UL Hospitals Group 2019 Operational Plan

Ospidéil OL
UL Hospitals
Working together, caring for you

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

Foreword from CEO

The attached Operational Plan sets out the level of health care services to be provide in 2019, having regard for the available funds to UL Hospitals.

It is aligned to UL Hospitals Strategic Plan 2018-2022 which sets out the 5 year vision for the Group, namely to be a valued, trusted and leading provider of excellence in healthcare which is patient-centred, clinically-integrated, team-based and research –driven.

The four priorities from the UL Hospitals Strategy, which also inform the CEOs Priorities, include

1. Clinical Transformation
2. Digital Health
3. Education, Research and Innovation
4. Collaboration & Alliances

These four strategic priorities are further defined and aligned in the CEOs Priorities 2019.

We are also cognisant and fully support the Implementation Plan for Sláintecare and the development of the Regional Integrated Care Organisations (RICOs) which are further outlined in the CEOs Priorities.

Ms Colette Cowan
Chief Executive Officer
UL Hospitals

Contents

UL Hospitals Group

University of Limerick (UL) Hospital Group is comprised of a group of six hospitals functioning collectively as a single hospital system in the Mid-West of Ireland. The six sites include:

University Hospital Limerick (UHL), one of eight designated cancer centres in the country, is the Model 4 hospital for the region and has a full 24/7/365 Emergency Department and critical care service. Emergency and complex surgeries are for the most part undertaken at UHL. The hospital is the hub for Ennis Hospital, Nenagh Hospital and St. John's Hospital Limerick, which manage the majority of their local population through their medical assessment units, injury units and inpatient beds. Patients who require access to critical and complex care are seen at University Hospital Limerick and either stabilised and transferred or admitted to UHL as required.

Croom Hospital is the designated Orthopaedic hospital for adults and children in the Mid-West region whilst also accepting the transfer of orthopaedic patients from UL hospital for post-acute care. In addition to Orthopaedic services, Rheumatology and Pain Management services are also provided.

University Maternity Hospital Limerick (UMHL), being one of the largest maternity hospitals outside of Dublin has up to 4,500 births per year and the sole provider of obstetrical, midwifery, perinatal and Level 3 Neonatal Intensive care to the Mid-West region. As per the National Maternity strategy developments under Project Ireland 2040, stand-alone maternity sites are to be replaced and as part of this University Maternity Hospital Limerick is due to relocate to the UHL campus in Dooradoyle allowing for the co-location of maternity and adult services.

Governance UL Hospitals

The hospitals in Ireland are currently organised into seven Hospital Groups (HGs). Each Group Chief Executive has full legal authority to manage the Group delegated to them under the Health Act 2004 in line with National Service Plan (NSP) 2019 and allocated Group budgets. The UL Hospitals Group Operational Plan 2019 is aligned with the NSP.

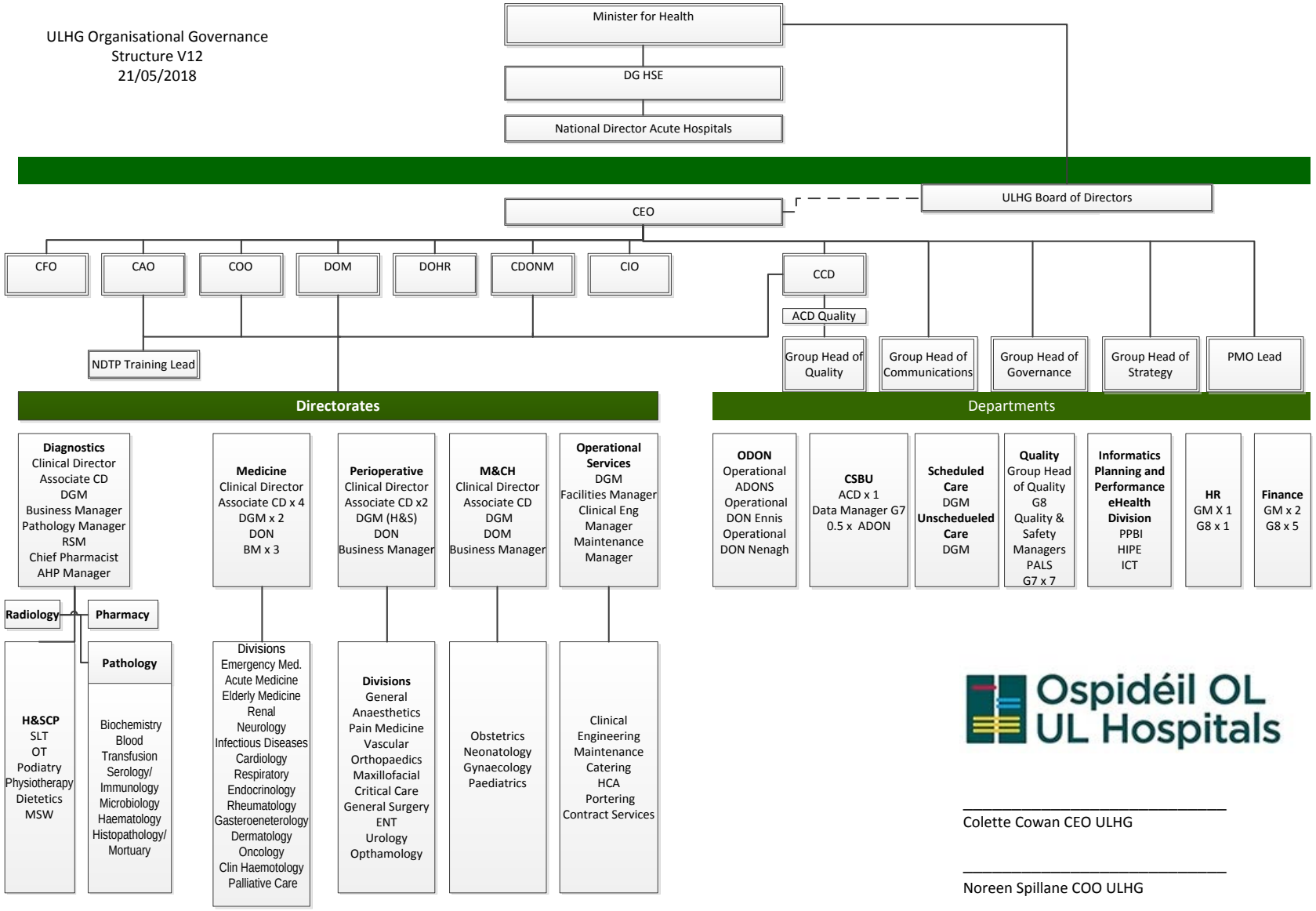
The Group Chief Executives report to the National Director for Acute Services and are accountable for their planning and performance under the Performance and Accountability Framework of the HSE. All targets and performance criteria adopted in the service plan and the divisional Operational Plan will be reported through this framework.

UL Hospitals is governed by a Board and an Executive Management Team led by a CEO who reports to the Acute Hospitals Division HSE and to the Board of UL Hospitals. Our services are delivered across the six sites under the leadership of five directorates namely, Medicine Directorate, Perioperative Directorate, Diagnostics Directorate, Maternal and Child Health Directorate and Operational Services Directorate. Each Directorate is led by a team of staff bringing Clinical, Managerial and Financial expertise together to provide quality driven safe services, focused on the experience and outcomes for the patient.

The Board of UL Hospitals Group

Back Row (L-R): Jim Canny, Alec Gabbett, Dr Mary Gray and Graham Knowles (Chairman) and, inset below, Michael Mulcahy SC and, bottom, Dr Des Fitzgerald.

ULHG Organisational Governance
Structure V12
21/05/2018



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UL Hospitals

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Colette Cowan CEO ULHG

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Noreen Spillane COO ULHG

UL Hospitals Group CEO's Priorities 2019

	Priority Action	Sponsor	Owner	Completion Date
	Strategic Priority 1 – Clinical Transformation			
1.	Implementation of Sláintecare. Implementation Strategy & Action Plan.	CEO	CEO/ Executive Team	Q 1-4
2.	Implement targets for Clinical Transformation to include Medical Transformation.	CEO	CCD	Q 4
3.	Plan & Co-Design place based Integrated Care Models.	CEO	CEO/ Executive Team	Q 1-4
	Strategic Priority 2 – Digital Health			
4.	Progress on Microsoft Projects & identify other early innovations in eHealth.	CEO	CIO	Q 3
5.	Establish accessible Data Analytics & Clinical Information for Clinical Groups.	CEO	CIO/CCD	Q 2
6.	Implement Clinical Information Systems including expansion of Maxims.	CEO	CIO/COO/ CCD	Q 4
7.	Enable Paperless Systems to support Patient Care & operational effectiveness.	CEO	CIO/COO/ CCD/ CDONM	Q 3
	Strategic Priority 3 – Research & Innovation			
8.	Progress Plans for Joint Health/University Health Science Academy.	CEO	Head of Strategy/ CAO/CCD/ CDONM	Q 3
9.	Continue Progress with Future Innovations in Robotics, Technology & Integrated Care	CEO	COO/ CDONM/ CAO/CCD/ CIO	Q 2-4
10.	Establish Formal Approach for Integrated Care & Age Related Disease	CEO	CEO/ Executive Team	Q 2-4
	Strategic Priority 4 – Collaboration & Alliance			
11.	Further establish Public Services Partnerships with Health, City Councils & Gardaí to introduce Preventative Care & Wellness.	CEO	CEO & Executive Team	Q 2-4
12.	Develop Collaborations with International Partners to support development of Regional Integrated Care Organisations (RICOs).	CEO	CEO	Q 2-4
13.	Establish a Change Programme to align with National Policy on RICOs.	CEO	CEO & Executive Team	Q 2-4
14.	Continue Learning for Lives Ghana Project	CEO	CEO/COO	Q 1-4
	Others			
15.	Implement National Clinical Programmes & Models of Care	CEO	Executive Team	Q 1-4
16.	Progress Funded Capital Development Plans	CEO	CEO	Q 2-4

Section 1:

NSP 2019

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ULHG Operational Plan 2019

HSE National Service Plan 2019

The HSE National Service Plan 2019 (NSP 2019) has been prepared in response to the funding allocation and associated requirements and conditions set out in the Department of Health's (DoH) Letter of Determination of 17th October 2018. The Plan sets out the type and volume of health and social care services to be provided by the Health Service Executive (HSE) in 2019 having regard to the funding made available and the level of staff to be deployed.

NSP 2019 reflects a comprehensive review of service activity and has been prepared following extensive engagement with the DoH. The Plan seeks to balance the many priorities across all of services, including those of the Minister for Health and the Government. It also seeks to plan and respond, as effectively as possible, to the predictable increases in demand for services in 2019.

The overall non-capital allocation to the HSE for 2019 is just over €16 billion; this represents a *maximum* amount of expenditure that may be incurred by the Executive during the forthcoming financial year. The services, levels of activity and performance detailed in NSP2019 are consistent with this level of funding.

For 2019, a key priority is to ensure that the resources which have been made available to health and social care are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively, consistent with best available evidence. It is more important than ever that value for money is secured, achieving maximum benefit from the available financial, staffing and infrastructure resources. UL Hospitals Group, consequently, will align itself to similar priorities and initiatives throughout 2019 prioritising quality and safe patient care at all times.

UL Hospitals Group Operational Plan 2019

The 2019 Operational Plan for UL Hospitals Group sets out the type and volume of health care services to be provided throughout the year, having regard for the available funding. Services continue to be delivered in an environment where the population is growing, the number of people seeking to access services is higher than ever before and where public expectations for quality services continue to increase. The growing cost of delivering core services is such that we face a very significant financial challenge in 2019 in maintaining the existing level of overall activity, to which we are fully committed. Demand for our service outweighs capacity yet the high performance of the clinical teams ensures patient care and treatment. To this end, we are conscious that maintaining services and driving improvements in patient safety and quality remain over-riding priorities across the health sector, and all savings and efficiency measures will be assessed with these priorities in mind.

For 2019, our objective is to maintain quality, deliver good outcomes and recognise that there are opportunities, even in a constrained financial environment, to provide excellent health care services to the population of the Mid-West of Ireland. In conjunction with this, our 5 year Strategic Plan 2018-2022 which sets out the future direction of the Group, will help to guide us as we continue to grow and redesign our services in the years ahead. We also acknowledge the vision of *Sláintecare* and support the ethos of organising and delivering healthcare in a cohesive and timely manner designed around the needs of people.

Service Quality and Improvement

The health service has committed itself to continuous learning and as such, recognises that there are significant opportunities for improvement in some services and are striving to secure these. It is acknowledged from surveys of patient experience that, while many people are happy with the service they receive, others unfortunately have difficulties in accessing services, or have a poor experience when they do. A priority in 2019 nationally is to continue to build capacity within each service delivery entity, to anticipate and respond to risks and challenges effectively and to strive for a culture that genuinely focuses on continuously improving quality of service for patients and service users, and values innovation. Similarly, UL Hospitals Group will continue to enhance the patient experience, improve quality of care and promote a culture of research and development.

Findings from the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* and other HSE reports have highlighted areas which need immediate attention. Ensuring real and meaningful involvement and engagement between patients, service users, families, health professionals and organisations across services will receive a renewed focus in 2019. In line with national policy, UL Hospitals Group are committed to implementing an Open Disclosure policy which provides transparency and assurance to those who use our services when things go wrong.

Service Redesign

The way in which services are planned and how and where they are provided needs to change. It is recognised that the current service delivery model is unsustainable. Given what is known about the growing numbers of people who live in Ireland, their age and health needs, the HSE have been investing at a small scale in different types of services that are more needed into the future and have been examining the benefits to patients in delivering them.

In line with *Sláintecare,* the HSE is committed in 2019 to exploring and demonstrating how these new models of care can be expanded in a sustainable manner and that will deliver a demonstrable impact in patient care, patient experience and patient outcomes. This will involve a greater focus on planning and increased investment over a number of years, to ensure the foundations for these service changes and improvements are in place, are sustainable, monitored and are effective.

The longer-term vision continues to be on providing improved access to services, the provision of an expanded range of primary care services, appropriately targeted investment in acute services to improve access in times of emergency and for planned procedures.

To deliver this, the principal challenge is to transform the way services are delivered, while in parallel continuing to meet the current needs of patients and service users under the existing system. Dealing with and responding to increased demand across a whole range of health and social care services and delivering programmes of work to improve service efficiency and meet the goals and objectives of key government strategies, is an on-going feature of health service management and delivery. UL Hospitals Group looks forward to the further development of proposals and supports the delivery of clinical and medical care in the most appropriate setting for the patient.

Service Challenges

The funding of €16,050 million (m) made available to the HSE in 2019 represents an increase of €848m (5.6%) over the final budget for 2018. This funding is required to meet the costs of new service developments set out by the DoH (€198m), the higher costs in 2019 of delivering 2018 levels of service activity, and the costs in 2019 of additional service activity to meet demographic changes and other service pressures.

In this context, endeavouring to prepare a plan that is financially balanced and, at the same time, seeks to respond to the most pressing service quality and safety issues in 2019 has presented a very significant challenge. Even with cost reductions and improved efficiency, it is not possible to respond fully to the level of health and social care needs expected in 2019. Inevitably, difficult choices have had to be made, in order that the HSE continues as far as possible to respond to the most pressing patient and client needs while operating within the resources available.

NSP2019 and consequently UL Hospitals Group Operational Plan have been prepared on the basis of a range of assumptions and with careful consideration of risks to delivery. These are outlined below:

- Delivering a volume of activity in 2019, consistent with available funding and reflecting improved efficiency, which fails to respond adequately to need. It is assumed that, as far as possible, levels of service will be maintained at 2018 outturn levels.
- Delivering a volume of activity in 2019 in demand-led service areas (e.g. emergency hospital services, emergency placements for people with a disability) – which are not usually amenable to normal budgetary control measures – which exceeds budgeted levels of activity and available funding.
- Ensuring an adequate response to the additional service pressures which will arise during the winter period in relation to hospital, community and primary care services. In preparing for winter, the HSE has prioritised funding to anticipate and manage critical demand pressures, within the funding envelope available.
- Ensuring that service delivery entities – Community Healthcare Organisations (CHOs), Hospital Groups such as UL Hospitals Group, and the myriad associated delivery organisations – operate within notified financial and staffing budget levels for 2019, and also ensure appropriate balancing of quality and risk issues at local level during a period of potential structural change, with escalation regionally and nationally as appropriate.
- Effectively managing our workforce, including recruitment and retention of a highly skilled and qualified workforce, delivering a reduction in overtime and the use of agency personnel and staying within our pay budget.
- Working within the constraints posed by limitations to clinical, business, financial and HR information systems.
- Progressing at scale and pace the required transformation agenda, in the context of the resources available.
- Responding adequately to urgent safety concerns and emergencies such as Carbapenemase-Producing Enterobacteriaceae (CPE), in the context of the resources available.
- Responding adequately to the impact of the Brexit process, in the context of the resources available.
- Responding adequately to unplanned and unforeseen events (e.g. further storms), in the absence of a contingency fund in 2019.

- Meeting public expectations in terms of access to services, new therapies, drugs and interventions, in the context of the resources available.
- Ensuring that levels of activity and costs in screening services, as a result of laboratory demands and requirements, remain within budgeted levels.
- Responding adequately to recommendations in new and existing reviews and reports, in the context of the resources available.
- Meeting the regulatory requirements in the disability sector, long-stay facilities and mental health and hospital services, within the limits of funding available without impacting on service levels.
- Responding adequately within available funding to support the delivery of key service developments and augmentations, including in relation to: sexual assault treatment units; children's palliative care services; disability services; and older persons' services.
- Complying with the General Data Protection Regulation requirements.

These and other risks will be kept under on-going review to ensure that they are mitigated as far as possible.

Performance and Accountability

A key principle of *Sláintecare* and enhanced operational management and oversight is the need for strengthened governance and accountability, at all levels.

The enactment of the *Health Service Executive (Governance) Bill 2018* will provide for the re-establishment of a HSE Board to strengthen independent oversight and performance of the HSE. The establishment of a HSE Board is an important step in strengthening governance arrangements. Once established, the Board will have a number of immediate priorities including to provide oversight of actions necessary to ensure improved service delivery, corporate and clinical governance, and financial control and accountability within the HSE. The HSE executive will work proactively with the new Chair and the new Board to ensure it can work effectively and respond efficiently and productively to a range of new governance requirements stemming from these new arrangements.

The HSE's Performance and Accountability Framework will be reviewed to reflect new Board governance and accountability arrangements, in line with legislation being developed by the DoH.

During 2019, the HSE will work with the new Board, the DoH and relevant stakeholders to progress the development of new health service structures in line with *Sláintecare*. The performance and accountability arrangements for these new organisations will be scoped and agreed, in addition to the respective roles of the DoH, the Board of the HSE and the range of voluntary, statutory, community and private providers. Work will be undertaken to ensure that all structural changes will be focused on and ultimately lead to improved services and outcomes for patients and service users. The intention is that new structures will provide a better balance between central decision-making, and flexibility and responsiveness at local level. This will facilitate more effective planning across the full range of services and at regional level to respond to defined needs of local populations.

Section 2:
Our Population

Our Population

Over 4.8m people live in Ireland (Central Statistics Office (CSO), 2018). An overall increase in the population of 64,500 was experienced from April 2017 to April 2018, the largest annual increase since 2008 (*Population and Migration Estimates April 2018*).

The greatest change in population structure over the last ten years is the growth in both the proportion and the number of people aged 65 years and over, increasing in the intercensal period from 11.6% in 2011 to 13.3% in 2016. It is projected that people aged 65 years and over will increase by 22,935 (3.5%) in 2018 and 21,969 (3.3%) in 2019 (*Population and Labour Force Projections 2017-2051*). Similarly, adults aged 85 years and over will increase by 2,505 (3.6%) in 2018 and by 3,116 (4.3%) in 2019. Notwithstanding this growth in the older population, in 2016 a quarter of our population are children aged 0-17 years.

There were 62,053 births in 2017, 1,844 fewer births compared with 2016. The death rate has remained static from 2016 to 2017 with a rate of 6.4 per 1,000 population. The infant mortality rate in 2017 was 2.8 per 1,000 live births (or 174 infant deaths). The average maternal age for all births registered in 2017 was 32.8 years, with teenage births reducing to 1,041 births in 2017 from 1,098 in 2016 (*Vital Statistics Yearly Summary, 2017*).

These statistics provide a brief profile of the size, growth and distribution of our population – the demographic changes which have implications for future planning and health service delivery.

Mid-West Population

Total population of Limerick city and county in 2016 was 194,899, an increase of 1.6% over the previous five years. Of this, 94,192 were resident in Limerick city and suburbs (growth of 3% from 2011).

Area	Persons 2011	Persons 2016	Actual change 2011-2016	% change 2011-2016
Limerick City & County	191,809	194,899	3,090	1.6%
Co. Tipperary	158,754	159,553	799	0.5%
Co. Clare	117,196	118,817	1,621	1.4%
Mid-West	467,759	473,269	5,510	1.2%
Ireland	4,588,252	4,761,865	173,613	3.8%

Data Source: Central Statistics Office (CSO)

Population Estimates ('000s) for Regional Authority Areas by Age Group, 2018

Category	Mid-West	Ireland
Male	240.8	2,405.8
Female	241.6	2,451.3
Total	**482.4**	**4,857.0**
Age Groups:		
0-14	98.3	1,008.8
15-24	61.3	605.5
25-34	54.6	629.9
35-44	71.5	768.2
45-54	65.8	647.9
55-64	56.0	526.4
65-74	44.1	393.5
75-84	22.8	207.0
85+	8.0	73.0
2016 Census	**473.3**	**4,762.0**
% Change 2016 - 2018	**1.9**	**2.0**

Data Source: Central Statistics Office (CSO) – Data for 2017 & 2018 are preliminary

Under the National Planning Framework, 'Project Ireland 2040', taking into account a projected 1 million increase in our population, 25% of this growth is expected across the cities of Cork, Limerick, Galway and Waterford. This will mean enabling all four to grow their population thus becoming cities of greater scale i.e. growing twice as much as they did over the previous 25 years to 2016.

City	Population 2016	Population Growth to 2040		Minimum Target Population 2040
		% Range	People	
Limerick – City and Suburbs	94,000	50 – 60%	47,000 – 56,000	141,000

Data Source: National Planning Framework 'Project Ireland 2040'

Life Expectancy and Health Status

Life expectancy in Ireland has increased by almost two and a half years since 2005 and is now above the EU average with women living to, on average, 83.4 years and men 79.6 years. The greatest gains in life expectancy have been achieved in the older age groups reflecting decreasing mortality rates from major diseases (*Health in Ireland – Key Trends 2017,* DoH). People living longer demonstrates that we are managing to prevent and treat diseases more effectively. The challenge remains to adapt health services, settings and models of care adequately meet the needs of an ageing population whilst providing a safe, dignified and patient centred service at all times within allocated budgets.

The 2016 census asked people to rate their perception of their overall health. At a national level, 87% of people perceived their general health to be very good or good. In Limerick city and county, 86% rated their health as good or very good.

Chronic Disease

The three most common chronic diseases are cancer, cardiovascular disease and respiratory disease. These diseases give rise to three quarters of deaths in Ireland. It is estimated that over 1.07m people over the age of 18 years currently have one or more chronic diseases (based on analysis of *The Irish Longitudinal Study on Ageing (TILDA), wave1, 2017* and *Quarterly National Household Survey, special module on health, 2010*). However, chronic disease increases with age, the highest prevalence observed in the population aged 50 years and over. The number of people in this age cohort, living with one or more chronic disease, is estimated to increase by 40% from 2016 levels, to 1.09m in 2030 (based on analysis of *TILDA data, 2018*). Multi-morbidity is common in older people with 45.3% of adults aged 65 years and over affected by arthritis, 44.4% by high blood pressure, 11.8% by diabetes and 3.7% by stroke (*TILDA wave 3, 2014-2015*).

Increasing Lifestyle Risk Factors for Poor Health

Many diseases and premature deaths are preventable. Increased morbidity and mortality are strongly related to lifestyle-based health determinants such as smoking, alcohol consumption, exercise and healthy eating.

The prevalence of smoking has declined from 23% in 2015 to 20% in 2018, with 44% of all smokers reporting they have made an attempt to quit in the past 12 months.

Three-quarters of the population reported drinking alcohol in the past year, with over half (55%) of drinkers drinking at least once a week (*Healthy Ireland Survey 2018*). Binge drinking is drinking six or more standard drinks on a typical drinking occasion, 37% of the population report binge drinking.

Almost two thirds (65%) of the population are aware that people should be active for at least 150 minutes each week (*Healthy Ireland Survey 2016*). The initial wave of this survey identified that 32% undertake a sufficient level of physical activity. The average amount of time spent sitting each day is 396 minutes.

Over a third (37%) of the population report that they consume at least five portions of fruit and vegetables daily (including juices) (*Healthy Ireland Survey 2018*). Of the five types of unhealthy foods measured by the survey, in 2018 34% of the population consumed at least one of them on a daily basis; this is down by 1% since the 2017 report. In 2018, 9% drink sugar-sweetened drinks on a daily basis; this is highest amongst those aged 15-24 (15%).

Wider Social Determinants of Health in Ireland

There is a strong link between poverty, socio-economic status and health. In 2016, the consistent poverty rate in Ireland was 8.3%, with 11.1% of children experiencing consistent poverty (*Survey on Income and Living Conditions 2016*).

Our social environment plays a key role in determining health status. In Ireland, certain groups, due largely to their socioeconomic status, are at greater risk of poor health outcomes. '*The social conditions in which people live powerfully influence their chances to be healthy. Indeed factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries*' (World Health Organization, 2004). Since the 1990s, a pattern showing that life expectancy is lower among unskilled workers compared to professional workers has emerged in Ireland (*Socioeconomic differentials in mortality by cause of death in the Republic of Ireland, 1984-2008*; European Journal of Public Health, 2016).

UL Hospitals Group serves a socially diverse population including Limerick City which was the most deprived local authority nationally with 36.8% of its inhabitants either very disadvantaged or disadvantaged (*Health Profile 2015 Limerick City*). In sharp contrast to this, Limerick County was ranked as the 8th most affluent local authority nationally with 54% of its population either being marginally above affluence or affluent (*Health Profile 2015 Limerick County*). Clare was ranked as the 13th most affluent at the same point.

There is a strong link between poverty, socio-economic status and health. Life expectancy is greater for professional workers compared to the unskilled. As measured by the census, the rate of unemployment in Ireland in April 2016 was 12.9%. There were 79 unemployment blackspots. (Blackspot refers to an area with at least 200 people in the labour force where the employment rate is 27% or higher). Eight of the top 10 were in Limerick.

Healthy Ireland, the HSE's national policy, promotes a reduction in health inequalities through improved lifestyle and health behaviours. This is an inter-sectoral whole of government approach to ensuring an improvement of the wider determinants of health. The *Healthy Ireland* / HSE policy priority programmes focus particularly on population health issues such as overweight and obesity, child health, mental health, smoking, alcohol and drugs, and positive ageing. *Healthy Ireland* provides people and communities with accurate information on how to improve their health and wellbeing and seeks to empower and motivate them by making the healthy choice the easier choice.

Health Inequalities among Socially Excluded Groups

Socially excluded groups have complex health needs, experience very poor health outcomes across a range of indicators like chronic disease, morbidity, mortality and self-reported health. Socially excluded groups include people who are homeless, people with substance use disorders, Travellers, asylum-seekers, prisoners and survivors of institutional abuse. These populations require a lot of support across a range of healthcare areas. The health inequalities experienced differ in their severity and their complexity, compared to those for the wider population.

People who are homeless

People who are homeless often experience complex and chronic health conditions. Of particular concern are adults who are persistently homeless and rough sleepers. There is a high risk of a combination of physical ill-health with dual diagnosis (co-existing mental ill-health and substance misuse) and consequent high healthcare needs. The average life expectancy for a homeless person is just over 40 years. In August 2018 there were 5,834 adults who were in Ireland – 2,547 were female and 3,287 were male, 60% were aged between 25 and 44 years. The number of children who were homeless was 3,693. Compared with July 2017, these figures have increased by 12.5% for adults (5,187) and 24.2% for children (2,973) nationally. The Dublin region accounts for 68% of all homelessness *(Department of Housing, Planning and Local Government, Homelessness Report, July 2018*).

Details of Households accessing local authority managed emergency accommodation week 19-25 November 2018

Region	Homeless Adults	Gender		Age Groups				Accomodation Type *			
		Male	Female	18-24	25-44	45-64	65+	PEA	STA	TEA	Other
Mid-West	385	239	146	58	211	108	8	136	199	50	0

Data Source: Department of Housing, Planning & Local Government – Homelessness Report November 2018

**PEA - Private Emergency Accommodation: this may include hotels, B&Bs and other residential facilities that are used on an emergency basis*
STA - Supported Temporary Accommodation: accommodation, including hostels, with onsite professional support
TEA -Temporary Emergency Accommodation: emergency accommodation with no (or minimal) support
Note: Clients may have accessed multiple accommodation types during the week

People with substance use disorders

People with substance use disorders can often have complex health needs. These include mental health problems and the combined effect of drug and alcohol misuse. Of particular concern are the needs of older people availing of treatment for heroin use, which is in excess of 4,000 (of a total of over 10,000 people on opioid substitution treatment) (*Drugnet Ireland, Issue 64, Winter 2018,* Health Research Board). They are vulnerable to a range of health problems, including poor dental health, liver damage, chronic lung and circulation disease, poor mental health, as well as the effects of long-term drug and alcohol use. According to a recent study (*Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods. 2017. Dublin: National Advisory Committee on Drugs and Alcohol)*, with regard to city differences, in 2014, after Dublin, Limerick City had the highest rate of opioid use at 8.82 per thousand population aged 15-64 years based on the sub-population of opioid users from study.

Suicide and Self-Harm

In Ireland, in 2016, 437 deaths by suicide occurred (*CSO)*. The greatest prevalence of these deaths were male related (350). During 2016 there were 44 deaths from suicide in the Mid-West with the highest number occurring in Clare.

The National Self-Harm Registry Ireland recorded from the period of 1 January to 31 December 2017, 11,600 self harm presentations to hospital that were made by 9,103 individuals. Self-harm, which is defined as an act with a non- fatal outcome, saw the national rate of self-harm per 100,000 persons was 181 for males and 218 for females. During 2017, the rate of self-harm for Limerick city for males and females was approximately twice the national average. The self-harm rates for males in Tipperary North, Clare and Limerick County was below the national average for males and females.

According to the *Connecting for Life Mid-West Suicide Prevention Action Plan, 2017-2020*, drug overdose is the most common method of self-harm along with alcohol abuse being allegedly responsible for a significant number of self-harm presentations to the Emergency Department. Recognising that every death by suicide is a tragedy for family, friends, workplaces and communities the development of the Mid-West plan by HSE Mid-West Community Healthcare, involved the engagement of a broad range of statutory, non statutory, community and voluntary groups in identifying agreed strategic priorities, and setting clear goals and actions relevant to the national goals identified in the national strategy *Connecting for Life*, preventing suicide and self-harm in Ireland.

Travellers and Roma

Severe health inequalities experienced by Traveller and Roma communities lead to poorer health outcomes, including lower life expectancy and higher infant mortality, compared to the general population. These outcomes are documented in the All Ireland Traveller Health Study. The 2016 Census recorded 30,987 Travellers living in the Republic of Ireland, an increase of 5.1% from Census 2011 (CSO, 2016). Irish Travellers are much younger than the general population. Almost three quarters of Travellers are aged 34 years or younger while just over 7% are 55 years and over. The estimated Roma population is between 3,000 and 5,000 (*National Traveller and Roma Inclusion Strategy 2017-2021*).

Section 3:
Reform and Transformation

Reform and Transformation

Over the last five years, the HSE has had programmes of work focusing on four pillars of healthcare reform. Significant work has been delivered under the health and wellbeing pillar, the financial reform pillar, the service reforms pillar and Hospital Groups and CHOs were established under the 'structural reform' pillar. During this time, the HSE advocated the need for a whole of government, cross-party vision for health and this was made possible by Government and delivered with the publication of the *Sláintecare Report* in May 2017.

Figure 3: Principles set out in the *Sláintecare Report*

Implementation of *Sláintecare*

The *Sláintecare Report* (2017) and *Sláintecare Implementation Strategy* (2018) signal a new direction for the delivery of health and social care services in Ireland. The opportunity that will come with implementation cannot be overestimated, as it has the potential to create a far more sustainable, equitable, cost effective system and one that delivers better value for patients and service users. It creates a more sustainable opportunity to transform the health and wellbeing of the population and how and where they access services.

At its core, the strategy focuses on establishing programmes of work to move to a community-led model, providing local populations with access to a comprehensive range of non-acute services at every stage of their lives. This will enable our healthcare system to provide care closer to home for patients and service users, to be more responsive to needs and deliver better outcomes, with a strong focus on prevention and population health improvement.

The context for reform and transformation in the HSE is extremely challenging. As set out in the *Sláintecare Report* and *Sláintecare Implementation Strategy*, services across all areas of the health system are stretched – with demand far outstripping supply. Hospitals, such as UL Hospitals Group are operating at maximum capacity, with occupancy rates across the country well in excess of safe and internationally benchmarked standards of 85% as defined by the DoH's recent capacity review. Waiting lists for surgery and other planned hospital services, and for community services are unacceptably high. Similarly, demands in other social care services for older people and people with disabilities are growing steadily. Changes in the demographic and morbidity profile in our population, in addition to regulatory and care requirements are driving this increase. The system has also under-invested in the necessary data, information and ICT systems that are needed to more effectively manage services, routinely share information and respond to patients' needs. Meeting both current and future challenges with the current service design of the HSE is not sustainable. *Sláintecare* recognises that we are 'facing extraordinary challenges, we need an extraordinary response' (*Sláintecare Implementation Strategy* pg.13).

Given the need to ensure *Sláintecare* becomes fully embedded in everything we do, in addition to simultaneously being mindful of real service challenges and further structural reconfiguration, five high level reform and transformation priorities have been identified by the HSE for 2019. These include:

- Governance, leadership and corporate strategy.
- Transitional funding to shift the balance of care.
- Managing demand and continuing productivity improvement.
- Delivering programmes of work aligned to the National *Sláintecare* Office Action Plan.
- Transformation support and enablement.

Governance, Leadership and Corporate Strategy

The enactment of the *Health Service Executive (Governance) Act 2018* will provide for the re-establishment of a HSE Board to strengthen independent oversight and performance of the HSE. The HSE executive will work proactively with the new Chair and support the new Board to ensure it can effectively lead, provide strategic clarity in the context of widespread service challenges and most importantly, guide the organisation and work with management, staff and all stakeholders in realising *Sláintecare*'s eight principles and associated actions.

UL Hospitals Group will continually work with its' Hospital Board to strive to be a valued, trusted and leading provider in healthcare with an overriding vision to be continually patient centred, clinically integrated, team based and research driven. Together, we look forward to the further development of *Sláintecare's* proposals and support the premise of delivering care in the most appropriate clinical setting for the patient.

Transitional Funding to Shift the Balance of Care

Sláintecare requires significant and substantial targeted investment to expand healthcare entitlements, address legacy issues and new eHealth architecture, implement system governance changes, and expand primary and community healthcare services. The publication of the Government's *National Development Plan 2018-2027* in 2018 is a significant development creating a funding pipeline for capital developments, aligned to *Sláintecare* in the years ahead. The challenge in 2019 is to prioritise actions, using largely existing resources and incremental funding increases, to continue putting the necessary building blocks in place.

Aligned to this thinking, UL Hospitals Group has developed a strategic plan, which sets out the corporate development over a five year period. One of its' key strategic priorities is Digital Health which presents a series of objectives to digitally enable and enhance processes rooted in patient care, research, education, innovation and collaboration (*UL Hospitals Group Strategic Plan 2018-2022*).

Managing Demand and Continuing Productivity Improvement

The health system and budget is constrained by the rate of growth in real national income. Expenditure demand is rising. The DoH has projected that demographic pressures would increase costs by between 1.4% and 1.6% annually. Responding to rising demand and expectations within available funding is an intractable feature of all healthcare systems.

The growing cost of delivering core services is such that UL Hospitals Group faces a significant challenge in 2019 in maintaining the existing level of overall activity, to which we are fully committed. To this end, we are conscious that maintaining services and driving improvements in patient safety and quality remain over riding priorities across the health sector, and all savings and efficiency measures will be assessed with these priorities in mind.

For 2019, UL Hospitals Group objective is to maintain quality, deliver good outcomes and recognise that there are opportunities, even in a constrained financial environment, to provide excellent health care services to the population of the Mid-West of Ireland.

Delivering Programmes of Work aligned to the National *Sláintecare* Office Action Plan

In 2019, UL Hospitals Group will await national guidance in terms of cementing the foundations for *Sláintecare* support, transformation, subsequent implementation and delivery of associated progammes of work keeping patient centred care to the fore at all times.

Transformation Support and Enablement

A dedicated *Sláintecare* Programme Office has been established to drive implementation of the reform programme. This approach needs to be mirrored in the HSE to support full implementation. UL Hospitals Group will be directed by national HSE guidelines in this regard.

Section 4:
Clinical, Quality and Patient Safety

Clinical, Quality and Patient Safety

Introduction

The HSE will continue to work to support the delivery of sustainable high-quality, effective, accessible and safe health and social care services to meet the needs of our population. The Office of the Chief Clinical Officer (CCO) supports the advancement of key strategic actions of *Sláintecare.* This will be facilitated by the review and re-orientation of national clinical programmes towards the objectives of *Sláintecare* to include development of new models of care. Prioritisation will be given to delivery of integrated care closer to home and reducing dependency on our hospital system. The experience of patients and leadership of clinicians and frontline staff is essential in designing and improving care, responsive to the needs of patients. Further development of patient safety initiatives, in collaboration with the delivery system, to maintain standards and minimise risk is an essential component of a modern healthcare system.

Against the above background, the HSE will progress actions under three priority areas in 2019:

- Strengthening clinical leadership in the development of healthcare strategy and in the planning and management of our services at a time of critical service transformation signalled by the *Sláintecare Report*.
- 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.
- Advancing a culture of patient safety, continuous quality improvement and learning.

Issues and Opportunities

There are a number of significant issues and opportunities associated with the three priority areas of the Office of the CCO. These include:

- Challenges in delivering safe, high quality, consistent care in the context of finite financial and staffing resources, an increasing population with an older age profile and increasing prevalence of chronic disease.
- Delays in access to care and the large number of delayed discharges in acute hospitals, particularly for patients who have specific requirements for rehabilitation, disability or residential care, result in increasing demands outside the hospital setting.
- Difficulties in recruiting and retaining staff, and ensuring that statutory, legislative and regulatory requirements are met.
- Opportunities, informed by feedback from staff and service users, to build on existing patient safety and quality improvement work and structures to enhance our services.

Responding to these pressures requires integration of health and social care services through further development of the structures already in place for the national clinical and integrated care programmes (ICPs). This provides the opportunity to have a more multi-disciplinary approach to planning and clinical leadership.

The HSE will seek during 2019 to enhance and greater co-ordinate all functions relating to patient experience. This will also allow them to respond to the recommendations of the *Scoping Inquiry into the*

CervicalCheck Screening Programme, 2018 (*Scally Report)*, with a priority focus aligned to areas such as communication and open disclosure, including mandatory reporting under the forthcoming *Patient Safety Bill*. The completion of a review of clinical audit within the HSE aims to ensure that activity and ownership of clinical audit is clear from design to implementation. The establishment of a co-ordinated programme of work for patient safety, working with and through care delivery organisations, is planned in collaboration with the National Patient Safety Office.

The HSE will, as far as possible within available resources in 2019, support a programme of work to address implementation of measures to control antimicrobial resistance (AMR), including Carbapenemase Producing Enterobacteriaceae (CPE), and to improve infection prevention and control and reduce spread of HCAIs in CHOs and Hospital Groups.

Opportunities exist to build on the foundations laid over the last couple of years through the National Incident Management System (NIMS), updated *Incident Management Framework 2018*, the *Framework for Improving Quality in our Health Service* and the *Improvement Knowledge and Skills Guide – Development Assessment Tool for all Staff* to support and enable staff to continuously improve the quality and safety of service delivery.

Clinical Leadership

The HSE needs to plan for a shift in health service delivery and improvement in line with *Sláintecare*, the *Health Service Capacity Review 2018* and the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* recommendations. The Office of the CCO, incorporating clinical programmes, nursing and midwifery, health and social care professions as well as quality and safety, provides the foundations for enhancing clinical leadership and enabling a multi-disciplinary approach to progressing improvements in care. Work to date in relation to clinical programmes and patient safety initiatives provides strong evidence that significant improvements in the delivery of health and social care services can be achieved when compared to previous models and ways of working.

UL Hospitals Group will continually work with and adopt recommendations from the HSE and The Office of the CCO in the interests of building a better health service, designed to meet the needs of our population.

Patient and Service User Engagement

Partnering with patients, service users and families to learn from their experience is an essential component in enabling improvements in care and ensuring a quality, effective and safe service that is responsive to the needs of patients and service users. They will need to be central to the design, planning and commissioning of services. The system needs to improve to achieve a more open and honest communication with patients and service users in relation to their care. Priority actions will aim to improve partnering with patients, service users and families and will play a key role in supporting the implementation of relevant learning from the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)*, building on the existing work in the area of open disclosure and communication with patients.

Within UL Hospitals Group, our hospital services, staff, patients and service users are engaged in many formal and informal activities to improve the way we lead and act with staff and service users to ensure that the culture of our services is aligned with our core values; Care, Compassion, Trust and Learning. A significant challenge for all parts of healthcare is to nurture cultures that ensure the delivery of continuously improving, high quality, safe and compassionate healthcare. Our Patient Council, which was launched in

2016, will continue to work with UL Hospitals Group to identify current and future opportunities to enhance the care experience for patients, families and caregivers.

UL Hospitals Group is a strong advocate of the annual National Patient Experience Survey and has been delighted to date to participate in two surveys. The results of these surveys enable UL Hospitals Group to pinpoint where positive progress has been made and identify from a patients perspective where further work is needed. The results each year show the impact we all have on our patients' experience and provides a real focus on what patients have said is most important about their experience.

UL Hospitals Group will continue to develop and promote internal enhancements in terms of improving the patient experience and engagement whilst supporting associated HSE national policies and programmes.

Quality, Patient Safety and Learning

Continual improvement, in the quality of care, learning from patient experience, and systems to manage major threats to sustainability to healthcare systems globally e.g. AMR, is essential in ensuring safer healthcare. This reduces harm to patients and helps create more effective evidence based care which is appropriate to patient needs.

The National HSE actions below aim to promote, and support staff to deliver on, a culture of patient safety, quality improvement and learning. UL Hospitals Group will be guided by these national priorities and actions and adapt and work accordingly to continually deliver on patient safety and quality care.

Priorities and Actions

Patient safety strategy

Priority	Accountable	Timeline
Support the HSE in the completion of the national patient safety strategy and await implementation instructions	ULHG	Q1-Q4
Implement and further develop specific and targeted patient safety initiatives in areas such as medication safety, pressure ulcers, falls, clinical handover underpinned by robust quality improvement methodologies, education and toolkits.	ULHG	Q1-Q4
Participate and progress the work undertaken to support the service delivery areas to complete a capacity and capability study for quality and patient safety.	ULHG	Q1-Q4

Patient safety governance

Priority	Accountable	Timeline
Implement the findings from the national patient safety strategy once unveiled, and strengthen the governance of current patient safety programmes.	ULHG	Q1-Q4
Enhance the capability for governance, for quality and patient safety across our services through the application of the Quality Improvement for Boards Programme, including development and use of quality profiles.	ULHG	Q1-Q4
Progress the improvement and management of AMR and infection prevention control: - Progress structures currently managing CPE to encompass AMR and infection prevention and control in line with the strategic action 1 of *Sláintecare* to implement *Ireland's National Action Plan on Antimicrobial Resistance 2017-2020,* to enhance governance and monitoring at national and local level.	ULHG	Q1-Q4

Learning through feedback systems

Priority	Accountable	Timeline
Support a clinical audit culture to ensure that suitable structures and supports are identified and implemented.	ULHG	Q1-Q4
Continue to support the roll-out of the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* (Phase 1).	ULHG	Q1-Q4
Support the implementation of the *Incident Management Framework 2018* in order to report, manage, review, disseminate and implement learning from safety incidents.	ULHG	Q1-Q4

Risk Management

Priority	Accountable	Timeline
Support the organisational review of its approach to risk management and reporting.	ULHG	Q1-Q4

UL Hospitals Group QPS priorities 2019

Patient Safety Strategy

- Implement and roll out the specific target patient safe initiatives (Falls, Pressure ulcers and medication safety) using new tools though governance committees.

Patient Safety governance

- Establish the sub board committee for patient safety, with new Terms of Reference and standing agenda using available metrics.
- Further support engagement with CHO with joint management of adverse events and complaints.
- Seek to obtain funding to implement recommendations from Capacity and Capability review.
- Embed the governance for management of HCAI with a sustainable quality improvement plan that have learning plans.
- Continue to review repository of documentation to ensure appropriate guidance documents are updated and available to staff.

Risk Management

- Embed the integrated risk management policy.
- Roll out all the different functionality of the incident management framework.
- Roll out Open Disclosure training engaging more physicians.
- Support the roll of the protection of Open disclosure under the civil liability act.

Quality assurance and Audit

- Undertake a self-assessment against National safer better healthcare standards.
- Develop a local audit plan across all sites and directorates.
- Continue to engage with local clinicians to develop improvements in relation to national audits.

Learning

- Continue to publish learning notices following adverse events.
- Expand these learning notices to include learning from audits and complaints.

Section 5:

Population Health and Wellbeing

Population Health and Wellbeing

Introduction

A fundamental goal of the health service is to support the health of its population. *Sláintecare* recognises the importance of supporting people to look after and protect their own health and wellbeing. *Healthy Ireland* is the national strategy for improved health and wellbeing. This strategy is underpinned by a whole-system philosophy involving cross-government and cross-societal responsibility. The health system will continue to play an important leadership role in driving this whole-system shift towards a culture that places greater emphasis and value on prevention and keeping people well.

There are many positive trends visible within our health service, life expectancy is increasing, mortality rates are declining and survival rates from conditions such as heart disease, stroke and cancer are improving. Despite these encouraging developments, we know changing lifestyles, chronic disease patterns and ageing population trends are altering our population's healthcare needs. This is creating an unsustainable horizon for the future provision of our health and social care services in Ireland.

To address these challenges the health service will continue to prioritise high quality evidence based prevention, early intervention and health protection strategies to help reduce demand on our health and social care services thereby ensuring a sustainable health system for future generations.

Services Provided

Population health is about helping our whole population to stay healthy and well by focusing on prevention, protection, and health promotion and improvement through the work of:

- The National Policy Priority Programmes for tobacco, alcohol, healthy eating and active living, sexual health and crisis pregnancy, and child health which provide expertise, strategic advice and direction to address known preventable lifestyle risk factors by designing and developing evidence based best practice policies, programmes and initiatives.
- Health Promotion and Improvement services which provide a range of education and training programmes focused primarily on building the capacity of staff across the health service and in key external bodies who are ideally placed to positively influence health behaviour. Health and Wellbeing services work with people across a variety of settings in the community, in hospitals, in schools and in workplaces.
- Public Health services which protect our population from threats to their health and wellbeing through the design and oversight of national immunisation and vaccination programmes and actions for the prevention and control of infectious diseases.
- CHOs and Hospital Groups implementing comprehensive *Healthy Ireland* plans to deliver upon the health and wellbeing reform agenda locally, improve the health and wellbeing of the local population by reducing the burden of chronic disease and improving staff health and wellbeing.
- National Screening Services which provide population-based screening programmes for BreastCheck, CervicalCheck, BowelScreen and Diabetic RetinaScreen.
- Environmental Health Services which take preventative actions and enforce legislation in areas such as food safety, tobacco control, cosmetic product safety, sunbed regulation, fluoridation of public water supplies, drinking and bathing water, to improve population health and wellbeing.

Issues and Opportunities

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

Individual lifestyle choices are heavily influenced by social and economic circumstances. A whole-system approach involving cross-government and cross-societal actions are required to help our most vulnerable and deprived communities.

Building upon *Sláintecar*e and HSE structural reforms and enablers, will create greater capacity within the organisation to lead and deliver upon the health and wellbeing reform agenda. The development and implementation of comprehensive *Healthy Ireland* plans in CHOs and Hospital Groups will deliver upon the health and wellbeing reform agenda locally, improving the health and wellbeing of the local population by reducing the burden of chronic disease, and improving staff health and wellbeing.

UL Hospitals Group published a Healthy Ireland Implementation Plan 2016-2019 in June 2016 following staff consultations and communication roadshows. Many key actions within the plan are in progress with many already delivered. Examples include the formation of a group-wide flu vaccination committee which oversaw the roll out of a peer vaccinator model. One of the pillars of Health and Wellbeing is the importance of promoting and maintaining staff health. Several physical activities across the sites within the Group have been organised such as the annual UL Hospitals 5K run event along with other initiatives to highlight the significance of positive mental health. Work will continue throughout 2019 to capitalise on the affirming results already achieved in terms of education and initiatives to further inform both patient and staff of the benefits of keeping healthy and well.

Priorities 2019

- Improve the health and wellbeing of the population by reducing the burden of chronic disease.
- Build upon *Sláintecare* and HSE structural reforms and enablers to create greater capacity within the organisation to lead and deliver upon a cross-sectoral health and wellbeing reform agenda.
- Support the implementation of comprehensive *Healthy Ireland* implementation plans in CHOs and Hospital Groups. UL Hospitals Group published its Healthy Implementation Plan 2016-2019 in June 2016.
- Progress the Early Years Intervention Programme including the National Healthy Childhood and Nurture Infant Health and Wellbeing Programmes.
- Continue to protect our population from threats to health and wellbeing through infectious disease control, immunisation, and environmental health services.
- Improve staff health and wellbeing.

Health and Wellbeing Services

Priorities and Actions

Improve the health and wellbeing of the population by reducing the burden of chronic disease

- Healthy Ireland Implementation Plan

Priority	Accountable	Timeline
Continue to implement Healthy Ireland plans in UL Hospital Group.	ULHG	Q1-Q4

- Making every contact count

Priority	Accountable	Timeline
Support the Making Every Contact Count (MECC) Framework as appropriate and feasible in conjunction with Health and Wellbeing Services.	ULHG	Q1-Q4

- Tobacco free Ireland

Priority	Accountable	Timeline
Continue to implement the HSE Tobacco Free Policy in UL Hospital Group.	ULHG	Q1-Q4

- Healthy Eating Active Living

Priority	Accountable	Timeline
Continue to implement key priority Health Eating Active Living (HEAL) actions in UL Hospital Group.	ULHG	Q1-Q4

Protect our Population from Threats to their Health and Wellbeing

Priority	Accountable	Timeline
Continue to improve influenza uptake rates amongst healthcare staff in UL Hospital Group.	ULHG	Q1-Q4
Progress the relevant 2019 actions set out in the HSE Antimicrobial Resistance, Infection Prevention and Control (AMR and IPC) implementation plan 2019-2020 within available resources.	ULHG	Q1-Q4

Implementing ULHG priorities in line with National Plan goals

Priorities and Actions

Continue the fourth year of Healthy Ireland Implementation at UL Hospitals Group. Review progress on actions contained within the UL Hospitals Group Implementation Plan and support and be guided by national policies and priorities.

- Review the implementation of UL Hospitals Healthy Ireland Implementation Plan 2016-2019 to date.
- Continue to support the implementation of Making Every Contact Count in 8 identified pilot areas across the group.
- Launch a revised Tobacco Free Campus policy for the group at the end of Q1 and participate in the forthcoming Tobacco Free Limerick programme in conjunction with Limerick City & County Council.

- Continue to support the growth of UL Hospitals Sports & Social Club for all staff.
- Continue to work with partners in public service in Limerick to create opportunities for health promotion for staff and among the general public.
- Continue to provide evidence based key messages on known preventable lifestyle risk factors to our staff and patients via noticeboards, e-screens and health promotion events across all sites.
- Implement the annual flu vaccination campaign to reach national targets for staff vaccination rates.
- Continue to progress Schwartz Rounds as a valuable tool for staff engagement.
- Continue to input to the roll out of local staff engagement forums following the results of the 2018 staff survey.
- Progress the opportunities to participate in national workplace physical activity promotion initiatives including Steps to Health & Love Life Love Walking.
- Launch internal *Slí na Sláinte* walking routes in UHL.
- Launch outdoor soft landscaped seating areas on four hospital sites for staff access.
- Provide opportunities for staff to engage in stress management and self-care education.
- Continue to create a positive work environment which respects the varied cultures of our staff with the second Multicultural Day of Celebrations in Q1.

National Screening Service

The National Screening Service (NSS) delivers four national population-based screening programmes – for cervical, breast and bowel cancer, and for detecting sight-threatening retinopathy in people with diabetes. These programmes aim to reduce morbidity and mortality in the population through early detection and treatment across the programmes. Screening programmes internationally and in Ireland are based on a call / re-call system where eligible populations are invited to take part and clinical services are provided for the further investigation and treatment of people identified as at risk of having or developing disease.

Scoping Inquiry into the CervicalCheck Screening Programme, 2018 (Scally Report)

In May 2018, the Government established a scoping inquiry led by Dr Gabriel Scally to investigate the issues that came to light in relation to the CervicalCheck screening programme.

Dr Scally published his final report in September 2018 which contained 50 recommendations that, when implemented, will improve the CervicalCheck screening programme and other screening programmes and will address the particular shortcomings within the health service that Dr Scally found during his scoping inquiry work.

The HSE has established a Steering Group chaired by the Chief Operations Officer and Chief Clinical Officer to oversee the implementation of the HSE recommendations. A senior manager has been appointed to lead on the development of a HSE implementation plan as part of an overall implementation plan, developed under the auspices of the CervicalCheck Steering Committee established by the Minister earlier this year.

The NSS will support the implementation of all recommendations contained in the *Scally Report* as a key priority for 2019. Many of the recommendations apply to all screening programmes.

National Priorities and Actions

National Screening Programmes

- Ensure full implementation of all recommendations of the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report).*
- Implement strengthened organisation and governance arrangements in line with the reviews undertaken of screening services.
- Implement a communications strategy, in conjunction with HSE communications, to ensure continued support, education and information for the public on screening programmes.
- Develop and implement a public and patient engagement plan across screening to enhance public input to screening programmes.
- Enhance the NSS Client Services function to support women and their families.
- Implement a staff engagement programme across all screening services.

CervicalCheck

- Ensure the continued operation of cervical screening including mitigating the impact of the cytology backlog on women.

- Provide for the introduction of HPV testing in 2019 including communications, training and education, ICT reconfiguration and for the increase in colposcopy referrals expected to arise as a result of the introduction of HPV testing.
- Support the International Clinical Expert Review Panel (RCOG) in their review process.
- Maintain the current screening uptake rate of greater than 80%.

BreastCheck

- Continue to implement the age-extension of the BreastCheck Programme by rolling out to remaining 67 year olds (50%) and 68 year olds (50%) in line with the agreed programme of implementation.
- Maintain uptake >70%.

BowelScreen

- Increase uptake through targeted communications and promotion amongst eligible men and women aged 60-69 years.
- Liaise with acute services to develop a capacity plan that meets the current endoscopy demand for the screening population.
- Develop a plan in collaboration with the DoH to ensure the roll-out of sufficient capacity within the wider endoscopy service to support extension of the BowelScreen programme as outlined in the *National Cancer Strategy 2017-2026*.

Diabetic RetinaScreen

- Roll out a digital surveillance screening programme and model of care that will improve timeframes for treatment of diabetic retinopathy to a further 2,500 patients in 2019.
- Increase uptake amongst eligible population aged 12 years and over.

Section 6:
Health and Social Care

Acute Hospital Care

Introduction

Acute services, including scheduled care (planned care), unscheduled care (unplanned / emergency care), specialist services, diagnostics, cancer services and maternity and children's services, are provided for adults and children by 49 acute hospitals within six Hospital Groups and Children's Health Ireland. These services are provided in response to population need, consistent with wider health policies and objectives, including those of *Sláintecare*. UL Hospitals Group continually works to improve access to healthcare, whilst ensuring quality and patient safety issues, including management of infection, are prioritised within allocated budgets. Hospital Groups provide the structure to deliver an integrated hospital network of acute care in each geographic area, the Mid-West in our case.

Hospitals play a key role in improving the health of the population by providing a range of health services, ranging from brief intervention and self-management support and early diagnosis to optimum care pathways and specialist tertiary services. Changes to the demographic profile of the population require increasing integration of acute services with primary and community care services through Integrated Care Programmes (ICPs) for older persons, children, and for patients with chronic diseases. There is a strong focus at national and Hospital Group level, working with CHOs, on the redesigning of health services to promote greater integration.

The *National Cancer Strategy 2017-2026* promotes early detection of disease in order to optimise patient outcomes, and acute hospitals continue to support aspects of screening services for bowel, breast and cervical cancer as well as rapid access pathways for breast, lung and prostate cancers. Acute hospitals also provide follow-up care for patients from the screening programmes in collaboration with the NSS. Implementation of the recommendations of the *Scoping Inquiry into the CervicalCheck Screening Programme, 2018* (*Scally Report)* will continue in 2019.

Issues and Opportunities

- Demand for acute services continues to grow as the population expands and ages and as technological advances facilitate new interventions in disease management.
- *Sláintecare* emphasises the need to invest in increased capacity while also shifting the balance of care from hospitals to community services for better health outcomes and a more sustainable health service.
- Bed occupancy is continuing to exceed 95% (*Health Service Capacity Review 2018*), which is above international norms and presents significant pressure on acute services. Plans are afoot for a new 60-bed modular bid at University Hospital Limerick to help alleviate overcrowding. In addition, a 96-bed acute ward block has been committed as part of *Project Ireland 2040.*
- The lack of single room availability is also a particular challenge in relation to the management of HCAIs.
- Improving access to diagnostics, particularly for low acuity conditions with the aim of reducing emergency attendances and emergency admissions. As part of the Winter Plan initiative, UHL has increased access to diagnostics (MRI) three evenings a week.

- Waiting time for admission following ED attendance is improving due to patient flow initiatives. However demand still outweighs capacity, particularly for inpatient beds, and regrettably some patients can still wait longer than they should for admission when presenting as an emergency.
- New ED presentations and admissions are expected to increase further in 2019.
- Improve access time to inpatient, day case elective procedures and outpatient consultations by implementing waiting list action plans aligned to the *Sláintecare Implementation Strategy*, and by working with the NTPF to drive the roll-out of the *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.*
- The continued implementation of the *National Cancer Strategy 2017-2026* and the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* will also lead to improvements in the standard of acute clinical care. However, the NCCP allocation for 2019 will not enable the service to match referral demands in areas such as radiotherapy, rapid access cancer clinics and diagnostics.
- There is also a renewed focus on activity based funding (ABF) with the advent of *Sláintecare*. Working with the DoH, the HSE will set out a roadmap for enhancing the existing infrastructure and developing the use of the funding mechanism to drive greater efficiency. The Hospital Groups, including UL Hospitals Group, will also continue to optimise their income potential following the external review of income-billing processes.

NSP2019 sets out the range of acute services for patients within the funding provided while also managing for patient safety and risk. A set of measures to improve the efficiency and the effectiveness of services is required in order to manage within available resources. These measures include:

- Implementation of value for money savings through improved procurement.
- Reducing agency and overtime costs.
- Controlling staff numbers to funded levels.
- Maximising the use of drugs with proven cost effectiveness such as biosimilars.
- Driving further efficiencies in relation to the utilisation of acute services.
- Preventing unplanned growth in relation to diagnostic tests and therapies, including drug therapies in order to stay within the funding levels available.

The financial context for 2019 is challenging, particularly in light of the growing demand for services. The acute service levels are calibrated to align activity with the available resources in 2019.

The activity profile for acute services (acute hospitals such as UL Hospitals Group) as set out in NSP2019 is dependent on the delivery of the above measures in a safe and sustainable manner having regard to risk. Key risks to be managed in this regard include the need to:

- Maintain safe staffing levels to deliver front line patient services.
- Provide for infection prevention and control of HCAIs in hospitals.
- Manage critical care bed access and utilisation in the context of existing bed capacity.
- Manage growing demands for diagnostic testing and new drug therapies beyond affordable levels to support both GPs and acute services.

Overarching Priorities and Actions

Improve quality of care and patient safety

Priority	Accountable	Timeline
Enhance quality and patient safety governance structures, patient partnership initiatives and monitoring systems, including the continued roll-out of clinical audit.	ULHG	Q1-Q4
Manage antimicrobial resistance and infection prevention within available resources in accordance with HIQA standards and the *National Action Plan on Antimicrobial Resistance 2017-2020.*	ULHG	Q1-Q4
Improve compliance with medication safety standards.	ULHG	Q1-Q4
Implement the *EU Falsified Medicines Directive 2016 / 161* to ensure an end-to-end verification system is in place.	ULHG	Q1-Q4
Improve compliance with Children First through enhanced awareness, information and training.	ULHG	Q1-Q4

Improve integration between community and acute services to promote a modernised and streamlined service model in line with *Sláintecare.*

Priority	Accountable	Timeline
Support national plans for scheduled and unscheduled care that promote integrated service provision through outreach services, telemedicine, virtual health clinics, integrated assessment services and cross-sector working, which will support independence and choice for patients.	ULHG	Q1-Q4
Co-ordinate effective service delivery between community and secondary care in a way that promotes enhanced use of technology.	ULHG	Q1-Q4
Ensure alignment of service developments in both acute and community service areas where there is an opportunity to build upon existing pathways of care (e.g. frail intervention therapy teams and older persons' services) which provide the most gain for patient outcomes across community and acute services.	ULHG	Q1-Q4

Improve patient and staff health and wellbeing by implementing *Healthy Ireland* plans

Priority	Accountable	Timeline
Support the on-going implementation of *Healthy Ireland* plans.	ULHG	Q1-Q4

Improve performance management of operational services

Priority	Accountable	Timeline
Monitor and manage financial allocations in line with the Performance and Accountability Framework.	ULHG	Q1-Q4

Support the development of eHealth capability

Priority	Accountable	Timeline
Support the implementation of eHealth programmes such as the Maternal and Newborn Clinical Management System (MN-CMS), the National Integrated Medical Imaging System (NIMIS) and the Individual Health Identifier (IHI).	ULHG	Q1-Q4
Support the planning for the implementation of the National Electronic Healthcare Record	ULHG	Q1-Q4

Support the progress of policies and initiatives led by the Office of the Chief Nursing Officer

Priority	Accountable	Timeline
Support the roll out the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland 2018* in model 4 hospitals, and establish the National Safe Nurse Staffing Unit within available resources.	ULHG	Q1-Q4

Scheduled Care – Planned care

Priorities and Actions

Improve access to scheduled care, maximising the resources available

- Reduce waiting times to promote fair, timely access to services, within available resources.

Priority	Accountable	Timeline
Develop and implement waiting list action plans for patients in outpatient, day case and inpatient scheduled care areas with a particular focus on long waiting patients.	ULHG	Q1-Q4
Support and progress initiatives between primary and secondary care that focus on reducing waiting times for scheduled care services and delivery of services closer to home.	ULHG	Q1-Q4

- Enhance capacity in secondary care to promote a safe, quality scheduled care service.

Priority	Accountable	Timeline
Maximise the move from inpatient to day case activity in line with clinical guidelines and international norms.	ULHG	Q1-Q4
Implement the NTPF *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.*	ULHG	Q1-Q4
Extend the clinical prioritisation system into the day case and inpatient areas for four specialties (urology, otolaryngology, ophthalmology and orthopaedics).	ULHG	Q1-Q4
Progress the development of care pathways in the outpatient, day case and inpatient areas.	ULHG	Q1-Q4

Unscheduled Care – Unplanned / emergency care

Priorities and Actions

Improve access to unscheduled care, maximising resources available

Priority	Accountable	Timeline
Plan activity and ensure alignment with the *Sláintecare Implementation Strategy* to anticipate and manage critical demand pressures, most particularly during winter.	ULHG	Q1-Q4

- Improve access to unscheduled care through integrated action with community services, with the focus on:

Priority	Accountable	Timeline
Develop and progress plans to improve access to diagnostics.	ULHG	Q1-Q4

Priority	Accountable	Timeline
Developing admission avoidance pathways, providing care closer to home and improving services for frail older persons within acute hospitals and in the community as part of care redesign.	ULHG	Q1-Q4
Support national proposals for enhanced senior decision-making capacity in emergency medicine to deliver more timely and appropriate assessment, streaming, treatment and care.	ULHG	Q1-Q4

UL Hospitals Group Winter Initiatives

The ED in University Hospital Limerick is one of the busiest in the country with over 72,000 attendances in 2018. The numbers presenting continues to increase year-on-year with a growth of 6.2% from 2017 to 2018.

Injury Units which are based in Nenagh, Ennis and St. John's Hospital Limerick are also treating more patients. Together, they account for approximately 31% of all emergency presentations across the Group. Attendances to the Injury Units grew by 6% from 2017 to 2018.

Measure to improve Patient Flow at University Hospital Limerick this winter

- A newly expanded Acute Medical Assessment Unit (AMAU) has opened (from 17 bays to 19 bays).
- Old AMAU (12 bays) will be opened in the coming weeks as an Acute Surgical Short Stay Unit to facilitate additional emergency procedures.
- Additional emergency theatre lists are being run.
- Increased access to diagnostics (MRI) three evenings a week.
- Opening of two additional critical care beds.
- An expanded Acute Surgical Assessment Unit will take in more acute surgical patients from the ED, with improved access to CT and ultra sound scanning allowing quicker diagnosis and earlier decision to admit or discharge.
- ULHG Winter Action team meet weekly. It includes UL Hospitals Group CEO and HSE Mid-West Community Care CO.
- ULHG works together with community colleagues to expedite the discharge of older patients to general rehab facilities, stroke units and nursing homes. Transitional funding and home care packages are provided. We liaise with Community Intervention Teams to provide appropriate care in a patient's home or care facility. We liaise with GP's to ensure patients are referred to ED only when appropriate.
- Transfer of patients to a new Clinical Recovery Unit in Nenagh Hospital has commenced.
- We urge patients to consider all their care options before attending ED, reminding them about Injury Units in Ennis and Nenagh open from 8am to 8pm, Monday to Sunday, and 8am to 6pm Monday to Friday at St. John's Hospital Limerick.

Cancer Services

Services Provided

Dealing with illness is a significant challenge for those diagnosed with cancer and their families. Each year approximately 38,000 people in Ireland develop cancer (National Cancer Registry Ireland, 2016). Cancer is the second most common cause of death after diseases of the circulatory system such as heart attack or stroke. The risk of developing cancer increases with age therefore rates are not expected to reduce as our population of over 65s increases. However, due to developments in the available treatments and organisation of services in Ireland, more people are living with cancer and survivorship support programmes are now a very important component of care.

The configuration and co-ordination of cancer services within the HSE is led by the National Cancer Control Programme (NCCP) which was established in response to the *National Cancer Strategy – A Strategy for Cancer Control in Ireland 2006*. The 2006 strategy advised that Ireland needed a comprehensive cancer control policy programme. A subsequent strategy, the *National Cancer Strategy 2017-2026* was published in 2017 to build on the developments driven by the earlier strategy and its implementation is a key priority for 2019.

The demand for cancer services, including chemotherapy, radiotherapy, surgery and medical care is continuously rising as the incidence of the disease increases and treatment and mortality improves. Therefore, the costs associated with cancer treatment and in particular cancer drugs are increasing every year.

Many cancers can be avoided by living a healthy lifestyle, for instance by not smoking, consuming only moderate amounts of alcohol, maintaining a healthy body mass index and availing of cancer screening services. Therefore, cancer prevention and early detection initiatives are key to reducing the cancer burden on people and on the health service.

As part of the new *National Cancer Strategy 2017-2026*, initiatives will be set up across the continuum of care, from diagnosis and treatment, to appropriate follow-up and support, in both the hospital and community setting. The strategy sets out four key priorities:

- Reduce the cancer burden.
- Provide optimal care.
- Maximise patient involvement and quality of life.
- Enable and assure change.

Priorities and Actions

Reduce the cancer burden

Priority	Accountable	Timeline
Contribute to the national skin cancer prevention action plan	ULHG	Q1-Q4
Support health and wellbeing and *Healthy Ireland* initiatives which will engage the public in positive health behaviours.	ULHG	Q1-Q4

Provide optimal care

Priority	Accountable	Timeline
Continue to develop and promote Rapid Access Prostate Clinic in conjunction with Saolta Hospital Group.	ULHG	Q1-Q4
Progress appointment of 0.5 Respiratory Consultant for Rapid Access Lung Clinic.	ULHG	Q1-Q4
Monitor and evaluate the provision of private radiotherapy providers in University Hospital Limerick (UHL)	ULHG	Q1-Q4
Support the Roll out and implement the NCIS (National Cancer Information System), formerly the Medical Oncology Clinical Information System and the NCIS multi-disciplinary meeting module.	ULHG	Q1-Q4

Maximise patient involvement and quality of life

Priority	Accountable	Timeline
Encourage active participation by patients, as partners, in the development of cancer care guidelines and strategic initiatives.	ULHG	Q1-Q4

Enable and assure change

Priority	Accountable	Timeline
Look to progress the appropriate clinical and non-clinical staff are in place across UL Hospitals Group.	ULHG	Q1-Q4

Women and Children's Services

The HSE is committed to the development of health services for women and children. The strategic development and organisation of maternity, benign gynaecology and neonatal services is being led by the National Women and Infants' Health Programme (NWIHP). The ICP for Children aims to improve the way healthcare services are designed and delivered to children and their families, including the development of the national paediatric model of care. The focus of both is on strengthening services by bringing together primary, community and acute services in an integrated way.

Women and Infants' Health Programme

Services Provided

Ireland's first *National Maternity Strategy 2016-2026 – Creating a Better Future Together* was launched in January 2016. The strategy sets out a blueprint to significantly improve the service provided to mothers and their babies. The implementation of the *National Maternity Strategy 2016-2026 – Creating a Better Future Together* is a key priority for the HSE, and is underpinned by 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

Improve services for women and infants guided by the *National Maternity Strategy 2016-2026 – Creating a Better Future Together*

Priority	Accountable	Timeline
Ensure anomaly scanning is available to all women attending ante-natal services.	ULHG	Q1-Q4
Support and enable the implementation of a safe, high quality termination of pregnancy service.	ULHG	Q1-Q4
Support the development of a national suite of KPIs for maternity services.	ULHG	Q1-Q4
Identify and define the educational supports and training programmes required by staff to ensure a safe, competent and supported maternity workforce.	ULHG	Q1-Q4

Paediatric Model of Care

Services Provided

Children comprise approximately 25% of the population. A national model of care has been developed to describe how children should be cared for in acute and community settings. The model of care sets out the vision for high quality, integrated, accessible healthcare services for children from birth to adulthood. The model aims to ensure that all children should be able to access high quality services in an appropriate location, within an appropriate timeframe, irrespective of their geographical location or social background.

Immunisation and early years intervention programmes are provided for children through public health, and health and wellbeing services, with community programmes including developmental screening and

paediatric home care packages provided through primary care services. Specific initiatives for children with disabilities and mental health issues are also provided through community services. Acute paediatric services are provided at UL Hospitals Group. The *Children's Health Act 2018* (No 27 of 2018) provides for the establishment of a single statutory entity, Children's Health Ireland, to provide paediatric services, including taking responsibility for the services currently provided by the existing three Dublin children's hospitals.

The national model of care strongly advocates a network model where a large unit providing more complex care supports a number of smaller units within a geographical area. The new children's hospital and the two paediatric outpatient and urgent care centres provide for this service design on two fronts. The new children's hospital will be the national hub providing support to the regional and local units and will act as the hub for the two paediatric outpatient and urgent care centres in the delivery of secondary paediatric care within the greater Dublin area. The model of care explicitly supports the development of the new children's hospital and an integrated national network for paediatrics, with strengthened and interconnected roles for local and regional paediatric units.

The initial priorities for children's services nationally are the progression of the children's hospital programme, which in 2019 will see the opening of the paediatric outpatient and urgent care centre at Connolly Hospital, Blanchardstown, and also the development of paediatric services in three regional centres with Limerick designated as one of them.

Priorities and Actions

Continue to oversee the new children's hospital development and development of paediatric services

Priority	Accountable	Timeline
Support the national roll-out of the paediatric model of care in 2019	ULHG	Q1-Q4
Progress the development of the acute Paediatric unit in Limerick in line with the national paediatric model of care, including additional consultant paediatricians, clinical nurse specialists and allied health professionals.	ULHG	Q1-Q4
Support and progress the development of the paediatric cardiology network in UHL.	ULHG	Q1-Q4

Section 7:
Finance

Finance

The notified budget for UL Hospitals Group for 2019 is €340.878m. This comprises of

- Gross Budget Allocation €402.783m
- Income Budget Allocation €61.905m
- Net Budget Allocation €340.878m

The 2019 funding allocation is assigned to the respective directorates and St John's Hospital for the fiscal years as follows:

Directorate and St Johns Hospital	Net Budget 2018 €m	Net Budget 2019 €m
Diagnostics	€53.206m	€53.819m
Peri Operative	€75.340m	€77.648m
Medicine	€94.080m	€96.086m
Maternal and Child Health	€31.558m	€32.681m
Operational Services	€33.668m	€35.777m
Shared Services	€24.013m	€24.507m
St John's Hospital	€20.010m	€20.360m
Net Budget	€331.875m	€340.878m

(All figures quoted exclude superannuation associated amounts)

The 2019 funding allocation of €340.878m compares to a final allocation of €331.875m in 2018. The Group has received a net funding movement upwards of €9.003m or 2.7%.

The main components of the 2019 allocation are in respect of:

1. Existing Level of Service

The cost of maintaining existing services increase each year due to a variety of factors:

- Incremental costs of developments commenced during 2018.
- Impact of national pay agreements (primarily public sector – wide)
- Increases in drugs and other clinical non pay costs including health technology innovations
- Inflation related to price increases
- Additional costs associated with demographic factors

2. Pay Rate Funding

The allocation issued includes provision for pay related approved items. This funding is provided in respect of the growth in pay costs associated with National Pay Agreements, Labour Relations Commission recommendations and other pay pressures. It is provided to offset the increased cost of employing existing levels of staff and does not allow for an increase in staff numbers.

3. Developments

The funding allocation issued to the Group, has no provision for 2019 approved developments. It is anticipated that notification of approved developments over the course of the year will result in an increase in the funding allocation as they arise.

Value Improvement Programme

The National Service Plan 2019 sets out the main focus areas for Value Improvement Programme (VIP) 2019. This programme will be deployed across three focus areas during the course of the year:

- Financial balance
- Pharmacy
- Improvement and accountability – clinical service development

The Group will work with the National VIP Team in identifying the value improvement opportunities, verifying their validity and measuring and reporting the value gained across the Quadruple Aim Framework.

Approach to Financial Challenge

The Group has established its financial projection for 2019 utilising the following key principles:

i. Extrapolation of quarter four 2018 run rates for the Group, applying the national forecasting model
ii. Inclusion of National notified Pay Pressures crystallising in 2019 determined by the National Pay Unit
iii. Student Nurse Intake 2019 for the Group
iv. Income review
v. Notified national expenditure approvals for 2019 in respect of a number of new initiatives

In determining the financial projection under the items above this has been established at €358.361m. A total of €4.098m of this projection relates to notified national expenditure approvals in respect of a number of new initiatives. It is envisaged that the approved developments over the course of the year will result in an increase in the funding allocation as they arise, therefore will not give rise to any financial gap. The Group has included bad debts at the budget level for 2019 in the determined projection.

The funding allocation notified to the Group as at February 2019 amounts to a net €340.878m. Included in the funding base is the National notified Pay Pressures crystallising in 2019.

Addressing the Financial Challenge

The Group will face a net 4% challenge in respect to items outlined above. In seeking to address the challenge, maximisation of income set at a level of €2.724m. The remainder of the financial challenge is proposed will be addressed in a twofold manner under the headings funding to be provided to the Group from separate commissioners e.g. NCCP, NRO, NTPF, etc. and the Value Improvement Programme (VIP).

Key Focus areas for the Group under the VIP will be respect of

- Agency
- Overtime
- Structured On Call (SoC)
- Office Expenses
    - Recruitment Fees
    - Off Site Storage
    - Printing / Stationary
    - Postage and usage
- Maintenance Works (reprioritisation)
- Medical Equipment (reprioritisation)

Section 8:
Workforce

Workforce

People Strategy 2019-2024

Building on progress to date and following a robust review process, the revised People Strategy 2019-2024 will guide all organisational people services in 2019 with an emphasis on encouraging leadership, talent and capability. The People Strategy is positioned to build a resilient workforce that is supported and enabled to deliver the *Sláintecare* vision. This will include a dedicated focus on workforce planning, enhancing leadership and accountability, and building organisational capacity. Supporting the delivery system and working with key strategic partners will be prioritised to ensure relevance and connectivity to meeting people's needs and local service requirements. This will be enabled by on-going attention to progressing national frameworks and standards that can add value, and support the delivery system.

National HR will work with the *Sláintecare* Office of the DoH to lead, develop and implement the strategic actions outlined in actions 4 and 9 of the *Sláintecare Implementation Strategy* (outlined below). This work will be determined within the context of the *Sláintecare Implementation Strategy* and action plan timelines.

Accelerating progress to date on the implementation of the People Strategy and extending the reach and relevance into the delivery system requires greater connectivity between national and local services. The focus for 2019 is on:

- Implementation of the People Strategy.
  - Working with Health Business Services (HBS) to attract, recruit and retain the right people, ensuring their integration and development into a workplace that cares about their wellbeing, motivation and opportunities at work.
  - Ensuring easy access to professional HR services in a way that meets the needs of those delivering services.
  - Connecting people services in a more integrated way to create the people and culture change platform for meaningful and healthy work environments.
- Implementation of *Working Together for Health – A National Strategic Framework for Health and Social Care Workforce Planning*.
- Implementation of the *Strategic Review of Medical Training and Career Structure* (MacCraith Report), including increased training on a two year phased basis and progressing a review of the recruitment of non-consultant hospital doctors (NCHDs).
- Implementation of 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.
- Implementation of workforce agreements.
  - Continued commitment to *Public Service Stability Agreement 2018-2020* including support for the work of the Public Service Pay Commission and implementation of recommendations where relevant.
  - Implementation of Consultant Contract 2008 Settlement Agreement and consultant contract compliance arrangements.

  - Implementation of Workplace Relations Commission (WRC) agreement on pay restoration in section 39 organisations.
  - On-going implementation of WRC nursing and midwifery recruitment and retention agreement and ED agreement.
- Building a sustainable, resilient workforce that is supported and enabled to deliver the *Sláintecare* vision.
- Complete review and risk assessment of consultants not on the specialist register.
- Expand community-based care to bring care closer to home.

People's Needs Defining Change – Health Services Change Guide

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

Wellbeing and Engagement

Active promotion of health and wellbeing in the workplace continues to be a priority. The Workplace Health and Wellbeing Unit provides support for all staff and assists in preventing staff becoming ill or injured at work. The unit maximises access to, and retention of, work through timely rehabilitation services via occupational health services, rehabilitation / case management services, and organisational health.

Staff bring a range of skills, talents, diverse thinking and experience to the organisation. The HSE is committed to creating a positive working environment whereby all employees inclusive of race, religion, ethnicity, gender, sexual orientation, responsibility for dependents, age, physical or mental disability, civil status, membership of the Traveller community, and geographic location are respected, valued and can reach their full potential. It aims to develop the workforce reflecting the diversity of HSE service users, and which is strengthened through accommodating and valuing different perspectives, ultimately resulting in improved service user experience. This is achieved by increasing awareness of diverse needs, and through supporting the disability bridging programme and other initiatives.

The national staff survey seeks employees' views on a range of themes concerning them directly such as culture and values, working environment, career progression and development, equality, diversity and inclusion, leadership direction and communications, staff engagements, managing change, terms and conditions and job satisfaction. National HR undertakes this staff survey every two years, the latest of which was in 2018.They will work with services to take actions based on the findings from this survey. In addition, staff engagement forums are on-going and provide valuable information and feedback from those working in frontline services, creating a space for conversations about what matters to staff, giving a sense of ownership and personal responsibility for engagement, promoting staff engagement.

The Workforce Position

Government policy on public service numbers and costs is focused on ensuring that the health workforce operates within the pay budgets available. It is projected that the number of WTE posts in place at the end of 2018 will be 116,712 WTEs. 2019 indicative WTE numbers for health service are 119,127.

Effective control over workforce numbers and associated pay expenditure will be essential to ensuring that we deliver services within the available financial resources for 2019. Further details in this regard are set out in the following paragraphs.

Pay and Staffing Strategy 2019

Based upon key learning from previous Pay and Staffing Strategies, the approach being taken in 2019 begins with a central 'top down' high level affordability assessment of the level of staff, on an average cost per WTE basis, that the indicative pay budget for 2019 can support. This approach is designed to enable more realistic and affordable forecasting and follows on from the WTE limits process implemented in late 2018. All key stakeholders (National Directors, CHOs and Hospital Groups, supported by Finance and HR) will operationalise the WTE limits through a 'bottom up' process that takes account of service priorities and maintenance of services, whilst equally identifying the opportunities for optimisation and efficiency. This year's combination of a top down affordability assessment to set the overall WTE limits, and the bottom up prioritisation by service providers, is intended to ensure maximum flexibility for services to determine the deployment of the limit across their services.

Central to the process for 2019 is:

- Engagement at key service levels on the development of robust operational workforce plans based on a centrally constructed WTE limit that takes account of a range of factors including priorities determined by the Government.
- Striking the balance between safe, effective, efficient service delivery and affordability.
- Realising opportunities to reinvest in the workforce through agency conversion, for example, as allowable growth factors within the WTE limits, enabling constructive WTE limits review at key intervals throughout the year, underpinned by evidence, notwithstanding that all services need to closely monitor agency and overtime spend and implementation of measures to reduce same.
- Realising opportunities to redeploy the existing workforce to ensure maximum alignment between our staffing and the delivery of priority health and social care needs.
- Necessity of monitoring WTE movement against the limits alongside overall pay expenditure so as to appropriately manage direct employment costs, in addition to overtime and agency costs.

WTE limit monitoring is an integral component of the overriding principle of compliance to allocated pay expenditure budgets. The monitoring of both WTE limits and pay expenditure at all service levels will further support and enhance performance and governance of same, with key actions and interventions on deviation in place, in line with the Performance and Accountability Framework. In line with this framework, as with any other key performance areas, performance against these WTE limits will ultimately be considered as part of the National Performance and Oversight Group.

Capability and Learning

The HSE's commitment is to engage, develop and value its' workforce to deliver the best possible care and services to the people who depend on them. Staff who are valued, supported in their development and treated well, improve patient care and overall performance. Improved people management is the responsibility of all leaders, managers and staff.

Leadership is the most influential factor in shaping organisation culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed in fundamental. The HSE are continuing to enhance leadership development, capacity and capability through the Health Service Leadership Academy. The first cohorts of both Leading Care I and Leading Care II commenced in October 2017, the second cohorts of both programmes commenced in April 2018 and the third cohort of both programmes have commenced in October 2018. There are approximately 50 participants in each cohort, with approximately 300 health service staff currently undertaking a Leading Care Programme.

All leadership and development programmes will have a people and culture change ethos to build change capacity at all levels with a particular emphasis on the skills and behaviours needed to lead change. This will be supplemented by 'on the job' practice-based learning.

HSELanD (Health Services eLearning and Development) is the HSE's online learning portal used by approximately 120,000 health and social care employees at all levels across the statutory and voluntary healthcare sectors. It will continue to be developed including through the wider implementation of the Health Electronic Learning Management project, which emphasises the need to develop a single overarching approach to learning and development throughout the health sector. A module of Respect and Dignity at Work has now been introduced and is mandatory for all staff.

The national coaching service is a free confidential service available to all staff working in the HSE and in our partner organisations. Its aim is to enhance employees' capacity to lead and flourish within their role in order to support the provision of safer better healthcare for all.

Performance and Partnering

The Health Services Change Guide is the agreed approach that will underpin our process for change and reform in line with the *Public Service Stability Agreement.* Over the past period, the HSE have continued to take the lead role for employers on all national industrial relations matters, with particular input into the extension of the *Public Service Stability Agreement*, which now remains until end 2020.

The HSE is committed to maintaining and progressing compliance with the requirements of the EWTD for both NCHDs and staff in the social care sector. Key indicators of performance agreed with the European Commission include a maximum 24 hour shift, maximum average 48 hour week, 30 minute breaks every six hours, 11 hour daily rest / equivalent compensatory rest and 35 hour weekly / 59 hour fortnightly / equivalent compensatory rest.

Code of Conduct for Health and Social Service Providers

Adherence to *Supporting a Culture of Safety, Quality and Kindness: A Code of Conduct for Health and Social Service Providers, 2018* is a key priority for the health services. Its primary purpose is to ensure the safety of those that access our services and to support staff in providing safe services. The Code assists in this by setting out both service provider obligations and individual responsibilities to deliver quality safe care.

Appendices

Appendix 1: HR Information

UL Hospitals Group Workforce WTE December 2019

Hospital / HG	Medical/ Dental	Nursing & Midwifery	Health & Social Care	Management/ Admin	General Support	Patient & Client Care	WTE December 2018
Croom Orthopaedic	21	67	2	19	8	47	164
Ennis	13	104	22	44	15	30	228
Nenagh	15	108	18	37	13	56	247
St. John's Limerick	26	130	20	66	39	32	313
UH Limerick	401	1,029	338	450	229	375	2,822
UMH Limerick	48	222	4	38	23	39	374
Other		2		4			6
University of Limerick Hospital Group	524	1,662	404	658	327	580	4,155

** Numbers rounded up to the nearest whole number*

Appendix 2(a): National Scorecard

National 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
	Child Health	% of newborn babies visited by a PHN within 72 hours of discharge from maternity services
		% of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age
		% of children aged 24 months who have received the measles, mumps, rubella (MMR) vaccine
	CAMHs Bed Days Used	% of bed days used in HSE Child and Adolescent Acute Inpatient Units as a total of bed days used by children in mental health acute inpatient units
	HIQA Inspection Compliance	% compliance with regulations following HIQA inspection of disability residential services
	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

National Scorecard		
Scorecard Quadrant	Priority Area	Key Performance Indicator
Access and Integration	Therapy Waiting Lists	Physiotherapy – % on waiting list for assessment ≤ 52 weeks
		Occupational Therapy – % on waiting list for assessment ≤ 52 weeks
		Speech and Language Therapy – % on waiting list for assessment ≤ 52 weeks
		Psychology – % on waiting list for treatment ≤ 52 weeks
	CAMHs Access to First Appointment	% of accepted referrals / re-referrals seen within 12 months by Child and Adolescent Community Mental Health Teams excluding DNAs
	Delayed Discharges	Number of beds subject to delayed discharge
	Disability Act Compliance	% of child assessments completed within the timelines as provided for in the regulations
	Ambulance Response Times	% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less
		% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less
	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
		% 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)
	Older Persons	No. of home support hours provided (excluding provision of hours from Intensive Home Care Packages (IHCPs))
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 2(b): National 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).

KPI Number	National Service Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	National Target 2019
A16	Outpatient Attendances - New : Return Ratio (excluding obstetrics, warfarin and haematology clinics)	M	1:2	1:2.5	1:2.3
A38	HIPE Completeness – Prior month: % of cases entered into HIPE	M (1 Mth in arrears)	100%	91%	95%
A18a	% of adults waiting <15 months for an elective procedure (inpatient)	M	90%	82%	85%
A18b	% of adults waiting <15 months for an elective procedure (day case)	M	95%	91%	95%
A20a	% of children waiting <15 months for an elective procedure (inpatient)	M	90%	84%	85%
A20b	% of children waiting <15 months for an elective procedure (day case)	M	90%	83%	90%
A23	% of people waiting <52 weeks for first access to OPD services	M	80%	71%	80%
A25	% of people waiting <13 weeks following a referral for routine colonoscopy or OGD	M	70%	53%	70%
A80	No. of people waiting > four weeks for access to an urgent colonoscopy	M	0	334	0
A26	% of all attendees at ED who are discharged or admitted within six hours of registration	M	75%	64%	75%
A27	% of all attendees at ED who are discharged or admitted within nine hours of registration	M	100%	79%	99%
A28	% of ED patients who leave before completion of treatment	M	<5%	6.4%	<5%
A29	% of all attendees at ED who are in ED <24 hours	M	100%	96%	99%
A32	% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration	M	95%	42%	95%
A30	% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration	M	100%	60%	99%
A96	% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration	M	100%	91%	99%
A39	ALOS for all inpatient discharges excluding LOS over 30 days	M (1 Mth in arrears)	4.3	4.8	≤4.8

KPI Number	National Service Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	National Target 2019
CPA11	Medical patient average length of stay	M (1 Mth in arrears)	≤6.3	7.2	≤7.2
CPA1	% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration	M (1 Mth in arrears)	75%	60%	75%
CPA31	% of all medical admissions via AMAU	M (1 Mth in arrears)	45%	31%	45%
CPA53	% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge	M (1 Mth in arrears)	≤11.1%	11.3%	≤11.1%
CPA12	Surgical patient average length of stay	M (1 Mth in arrears)	≤5.0	5.5	≤5.5
CPA27	% of elective surgical inpatients who had principal procedure conducted on day of admission	M (1 Mth in arrears)	82%	74.5%	82%
CPA28	% day case rate for Elective Laparoscopic Cholecystectomy	M (1 Mth in arrears)	60%	48%	60%
A99	% hip fracture surgery carried out within 48 hours of initial assessment (Hip fracture database)	Q (1 Qtr in arrears)	New PI NSP2019	New PI	85%
A45	% of surgical re-admissions to the same hospital within 30 days of discharge	M (1 Mth in arrears)	≤3%	2%	≤3%
CPA51	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
CPA52	Rate of new cases of hospital acquired C. difficile infection	M	<2/10,000 bed days used	2.2	<2/10,000 bed days used
A97	% of acute hospitals implementing the requirements for screening of patients with CPE guidelines	Q	100%	36%	100%
A98	% of acute hospitals implementing the national policy on restricted antimicrobial agents	Q	100%	35%	100%
A113	Rate of medication incidents as reported to NIMS per 1,000 beds	M (3 Mth in arrears)	New PI NSP2019	New PI	2.4 per 1,000 bed days
A114	% of hospitals with implementation of NEWS in all clinical areas of acute hospitals (as per 2019 definition)	Q	New PI	New PI	100%
A56	% of hospitals with implementation of PEWS (Paediatric Early Warning System)	Q	100%	72.4%	100%
a117	% of hospitals that have completed a self-assessment against all 53 essential elements of the National Standards for Safer, Better Healthcare	Q	New PI NSP2019	New PI	100%

KPI Number	National Service Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	National Target 2019
A62	% of acute hospitals which have completed and published monthly hospital patient safety indicator report	M	100%	67%	100%
CPA19	% 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%
CPA20	% of patients with confirmed acute ischaemic stroke who receive thrombolysis	Q (2 Qtrs in arrears)	12%	9.1%	12%
CPA21	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	Q (2 Qtrs in arrears)	90%	73.8%	90%
CPA25	% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	Q	90%	95%	95%
CPA26	% of reperfused STEMI patients (or LBBB) who get timely PPCI	Q	80%	65%	80%
A115	% of maternity units / hospitals with full implementation of IMEWS (as per 2019 definition)	Q	New PI	New PI	100%
A116	% of all hospitals with implementation of IMEWS (as per 2019 definition)	Q	New PI	New PI	100%
A61	% 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%
NCCP24	% of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe	M	New PI	New PI	95%
NCCP6	% 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)	M	95%	73%	95%
NCCP8	% of new attendances to the rapid access clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	M	6%	10%	>6%
NCCP13	% of new attendances to the rapid access clinic that have a subsequent primary diagnosis of lung cancer	M	25%	30%	>25%
NCCP19	% of new attendances to the rapid access clinic that have a subsequent primary diagnosis of prostate cancer	M	30%	33%	>30%
NCCP22	% 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)	M	90%	80%	90%
A48	No. of bed days lost through delayed discharges	M	182,500	205,047	≤200,750
A49	No. of beds subject to delayed discharges	M	500	564	≤550
A105	No. of new cases of CPE	M	0	512	N/A

KPI Number	Operational Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	National Target 2019
A31	% of patients attending ED aged 75 years and over **	M	13%	13.7%	13%
A33	% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	M	90%	82.5%	90%
A40	ALOS for all inpatients **	M-1M	5 days	5.6	5 days
A41	New OPD attendance DNA rates **	M	12%	13.9%	12%
A42	% of emergency hip fracture surgery carried out within 48 hours (HPO / HIPE)	M	95%	86.6%	95%
A43	Elective Scheduled care waiting list cancellation rate **	M	1%	1.4%	1%
A101	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%
A102	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%
A112	Rate of venous thromboembolism (VTE, blood clots) associated with hospitalisation **	Q (1 Mth in arrears)	New in 2018	11.3	TBC
CPA29	% bed day utilisation by acute surgical admissions who do not have an operation **	M	35.8%	36.8%	35.8%
CPA34b	Median LOS for patients admitted with COPD **	Q (1 Mth in arrears)	5 days	5	5 days
CPA35	% re-admission to same acute hospitals of patients with COPD within 90 days **	Q (1 Mth in arrears)	24%	25.6%	24%
CPA37	Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	BA-1M	33 SITES	30	33 SITES
CPA38	% nurses in secondary care who are trained by national asthma programme **	Q (1 Mth in arrears)	70%	N/A	70%
CPA41	No. of lower limb amputation performed on Diabetic patients **	A	<488	N/A	<488
CPA42	Average length of stay for Diabetic patients with foot ulcers **	A	≤17.5 days	N/A	≤17.5 days
CPA43	% increase in hospital discharges following emergency admission for uncontrolled diabetes **	A	≤10% increase	N/A	≤10% increase
A118	Breastfeeding initiation - % of babies breastfed at first feed following birth**	Q -1Q	New PI	New PI	64%
A119	Rate of Emergency Paediatric Inpatients (patients <16 years old as a % of those presenting) **	Q	New PI	New PI	TBC
A120	Rate of clinical incidents as reported to NIMS per 1000 bed days **	M-3M	New PI	New PI	N/A
A121	% of paediatric patients waiting < 6 weeks following a referral for a routine colonoscopy **	M	New PI	New PI	70%
A122	% of paediatric patients waiting < 6 weeks following a referral for a routine oesophago-gastroduodenoscopy (OGD) endoscopy **	M	New PI	New PI	70%
A123	% of adult patients waiting < 13 weeks following a referral for a routine colonoscopy **	M	New PI	New PI	70%
A124	% of adult patients waiting < 13 weeks following a referral for a routine oesophago-gastroduodenoscopy (OGD) endoscopy **	M	New PI	New PI	70%
A125	% of urgent elective outpatients waiting < 3 months for CT, MR & US **	Q	New PI	New PI	TBC
A126	% of routine elective outpatients waiting < 6 months for CT, MR & US **	Q	New PI	New PI	TBC

KPI Number	Operational Plan KPI Title	Reporting Period	2018 Target	Projected Outturn 2018	Hospital Group Target 2019
A1	Beds Available Inpatient **	M	N/A	N/A	770 *
A2	Day Beds / Places **	M	N/A	N/A	181 *

* Bed availability may fluctuate during the year due to additional funded initiatives and/or operational reasons.

Appendix 2(c): Activity 2019

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).

KPI Title	ULHG Expected Activity/ Target 2018	ULHG Projected Outturn 2018	Croom Hospital	Ennis Hospital	Nenagh Hospital	St. John's Hospital	University Hospital, Limerick	University Maternity Hospital, [illegible]	ULHG Expected Activity/ Target 2019
Discharge Activity Inpatient Cases	51,761	52,727	1,514	5,752	3,409	4,925	29,960	7,138	52,698
Inpatient Weighted Units	42,857	42,821	2,587	2,498	1,603	3,679	27,526	4,860	42,754
Daycase Cases (includes dialysis)	60,239	60,134	2,925	7,357	7,915	5,125	37,126	72	60,520
Day Case Weighted Units (includes dialysis)	68,935	67,827	4,877	7,406	9,980	7,188	38,248	128	67,827
Total inpatient & day cases	112,000	112,861	4,439	13,109	11,324	10,050	67,086	7,210	113,218
Emergency Inpatient Discharges	37,659	39,237	458	5,526	3,193	3,343	26,623	910	40,053
Elective Inpatient Discharges	7,488	7,025	1,056	226	216	1,582	3,214	12	6,306
Maternity Inpatient Discharges	6,614	6,465					123	6,216	6,339
Inpatient Discharges ≥ 75 years	10,580	11,216	343	2,020	1,102	1,553	6,254		11,272
Day case discharges ≥ 75 years	10,175	11,094	241	1,122	946	559	8,299		11,167
Emergency Care - New ED attendances	62,830	67,197	-	-	-	-	67,507	-	67,507
- Return ED attendances	3,632	4,766	-	-	-	-	4,788	-	4,788
Injury Unit attendances	31,088	32,913	-	11,520	9,863	11,681	-	-	33,064
Other emergency presentations	-	-	-	-	-	-	-	-	-
Births Total number of births	4,449	4,429	-	-	-	-	-	4,429	4,429
Outpatients Number of new and return outpatient attendances	219,737	212,350	9,885	15,442	11,135	8,969	147,339	22,190	214,961

Appendix 3: Capital Infrastructure

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

UL Hospitals Group						Capital Cost €m		2019 implications	
Facility	Project details	Project completion	Fully Operational	Additional Beds	Replacement Beds	2019	Total	WTE	Rev Costs €m
Nenagh Hospital, Co. Tipperary	Ward Block extension and refurbishment programme, incl. 16 single rooms and 4 double rooms - part funded by the Friends of Nenagh Hospital.	Q3 2019	Q4 2019	3	21	1.77	6.11	0	0
Ennis General Hospital, Co. Clare	Outpatients (off site solution)	Q3 2019	Q4 2019	0	0	0.60	0.60	0	0
University Hospital Limerick	AMAU and OPD reconfiguration	Q4 2019	Q4 2019	0	0	1.40	1.65	0	0

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