbapenemase Producing Enterobacteriaceae (CPE), and to manage antimicrobial resistance and infection prevention in accordance with HIQA standards and the National Action Plan on Antimicrobial Resistance.
- Support the deployment of the IEHG Flu Vaccination uptake plan 2019/2020

Clinical Effectiveness:

- Progress the development of Group wide Clinical / Healthcare Audit Programme
- Monitor and support implementation of National Standards for Safer Better Healthcare modelling on CQC assessment NHS
- Support the implementation and evaluation of the National Clinical Effectiveness Committee (NCEC) clinical guidelines; National Early Warning System (NEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS), Emergency Medicine Early Warning System (EMEWS) and Sepsis Management guideline through the enablement of the National Deteriorating Patient Recognition and Response Improvement Programme.
- Support the development of prevention and management of VTE (blood clots) initiatives in patient across the Group.

Patient Experience:

- Continue to embed a culture of open disclosure.
- Implementation and compliance with "Your Service Your Say" recommendations
- Work with the HSE in the development of a programme on engagement service users, families and communities to establish a programme to facilitate learning from the National Patient Experience Survey, '*Your Service Your Say'* and complaints mechanisms, *Your Voice Matters* (Patient Narrative Project) and the Incident Management Framework 2018.
- Implementation of the National Hospitals Communication Programme aligned to the NPES within each hospital
- Empower and engage patients in patient safety through the develop and implement partnership initiatives with patients and service users

Quality improvement:

- Develop robust governance structures to support clinical leadership in delivering National Quality Improvement programmes to delivery reliable and effective services for patients: National GI Endoscopy Quality Improvement Program
- Build Quality and Patient Safety capacity and capability at hospital group and individual hospital level to support Quality Improvement initiatives

Assurance:

- Development of a Board on Board monthly quality report
- Produce a mid-year and end of year quality report
- Develop and deployment of IEHG Quality and Patient Safety Strategy
- Implementation and monitoring of learning and recommendations from external reviews & bodies (HIQA)

5. Health Care Delivery

IEHG provides a wide range of acute elective inpatient and outpatient services across our 11 hospital sites and provide services on three levels; those serving local catchment areas, specialist/tertiary services delivered to regional populations and quaternary services delivered on a national basis as follows:

- National /Liver/Pancreas, Heart & Lung Transplant Units
- National Unit for adult Cystic Fibrosis
- National Spinal Unit
- National Isolation Unit for Infectious Diseases
- National Unit for Pulmonary Hypertension
- National Unit for Neuroendocrine Tumours
- National Extra Corporeal Life Support
- Cardiothoracic Surgery

Six hospitals in the Group operate an Emergency Department (one with a local minor injuries unit), one has a 12-hour urgent care centre and another hospital operates an Acute Medical Assessment / Local Injuries Unit. We also have two designated cancer centres within the Group.

Improving the way clinical care is currently delivered has been at the core of IEHG planning. We have established a Clinical Service Redesign Programme to monitor and oversee clinical services across the group with the aim of having clinical services cross-site based, rather than individual hospital-based, in their structures, management, and operation. This redesign programme ensures clinical integration and is delivering a higher quality of service to our patients. This work has been made possible through the proactive work undertaken by IEHG member hospitals, steering group and working group members. Work streams have been agreed to capture activity and improve quality of care while exploring potential for service innovation. A key success factor is building and maintaining effective partnerships and relationships with internal and external key stakeholders across the Group and with UCD.

In 2018, we have witnessed an improvement in the Group's PET times with the greatest improvement of 11% seen in the PET for the over 75s. This can be attributed to the dynamic frailty programme we are rolling out across the Group which is taking place against a backdrop of increasing emergency presentations. Thanks to the efforts of our Service Improvement team, our four Model 3 hospitals (St Luke's General Hospital, Carlow/Kilkenny, Mullingar Regional Hospital, Wexford General Hospital and Our Lady's Hospital, Navan) are now implementing 100% frailty screening for patients over 75 through the work of dedicated Frailty Intervention Teams (FIT).

Under our priority Clinical Services Redesign Programme work flows will continue in ophthalmology, Venous Thromboembolism (VTE) Service, critical care, apheresis, neuroscience, orthopaedic, vascular and ENT services. This programme has facilitated the transfer of elective day case activity from model 4 hospitals (SVUH & MMUH) to model 2 hospitals (SCH & Navan) which is key to management of capacity and demand within the Group.

5.1 Unscheduled Care

Delivering timely access to unscheduled care services is increasingly challenging arising from the increase in attendances and in particular the numbers of elderly patients presenting to ED. The past year has seen a 4.4% increase in ED attendances and a 9% increase in Emergency admissions to our hospitals. This has had consequences for scheduled/elective surgery.

Despite the increase in attendances and admissions, the IEHG PET performances has shown improvement in all areas in recent years. We are aiming to continue to improve all unscheduled care metrics throughout 2019.

Annualized trends indicate that in 2019, emergency presentations will continue to increase and those admitted will use more hospital bed days. However our ability to significantly reduce TrolleyGAR numbers is likely to remain constrained due to the increase in demand for isolation facilities.

We are directing further improvements in our unscheduled care metrics through implementation of focused service improvement using Lean methodology and integrated winter planning.
In particular the IEHG's Unscheduled Care and Service Improvement Programmes are working to improve Patient Experience Times (PETs) and 8am TrolleyGAR performance by focusing on Frailty, Patient Flow and Acute Floor initiatives. We are working closely with our Community Care colleagues, increasing collaboration on integrated pathways, acute hospital egress and seamless patient care.

The continuous high occupancy rates in all of our hospitals results in a lack of surge capacity to accommodate periods of additional demand. In recent years the allocation of Winter initiative funding and additional support to fund earlier access to diagnostics, improve hospital discharges and enhanced minor injuries has enabled individual hospitals to manage increased demand over the winter period. Similar funding will be required for winter 2019/20.

Priorities and Actions:

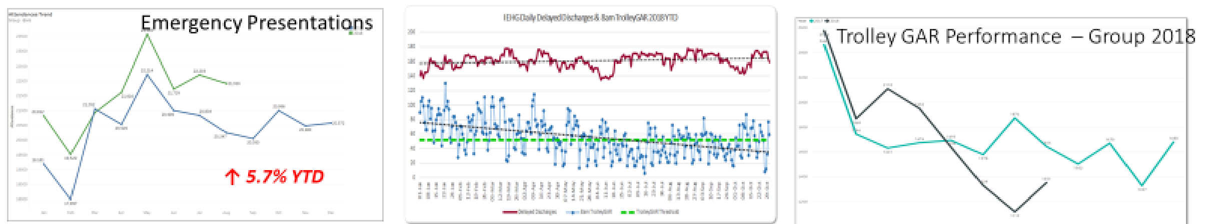
Integrated Patient Flow

Building on our integrated approach to planning, our hospitals together with their CHOs have identified escalation triggers and developed combined processes to improve patient flow and discharge during surges in emergency attendances. We have agreed maximum delayed discharge numbers with our hospitals. Achieving these will require the support of winter initiatives aimed at timely discharge of patients who require Nursing Home care, packages of care or other community supports.

Service Improvement

Using lean principles, the IEHG Service Improvement Team have worked with all our hospitals to improve patient flow and manage frailty. Hospitals have undertaken Value Stream Analysis (VSAs) of patient pathways followed by Rapid Improvement Events (RIEs) to improve these pathways for patients and achieve operational efficiencies. The frailty screening programme currently operational in all of our Model 3 hospitals.

Supporting delivery of this operational excellence is a programme of training and development in Lean philosophy and methodology. To date almost 2000 IEHG staff have participated in Lean training. A focus on engagement of Clinical leaders and nursing is already apparent in the leadership of key events.

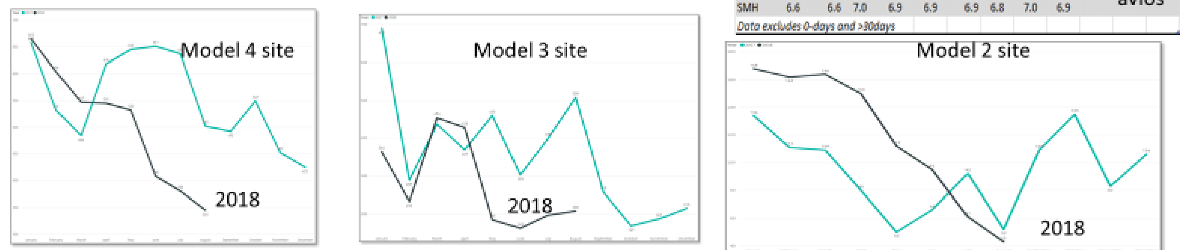


Trolley GAR Performance Improving
In Model 2/3/4 IEHG Hospitals 2017-2018

Inpatient Medical AvLOS: 2018 YTD												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
SLHK	6.6	6.0	6.0	5.9	5.9	5.8	5.8	5.8	5.7			
MMUH	7.0	6.8	6.9	6.9	6.8	6.8	6.8	6.8	6.7			
RHM	6.6	6.4	6.3	6.2	6.1	6.0	6.0	5.9	5.8			
OLHN	6.2	6.3	6.4	6.4	6.3	6.2	6.1	6.0	6.0			
SCH	6.3	6.8	6.9	6.9	6.8	7.0	7.2	7.2	7.3			
SVUH	7.0	6.9	6.8	6.7	6.7	6.6	6.5	6.4	6.4			
WGH	5.6	5.2	5.3	5.0	5.0	5.0	5.0	5.0	5.0			
SMH	6.6	6.6	7.0	6.9	6.9	6.9	6.8	7.0	6.9			

Data excludes 0-days and >30days

avlos



Priorities for 2019

Managing Frailty: A Model of Care for the Older Person is being developed in IEHG with the intention to develop integrated health care across IEHG. The IEHG Service Improvement Team have delivered a series of Group wide events including visioning workshops and masterclasses. Through this process the following key priorities have been identified:

- Standardised application of frailty assessment tools/ CGA for IEHG and partners
- Shared training and education across all relevant services
- Integrated forums for stakeholders to meet and develop new/ realigned care delivery models

The key priorities for service improvement are in the first incidence to develop standardised processes to ensure identification of frailty at the front door with a rapid and robust response mechanism.

Planning for Green: IEHG are working closely with hospitals and our CHO partners to ensure we achieve National Targets in unscheduled care performance. In terms of TrolleyGAR, we are ***"Planning for Green".*** In the drive to achieving this we expect to see **10% improvement in PET performance** in each of our sites. Notwithstanding the initiatives underway we anticipate that maintaining our 24-hour PET performance at its

current 98% will be challenging during winter primarily due to the increasing demand for isolation for infection control purposes.

Our process improvement plans will be supported by additional social care funding which should improve timely appropriate discharges for frail elderly patients across the group. Cumulatively these measures will contribute to reducing delays for patients attending hospitals and during their hospital stay.

Implementing Priorities in 2019

Priority	Priority Action
Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care Programme for Older Persons.	Forge links between acute sector and primary and community care to integrate services
Continue to ensure that no patient remains over 24 hours in ED	Implementing 'Planning for Green'
Continue to implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare	Collaborate with Community Healthcare Partners to improve timely discharges for patients across the group
Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics	Improve access to unscheduled care through integrated action with community services, with the focus on access to diagnostics, developing pathways for admission avoidance.

5.2 Scheduled Care

The sustained increase in emergency admissions has negatively impacted scheduled care capacity resulting in increasing waiting lists. Over the past three years there has been a 16% increase in emergency admissions and an 8% reduction in elective admission. All IEHG hospitals provide elective surgery and out patient clinics and many struggle to deliver timely access to outpatient appointments and surgical procedures.

Ophthalmology and orthopaedics remain the specialities with the most challenging waiting lists. We have established clinical forums in both specialities to promote across sites delivery of services and improve referral pathways.

Work undertaken in conjunction with the IEHG Service Improvement Team has highlighted the need to review processes in order to drive performance improvement. To date much the service improvement work has focused on unscheduled care however 2019 will specifically target scheduled care to improve productivity and efficiency. Initial work will be undertaken in ophthalmology services.

Endoscopy: The on-going increase in endoscopy referrals continues to remain a challenge for the Group. While priority 1/urgent referrals are seen within the four-week timeframe, there are ongoing challenges in treating Category 2/'non-urgent' and surveillance referrals within the 13-week target.

Managing P2 referrals in line with national targets has become particularly challenging due to the limited capacity, volume of referrals and the complexity of procedures being performed.

In particular our Model 4 hospitals are experiencing increasing referrals for complex inpatient and tertiary care therapeutic procedures, such as ERCP (endoscopic retrograde cholangiopancreatography), endoscopic ultrasound (EUS), EMR/complex polyps, enteric stenting and gastrointestinal (GI) bleeds. These referred are received both from within IEHG and from other Hospital groups, predominantly Mid-West and North West.

IEHG is one of the largest providers of endoscopy to the National BowelScreen programme. Three hospitals within the Group currently participate in the Colorectal Screening Programme (Bowelscreen). Some of these units continue to experience capacity challenges to accommodate Bowelscreen referrals in line with service level agreements. We will continue to engage with the National Screening Service to manage their capacity requirements however, the anticipated demand for screening cannot be accommodated without the opening of the 5th endoscopy room in St. Vincent's University Hospital. In the interim where possible we will avail of NTPF funding to run additional lists or refer long waiting 'routine' patients to external hospitals.

All hospitals will be supported in their application for JAG accreditation. Monitoring of standards and performance will be closely managed in conjunction with the clinical lead for endoscopy services.

Issues and opportunities

The increased allocation of €75m to the National Treatment Purchase Fund (NTPF) provides an unprecedented opportunity to make significant reductions in waiting lists. In particular, NTPF funding will enable us to maximise existing capacity and undertake additional elective work particularly in both of our dedicated elective facilities.

We are liaising with the HSE Acute Operations and the NTPF to agree additional support measures in individual hospitals to ensure that CANs are processed in a timely manner.

Priorities and Actions

- Manage In-Patient, Day Case, Out Patient and endoscopy waiting lists in line with national targets.
    - Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate.
    - Monitor length of stay and opportunities for improvement using NQAIS

- Avail of NTPF funding to use available capacity to address waiting lists.
    - Continue to fund the dedicated cataract theatre in the Royal Victoria Hospital to undertaking > 2,200 additional cataracts during 2019 and fund ~450 additional hip and knee replacement surgeries in Cappagh Hospital.
    - Continue to support the transfer of appropriate elective day case surgeries from MMUH to Our Lady's Hospital Navan and SVUH to St Columcille's Hospital.

  - Continue to develop St. Vincent's University Hospital as the national centre for bariatric surgery and undertake 100 additional surgeries in 2019 with the support of the NTPF

- Improve access to scheduled care
  - Agree waiting lists targets for each hospital and monitor performance
  - Liaise with the NTPF to accommodate long waiting patients for surgery through funding of additional elective lists, referral across other IEHG hospitals or, where insourcing is not an option, to refer to the private sector.
  - Avail of NTPF funding to develop bespoke solutions for complex long waiting patients
  - Agree local plans for waiting list validation
  - Work to progress the opening of the 5th endoscopy room in SVUH
  - Improve access to scoliosis surgery in Mater and Cappagh hospitals

- Specifically target OPD long waiters waiting times
  - Develop targeted initiatives to reduce waiting lists >15months in ophthalmology and orthopaedic services.
  - Review DNA and CAN rates by hospital and by speciality to increase and maximise access to new patient appointment time

- Manage endoscopy waiting lists in line with national targets
  - Engage with National Screening service to manage Bowelscreen referrals and follow up treatment.
  - Avail of Dynamic Purchasing Framework as part of the IEHG solution to endoscopy waiting lists
  - Avail of NTPF funding to undertaken additional insourcing activity in IEHG units or refer eligible patients for treatment in external units.

Implementing Priorities in 2019

Priority	Priority Action
Reduce waiting lists and waiting times in line with national targets	Maximise insourcing and outsourcing opportunities to treat long waiting IPDC, OPD and endoscopy patients - ensure all eligible patients are referred for treatment under NTPF
Address priority waiting list services	Secure agreement from the NTPF to treat 100 additional bariatric surgeries (and follow up care), 2,200 cataracts, 450 long waiting hip/knee procedures and other insourcing proposals within IEHG hospitals developed during the year. Priority address ophthalmology Review theatre capacity and activity
Reduce OPD Long Waiters	Agree local plans to address OPD long waiting lists in line with individual hospital targets
Increase endoscopy capacity	Open 5th endoscopy room SVUH

5.3 Specialist Services

Service development funding was allocated in 2018 to support the expansion of a number of specialist clinical services based within the Group. The full effects of these will take effect from 2019. IEHG will liaise closely with HSE Acute Operations Division to track performance and impact of new developments.

Critical Care: The additional ICU bed opened in November 2018 and 2 of the HDU beds were opened at the end of August 2018. One additional HDU bed will open at the end of March 2019 and, pending successful recruitment the remaining 3 HDU beds will open in Q2/3.

Transplant: Phased opening of additional Heart/Lung assessment beds in Mater Hospital will continue through 2019 with the appointment of the agreed additional staff. These beds will open on a phased basis with the first two due to open in early 2019.

Neurology: Deep Brain Stimulation: The appointment of an additional clinical nurse specialist, speech therapy, psychology, nursing and a half time physiotherapist progressed during 2018. The remaining posts of 0.5 consultant neurologist and admin support will be appointed this year. These posts will provide improved access to pre and post-op DBS patients to specialist services. The increasing links to the Royal Victoria Belfast and other neurologist expertise will also prove beneficial to the wider neurology service.

Transgender Service: Work is ongoing to progress the Model of Care for the new service in St Columcille's Hospital. Recruitment of staff is ongoing, and all posts are will be filled during the year. Provision of an appropriate clinic space remains a concern.

Scoliosis: Significant investment has been made to develop and enhance access to scoliosis surgery within IEHG with significant reductions seen in the surgical waiting list. This increased surgical activity is expected to continue during 2019 as the outstanding staff take up their posts.

Neonatal Transport: The new neonatologist post shared with Our Lady's Children's Hospital and the National Maternity Hospital has been appointed. This post will support the rapid transfer of critically ill neonates for specialist care.

Implementing Priorities in 2019

Priority	Priority Action	Timeline
Transplant	Opening of 2 new heart/lung transplant beds in 2019	Q2
Critical Care	Open remaining 4 HDU beds in MMUH. It is envisaged in 2019 with full consultant manpower that the full 36 bed complement will open in MMUH.	Q3

5.4 Women and Children's Services

Four hospitals within the Group provide maternity services, Regional Hosptial Mullingar, Wexford General, St Luke's Hospital, Kilkenny and the National Maternity Hospital. Each year on average fourteen thousand women deliver their babies in an IEHG Hospital. Our aim is to support these four units to deliver high quality women centred, safe care to all mothers and their families.

Working in parallel with the National Women and Infants' Health Programme (NWIHP), IEHG will progress the implementation of the National Maternity Strategy 2016-2026 (NMS) and its four core principles:

- Health and wellbeing;
- High quality, safe, consistent, women centred care;
- Facilitation of appropriate choice for women;
- Maternity services with appropriate resourcing, governance and leadership.

Priorities and Actions

During 2019 we will formally establish a Clinical Academic Directorate/Maternity Network for maternity, paediatric and women's health across the Group. The new clinical lead will commence in Spring of 2019 and will provide governance and oversight of maternity (and paediatric) service across within the Group The directorate, will oversee the development of robust referral pathways, standardised clinical protocols, regional-based educational programmes and shared learning, clinical governance and management arrangements and enhanced oversight and deployment of resources within the Group. The clinical lead will work collaboratively with the NWIHP to ensure connectivity at national level.

IEHG also intends to establish a paediatric / neonatal services Clinical Academic Directorate, in 2019 to ensure delivery of high-quality care and treatment of children and to liaise with Children's Health Ireland and the national paediatric clinical programme. An Executive Director will be appointed in early 2019.

The clinical lead will also oversee the development of a plan for a Serious Incident Management Forum for maternity services within the Group.

Challenges within the service include support for the roll-out of the national termination of pregnancy service and recruitment and retention of nursing, midwifery and consultant staff.

Priorities 2019

- Continue to recruit specialist midwifery posts approved in 2018
- Expand access to anomaly scanning in line with national recommendations
- Progress the development of the National Maternity Hospital onto the campus of St Vincent's University Hospital

Implementing Priorities in 2019

Priority	Priority Action
Clinical Governance	Appointment of an executive clinical director for maternity services with liaison role for paediatric services within the Group. Work with the NWIHP to implement the TOP clinical guidelines and recommendations set out in the report on the use of transvaginal mesh.
Quality	Work towards implementation of the HIQA National Standards for Safer Better Maternity Care. We will also work with the NWIHP to implement the new framework on management of maternity related incidents and to implement the recommendations of the relevant reports and reviews. Establish a Group wide plan for Serious Incident Management Participate with the NWIHP in the development of a national suite of KPIs for maternity services
Implement National Model of Care	Throughout 2019 we will implement the national model of integrated, multi-disciplinary maternity care and the establishment of community midwives where these are not currently in place. This will ensure that women who have a normal risk pregnancy can avail of the supported care pathway in their own community. Full implementation of the model of care (and specialist in perinatal mental health posts) is contingent upon the ability to successfully recruit additional midwives.
Quality	Undertake a review of maternity services across the Group

5.5 Cancer Services

Services provided

The Ireland East Hospital Group (IEHG), is developing as an academic hospital system with our partner UCD in an advanced integrated Academic Health Science Centre (AHSC) model. The Cancer Clinical Academic Directorate (CaCAD) launched in June 2016 is the first Clinical Academic Directorate in the IEHG aligning the two cancer centres at the Mater Misericordiae University Hospital (MMUH) and St. Vincent's University Hospital (SVUH) into a single function operating across two sites. The directorate is designed to enable IEHG to leverage the expertise of both hospitals with the research and teaching expertise in UCD to deliver state of the art cancer care.

The IEHG is the largest provider of cancer services in the country, the MMUH & SVUH as designated Cancer centers have a number of Rapid Access Clinic's (RAC's) in place for Lung Cancer, Prostate Cancer and Symptomatic Breast. Our two cancer centers account for approx. 27% of the national volume of lung, prostate and breast cancer patients accessing cancer services via the RAC's.

Our mission, in alignment to the National Cancer Strategy 2017-2026, is to increase the life expectancy of patients with cancer, to alleviate suffering, to deepen knowledge and understanding of cancer, thereby improving the outcomes for patients. Our cancer services provide an integrated approach to patient care that is supported by research and training.

Issues and Opportunities:

In 2018 the IEHG, experienced some challenges achieving the KPI target for Symptomatic Breast and Prostate Rapid Access Clinics (RAC). By the end of 2018 the Prostate RAC KPI and "urgent" Symptomatic Breast KPI performance had recovered significantly. Work is underway via the Tumour groups to maintain and improve on the KPI performance on an ongoing basis.

The CaCAD has established a number of Tumour groups. The purpose of these tumour groups is to bring the cross functional team working on a specific cancer area, across the IEHG Hospitals, together to:

- Define a strategy for across the group for their cancer service that prioritises patient care, access and outcomes aligned to the CaCAD
- Map the service against international best practice for cancer care (OECI Accreditation Standards)
- Define a standardised day to day working structure across the sites to help resolve operational and service issues and improve performance including Rapid Access Clinics (RAC's)
- Review referral pathways within and external to Ireland East Hospital Group
- Review the training and education requirements for the service

In 2019 the IEHG CaCAD will progress a number of ongoing cross institutional service improvement and integration programmes. Integrated Care at the CaCAD starts with the formation of tumour groups in each specialty and ends with a fully integrated service with clearly defined care pathways. Gynaecological oncology and head and neck cancer are the most advanced services in the CaCAD leading to defined patient benefits including:

- Access: Reform of the tertiary hospital referral form and increased capacity in our triaging and diagnostic services and streamlined the referral process.
- Efficiency: Improved efficiency within our Oncology service by standardisation of processes and data across the group leading to more effective utilisation of available OPD and theatre capacity across hospitals
- Outcome: More person centred, expedited and efficient access and management for the patient through the Oncology service from referral through treatment and to survivorship.

The IEHG CaCAD and cancer centers will continue to work with the National Cancer Control Programme (NCCP) on programmes and initiatives such as:

- Resilience of supply of compounded parenteral systemic anti-cancer therapy (SACT) in hospitals following Brexit
- NCCP Oral Anti-Cancer Medicines (OAM) Model of Care Recommendations 2018
- NCCP Rapid Access Clinic (RAC) performance improvement project
- Hospital processes relating to the Oncology Drug Management System (ODMS)
- Implementation of the National Cancer Information System (NCIS)
- Centralisation of Surgery for Cancer within the two Cancer center hospitals in the group

The CaCAD will also continue to work with the Cancer centers to address staffing shortages, in particular in the recruitment and retention of experienced specialist oncology nurses.

Implementing Priorities in 2019

Priority	Priority Action
Improve and enhance the quality of Cancer services for the 1.1million catchment area served by the group:	Finalise and implement the CaCAD strategy to develop services in alignment with the National Cancer Strategy in areas such as palliative care, cancer survivorship, psycho-oncology services. Increase the access to and capacity of the cancer services through the appointment of approved consultant posts in Oncology, Haematology, Gynae Onc, Hepatology and ENT. Link with other Clinical Academic/Service Directorates being established within IEHG in the areas of Women's' Health Adults & Young Adolescents Health, Cardio Thoracic, Genomics and Research. Support the development of the genomic testing and cancer genetics service to treat patients with the right therapy first time and to manage disease free high-risk patients. Work with the cancer centers to implement recommendations related to performance improvements for the Rapid Access Clinics and monitor performance on an ongoing basis. Promote the Healthy Ireland initiative by working with UCD's School of Public Health, Physiotherapy and Sports Science. Support the roll out of the National Cancer Information System (NCIS)
Development of a Single Cancer Service: **Progress the creation of a single cancer centre by:**	Deliver a unified Strategic and Operational Plan for the CaCAD's two designated cancer services to operate as one cancer centre. Strengthening of the CaCAD Executive structure and Cancer Directorate Structure at both Hospitals/Institutions. Further develop existing cross cancer centre and cross functional operational oversight groups to monitor performance, activity and service levels within the CaCAD sites Expand the number of existing cross centre tumour groups to cover all cancer specialty areas Consolidation and standardisation of reporting and data relating to cancer services across the group Further development and roll out of the Lean methodology Service Improvement framework across all cancer specialties To align with the National Cancer Strategy's (July 2017) aim of moving to four main surgical oncology centres and the development of comprehensive cancer centres advance the process to seek Organisation of European Cancer Institutes (OECI) accreditation for the CaCAD as a single comprehensive cancer centre

Develop the Research, innovation and Academic functions through the projects and programmes under the CaCAD including	The CaCAD works very closely with the Research Directorate to increase the options for patients in clinical research. Our goal is to double the number of patients having access to clinical trials in the next five years. To do this we will: • *Unify Cancer Research:* in 2019 we will unify cancer research in the Mater Misericordiae University Hospital and St Vincent's University Hospital under the Research Directorate. This unified structure and governance for clinical research will enable the CaCAD to provide greater access for cancer patients to treatment options. • *Early Phase Clinical Trial Unit:* In recognition of the significant deficits in the Irish cancer clinical trial model, the Cancer CAD will support the Research Directorate in the opening of the country's first Early Phase Clinical Trial Unit (EPCTU) in 2019 to provide enhanced treatment options for patients. The new unit will address the deficits in the current clinical trial model principally for: **Refractory Patients**: The majority of cancer studies in this country involve drugs that are already well down their development path, mainly large phase 3 trials in a front-line setting. There are little of no options for patients with refractory cancer. **Placebo**: Current trials are generally randomised and contain a placebo arm, which can be extremely off-putting for patients who are considering enrolling in a research study. The EPCTU will be delivered through Research Directorate, utilising their expertise and that of the medical oncologists within the groups two designated cancer centres. **Biobanking & Genomics linking in with the Genomics Directorate** • Working with the newly formed Genomics Clinical Academic Service Directorate (CSAD) develop a genomics services that is innovative, responsive and well-connected to the major genetics and genomics initiatives that are evolving worldwide. **Develop additional education programmes around Cancer** • Develop oncological component for undergraduate programmes. • Develop a bioinformatics programme to facilitate the development of precision medicine.

ICT and Health Informatics

Top of the agenda for 2019 is the completion of Group's Digital Plan of Action. While work is on-going on the development of this at present, it is hoped to complete and publish the Plan in Q1 of 2019. This will be a deliverables-based plan that is designed to provide an overall direction for the next 3-5 years, identify key activities that the Informatics function will progress, and will be developed in such a way as to be non-static, agile, and publicly accessible.

One of the key elements in the Plan is the need for an integrated approach to our work in driving a digital agenda. It is essential that this approach embeds UCD into our activities, developments, and research. The need for an encompassing education framework to support the development of Health informatics within the group, and wider afield, is also paramount. Therefore, we will be progressing the establishment of a Centre for Health Informatics that brings together all the relevant parties including the hospitals, UCD and external advisors. It is planned to have the proposal for the Centre submitted in Q1(2019) with it established in Q2/3 (2019). This Centre will be headed up by the Group Chief Information Officer.

Early 2019 will see the formal appointment of a Chief Medical Information Officer. This is one of only a handful of such posts nationally, the others being primarily single hospital focused. The Chief Medical Information Officer and Group Chief information Officer will drive the digital agenda with a particular focus on clinical elements.

In addition to these elements, other key developments planned for 2019 include:

- Approval and commence procurement of Electronic Document Management System (Q1/2) to reduce the major issues related to medical chart storage and management initially in three hospitals – Mater, St. Vincent and Cappagh Orthopaedic Hospitals.
- On-going development of Group Performance Dashboard, moving to more real-time data.
- Commence Patient Administration System replacement projects in CNOH, RVEEH and SCH (Q2)
- Roll-Out of electronic Discharge Summaries Project (Q1/2) to provide greater information for our GPs and community organisations.
- Hold a Symposium on Digital Pathology (Q2) / Submit a Business Case for DP (Q3)
- Implementation of Outpatient Patient Self-Management Solution (Q2-Q3)
- Cardio-Vascular Information System Business Case for MMUH submitted (Q1)
- Business Case and Procurement of Critical Care EPR System for WGH, RMHM and SLK (Q2/3)
- Commencement of MSc Health Informatics, UCD (Q3)
- Roll-Out Go-Lives of Ophthalmology EPR (Q1-Q4)
- Infrastructure Review in Level 2/3 Hospitals (Q1-3)

2018 saw the go-live date for the GDPR. This has further highlighted the need to manage our patients' data in an efficient and secure way. While there is a need to share and transfer sensitive data to support patient care, there is also a need to do so to support service delivery, audit, education & training, and research. One of the initiatives planned for 2019 is the development of WIMI (Where is my info?) proposal. This would be a patient focused system that would identify where and what data the Group's hospitals have on a patient and provide control to them for the sharing of this data in support of a range of activities. Such a solution would help substantially in how we engage with our patients around their data and support new initiatives areas such as Genomics, Population Health and many facets of education and research.

Healthy Ireland:

We are committed to improving patient and staff health and wellbeing. We aim to promote healthy lifestyles for patients and staff and support optimal management of chronic diseases in patients. This will be undertaken in part through the continuing implementation of the IEHG Healthy Ireland Implementation Plan 2016 – 2019. While we are limited in our ability to support the roll out of the 'Making Every Contact Count' programme we will continue to work with the Health and Wellbeing Division to implement the priority programmes.

6. Finance

2019 IEHG Budget Allocation

The Net Expenditure Allocation for 2019 is €1,016.812m which is an increase of €21.640m or 2.2% on the final 2018 allocation.

The allocation for the IEHG is summarised in the table below. The allocation excludes pension pay and income in our Voluntary Hospitals. It also excludes the costs and income for services from external commissioners.

Budget excl. Pensions	2019 Budget €M	2018 Budget €M	Movement €M	Movement %
Gross Budget	1,182.524	1,161.848	20.676	1.8%
Income Budget	(165.712)	(166.676)	0.964	0.6%
Net Budget	**1,016.812**	**995.172**	**21.640**	**2.2%**

Summary of 2019 Allocation

The following table is a summary of the various funded elements for 2019:

Budget excl. Pensions	2019 Budget €M
ABF Funding - Gross	809.208
Transition Adjustment	(8.074)
Net ABF Funding	**801.134**
Block Grant	370.626
Total ABF and Block Allocation	**1,171.760**
Less: Retraction of 2018 Once-off Funding	(9.981)
2019 Opening Base Funding	**1,161.779**
Add: 2019 Pay Cost Pressure Funding	16.965
Add: 2018 Development – Full Year Cost	2.787
Add: Special Purpose Funds	0.993
2019 Gross Allocation	**1,182.524**
Income Target	**(165.712)**
2019 Net Allocation	**1,016.812**

The 2019 budget consists of the following:

1. Activity Based Funding Allocation in respect of prescribed inpatient and day case activity of €801.134m.
2. Block Allocation of €370.626m in respect of all other services provided in each hospital such as ED, Outpatients etc.
3. Retraction of 2018 once-off funding €9.981m.
4. Funding of €16.965m has been provided for pay cost pressures such as National Pay Agreements and increments.
5. Funding of €2.787m in respect of the full year costs of approved 2018 developments.
6. Funding of €0.993m for a number of special purpose payments.
7. 2018 funding received from external commissioners was retracted. It is anticipated that this funding will return to the group during 2019. We are currently in negotiations with those commissioners.

The 2019 budget is 2.2% greater than the final 2018 Allocation expenditure but only marginally greater than the final 2018 actual expenditure (0.05%). There are significant pay and non-pay cost pressures in 2019, negative trending in private health insurance income and increasing service demand due to demographic pressures. In the context of those issues, cost and WTE control is required in order to achieve a financial breakeven position without the appropriate financial support from the HSE.

The growing cost of delivering core services is such that IEHG faces a significant financial challenge in 2019 in maintaining the existing level of overall activity, to which we are fully committed. Developing and implementing a Financial Plan will be the focus of the Hospital Group in the weeks following the publication of the Operations Plan. We will work with the HSE to develop a shared understanding of the financial constraints and agree a methodology of dealing with these pressures.

Budget 2019 and Existing Level of Service

While the existing level of service is arguably funded for 2019, it is not without challenge.

It should be noted that the cost of maintaining existing services increases each year due to a variety of factors including:

1. Impact of National Pay Agreements *(Funded)*
2. Increases in drugs – volume and price *(Unfunded)*
3. Other clinical non pay costs e.g. Laboratory costs and increasing demand, Medical equipment *(Unfunded)*
4. Clinical and non-clinical inflation – service demand and price increases *(Unfunded)*
5. Demographic factors *(Unfunded)*
6. Full year cost of approved 2018 developments (Discussions ongoing)
7. Deferred costs in 2018 to achieve the financial outturn *(Unfunded)*
8. Shortfall in funding of 2018 approved Gross Expenditure *(Not fully funded)*
9. Downward trending in the level of Private income required under the NSP *(Unfunded)*

Approach to Financial Challenge 2019

The IEHG is cost-efficient in-service delivery as evidenced by the €8m negative transition adjustment within the ABF model. However, there are also indications within that model that further efficiencies can be achieved and we will continue with our programme of service improvement strategies in order to extract such efficiencies across the Group.

In line with the 2019 NSP, it is our intention, from the start of 2019, to continue our programme service improvements and cost-efficient strategies evidenced by the 2019 transition adjustment in ABF.

Within this programme, we will focus on the four broad priority cost control themes outlined in the 2019 NSP:

1. Cost avoidance
2. Cost reductions
3. WTE control
4. Income generation initiatives

Delivering the level of services included in our ABF Allocation, as safely and effectively as possible, within the overall limit of available funding will remain a critical area of focus for 2019. Our Group CEO, Hospital Managers and other senior managers will face specific challenges in respect of ensuring the type and volume of safe services outlined in the allocation are delivered within the resource available.

The growing level of emergency presentations, ageing profile of our patients and the growing use and cost of drugs and medical technologies and retention of staff are just some of the pressures that impact on our services each year.

Our approach to dealing with the financial challenge will include:

1. Reconciling the expected level of activity to the funding provided directly by the HSE and anticipated funding from external commissioners.
2. Governance – Continued focus on budgetary control through regular performance meetings
3. Cost Improvement Committee to oversee and monitor the implementation of our cost efficiency initiatives.
4. Initiate specific finance meetings with hospitals that are experiencing significant financial pressures.
5. Pay – Managing the Pay Budget through robust control of WTE, agency and overtime.
6. Non-Pay – Implement targeted cost containment programmes for specific high growth categories
7. Income – Endeavour to stem the reduction in patients availing of the private health insurance that was experienced in the latter half of 2017 and into 2018.
8. Activity – Control of activity will be a focus of 2019 together with utilising the ABF Data to identify services where cost reductions or service efficiencies may be possible.

The Group is conscious of the ongoing considerable challenges faced by staff in managing increasing demands within an environment of fiscal constraint, challenging budgets and increasing patient expectations. Notwithstanding the cost reduction measures implemented in recent years, the Group will continue to impose a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact on clinical services. There is however limited scope to manage within the allocated funding without risk of compromising service delivery.

Options to address the financial challenge are being considered as part of the service planning process and there will be ongoing discussions with hospitals and the HSE during the year to align activity levels to the funding available. Cost containment measures may impact the ability of hospitals to address the growing demand for services, delivery of new developments and the management of waiting lists.

Specific control measures currently established by the Group are as follows:

1. ***WTE Control***
    a. Employment Control Committee (ECC) is established to consider all vacant positions in our statutory hospitals. This committee meets on a monthly basis to consider submissions from statutory hospitals in respect of vacant positions and development positions.
    b. Consultant Appointment Screening Committee (CASC). This committee meets on a monthly basis to consider submissions from all Group hospitals, both statutory and voluntary, in relation to vacant and development Consultant positions.

2. ***Expenditure Control***
    a. A Value Improvement Plan Committee is established to consider and review potential cost efficiencies across all hospitals. It can share information in relation efficiencies being achieved in individual hospitals across all group hospitals
    b. Procurement Directorate. The IEHG have established a Procurement Directorate to consider tendering processes for common goods across the Group and to work with the HBS to ensure delivery of savings from central contracts
    c. Estates Directorate: The IEHG have established an Estates Directorate to consider cost efficiency projects across all hospitals. The Directorate has established an energy efficiency

project in one of our Level 4 hospitals. This project has already commenced and savings will be monitored for the duration of the project.

3. ***Service Improvement Team***
   a. The IEHG has established a Service Improvement Team and engaged an external management consultancy firm to review service processes in all hospitals and to run rapid improvement events (RIE's) to ensure that services and patient flow is continuously improved.
   b. Implemented a Lean Sigma Six programme and process in our hospitals.

4. ***Monthly Performance Meetings***
   a. The IEHG hold monthly performance meetings with all hospitals in relation to both operational performance and financial performance. In respect of financial performance we received monthly expenditure and savings projections form all hospitals and this is monitored on a regular basis.

Risks to the Delivery of the Operations Service Plan 2019

There are a number of risks to the successful delivery of 2019 Operations Plan. While every effort will be made to manage these risks, it may not be possible to eliminate them in full and they may impact on planned levels of service delivery or achievement of targeted performance. Particular management focus will be required to mitigate risk in the following areas:

Demand led activity:

- Sustaining a level of service where the nature of the response is such that activity cannot be stopped or spend avoided such as activity driven by emergency departments and other hospital services.
- Meeting the level of changing needs and emergency presentations and responding to increasing levels of demand for unscheduled care services.
- Increased demand for services beyond the funded levels.
- Demographics – Managing the continuing impact of an increasing and aging population on our hospitals within the current envelope of funding.
- Our ability to meet the demand for new drug approvals within funded levels
- Delivery on 2019 activity targets is predicated upon a similar level of externally commissioned activity as was undertaken/funded in 2018.

Regulatory requirements

- Regulatory recommendations/hospital services which must be responded to within the limits of the revenue and capital funding available.
- Control over pay and staff numbers at the same time as managing specific safety, regulatory, demand driven pressures while seeking to ensure recruitment and retention of a highly skilled and qualified workforce, particularly in high-demand areas and specialties.

Structural Challenges

- Balancing quality and risk issues at local and Group level in yet another period of potential structural change.
- Managing the scale of change required to support new models of service delivery and structures while supporting innovation and reorganisation across the Group.
- Managing within the limitations of our clinical business information, financial and HR systems to support an information driven health service

- Our capacity to invest in and maintain our infrastructure and address critical risks resulting from ageing medical equipment and physical infrastructure while managing within the Health and Safety regulations.
- The scale of financial management required across a demand led service environment particularly when there is a lack of data visibility across all hospitals within the Group

Others:

- The yet as unknown risks associated with Brexit
- Ability to respond to significant spikes in demand given that hospitals normally operate at full capacity. This would include unknown or unforeseen events such as storms in the absence of contingency funding.
- Income – delivering the income target given a downward trend in patients presenting with private health insurance towards the end of 2017 and 2018.

Capital

There is minimal provision for capital infrastructure identified for the IEHG in the 2019 NSP. The allocation is insufficient to deal with the necessary infrastructural improvements required across all hospitals in the Group and is insignificant given the Asset base of the Group. Discussions are underway with HSE Estates to secure the necessary capital to address ageing infrastructure, additional capacity and equipment replacement.

The minor capital allocation and equipment replacement allocation have not yet been notified to the Group. This will be considered at a future date.

Cash Risk

Given the carrying accumulated deficits in the Voluntary Hospitals and the increasing service demands, it is expected that the management of the cash position will be challenging in 2019. Significant cash acceleration was required for one of our hospitals in 2018 and it is projected that this will again be required in 2019.

Pensions

While the Acute Operations Division of the HSE is not responsible for Pensions, as a Hospital Group, that reports to an Executive, and to a Board in 2019, the Group reports on all finances relevant to the Hospitals, which includes Pensions. Budgets are reconciled to Rosetta, which also includes Pensions. Any Pension costs beyond budget will be reported to the relevant HSE division, with the anticipation that it will be funded.

The issuing of reports by the AHD in respect of our Voluntary Hospitals excluding pension costs and associated income is problematic for the Group. Our Voluntary Hospitals engage with the IEHG with regard to the totality of their finances and therefore the national financial system does not produce the appropriate inclusive reports in order to allow us to rely on the HSE Financial System to manage our hospitals.

Data Caveat

The financial information underpinning the plan is subject to the specific limitations of the HSE's financial systems, currently available within the overall finance operating model, which are well documented and are being addressed via a major improvement programme. This includes our reliance on the receipt of financial and other information from a large number of voluntary organisations which are separate legal entities with their own separate financial

systems. Every effort has been made within the time and resources available to ensure that the information provided in the plan is as accurate as possible.

There is no capacity within the plan for the HSE to respond in 2019 to further pay or other pressures, beyond those already specifically funded. In the event that additional pressures emerge, for example, via the industrial relations machinery of the state, regulatory processes, government decisions or the courts etc., the HSE will need to engage with the Department of Health for guidance on how to proceed.

7. Workforce

The Ireland East Hospital Group workforce totals 11,773 employees (whole time equivalents) working across the eleven hospitals in the Group providing acute hospital services to 1.1 m people. Working together as a collective and emerging organisation since 2015 our employees continue to develop and deliver world class healthcare through the provision of an integrated patient-focused, consistently high-quality healthcare service that is accessible and sustainable for all patients.

Building on the Strategic Framework developed for IEHG in 2015 and implemented during the period 2015 – 2017, it is the stated ambition of the IEHG to become the first Academic Health Science Centre (AHSC) in Irish healthcare. This ambition serves as a rationale for striving to continuously improve Group performance which is facilitated through the Clinical Service Reconfiguration and Redesign of hospital services delivered through a Transformation Plan of Care based on the Group's three strategic goals of (1) Operational Excellence; (2) Integrated Care Services; and (3) Academic Health Science System. The continued engagement and willingness of our staff to actively participate in this significant change management programme is vital and work undertaken to date is acknowledged and appreciated. Continuing on this journey in 2019 to develop and deliver services through the full engagement of staff through Strategy Deployment will ensure that the IEHG transformation is aligned to Government Policy on the future of healthcare as outlined in the Slaintecare Report.

Workforce Priorities 2019

People Strategy

A People Strategy for the Group will be developed in 2019 through the application of A3 Thinking in line with the Lean Methodology adopted by the Group on the journey to transform the delivery of healthcare with the ultimate goal to become a leader in healthcare delivery and research through the development of an AHSC.

A key deliverable in the development of the People Strategy will be the development and implementation of a Recruitment and Employer Branding Strategy for the Group that maximises the employee value proposition of being an employee of a group of eleven hospitals. This will be done across four key improvement areas: -

1. People - By developing a people centric transformation culture
2. Quality - Ensuring all employees have access to learning and development resources to enable them to 'operate at the top of their licence'
3. Timeliness - Ensure two-way staff dialogue throughout the employee continuum (hire to retire)
4. Productivity – HR processes result in breakthrough improvement in HR metrics

Leadership and Culture

The IEHG Transformation Programme has successfully adopted Lean principles and methodology to deliver improvement and change across a number of Clinical pathways and services and this has been done through the successful engagement of more than 2,500 employees who have been actively leading and participating in the change. A number of other significant initiatives where staff leadership and involvement have been instrumental in progressing this change include: the Collective Leadership Project undertaken in collaboration with our Academic Partner, University College Dublin (UCD); the National

Patient Centredness Programme currently being piloted in the Regional Hospital Mullingar; the outcome of the National Patient Experience Survey; quality improvement/service improvement.

Through our Transformation Programme the Leaders and Management Teams of our hospitals have developed and delivered leadership behaviours that support front line staff to contribute to and drive improvements in the care provided through a continuous learning culture. This work will continue in 2019 as our Leadership capability and capacity is further developed in partnership with our Academic Partner, UCD and the Smurfit Business School.

Employee Wellbeing and Engagement

In line with Government Policy on population health and wellbeing, work will continue to progress the implementation of the IEHG Healthy Ireland Implementation Plan by supporting each hospital within the Group to plan, organise and structure resources for the successful delivery of the Group Plan. The delivery of Healthy Ireland will ensure support is provided to both staff and patients and from a workforce position ensure improved staff health and wellbeing. The positive benefits of a healthy workforce and healthy workplace is acknowledged and supported by IEHG. Recognising the challenges facing our staff to maintain a healthy work/life balance, our objective through our dedicated Healthy Ireland Plan is to create a culture of health and wellbeing by supporting our staff to look after their own health and wellbeing both in the workplace and at home in their community.

Building on the local work undertaken across the Group since 2017 in our hospitals engaged with the Great Place to Work Institute (GPTW), employee engagement improvement plans will be further developed during 2019 to develop common initiatives that support team working, enhance communications, demonstrate employee value, maximise employee potential and embrace diversity. In addition, the results from the National Staff Engagement Survey undertaken in 2018 and published in January 2019 will be used to identify improvements that need to be made with particular emphasis on culture, working conditions and employee value and recognition.

Pay and Staffing Strategy 2019

The Pay and Staffing Strategy for the Group in 2019 is being informed by a central 'top down' approach taken by the HSE to the level of affordability of staffing requirements, based on an average cost per whole time equivalent (WTE). This has resulted in a subsequent WTE limit for 2019 advised to the Group set at both Group and hospital level. Work will be ongoing during the year to ensure that the operationalisation of the WTE limits is addressed through a 'bottom up' process that takes account of service priorities and maintenance of services, while also identifying and exploiting opportunities for optimisation and efficiency. However this must be done by achieving a balance between safe quality patient care and affordability.

Key to delivering on this Strategy will be the development of a comprehensive funded workforce plan for the Group in line with the implementation of *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning*. The funded workforce plan will also be informed by the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* and the phase 2 Framework for Staffing and Skill Mix for Nursing in Emergency Care Settings.

In addition work will continue on the further implementation of other workforce agreements including:

- 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
- On-going implementation of WRC nursing and midwifery recruitment and retention agreement and ED agreement
- Full compliance with the European Working Time Directive (EWTD)

Recruitment and Retention

A key deliverable of the IEHG People Strategy in 2019 will be the development of a Recruitment Function that will initially support our Statutory Hospitals in addressing the current challenges being faced in the timely delivery of new recruits through the national shared service model delivered by HBS. This development will be done in line with Government Policy on the future development of healthcare in Ireland, Slaintecare. The aim of this recruitment and retention strategy is to recruit, support and retain the 'best-in-class' talent workforce that is supported and valued in a workplace that fosters a culture of high trust, openness and continuous professional development.

Appendices

Appendix 1: Financial Tables

The Net Expenditure Allocation for 2019 is €1,016.812m. The allocation excludes pension pay and income in our Voluntary Hospitals. It also excludes the costs and income for services from external commissioners.

Budget excl. Pensions	**2019 Budget €M**	**2018 Budget €M**	**Movement €M**	**Movement %**
Gross Budget	1,182.524	1,161.848	20.676	1.8%
Income Budget	(165.712)	(166.676)	0.964	0.6%
Net Budget	**1,016.812**	**995.172**	**21.640**	**2.2%**

Summary of 2019 Allocation

The following table is a summary of the various funded elements for 2019:

Budget excl. Pensions	**2019 Budget €M**
ABF Funding - Gross	809.208
Transition Adjustment	(8.074)
Net ABF Funding	**801.134**
Block Grant	370.626
Total ABF and Block Allocation	**1,171.760**
Less: Retraction of 2018 Once-off Funding	(9.981)
2019 Opening Base Funding	**1,161.779**
Add: 2019 Pay Cost Pressure Funding	16.965
Add: 2018 Development – Full Year Cost	2.787
Add: Special Purpose Funds	0.993
2019 Gross Allocation	**1,182.524**
Income Target	**(165.712)**
2019 Net Allocation	**1,016.812**

Appendix 2: HR Information

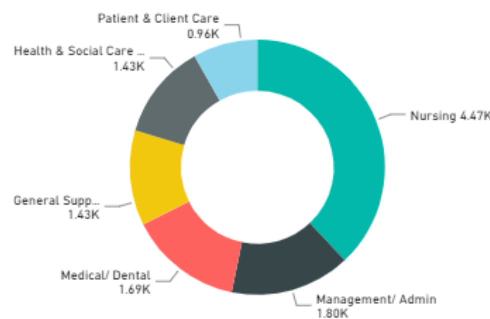
Appendix 2 Acute Hospitals Workforce 2019
WTE December 2018

Hospital / HG	Medical/ Dental	Nursing & Midwifery	Health & Social Care	Management/ Admin	General Support	Patient & Client Care	WTE December 2018
Cappagh National Orthopaedic	44	149	64	64	61	26	**408**
Mater Misericordiae University	472	1,187	433	431	274	237	**3,034**
MRH Mullingar	140	325	118	132	36	168	**919**
National Maternity	93	403	65	131	138	31	**860**
Our Lady's Navan	74	183	54	68	29	101	**509**
Royal Victoria Eye and Ear	62	114	15	63	28	9	**292**
St. Columcille's	43	154	61	71	57	55	**441**
St Luke's General Kilkenny	153	420	91	157	219	80	**1,121**
St. Michael's	39	170	43	66	49	29	**396**
St. Vincent's University	429	964	414	450	322	174	**2,752**
Wexford General	144	396	67	135	211	54	**1,007**
Other		3	1	28	1		**32**
Ireland East Hospital Group	**1,692**	**4,470**	**1,426**	**1,795**	**1,426**	**964**	**11,773**

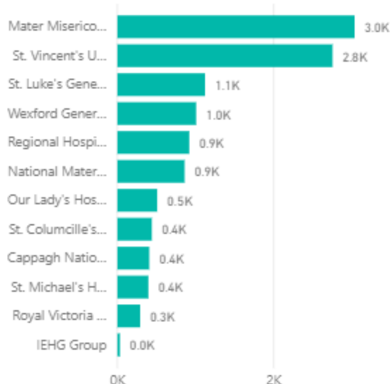
IEHG WTE (December 2018)

WTE Number

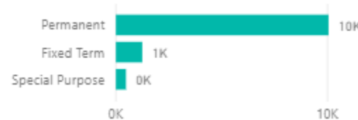
WTE Number by Staff Category



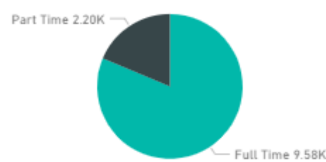
WTE Number by Hospital



WTE Number by Contract Status



WTE Number by Contract Type



Appendix 3 (a) Scorecard

Acute Hospital Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
Quality and Safety	**Complaints investigated within 30 days**	% of complaints investigated within 30 working days of being acknowledged by complaints officer
	Serious Incidents	% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident
	HCAI Rates	Rate of new cases of hospital acquired Staph. Aureus bloodstream infection
		Rate of new cases of hospital acquired C. difficile infection
		% of acute hospitals implementing the requirements for screening of patient with CPE guidelines
	Urgent Colonoscopy within 4 weeks	No. of people waiting > 4 weeks for access to an urgent colonoscopy
	Surgery	% hip fracture surgery carried out within 48 hours of initial assessment (Hip Fracture Database)
		% of surgical re-admissions to the same hospital within 30 days of discharge
	Medical	% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge
	Ambulance Turnaround	% of ambulance turnaround delays escalated where ambulance crews were not cleared nationally (from ambulance arrival time through clinical handover in ED or specialist unit to when the ambulance crew declares readiness of the ambulance to accept another call) in line with the process / flow path in the ambulance turnaround framework within 30 minutes
	Chronic Disease Management	No. of people who have completed a structured patient education programme for type 2 diabetes
	Healthy Ireland	% of smokers on cessation programmes who were quit at four weeks
Access and Integration	**Emergency Department Patient Experience Time**	% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration
		% of all attendees at ED who are discharged or admitted within six hours of registration
	Waiting times for procedures	% of adults waiting < 15 months for an elective procedure (inpatient and day case)
		% of children waiting < 15 months for an elective procedure (inpatient and day case)
		% of people waiting < 52 weeks for first access to OPD services
	Cancer	% of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe

Acute Hospital Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
		% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)
Finance, Governance and Compliance	**Financial Management**	Net expenditure variance from plan (pay + non-pay - income)
	Governance and Compliance	% of the monetary value of service arrangements signed
		Procurement – expenditure (non-pay) under management
		% of internal audit recommendations implemented, against total no. of recommendations, within 12 months of report being received
Workforce	**EWTD**	<48 hour working week
	Attendance Management	% absence rates by staff category

Appendix 3(b): Performance Indicator Suite

Note: 2018 and 2019 expected activity and targets are assumed to be judged on a performance that is equal or greater than (≥) unless otherwise stated (i.e. if less than (<) or, less than or equal to symbol (≤) is included in the target).

Acute Hospital Care				
Indicator	**Reporting Period**	**NSP2018 Target**	**Projected Outturn 2018**	**Target 2019**
Outpatient attendances New: Return Ratio (excluding obstetrics, warfarin and haematology clinics)	M	1:2	1:2.5	1:2.3
Activity Based Funding (MFTP) model HIPE Completeness – Prior month: % of cases entered into HIPE	M (1 Mth in arrears)	100%	91%	95%
Inpatient, Day Case and Outpatient Waiting Times* % of adults waiting <15 months for an elective procedure (inpatient)	M	90%	82%	85%
% of adults waiting <15 months for an elective procedure (day case)		95%	91%	95%
% of children waiting <15 months for an elective procedure (inpatient)		90%	84%	85%
% of children waiting <15 months for an elective procedure (day case)		90%	83%	90%
% of people waiting <52 weeks for first access to OPD services		80%	71%	80%
Colonoscopy / Gastrointestinal Service % of people waiting <13 weeks following a referral for routine colonoscopy or OGD		70%	53%	70%
No. of people waiting > four weeks for access to an urgent colonoscopy		0	334	0
Emergency Care and Patient Experience Time % of all attendees at ED who are discharged or admitted within six hours of registration		75%	64%	75%
% of all attendees at ED who are discharged or admitted within nine hours of registration		100%	79%	99%
% of ED patients who leave before completion of treatment		<5%	6.4%	<5%
% of all attendees at ED who are in ED <24 hours		100%	96%	99%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration		95%	42%	95%
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration		100%	60%	99%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration		100%	91%	99%
Length of Stay ALOS for all inpatient discharges excluding LOS over 30 days	M (1 Mth in arrears)	4.3	4.8	≤4.8
Medical Medical patient average length of stay		≤6.3	7.2	≤7.2

Acute Hospital Care				
Indicator	**Reporting Period**	**NSP2018 Target**	**Projected Outturn 2018**	**Target 2019**
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration		75%	60%	75%
% of all medical admissions via AMAU		45%	31%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge		≤11.1%	11.3%	≤11.1%
Surgery Surgical patient average length of stay		≤5.0	5.5	≤5.5
% of elective surgical inpatients who had principal procedure conducted on day of admission		82%	74.5%	82%
% day case rate for Elective Laparoscopic Cholecystectomy		60%	48%	60%
% hip fracture surgery carried out within 48 hours of initial assessment (Hip fracture database)	Q (1 Qtr in arrears)	New PI NSP2019	New PI NSP2019	85%
% of surgical re-admissions to the same hospital within 30 days of discharge	M (1 Mth in arrears)	≤3%	2%	≤3%
Healthcare Associated Infections (HCAI) Rate of new cases of hospital acquired Staph. Aureus bloodstream infection	M	<1/10,000 bed days used	0.9	<1/10,000 bed days used
Rate of new cases of hospital acquired C. difficile infection		<2/10,000 bed days used	2.2	<2/10,000 bed days used
No. of new cases of CPE		0	512	N/A
% of acute hospitals implementing the requirements for screening of patients with CPE guidelines	Q	100%	36%	100%
% of acute hospitals implementing the national policy on restricted antimicrobial agents		100%	35%	100%
Medication Safety Rate of medication incidents as reported to NIMS per 1,000 beds	M	New PI NSP2019	New PI NSP2019	2.4 per 1,000 bed days
National Early Warning System (NEWS) % of hospitals with implementation of NEWS in all clinical areas of acute hospitals (as per 2019 definition)	Q	New PI NSP2019	New PI NSP2019	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning System)		100%	72.4%	100%
National Standards % of hospitals that have completed a self-assessment against all 53 essential elements of the National Standards for Safer, Better Healthcare		New PI NSP2019	New PI NSP2019	100%
% of acute hospitals which have completed and published monthly hospital patient safety indicator report	M	100%	67%	100%

Acute Hospital Care				
Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
Stroke % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	Q (2 Qtrs in arrears)	90%	68.9%	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis		12%	9.1%	12%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		90%	73.8%	90%
Acute Coronary Syndrome % STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Q	90%	95%	95%
% of reperfused STEMI patients (or LBBB) who get timely PPCI		80%	65%	80%
National Women and Infants Health Programme **Irish Maternity Early Warning System (IMEWS)** % of maternity units / hospitals with full implementation of IMEWS (as per 2019 definition)		New PI NSP2019	New PI NSP2019	100%
% of all hospitals with implementation of IMEWS (as per 2019 definition)		New PI NSP2019	New PI NSP2019	100%
% maternity hospitals / units which have completed and published Maternity Patient Safety Statement and discussed same at hospital management team / Hospital Group / NWIHP meetings each month	M (2 Mths in arrears)	100%	94.7%	100%
Cancer Services				
% of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe	M	New PI NSP2019	New PI NSP2019	95%
Symptomatic Breast Disease Services **Non-urgent** % of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)		95%	73%	95%
Clinical Detection Rate – breast cancer % of new attendances to the rapid access clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer		6%	10%	>6%
Clinical Detection Rate – lung cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of lung cancer		25%	30%	>25%
Clinical Detection Rate – prostate cancer % of new attendances to the rapid access clinic that have a subsequent primary diagnosis of prostate cancer		30%	33%	>30%
Radiotherapy % of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)		90%	80%	90%
Access to Community Beds No. of bed days lost through delayed discharges	M	182,500	205,047	≤200,750

Acute Hospital Care

Indicator	Reporting Period	NSP2018 Target	Projected Outturn 2018	Target 2019
No. of beds subject to delayed discharges	M	500	564	≤550

** Projected Outturn 2018 and Expected Activity does not include or take account of the impact on performance of any NTPF funded inpatient, day case or outpatient procedures in public hospitals or private hospitals.*

Acute Hospitals

Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title
% of patients attending ED aged 75 years and over **	M	13%	13.7%	13%
% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	M	90%	82.5%	90%
ALOS for all inpatients **	M-1M	5 days	5.6	5 days
New OPD attendance DNA rates **	M	12%	13.9%	12%
% of emergency hip fracture surgery carried out within 48 hours (HPO / HIPE)	M	95%	86.6%	95%
Elective Scheduled care waiting list cancellation rate **	M	1%	1.4%	1%
The % of patients admitted to an ICU (or HDU) from the ward or ED within one hour of a decision to admit **	Q (1 Mth in arrears)	50%	N/A	50%
The % of patients admitted to an ICU/HDU from the ward or ED within four hours of a decision to admit (A98)**	Q (1 Mth in arrears)	80%	N/A	80%
Rate of venous thromboembolism (VTE, blood clots) associated with hospitalisation **	Q (1 Mth in arrears)	New in 2018	11.3	TBC
% bed day utilisation by acute surgical admissions who do not have an operation **	M	35.8%	36.8%	35.8%
Median LOS for patients admitted with COPD **	Q (1 Mth in arrears)	5 days	5	5 days
% re-admission to same acute hospitals of patients with COPD within 90 days **	Q (1 Mth in arrears)	24%	25.6%	24%
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	BA-1M	33 SITES	30	33 SITES
% nurses in secondary care who are trained by national asthma programme **	Q (1 Mth in arrears)	70%	N/A	70%
No. of lower limb amputation performed on Diabetic patients **	A	<488	N/A	<488
Average length of stay for Diabetic patients with foot ulcers **	A	≤17.5 days	N/A	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes **	A	≤10% increase	N/A	≤10% increase

Acute Hospitals				
Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title	Operational Plan KPI Title
Breastfeeding initiation - % of babies breastfed at first feed following birth**	Q -1Q	New PI	New PI	64%
Rate of Emergency Paediatric Inpatients (patients <16 years old as a % of those presenting) **	Q	New PI	New PI	TBC
Rate of clinical incidents as reported to NIMS per 1000 bed days **	M-3M	New PI	New PI	N/A
% of pediatric patients waiting < 6 weeks following a referral for a routine colonoscopy **	M	New PI	New PI	70%
% of pediatric patients waiting < 6 weeks following a referral for a routine oesophago-gastroduodenoscopy (OGD) endoscopy **	M	New PI	New PI	70%
% of adult patients waiting < 13 weeks following a referral for a routine colonoscopy **	M	New PI	New PI	70%
% of adult patients waiting < 13 weeks following a referral for a routine oesophago-gastroduodenoscopy (OGD) endoscopy **	M	New PI	New PI	70%
% of urgent elective outpatients waiting < 3 months for CT, MR & US **	Q	New PI	New PI	TBC
% of routine elective outpatients waiting < 6 months for CT, MR & US **	Q	New PI	New PI	TBC

Operational Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	Hospital Group Target 2019
Beds Available Inpatient **	M	N/A	N/A	2282
Day Beds / Places **	M	N/A	N/A	485

Appendix 3(c): IEHG Activity Targets 2019

KPI Title	IEHG Expected Activity/ Target 2018	IEHG Projected Outturn 2018	Cappagh National Orthopaedic Hospital	Mater Misericordiae University Hospital	Midland Regional Hospital Mullingar	National Maternity Hospital	Our Lady's Hospital Navan	Royal Victoria Eye and Ear Hospital	St. Columcilles Hospital	St Luke's Hospital Kilkenny	St. Michael's Hospital	St. Vincent's University Hospital	Wexford General Hospital	IEHG Expected Activity/ Target 2019
Discharge Activity Inpatient Cases	128,763	132,058	2,489	22,929	18,358	14,206	6,617	2,263	5,595	18,693	3,422	21,526	15,980	132,078
Inpatient Weighted Units	133,328	137,266	5,441	38,994	10,810	9,313	5,417	2,264	3,540	11,434	3,260	34,622	11,933	137,027
Daycase Cases (includes dialysis)	190,679	191,936	7,672	57,103	9,885	2,924	6,024	12,072	2,957	10,606	5,963	69,192	9,340	193,738
Day Case Weighted Units (includes dialysis)	207,394	206,741	10,045	59,449	10,330	3,973	8,808	18,652	4,498	11,267	6,625	61,929	11,167	206,741
Total inpatient & day cases Cases	**319,442**	**323,994**	**10,161**	**80,032**	**28,243**	**17,130**	**12,641**	**14,335**	**8,552**	**29,299**	**9,385**	**90,718**	**25,320**	**325,816**
Emergency Inpatient Discharges	85,625	89,720	10	18,347	11,400	1,835	5,645	855	5,307	15,419	2,375	17,236	12,733	91,162
Elective Inpatient Discharges	18,328	18,056	2,479	4,472	677	380	971	1,408	288	431	1,047	4,217	743	17,113
Maternity Inpatient Discharges	24,810	24,282		110	6,281	11,991	1			2,843		73	2,504	23,803
Inpatient Discharges ≥ 75 years	25,949	27,502	545	5,467	2,820	20	2,010	334	1,798	3,557	1,252	6,226	3,706	27,735
Day case dishcarges ≥ 75 years	36,309	36,708	930	12,941	724	14	692	4,999	330	1,305	679	13,267	1,216	37,097
Emergency Care - New ED attendances	261,520	274,035	-	78,974	32,348	-	18,968	-	-	38,606	14,029	55,527	36,843	275,295
- Return ED attendances	23,108	24,764	-	3,984	4,109	-	1,327	-	-	3,228	5,671	2,011	4,549	24,878
Injury Unit attendances	7,976	7,704	-	-	-	-	-	-	7,739	-	-	-	-	7,739
Other emergency presentations	11,862	10,966	-	-	-	-	-	-	-	8,109	-	-	2,908	11,016
Births Total number of births	13,959	13,066	-	-	1,951	7,906	-	-	-	1,576	-	-	1,634	13,066
Outpatients Number of new and return outpatient attendances	732,421	721,293	7,668	221,558	50,084	116,708	29,611	41,727	12,031	36,994	22,028	153,207	38,547	730,161

Appendix 4: Capital Infrastructure

- The projects set out here should align with those set out in NSP2019 and in the Acute and Pre-Hospital Services Plan 2019 as appropriate to your Hospital Group. Please see NSP2019 for the criteria to be followed in the inclusion of any projects.

This appendix outlines capital projects that: 1) were completed in 2017 / 2018 and will be operational in 2019; 2) are due to be completed and operational in 2019; or 3) are due to be completed in 2019 and will be operational in 2020

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replacement Beds	Capital Cost €m		2019 Implications	
						2019	Total	WTE	Rev Costs €m
Healthcare									
St. Vincent's University Hospital, Elm Park, Dublin	Provision of two cath labs through the Equipment Replacement Programme	Q4 2018	Q3 2019	0	0	0.10	2.85	0	0

Appendix 5: Organisational Structure

Appendix 5: Organisational Structure