Grúpa Ospidéal
Oirthear na hÉireann

Ireland East
HOSPITAL GROUP

UCD
DUBLIN

Ireland East Hospital Group Operational Plan 2018

HSE

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

Mission and Vision

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

Our mission is to deliver improved healthcare outcomes through:

- Provision of patient-centred care
- Access to world-class education, training, research and innovation through our partnership with UCD, leading to the delivery of innovative, evidence-based healthcare
- Application of a Lean management system in order to build a strategic and management model for operational excellence and continuous improvement
- Improved communications across the speciality disciplines contained within the Group

Our Goals

Quality and safety culture	Develop a best in class quality and safety culture around patients and associated services across the Group
Integrate clinical services	Transform, re-organise, rationalise, expand, develop and integrate clinical services across the Group to meet community and population needs and expectations at catchment, regional, supra regional and national levels
Leading Irish Academic Health Science Centre (AHSC)	Create and develop an IEHG affiliation with UCD as the leading Irish Academic Health Science Centre (AHSC) partnership with international peer status and association
Best-in-class talent workforce	Develop a best-in-class talent workforce which is engaged and committed and continuously challenges and drives Group and system functioning
Develop physical infrastructure	Rationalise and develop physical infrastructure across the Group to fit-for-purpose/contemporary model reflective of an AHSC of highest international peer status
Key tertiary/quaternary services	Specify the key tertiary/quaternary services to apply at IEHG and develop them to best-in-class international peer status
Technologically advanced	Develop the Group as the most technologically advanced entity in the Irish health system to comparable best-in-class international peer status
GP integration with our hospitals	Integrate with our CHO partners and further develop GP integration with our hospitals. The formation of IEHG enables the coalescence of a broad range of clinical services across 11 hospitals combined with the cutting-edge research and academia of University College Dublin (UCD)

Introduction:

The Ireland East Hospital Group (IEHG) is Ireland's largest Hospital Group with UCD as the academic partner. Serving a population of 1.1m the Group overlaps with 4 Community Health Organisations (CHOs), employs 11,400 staff and has gross expenditure of over €1bn. IEHG is an emerging organisation of 11 hospitals, six voluntary and five statutory, and has a unique profile of local services and focused tertiary and quaternary services.

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

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

The Group Chief Executive has delegated authority to manage Hospitals within the Group under the Health Act 2004. In respect of Voluntary Hospitals this authority is operated through the Service Level Arrangement. The Group CEO is accountable for the Group's planning and performance in line with the Performance and Accountability Framework of the HSE. Targets and performance criteria adopted in the plan are reported regularly through this framework.

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

Six hospitals in the Group operate an Emergency Department, one has a 12-hour urgent care centre and another hospital operates an Acute Medical Assessment / Local Injuries Unit.

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

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

Our Population

IEHG serves a population of 1.1 million, covering the counties of Dublin, Meath, Westmeath, Carlow, Kilkenny, Wicklow and Wexford.

The total population growth in Ireland for 2017-2018 is projected at 0.8% (39,691 people). However, the growth of the over 65-year age group is increasing at a faster rate of 3% – 4%. Each year, the population aged 65 years and over increases by almost 20,000 people, and by over 2,500 for those aged 85 years and over. As individuals age, the likelihood of developing chronic diseases or cancer, requiring acute hospital care, increases. Similar to the rest of the country IEHG has seen the increase in demand for acute hospital care which results from an increasing and ageing population. Our acute hospitals are challenged in addressing increased demand in terms of the overall number of patients being treated by hospitals and the complexity of their conditions.

Of the population served by IEHG 18% is over 65 years old, with 3.4% of that age group over 85 years. These figures are in line with the national average. However, what is of particular note in the 2016 Population Census is that while the majority of age categories in the population in IEHG are in line with national norms there are three distinct younger age groups that are recording above average figures, as follows:

Age Group	National %	IEHG %	Variance
20 – 24	5.5%	6.2%	0.7%
25 – 29	6.2%	7.2%	1.0%
30 – 34	7.6%	8.0%	0.4%

The increase in these age groups can significantly impact on service provision, including a requirement for increased maternity and paediatric services in the years ahead. Work is currently on-going in the Group to undertake a detailed population mapping across the Group to assist in planning services for the future. This work is based on the premise that we must first know our population in order to know their needs. The data that gathered will inform/drive integrated care, investment/service development, population health management and the quadruple aim of better care, better outcomes, reducing costs and retaining staff.

IEHG at a glance

297,364
Inpatient/ Day case YTD Nov*

717,383
Outpatients 2017

Our Academic Partner

UCD DUBLIN

UNIVERSITY COLLEGE DUBLIN

303,148
People seen in ED 2017

2 Hospitals have JCI accreditation

Joint Commission International

11,382
Total WTE

1,647 Medical/ Dental

4,358 Nursing

1,351 Health & Social Care

Strong integration platform with GPs across the Group

CLINICAL ACADEMIC DIRECTORATES (CADs)

Cancer CAD

45% of all patients with breast cancer in Ireland

50% of all Gynae Cancers treated of all breast cancer screening

Women's, Children and Adolescents CAD

Cardiovascular CAD

Genomics CSAD

Largest number of national specialities

ational Heart/ ung/Liver/Pancreas ransplant Units	National Spinal Unit	National Unit for Cystic Fibrosis	National Unit for Neuroendocrine Tumours	National Extra Corporeal Life Support, Cardiothoracic Surgery	National Unit for Pulmonary Hypertension	National Isolation Unit for Infectious Diseases

*Cancer data includes Mater Private and St. Vincent's Private activity and attendances.

Building a Better Health Service

IEHG Priorities for 2108 include:

1. **Performance Management –** Recognising the strong relationship between the quality of care and appropriate financial management, our priority is to achieve the maximum benefit from the available financial, staffing and infrastructure resources, while ensuring value for money.
2. **Unscheduled Care** - Manage ED waiting times (PET & Trolleys) through the delivery of safe, high quality emergency care. Implement the Acute Floor clinical design model.
3. **Scheduled Care** - Manage waiting lists in line with HSE targets and working closely with the NTPF to ensure all eligible patients are referred for treatment. Particular focus will be place on ophthalmology, orthopaedics, scoliosis and endocopy waiting times.
4. **Critical Care**: Expand access to critical care by opening additional critical care beds in MMUH.
5. **Quality, Safety & Risk:** - Build the capacity and capability in our hospitals and services to further develop a quality and patient safety culture centred around patients. Information from the feedback received from the first National Patient Experience Survey will inform this development.
6. **Transformation Programme** - Progress the transformation of IEHG into an integrated healthcare system delivering higher value care through a research and development culture.
7. **Clinical Services Redesign:** continue to transform, re-organise, rationalise, expand, develop and integrate clinical services across the Group to meet community and population needs.
8. **Capacity Modeling**: Development of a Bed and Theatre capacity model for the Group. Including detailed bed stock mapping exercise
9. **Integrated Care**: Integrate with CHO partners and further develop GP integration with our hospitals. Progress the Integrated Care Programme for the Prevention and Management of Chronic Diseases
10. **Organisational Design**: Ensure the Hospital Group has a clear structure to provide and deliver quality care through the implementation of Clinical Academic Directorates and Clinical Directorates.
11. **Cancer**: Delivery of the Work Programme for the Clinical Academic Directorate in Cancer which will enhance the strategic alignment of research, health education and patient care. Support the roll out of the new cancer strategy
12. **Workforce Development**: Recruit, support and retain a 'best-in-class' talent workforce that is supported and valued in a workplace that fosters a culture of high trust, openness and continuous professional development
13. **Workforce Planning**: Implement a comprehensive Workforce Plan across the Group based on current and predicted service needs
14. **Healthy Ireland:** Improve patient and staff health and wellbeing by continuing to implement the Healthy Ireland plans set out in the *IEHG Healthy Ireland Implementation Plan 2016 - 2019*.
15. **National Programmes**: Support the Implementation of all National Policy Programmes including the *National Cancer Strategy 2017-2026* and the *National Maternity Strategy 2016-2026, Strategy for the Design of Integrated Out Patients 2016-2020* and the Models of Care developed by the National Clinical Programmes.
16. **Improving Value**: Work with the Acute Hospitals Division on the **Value Improvement Programme** to ensure services are delivered in the most efficient and effective way and in the most appropriate setting

Service Developments 2018.

Additional development funding has been allocated in 2018 for a number of new and enhanced services in 2018. IEHG will liaise closely with HSE Acute Hospital Division to track performance and impact of these new developments.

Critical Care:

- Opening of 1 ICU and 6 HDU beds in the Mater Hospital: 39.8 WTE: €1m

Transplantation:

- Phased opening of additional Heart/Lung assessment beds in Mater Hospital: 15.5 WTE; €0.4m

Neonatal Transport:

- Consultant Neonatologist: 1 WTE (NMH post shared with OLCHC): €0.1m

Rare Diseases Office:

- VINE Co-ordinator: 5 WTE: €0.05m

Neurology:

- Deep Brain Stimulation: Dublin Neurological Institute: 6 WTE: €0.215m

Demographics:

- Cardiology: Additional 10 TAVI procedures Mater Hospital:

Orthopaedics:

- As part of the long-term solution to addressing the waiting list for Scoliosis Surgery, the Mater Hospital is now the referral and transition centre from paediatric services for patients over 16 years. Additional resources have been invested in the Mater Hospital to enable up to 50 scoliosis cases to be undertaken this year and to support an additional 24 scoliosis cases in Cappagh Hospital.

Transgender Services:

- Adult transgender services in St Columcille's Hospital will be enhanced. €0.1m

Service Delivery:

The key challenges for IEHG in 2018 is to deliver the quantum of services in the context of the funding envelope available. Increasing demands on our services, an ageing population and limited bed capacity means we are challenged in providing timely access for both elective and emergency care.

Unscheduled Care:

Activity in Emergency Department and unscheduled care has continued to grow year on year and the increase in attendances and admissions seen in 2017 posted a significant challenge to Hospitals within the Group. It has also had consequences for scheduled and elective care. As a result of an ageing population and increases in chronic illness this level of presentations to emergency departments is expected to continue. One of the primary focuses in 2018 will be to reduce trolley waits and improve ED performance for patients presenting to Emergency Departments. We aim to achieve and sustain winter **performance** targets aligned to NHS SAFER bundle implementation across all unscheduled care sites and to improve the 6 and 9-hour Patient Experience Times (PET) for all patients in line with national targets.

Delayed Discharge Thresholds by hospital

Hospital	Threshold
MMUH	30
SVUH	25
WGH	10
SLHK	8
RHM	4
OLHN	5
SCH	15
SMH	7
Cappagh	4

- Zero Tolerance for 24 hour PET breaches.
- 33% of all discharges will be at or before 11am
- Delayed Discharge numbers to be maintained at 2016/2017 winter threshold levels (see table on left)
- 8am TrolleyGAR target: +/- 15% of daily group threshold:
  - (threshold = 52, -15% = 44 +15% = 60)

Hospital	Threshold	-15%	+15%
MMUH	12	10	14
SVUH	12	10	14
WGH	8	7	9
SLGH	8	7	9
RHM	8	7	9
OLHN	4	3	3

- *Monitoring will be by SDU: weekly and monthly*

During 2017/2018 IEHG will continue the roll out of our 3-year Unscheduled Care Transformation Programme. The programme involves mapping processes from the emergency department to inpatient wards to discharge destination and will be redesigning these pathways to deliver a more efficient and timely service. Operationally the programme focuses on process improvement in 4 patient journey pathways: Emergency Care, Assessment and Decision Making: Bed Flow and Post-Acute Care.

Participating hospitals will continue to undertake rapid improvement events in each of the 4 pathways. A suite of key performance indicators covering patient safety, patient outcomes, patient and staff experience, efficiency and governance have been developed to align with the programme outcomes.

Winter initiative funding has been provided to support the opening of some additional beds in St. Vincent's University Hospital and St. Luke's Hospital Kilkenny. The ongoing increase in admissions has negated any additional capacity. Funding has also been provided to support earlier access to diagnostics, hospital discharging and enhanced minor injuries capacity within the Group.

Priorities 2018:

1. **Integration**: The continue development and implementation of care pathways through hospital unscheduled care planning, Local Integrated Care Committees (LICC's) with GP's and all Community Healthcare Organisations (CHOs). In 2018 we will focus on stroke management, rapid access to OPD appointments, access to diagnostics and rehabilitation. We will work with LICCs and CHOs to streamline surgical services from GP to Level 4 hospitals for specific conditions and develop new pathways to support rehabilitation services for frail elderly
2. Continue to progress **delayed discharge** process improvement in collaboration with our CHO partners
3. **Work force planning**: a) Development of DoH Advanced Nurse Practitioner initiative and b) Continued roll-out of the DOH Task Force on Medical and Surgical nursing project.
4. Support **hospital-based initiatives** including workshop on SBAR completion & compliance to support performance improvement.

These hospital measures will be supported by the additional social care funding which is aimed at reducing delayed discharges across the group. Cumulatively these measures will contribute to reducing delays for patients attending hospitals and achieving winter targets set by HSE.

Scheduled Care

Managing waiting times for inpatients, day cases, out patients and endoscopy services remains the key priority for scheduled care in 2018. There are currently (December 2017) 17,888 active patients on the In-Patient/Day Case waiting list waiting for admission to an IEHG Hospital. Overall 95% of patients are waiting less than 15 month, however, significant challenges exist in a number of services including ophthalmology, general surgery, orthopaedics and endoscopy.

IPDC Waiting List IEHG December 2017 (data from the NTPF)

During 2017 significant improvements were seen in the numbers of patients waiting for over 15 months for surgery through the NTPF waiting list initiative. This year we will work closely with the NTPF to expand access to treatment via insourcing or outsourcing initiatives to ensure patients are provided with timely access to surgery and to comply with national waiting list targets.

Waiting list actions plans will be developed for target specialties particularly orthopaedic and ophthalmology lists which remain the greatest challenge for the Group. Working with the NTPF we aim to significantly expand the amount of bariatric surgery undertaken in St. Vincent's University Hospital.

Timely access to Out Patient Departments (OPD) remains a significant challenge for the Group. There are over 15,000 people waiting for a first OPD appointment for longer than 15 months most of whom do not have an appointment date. To address this challenge, a review is planned for 2018 to examine patient flows for specialist and non-specialist services. However, without a considerable investment in resources it is unlikely that any significant progress can be made in meeting this demand for OPD services.

The on-going increase in endoscopy referrals continues to remain a challenge for the Group. While priority 1/urgent referrals within the Group are seen within the four-week timeframe, there are ongoing challenges in treating Category 2/'non-urgent' referrals within the 13-week target. We plan to work with the NTPF and the new clinical lead for endoscopy to expand capacity and to oversee quality and safety for the service.

All hospitals will be required to implement the National Inpatient, Day Case and Planned Procedure (IDPP) Waiting List Management Protocol developed by the National Treatment Purchase Fund (NTPF). Process improvement initiatives will be undertaken in conjunction with the IEHG Service Improvement Teams to drive process and performance improvement in scheduled care.

Cancer Services:

The IEHG Cancer Clinical Academic Directorate (CaCAD) was launched in June 2016 with the aim of aligning the two cancer centres at the Mater Misericordiae University Hospital (MMUH) and St. Vincent's University Hospital (SVUH) into a single function operating across two sites. The directorate is designed to enable IEHG to leverage the expertise of both hospitals with the research and teaching expertise in UCD to deliver state of the art cancer care.

The recommendations of the National Cancer Strategy 2017-2026 have been incorporated into the operational plan and key priorities of the CaCAD to ensure alignment with the report and delivery of the recommendations outlined in the new cancer strategy.

Key priorities 2018:

- Improve and enhance the quality of Cancer services for the 1.1million catchment area served by the group:
    - Promote the Healthy Ireland initiative by working with UCD's School of Public Health, Physiotherapy and Sports Science.
    - Define a Cancer Directorate strategy to develop services in alignment with the National Cancer Strategy in areas such as palliative care, cancer survivorship, psycho-oncology services.
    - Increase capacity of the cancer services through the appointment of approved consultant posts in Oncology, Haematology, Gynae Onc, Hepatology and ENT.
    - Link with other Clinical Academic Directorates being established within IEHG in the areas of Genomics, Women's' Health Adults & Young Adolescents Health and Cardio Thoracic.
    - Support the development of the genomic testing and cancer genetics service to treat patients with the right therapy first time and to manage disease free high-risk patients.

        - Work with the cancer centers to implement recommendations related to performance improvements for the Rapid Access Clinics and monitor performance on an ongoing basis.
        - Support the roll out of the medical oncology clinical information system (MOCIS)
- Single Cancer Service: Progress the creation of a single cancer centre by
    - Deliver a unified Strategic and Operational Plan for the Cancer Directorates two designated cancer services to operate as one cancer centre.
    - Strengthening of the CaCAD Executive structure
    - Set up of cross cancer centre and cross functional operational oversight groups to monitor activity and service levels within the CaCAD sites
    - Expand the number of existing cross centre tumour groups to cover all cancer specialty areas
    - Consolidation and standardisation of reporting and data relating to cancer services across the group
    - Initiate process to seek accreditation for the CaCAD as a single comprehensive cancer centre
- Develop the Research, innovation and Academic functions through the projects and programmes under the CaCAD including:
    - Robotics Assisted Surgery
    - Unify Clinical Research activities across the IEHG under one governance and coordination structure.
    - Deliver extended therapeutic options for patients through the expansion of clinical research activity including early phase Clinical Trials.
    - Biobanking & Genomics linking in with the Genomics Directorate
    - Education sub group

Maternity Services

Working in parallel with the National Women and Infants' Health Programme (NWIHP), IEHG will progress the implementation of the National Maternity Strategy *2016-2026* (NMS). Our aim is to support the four maternity units to deliver high quality women centred, safe care. This year we will establish a Clinical Academic Directorate for maternity, paediatric and women's health across the Group. The programme will be clinically led and will provide governance and oversight of maternity (and paediatric) service across our hospitals.

We will continue to focus on quality and safety and work towards implementation of the HIQA National Standards for Safer Better Maternity Care. We will also work with the NWIHP to implement the new framework on management of maternity related incidents and to implement the recommendations of the relevant reports and reviews.

Access to anomaly scanning We will also work with the NWIHP to improve quality and safety with the implementation of a programme of anomaly scanning across all four maternity units. At present only the National Maternity Hospital undertaken anomaly scanning for all mothers.

IEHG is particularly focused on rolling out the **new model of integrated, multi-disciplinary care** and in particular to develop teams of community midwives where these are not currently in place. This will ensure that women who have a normal risk pregnancy can avail of the supported care pathway in their own community. However, the ability to establish new care pathways in the community will be dependent upon our ability to successfully recruit additional midwives.

Group Strategic Priorities

1. Progression towards an Academic Health Science Centre:

International experience that shows that the integration of education and research in an Academic Health Science Centre model improves quality of care and patient outcomes. IEHG with its academic partner University College Dublin (UCD), has embarked on a fundamental reshaping of the hospital-university model with its strategic decision to develop as an Academic Health Science Centre (AHSC). It is our goal to become a fully integrated Academic Health Science Centre by 2020.

IEHG/UCD have initially identified four key service themes which reflect our combined national and international strengths and ambitions in research, clinical practice and education. The themes are: Cancer, Cardiovascular, Genomics and Women's Health/Paediatrics/Adolescents. These four service areas are to be restructured into Clinical Academic Directorates (CADs) and will be charged with delivering high quality care, educating and training healthcare professionals, embedding research into the system and translating those research benefits into patient benefits. The blueprint for these academic directorates will be aligned to National Clinical Strategies, including, The National Cancer Strategy 2017-2026 and the National Maternity Strategy 2016-2026. The Genomics Service Academic Directorate will work towards the recommendations of the National Genetic and Genomics Medicine Network Strategy Group 2016.

To support our progression towards an Academic Health Science Centre we have appointed a Chief Academic Officer and a Clinical Lead for Genomics within the Group. The appointment of Professor of Health Informatics (UCD)/Director of Knowledge and Information Systems(IEHG) early in 2018 will be a valuable addition in supporting UCD and IEHG in the future development of Information Systems.

2. Adopting Lean for Healthcare Transformation

IEHG adopted Lean principles, methodology and philosophy as an organisational management system for improvement and operational excellence. In 2017 we commenced a 3year Transformation programme (TP) which aims to standardise the delivery of healthcare across the group. The objectives are to:

- Improve patient and staff experience and patient outcomes
- Enhance capability of our hospitals to deliver operational excellence
- Develop and enhance continuous improvement capabilities
- Optimise patient flow and resource utilisation

To support this transformation, we have established a skills improvement team (SIT) to support and enable frontline staff to undertake the changes required to redesign services. The team has been supporting IEHG hospitals in mapping their existing Unscheduled Care Pathways to identify areas for improvement and deliver rapid improvement events to deliver positive change.

The priority for 2018 is to focus on improving four patient journey pathways: Emergency Care, Assessment and Decision Making: Bed Flow and Post-Acute Care. Success will be demonstrated by improved performance against national KPIs.

Additional Service Delivery Improvement priorities for 2018 include the design and implementation of the **Acute Floor** and a focus on delivering **Ambulatory Emergency Care** (AEC) for medicine and surgery.
To support the IEHG Lean transformation we have developed an accredited Lean programme to help develop sustainable local expertise.

3. IEHG Integrated Acute Frailty Network (AFN)

In collaboration with the NHS Acute Frailty Network (AFN) IEHG has developed an innovative approach for the care of all frail and elderly patients (a national priority). This will be achieved within the IEHG through the creation of an integrated frailty pathway for the care of our frail older patients. This work encompasses:

- Shared Learning networks in IEHG for Frailty Care
- Person Centred Care
- Creating a vision for frailty care in IEHG- building on capacity and capability for change
- Understanding our system

4. Delivery of Operational Excellence

The development of capability and capacity to deliver **operational excellence** will be a key priority for IEHG in 2018. Development of operational visual management systems and dashboards will support data driven decision making across the group. Navigational hubs will support management for daily improvement. The use of NQAIS Clinical to support data driven decision making will be a focus for Clinical Leadership teams.

Clinical leadership is at the core of the ability to successfully design and implement sustainable improvement in healthcare. A strategy to engage clinical staff in the improvement agenda is a key focus of this endeavour. Advanced clinical leadership and governance will be required to motivate, guide and support the cultural and operational shift required for transformation of the Un-Scheduled Care (USC) pathway in the IEHG.

The establishment of a **Clinical Senate** for change will support Group Transformation in four key areas;

1. Establish shared goals
2. Support the group to achieve agreed goals
3. Monitor system performance
4. Improve performance

5. Transformation and Innovation

To ensure the appropriate Leadership and Governance of the Reform Agenda within IEHG a Transformation and Innovation Office was established in late 2017. This team was resourced with support from the HSE Programme for Health Service Improvement (PHSI) to provide overarching support to the development and implementation of the Strategic direction and Plan for the Group for the next 3 -5 years. The office will apply a co-ordinated programmatic approach to the change implementation and ensure:

- The formation of a single coherent Hospital Group structure and organisation as it evolves into an Academic Health Science Centre
- Reorganisation of services within the Group to ensure optimal care provisions to the population served
- The provision of safe effective, efficient and relevant patient services within budget.
- Integration and synergy within the Group and with other Hospital Groups and Community Healthcare Partners, particularly primary and community care services

6. Clinical Services Redesign Programme

The redesign programme currently underway will continue in 2018. This programme will result in the realignment of clinical services across the 11 hospitals to ensure appropriate response to the rapidly changing shift in the design and performance of our current systems of care. To succeed, collaboration with a wide range of internal and external partners is a prerequisite, thereby facilitating an integrated approach and response to changes in technology, patient demands and service delivery.

A clinically led engagement process, which challenges the way services are currently designed and delivered is underway. A number of proactive Service Review and Working Group forums have been established to focus on improving the patient's experience and outcomes of care in agreed specialities. Several initiatives and working group work-flows are underway and will continue in 2018. This includes work flows relating to orthopaedics, ophthalmology, critical care, pharmacy services, venous thromboembolism (VTE), weight management, vascular services, diagnostics, neurology, paediatric and neonatal services. The work streams underway captures all activity and looks at enhancing high quality safe care while exploring potential for service innovation and aligned to the value improvement programme.

In defining our redesign principles and key steps aimed at improving outcomes and efficiency for any clinical service under review, whole patient pathways have been developed focusing on developing integrated clinical services, rather than individual hospital-based. This approach aligns with the IEHG Strategic Goals 2015 – 2018 to transform, re-organise, rationalise, expand, develop, and integrate clinical services across the Group to meet community and population needs and expectations.

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

7. Community Integration

Shifting care out of hospitals and into the primary and community setting is a key priority for the Health Services and for IEHG. This approach will enable IEHG to deliver care at the lowest level of complexity as is safe, efficient and meeting the needs of patients. This model is particularly suited to management of chronic illness and will assist in addressing the challenge of access to the hospital system and maintain patients in the community. This work also supports the National Clinical and Integrated Care Programmes in their focus on developing new integrated care models and pathways to ensure safe, timely, efficient healthcare which is provided as close to home as possible.

The IEHG fully committed to integration across primary and secondary care facilities which has been demonstrated by the appointment of a Director of Integration to the Group. We have a number of integration programmes already underway which will be enhanced during the year. These projects include virtual heart failure clinics between GPs in the South East and cardiologists in St. Michael's Hospital, Frailty pathways in Kilkenny and St. Vincent's, and a shared care/outreach programme for community treatment of patients with Hepatitis C with new drug therapies.

A number of Local Integrated Care Committees (LICC) have been established to improve communication and develop shared care pathways between GPs and hospitals. These committees are now operational in Kilkenny, Loughlinstown, Navan and Mullingar. Further development of these committees will be undertaken in 2018.

The priority for integration of care will be the undertaking of a Population Health Mapping across the Group. This work is based on the premise that we must first know our population in order to know their needs. The data that gathered will inform/drive integrated care, investment/service development, population health management and the quadruple aim of better care, better outcomes, reducing costs and retaining staff.

We will continue to work closely with the four Chief Officers in the Community Healthcare Organisations (CHOs) across the IEHG to achieve integration of health system within IEHG. In 2017, we instigated strategic meetings with our CHO partners to address areas for improved collaboration on both strategic and operational priorities.

Section 3: Finance

The HSE Acute Hospital Division's 2018 net budget allocation to IEHG, excluding Pensions is €930.139m. This allocation represents an increase of €18.478m (2.0%) on the 2017 final allocation. This allocation excludes funding for pensions pay and income. Service specific additional funding for approved new developments is retained by DoH and will be available when agreed criteria have been met. Funding from external commissioners, such as the NTPF, NCCP and NCSS, is required to meet the activity levels set in the Plan. The following table shows the gross and income budgets for 2018, with the 2017 comparative:

Budget excl. Pensions	2018 Budget €M	2017 Budget €M	Movement €M
Gross Budget	1,115.849	1,095.847	20.002
Income Budget	(185.710)	(184.186)	(1.524)
Net Budget	**930.139**	**911.661**	**18.478**

The gross budget has increased by €20.002m. Funding of €24.579m has been provided for pay cost pressures such as National Pay Agreements and increments; Funding of €5.071m for a number of special purpose payments. Some once-off funding received in 2017 is retracted and external commissioners have retracted their 2017 funding. The latter is anticipated to return to the group during the year. The 2018 budget also includes a reduction of €30.750m representing the projected deficit in 2017.

The 2018 budget is significantly lower than 2017 expenditure. A significant amount of this unfunded expenditure is in the Hospital's run rate and will further add to the financial challenge in 2018. There are significant pay and non-pay cost pressures in 2018, negative trending in private health insurance income and increasing service demand due to demographic pressures. In the context of those issues, it will prove difficult to achieve a financial breakeven position in the current year.

The growing cost of delivering core services is such that IEHG faces a very significant financial challenge in 2018 in maintaining the existing level of overall activity, to which we are fully committed. Developing and implementing a Financial Plan will be the focus of the Hospital Group in the weeks following the publication of the Operations Plan. We will work with the HSE to develop a shared understanding of the financial constraints and agree a methodology of dealing with these pressures. We will also work with the HSE to agree a maximum level of expenditure for the existing level of service and this will determine the overall financial challenge facing the IEHG for 2018.

Budget 2018 and Existing Level of Service

The 2017 level of expenditure incurred in delivering the level of activity is not fully funded in 2018. The level of activity notified to the IEHG for 2018 is similar to the 2017 level and therefore it will prove difficult for IEHG to deliver this level of services within the funding envelope allocated in 2018. However, the Group will endeavour to achieve the maximum expenditure level when agreed with the HSE for 2018.

However, it must be noted that the cost of maintaining existing services increases each year due to a variety of factors including:

1. Impact of National Pay Agreements
2. Increases in drugs – volume and price

3. Other clinical non pay costs e.g. Laboratory costs and increasing demand, Medical equipment
4. Clinical and non-clinical inflation - price increases
5. Demographic factors
6. Additional costs in relation to 2017 developments
7. Deferred costs in 2017 to achieve the financial outturn
8. Reduction in level of Private income

Approach to Financial Challenge 2018

In line with the 2018 NSP, it is our intention, from the start of 2018, to put in place a Value Improvement Programme, targeting improvement opportunities to assist in addressing the financial challenge.

Within the over-arching Value Improvement Programme, we will focus on the three broad priority themes outlined in the 2018 NSP: Improving value within existing services; Improving value within non-direct service areas; and strategic value improvement. Robust governance and appropriate support arrangements will be established to manage the Programme.

Delivering the level of services included in our ABF Allocation, as safely and effectively as possible, within the overall limit of available funding will remain a critical area of focus and concern for 2018. Our Group CEO, Hospital Managers and other senior managers will face specific challenges in respect of ensuring the type and volume of safe services are delivered within the resource available.

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

Our approach to dealing with the financial challenge will include:

1. Reconciling the expected level of activity to the funding provided directly by the HSE and anticipated funding from external commissioners.
2. Governance – Continued focus on budgetary control through regular performance meetings
3. Value Improvement Programme Committee to oversee and monitor the implementation of our Value Improvement Programme
4. Initiate specific finance meetings with hospitals that are experiencing significant financial pressures.
5. Pay – Managing the Pay and Numbers Strategy 2018 with each of our hospitals
6. Non Pay – Implement targeted cost containment programmes for specific high growth categories
7. Income – Endeavour to stem the reduction in patients availing of the private health insurance that was experienced in the latter half of 2017.
8. Activity – Control of activity will be a focus of 2018 together with the further development of ABF model to identify services where cost reductions may be possible.

When account is taken of the 2017 cost of services, known cost growth, approved service developments and initial cost saving measures, a financial challenge that is yet to be determined, remains to be addressed. The Group is conscious of the ongoing considerable challenges faced by staff in managing increasing demands within an environment of fiscal constraint, challenging budgets and higher public expectations. Notwithstanding the cost reduction measures implemented in recent years, the Group will continue to impose a number of measures to control costs, reduce waste and improve efficiency aimed at minimising any impact

on clinical services. There is however limited scope to manage within the allocated funding without risk of compromising service delivery.

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

Risks to the Delivery of the Operations Service Plan 2018

There are a number of risks to the successful delivery of 2018 Operations Plan. While every effort will be made to manage these risks, it may not be possible to eliminate them in full and they may impact on planned levels of service delivery or achievement of targeted performance. Particular management focus will be required to mitigate risk in the following areas:

- Sustaining a level of service where the nature of the response is such that activity cannot be stopped or spend avoided such as activity driven by emergency departments and other hospital services
- Increased demand for services beyond the funded levels
- Meeting the level of changing needs and emergency presentations and responding to increasing levels of demand for unscheduled care services.
- Regulatory requirements in hospital services which must be responded to within the limits of the revenue and capital funding available.
- Delivery on 2018 activity targets is predicated upon a similar level of externally commissioned activity as was undertaken/funded in 2017.
- Demographics – Managing the continuing impact of an increasing and aging population on our hospitals within the current envelope of funding.
- Responding to urgent safety concerns and emergencies such as risk or incidence of carbapenemase-producing enterobacteriaceae (CPE).
- Control over pay and staff numbers at the same time as managing specific safety, regulatory, demand driven pressures while seeking to ensure recruitment and retention of a highly skilled and qualified workforce, particularly in high-demand areas and specialties.
- Delivery of savings in respect of the first charge applied and efficiency targets being set within the allocation.
- Managing within the limitations of our clinical business information, financial and HR systems to support an information driven health service
- Managing the scale of change required to support new models of service delivery and structures while supporting innovation and reorganisation across the Group.
- Our capacity to invest in and maintain our infrastructure and address critical risks resulting from ageing medical equipment and physical infrastructure while managing within the Health and Safety regulations.
- Our ability to meet the demand for new drug approvals within funded levels
- The scale of financial management required across a demand led service environment particularly when there is a lack of data visibility across all hospitals within the Group
- Income – delivering the income target given a downward trend in patients presenting with private health insurance towards the end of 2017.
- Ability to respond to significant spikes in demand given that hospitals normally operate at full capacity.

Capital

There is a small provision for capital infrastructure identified for the IEHG in the 2018 NSP. The allocation is insufficient to deal with the necessary infrastructural improvements required across all hospitals in the Group and is insignificant given the Asset base of the Group. Discussions are underway with HSE Estates to secure the necessary capital to address ageing infrastructure, additional capacity and equipment replacement.

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

Cash Risk

Given the brought forward accumulated deficits in the Voluntary Hospitals, and the scale of the 2018 financial challenge to be dealt with as outlined above, it is expected that the management of the cash position will be challenging in 2018.

Pensions

While the Acute Hospital Division of the HSE is not responsible for Pensions, as a Hospital Group, that reports to an Executive, and anticipated to a Board in 2018, the Group reports on all finances relevant to the Hospitals, which includes Pensions. Budgets are reconciled to Rosetta, which also includes Pensions. Any Pension costs beyond budget will be reported to the relevant HSE division, with the anticipation that it will be funded.

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

Data Caveat

The financial information underpinning the plan is subject to the specific limitations of the HSE's financial systems, currently available within the overall finance operating model, which are well documented and are being addressed via a major improvement programme. This includes our reliance on the receipt of financial and other information from a large number of voluntary organisations which are separate legal entities with their own separate financial systems. Every effort has been made within the time and resources available to ensure that the information provided in the plan is as accurate as possible. However, it must be read in the above context and it is noted that a margin of error of 1% equates to €11m for the Group.

There is no capacity within the plan for the HSE to respond in 2018 to further pay or other pressures, beyond those already specifically funded. In the event that additional pressures emerge, for example, via the industrial relations machinery of the state, regulatory processes, government decisions or the courts etc., the HSE will need to engage with the Department of Health for guidance on how to proceed.

Value Improvement Programme

Delivery of the level of service required and management of pay and non-pay budgets within the funding allocation this year will require robust financial and activity controls. In line with national direction IEHG will

establish a Value Improvement Programme to address the financial challenges in the Group while maintaining levels of activity and patient care.

The initial focus will be on high cost issues such as work force planning, procurement, agency conversion and flow efficiencies in all hospitals. Our procurement services will continue to engage with the Health Business Services (HBS) and local leads to ensure continuous improvement in procurement services. This will include a specific focus on opportunities for consolidated tenders across the region.

Section 4: Quality Improvement and Patient Safety

One of the key strategic goals of the Ireland East Hospital Group is to provide consistent, high quality care across our hospitals, putting the patient at the core of everything we do. We have recently established a Quality and Patient Safety Directorate with the goal of developing a strong inspired culture of safety throughout our hospitals. The directorate will develop oversight of all IEHG involvement with HIQA, the National Office for Clinical Audit, the National Patient Safety Programme and will drive quality initiatives and standards across the Group.

The priority for 2018 is to advance the QPS governance structures and to develop the Group QPS strategy as well as a quality dashboard to facilitate Group oversite and enable individual hospitals to monitor performance.

The directorate will focus on 5 key areas:

1. Leadership and governance
2. Patient safety and quality improvement
3. Performance monitoring and assurance
4. Incident and risk management
5. Patient, public and staff participation and feedback

Other priorities for the year include

- Build Quality and Patient Safety capacity and capability at hospital group and individual hospital level to support Quality Improvement initiatives
- Monitor and support implementation of National Standards for Safer Better Healthcare
- Support the development and implementation of the HSE Integrated Incident Management Framework
- Continue to embed a culture of open disclosure.
- Develop Group wide Clinical / Healthcare Audit Programme
- Improve overall response to safety incidents (reporting and investigation).
- Improve compliance with National Clinical Guideline No. 6, Sepsis Management training is now mandatory for relevant staff in IEHG hospitals.
- Improve compliance with the use of the sepsis forms.
- Develop plans for the implementation of National Clinical Guideline – No. 5 Communication (Clinical Handover) in Maternity Services and No. 6 the Communication (Clinical Handover) in Acute and Children's Hospital Services.
- Support the development of prevention and management of VTE (blood clots)initiatives in patient across the Group.
- Continue to support improvement and monitor compliance with targets for HCAIs / AMR and Flu Vaccination uptake at Group level
- Ensure governance structures are in place in each hospital to drive improvement and monitor compliance with targets for HCAIs / AMR with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms.

Section 5: HR

IEHG is the largest Hospital Group with 11,382 employees (whole time equivalents) working together to deliver world class healthcare through the provision of a patient-focused, quality health service that is accessible and sustainable for all patients receiving or needing care within our Group.

Key to delivering on our strategic ambitions is the willingness of our staff to engage in this significant change management programme which will see Clinical Service Reconfiguration and Redesign to meet the current and future needs of our patients.

Recognising the vital role all our employees will play in the achievement of the Group goals IEHG is committed to develop, value and support all employees and create a workplace that fosters a culture of high trust, openness and continuous professional development. Recognising the need for leadership and support at every level in the organisation we will seek to improve our performance, optimise our workforce and develop further as a learning organisation. In this regard we will align our efforts to the objectives of 'The People Strategy 2015 – 2018' developed for the entire health service.

Priorities 2018

- Pay bill management and Control.
- A key element of managing within the financial resources provided is the strict control of staffing levels within each hospital. This includes the close monitoring and management of staffing costs across the three pay domains of directly employed staff, overtime and agency costs
- Develop a comprehensive workforce plan for the Group
- Develop standardised HR practices and protocols across the Group, within the framework of existing national PPPGs.
- Employee Engagement
- Develop employee Engagement Improvement Plans in each hospital through common initiatives that support team working, enhance communications, demonstrate employee value, maximise employee potential and embrace diversity. The Great Place to Work Institute (GPTW) is working with the Group to develop these plans.
- Staffing and Recruitment
- Promote the recruitment and retention of nursing staff in 2018
- Develop a Nurse Bank to reduce reliance on agency staff across the group, together with continued development of a Nursing bank App
- Improve compliance with European Working Time Directive

Key Results Areas

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

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

Priority	Accountable	Date
Continue implementing *Healthy Ireland* plans in each IEHG Hospital.	All Hospitals	Q1-Q4
Continue to Improve staff uptake of the flu vaccine.	All Hospitals	Q1-Q4
Prioritise the implementation of Making Every Contact Count in all care settings.	All Hospitals	Q1-Q4
Progress the implementation of the Diabetes, Asthma, COPD and Heart Failure chronic disease demonstrator projects within the Group.	All Hospitals	Q1-Q4

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

Increase critical care capacity

Enhance critical care capacity with the opening of additional capacity at Mater Misericordiae University Hospital, Dublin.1 ICU Beds, 6 HDU Beds	MMUH	Q1-Q4
Commence monitoring of time from decision to admit to admission to Intensive Care Unit	IEHG	Q1-Q4

Improve the provision of unscheduled care

Improve pathways for care of older people living with frailty in acute hospitals in association with the Integrated Care Programme for Older Persons.	IEHG	Q1-Q4
Continue to ensure that no patient remains over 24 hours in ED.	IEHG	Q1-Q4
Continue to implement measures to address seasonal increase and reduce delayed discharges in association with community healthcare.		Q1-Q4
Generate improved capacity by improving internal efficiencies and more appropriate bed usage by reducing length of stay, early discharge and improving access to diagnostics	IEHG	Q1-Q4

Improve the provision of scheduled care

Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate.	All hospitals	Q1-Q4
Monitor length of stay and opportunities for improvement using NQAIS	IEHG	Q1-Q4
Reduce waiting times for all patients and particularly those waiting over 15 months on outpatient and inpatient / day case waiting lists by implementing waiting list action plans.	IEHG & NTPF	Q1-Q4
Develop a plan to address waiting lists challenges in Orthopaedics and Ophthalmology	IEHG& NTPF	Q1-Q4
Improve efficiencies relating to inpatient and day case activity by streamlining processes and maximising capacity in acute hospitals.	All hospitals	Q1-Q4
Work with the NTPF to implement the *National Inpatient, Day Case and Planned Procedure (IDPP) Waiting List Management Protocol.*	All hospitals	Q1-Q4

Work with the NTPF to develop and implement a waiting list action plan for 2018.	All hospitals	Q1-Q4
Implement the findings and recommendations of the NTPF special audit to drive process and performance improvement in scheduled care.	All hospitals	Q1-Q4
Work with the clinical programmes to complete a suite of pathways of care at condition-level, through the Outpatient Services Performance Improvement Programme.	AHD, OSPIP and HGs	Q1-Q4
Further develop GP referral guidelines and standardised pathways, supported by efficient electronic referral systems.	OSPIP and HGs	Q1-Q4
Roll out the national validation project for inpatient, day case and outpatient waiting lists.	All hospitals	Q1-Q4

Increase acute hospital capacity

Open additional beds and new units to increase capacity and improve access over the winter period.		
St. Vincent's University Hospital, Dublin • 22 additional beds.	IEHG & SVUH	Q1-Q4
St. Luke's Hospital, Kilkenny • Additional 14 Beds	IEHG & S Luke's	Q1-Q4

Continue to oversee the new clinical development

Continue the development of the orthopaedic service for young adults with scoliosis in the Mater Misericordiae University Hospital, and Cappagh Orthopaedic Hospital for patients transferring from paediatric services.	IEHG and MMUH + CNOH	Q1-Q4
Progress the recruitment of consultant and support staff to open additional assessment beds to support the national transplant service in the Mater Misericordiae University Hospital, Dublin.	IEHG and MMUH	Q1-Q4
Commence development of an All- Island deep brain stimulation service	IEHG and MMUH	Q1-Q4
Support the Neonatal Transport Programme with the appointment of additional Neonatologists.	IEHG and NMH	Q1-Q4
Commence development of transgender services	IEHG & SCH	Q1-Q4
Additional Transcatheter Aortic Valve Implantation (TAVI) will be provided	MMUH	Q1-Q4
Continue to support the implementation of National Strategies for Cancer Services, Women and Infant Health and National Ambulance Services	IEHG, NCCP NWIP, NAS	Q1-Q4
Ensure anomaly scanning is available to all mothers attending antenatal services	IEHG NWIP	Q3 2019

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

Ensure quality and patient safety

Facilitate initiatives which promote a culture of patient partnership including next phase of the National Patient Experience Survey.	IEHG	Q1-Q4
Monitor and control HCAIs in line with guidance documents	IEHG	Q1-Q4
Continue to develop robust governance structures at hospital and Group level to support management of HCAI / AMR.	IEHG	Q1-Q4
Collate information on incidence of CPE and associated infection control measures including use of screening guidelines and appropriate accommodation of patients	IEHG	Q1-Q4

Review assessment process for National Standards for Safer Better Healthcare and develop guidance to support monitoring and compliance against same	IEHG	Q1-Q4

Enhance medicines management

Collaborate with AHD to further enhance medicines management, improve equitable access to medicines for patients and continue to optimise pharmaceutical value through the Acute Hospitals Drugs Management Programme with a focus on the use of biosimilars.	IEHG	Q1-Q4
Collaborate with AHD to implement the Report on the Review of Hospital Pharmacy, 2011 (McLoughlin Report) with a focus on the development of pharmacist roles to improve and enhance medication safety and implement HIQA medication safety reports.	IEHG	Q1-Q4

Implement Children First

Commence implementation of the *Children First Act 2015* including mandatory training for staff as appropriate	IEHG	Q1-Q4

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

Support and progress HR policies and initiatives

Enhance the training and development of Advanced Nurse Practitioners in association with HSE, DOH and NMPDU	IEHG	Q1-Q4
Continue to improve compliance with the European Working Time Directorate with particular focus on the 24 and 48-hour targets	IEHG	Q1-Q4

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

On-going monitoring and performance management of financial allocations in line with the Performance and Accountability Framework

Monitor and control hospital budgets and expenditure in line with allocations.	IEHG	Q1-Q4
Continue to focus on initiatives that will drive quality of care and value for money.	IEHG	Q1-Q4
Identify and progress realistic and achievable opportunities to improve economy efficiency and effectiveness	All Hospitals	Q1-Q4
Secure reductions in cost and or improvements in efficiency of services currently provided	AHD and HGs	Q1-Q4
Progress implementation of the recommendations of the '*Patient Income Review'* which will focus on training, standardisation of processes and measurement of improvements in billing and collection by hospitals.		Q1-Q4

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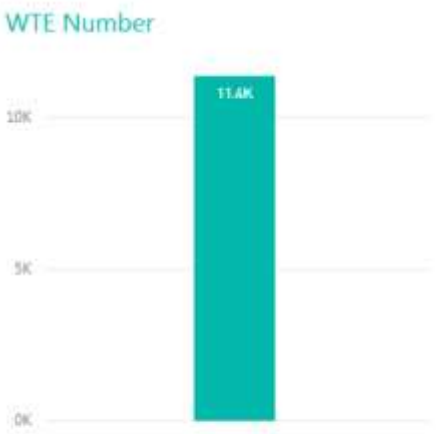
Appendices

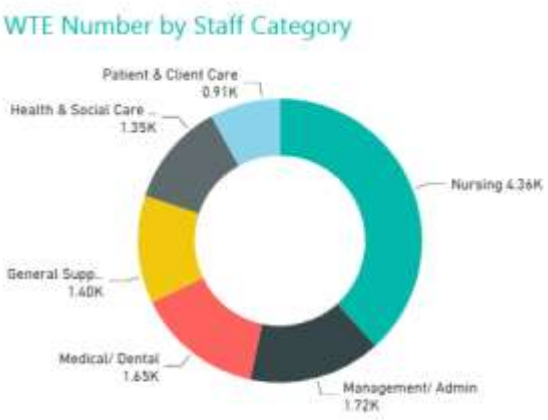
Appendix 1: Financial Tables

Ireland East Hospital Group			
Rosetta budget as at 15th February 2018			
			€
	ABF Revenue DRGs		€ 769,372,801
	Block Allocation General		€ 298,187,721
	Block Allocation - Prev Yr Surplus/(Deficits)		-€ 1,044,894
	ABF Transition adjustment - part 2		-€ 236,000
	ABF Costing Submission adj		€ 48,831
	HSE/Externally funded initiatives		€ 19,870,884
	Pay Awards		€ 24,578,835
	Special Purpose Payments		€ 5,071,205
	2018 Gross Budget		€ 1,115,849,383
	Income		-€ 185,710,200
	Net Budget Allocation		€ 930,139,183

Appendix 2: HR Information

Ireland East Hospitals by Staff Category: Dec 2017	Medical/ Dental	Nursing	Health & Social Care Professionals	Management/ Admin	General Support	Patient & Client Care	Total
Ireland East Hospitals	**1,647**	**4,358**	**1,351**	**1,717**	**1,399**	**910**	**11,382**
Cappagh National Orthopaedic Hospital	45	135	63	62	62	29	**395**
Mater Misericordiae University Hospital	470	1,153	416	410	272	213	**2,934**
Midland Regional Hospital, Mullingar	136	320	114	132	42	148	**892**
National Maternity Hospital	92	378	58	130	133	28	**820**
Our Lady's Hospital, Navan	72	177	52	70	27	99	**496**
Royal Victoria Eye & Ear Hospital	58	106	13	58	28	11	**273**
St. Columcille's Hospital	43	144	52	66	58	47	**411**
St. Luke's General Hospital	147	394	90	140	202	61	**1,034**
St. Michael's Hospital	38	164	43	61	52	28	**386**
St. Vincent's University Hospital	408	1,027	393	435	318	192	**2,774**
Wexford General Hospital	139	359	57	134	206	53	**947**
other		1		19			**20**





Appendix 3: Scorecard and Performance Indicator Suite

Acute Hospitals Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
Quality and Safety	**Complaints investigated within 30 days**	% of complaints investigated within 30 working days of being acknowledged by complaints officer
	Serious Incidents	% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident
	HCAI Rates	Rate of new cases of hospital acquired Staph. Aureus bloodstream infection (<1 per 10,000 bed days used)
		Rate of new cases of hospital acquired C. difficile infection (<2 per 10,000 bed days used)
		No. of new cases of CPE
	Urgent Colonoscopy within four weeks	No. of people waiting > four weeks for access to an urgent colonoscopy
	Surgery	% of emergency hip fracture surgery carried out within 48 hours
Access and Integration	**Delayed Discharges**	No. of beds subject to delayed discharges
	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)
		% of adults waiting <15 months for an elective procedure (day case)
		% of children waiting <15 months for an elective procedure (inpatient)

Acute Hospitals Scorecard		
Scorecard Quadrant	**Priority Area**	**Key Performance Indicator**
		% of children waiting <15 months for an elective procedure (day case)
		% of people waiting <52 weeks for first access to OPD services
	Cancer	Breast cancer: % of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of two weeks for urgent referrals
		Lung Cancer: % of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres
		Prostate cancer: % of patients attending prostate rapid access clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres
		% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)
Finance, Governance and Compliance	**Financial Management**	Net expenditure variance from plan (total expenditure)
		Gross expenditure variance from plan (pay + non-pay)
		% of the monetary value of service arrangements signed
	Governance and Compliance	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
	Funded Workforce Plan	Pay expenditure variance from plan

IEHG Activity Targets 2018

KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	Cappagh National Orthopaedic Hospital	Mater Misericordiae University Hospital	Midland Regional Hospital Mullingar	National Maternity Hospital	Our Lady's Hospital Navan	Royal Victoria Eye and Ear Hospital	St. Columcilles Hospital	St Luke's Hospital Kilkenny	St. Michael's Hospital	St. Vincent's University Hospital	Wexford General Hospital	IEHG Expected Activity/ Target 2018	National Expected Activity/ Target 2018**
Discharge Activity Inpatient Cases	640,627	634,815	2,940	21,317	18,194	15,557	6,637	2,247	5,470	17,832	3,191	19,948	15,430	128,763	633,786
Inpatient Weighted Units	639,487		6,453	38,200	10,624	9,836	5,709	2,345	3,080	10,596	3,012	32,268	11,204	133,328	635,439
Daycase Cases (includes dialysis)	1,062,363	1,049,851	7,332	55,042	10,656	2,664	5,523	11,584	2,744	9,868	6,051	69,969	9,246	190,679	1,056,880
Day Case Weighted Units (includes dialysis)	1,028,669		10,028	59,063	10,459	3,102	8,167	19,575	4,332	10,449	6,980	63,845	11,394	207,394	1,026,007
Total inpatient & day cases Cases	**1,702,990**	**1,684,666**	**10,272**	**76,359**	**28,850**	**18,221**	**12,160**	**13,831**	**8,214**	**27,700**	**9,242**	**89,917**	**24,676**	**319,442**	**1,690,666**
Emergency Inpatient Discharges	429,872	430,995	16	16,732	11,035	2,234	5,539	633	5,240	14,461	2,152	15,759	11,824	85,625	430,859
Elective Inpatient Discharges	94,587	92,172	2,924	4,504	973	463	1,097	1,614	230	540	1,039	4,098	846	18,328	91,427
Maternity Inpatient Discharges	116,168	111,648		81	6,186	12,860	1			2,831		91	2,760	24,810	111,500
Inpatient Discharges ≥ 75 years	New NSP 2018	New NSP 2018	627	5,228	2,777	19	1,879	279	1,651	3,432	1,199	5,545	3,313	25,949	119,166
Day case dishcarges ≥ 75 years	New NSP 2018	New NSP 2018	917	13,287	776	2	620	4,803	303	1,155	622	12,658	1,166	36,309	183,538
Emergency Care - New ED attendances	1,168,318	1,177,362		71,946	31,766		18,885			37,907	15,130	51,479	34,408	261,520	1,178,977
- Return ED attendances	94,225	97,238		4,171	4,224		1,762			3,213	3,414	1,783	4,541	23,108	97,371
Injury Unit attendances	81,919	91,463							7,976					7,976	91,588
Other emergency presentations	48,895	48,642								8,038			3,824	11,862	48,709
Births Total number of births	63,247	61,720			2,044	8,628				1,547			1,739	13,959	61,720
Outpatients Number of new and return outpatient attendances	3,340,981	3,324,615	7,876	225,738	52,238	122,392	29,889	38,148	11,931	32,919	18,524	153,677	39,088	732,421	3,337,967

** please note that National expected Activity targets for day case and inpatient allocations have been modified from NSP 2018 further to end of year coding, however total number of cases remains the same

IEHG delivery on 2018 activity targets is predicated upon a similar level of externally commissioned activity as was funded in 2017.

Acute Hospital Division, 2018 KPI's			
KPI Title 2018	National Expected Activity/ Target 2017	National Projected Outturn 2017	National Expected Activity/ Target 2018
Beds Available			
In-patient **	10,681	10,771	10,857
Day Beds / Places **	2,150	2,239	2,239
Outpatient Attendances - New : Return Ratio (excluding obstetrics, warfarin and haematology clinics)	1:2	1:2.5	1:2
Activity Based Funding (MFTP) model			
HIPE Completeness - Prior month: % of cases entered into HIPE	100%	93%	100%
Dialysis			
Number of haemodialysis patients treated in Acute Hospitals **	170002	168,337	168,337
Number of haemodialysis patients treatments treated in Contracted Centres **	81,900 – 83,304	82,000	92,500
Number of Home Therapies dialysis Patients Treatments **	90,400 – 98,215	85,000	93,750
Outpatients (OPD)			
New OPD attendance DNA rates **	12%	13.5%	12%
Inpatient & Day Case Waiting Times			
% of adults waiting <15 months for an elective procedure (inpatient)	90%	82.70%	90%
% of adults waiting <15 months for an elective procedure (day case)	95%	89.30%	95%
% of children waiting <15 months for an elective procedure (inpatient)	95%	82.50%	90%
% of children waiting <15 months for an elective procedure (day case)	97%	85.30%	90%
% of people waiting < 52 weeks for first access to OPD services	85%	74.30%	80%
% of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **	90%	76.30%	90.00%
Elective Scheduled care waiting list cancellation rate **	1.7%	1.70%	1%
Colonoscopy / Gastrointestinal Service			

Number of people waiting greater than 4 weeks for an urgent colonoscopy	0	0	0
% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD	70%	51.90%	70%
Number of paediatric patients waiting greater than 2 weeks for access to an urgent colonoscopy **	New KPI 2018	New KPI 2018	0
Number of adult patients waiting greater than 4 weeks for access to an urgent colonoscopy **	New KPI 2018	New KPI 2018	0
Number of paediatric patients waiting greater than 2 weeks for access to an urgent oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	0
Number of adult patients waiting greater than 4 weeks for access to an urgent oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	0
% of paediatric patients waiting > 6 weeks following a referral for a routine colonoscopy or oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	70%
% of adult patients waiting < 13 weeks following a referral for a routine colonoscopy or oesophago-gastroduodenoscopy (OGD) endoscopy **	New KPI 2018	New KPI 2018	70%
Emergency Care and Patient Experience Time			
% of all attendees at ED who are discharged or admitted within six hours of registration	75%	66.80%	75%
% of all attendees at ED who are discharged or admitted within nine hours of registration	100%	81.30%	100%
% of ED patients who leave before completion of treatment	<5%	5%	<5%
% of all attendees at ED who are in ED <24 hours	100%	96.90%	100%
% of patients attending ED aged 75 years and over **	13%	11.70%	13%
% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration	95%	44.30%	95%
% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration	100%	63%	100%
% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration	100%	92.50%	100%
Ambulance Turnaround Times			
% of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)	95%	92.60%	95%
Length of Stay			
ALOS for all inpatient discharges excluding LOS over 30 days	4.3	4.7	4.3
ALOS for all inpatients **	5	5.3	5
Medical			

Medical patient average length of stay	6.3	6.8	≤6.3
% of medical patients who are discharged or admitted from AMAU within six hours AMAU registration	75%	63.80%	75%
% of all medical admissions via AMAU	45%	33.70%	45%
% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge	11.10%	11.00%	≤11.1%
Surgery			
Surgical patient average length of stay	5	5.3	≤5.0
% of elective surgical inpatients who had principal procedure conducted on day of admission	82%	74.70%	82%
% day case rate for Elective Laparoscopic Cholecystectomy	>60%	45.70%	>60%
Percentage bed day utilisation by acute surgical admissions who do not have an operation **	35.80%	38.00%	35.80%
% of emergency hip fracture surgery carried out within 48 hours	95%	84.90%	95%
% of surgical re-admissions to the same hospital within 30 days of discharge	<3%	2%	≤3%
Delayed Discharges			
Number of bed days lost through delayed discharges	≤182,500	≤193,661	≤182,500
Number of beds subject to delayed discharges	<500 (475)	563	500
Mortality			
Standardised Mortality Ratio (SMR) for inpatient deaths by hospital and defined clinical condition	New KPI 2018	New KPI 2018	N/A
Patient Experience			
% of Hospitals Groups conducting annual patient experience surveys amongst representative samples of their patient population	100%	To be reported in Jan 2018	100%
National Early Warning Score (NEWS)			
% of Hospitals with implementation of NEWS in all clinical areas of acute Hospitals and single specialty hospitals	100%	98%	100%
% of hospitals with implementation of PEWS (Paediatric Early Warning System)	New NSP KPI 2018	New NSP KPI 2018	100%
Stroke			
% acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit	New NSP KPI 2018	New NSP KPI 2018	90%
% of patients with confirmed acute ischaemic stroke who receive thrombolysis	9%	12%	12%

% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	90%	65%	90%
Acute Coronary Syndrome			
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	90%	TBC	90%
% reperfused STEMI patients (or LBBB) who get timely PPCI	80%	TBC	80%
COPD			
median LOS for patients admitted with COPD **	New KPI 2018	New KPI 2018	5 days
% re-admission to same acute hospitals of patients with COPD within 90 days **	24%	25%	24%
Access to structured Pulmonary Rehabilitation Programme in acute hospital services **	33 sites	29 sites	33 sites
Asthma			
% nurses in secondary care who are trained by national asthma programme **	70%	1.30%	70%
Diabetes			
Number of lower limb amputation performed on Diabetic patients **	<488	513	<488
Average length of stay for Diabetic patients with foot ulcers **	≤17.5 days	15.8	≤17.5 days
% increase in hospital discharges following emergency admission for uncontrolled diabetes **	≤10% increase	4%	≤10% increase
ICU Access			
The % of patients admitted within one hour of a decision to admit **	New KPI 2018	New KPI 2018	50%
The % of patients admitted within four hours of a decision to admit **	New KPI 2018	New KPI 2018	80%
Hip Fracture			
% of patients with hip fracture who have surgery within 48 hours from first presentation **	New KPI 2018	New KPI 2018	85%
Rate of Hospital Acquired Venous thromboembolism (VTE, blood clots)**	New KPI 2018	New KPI 2018	TBC
Quality			
Rate of slip, trip or fall incidents as reported to NIMS that were classified as major or extreme	Reporting to commence in 2017	0.01	NA
Rate of medication incidents as reported to NIMS that were classified as major or extreme	Reporting to commence in 2017	0.01	NA
% of acute hospitals with an implementation plan for the guideline for clinical handover	100%	TBC	100%
% of Hospitals who have completed second assessment against the NSSBH	100%	27%	100%

% of Acute Hospitals which have completed and published monthly hospital patient safety indicator report	New NSP KPI 2018	New NSP KPI 2018	100%
Ratio of compliments to complaints **	2:1	Data not available	2:1
CPE			
Rate of new cases of Hospital acquired Staph. Aureus bloodstream infection	<1/10,000 BDU	0.7	<1/10,000 BDU
Rate of new cases of Hospital acquired C. difficile infection	<2/ 10,000 BDU	2.4	<2/ 10,000 BDU
Number of new cases of CPE	New KPI 2018	New KPI 2018	Reporting to commence in 2018
% of acute hospitals implementing the requirements for screening of patients with CPE guidelines	New KPI 2018	New KPI 2018	100%
% of acute hospitals implementing the national policy on restricted anti-microbial agents	New KPI 2018	New KPI 2018	100%
National Women and Infants Health Programme			
Irish Maternity Early Warning Score (IMEWS)			
% of maternity units/ hospitals with implementation of IMEWS	100%	100%	100%
% of hospitals with implementation of IMEWS	100%	94.30%	100%
Clinical Guidelines			
% of maternity units / hospitals with an implementation plan for the guideline for clinical handover in maternity services	100%	Data not available	100%
% Maternity Units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management team/ Hospital Group/ NWIHP meetings each month	100%	100%	100%
National Cancer Control Programme			
Symptomatic Breast Cancer Services			
Number of patients triaged as urgent presenting to symptomatic breast clinics	18000	19,000	19600
Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	17100	14,060	18620
% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the national standard of 2 weeks for urgent referrals	95%	74%	95%
Number of Non-urgent attendances presenting to Symptomatic Breast clinics	24000	22,500	22500

Number 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 (Number offered an appointment that falls within 12 weeks)	22800	16,200	21375
% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)	95%	72%	95%
Clinical detection rate: Number of new attendances to clinic, triaged as urgent, which have a subsequent primary diagnosis of breast cancer	>1,100	1,960	1,176
% of new attendances to clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer	>6%	10%	>6%
Lung Cancer			
Number of patients attending the rapid access lung clinic in designated cancer centres	3300	3,600	3700
Number of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	3135	2,880	3515
% of patients attending lung rapid access clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres	95%	80%	95%
Clinical detection rate: Number of new attendances to clinic, that have a subsequent primary diagnosis of lung cancer	>825	1,160	925
% of new attendances to clinic, that have a subsequent primary diagnosis of lung cancer	>25%	32%	>25%
Prostate			
Number of patients attending the prostate rapid access clinic in the cancer centres	2600	3,000	3100
Number of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres	2340	1800	2790
% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres	90%	60%	90%
Clinical detection rate: Number of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer	>780	1100	930
% of new attendances to clinic that have a subsequent primary diagnosis of prostate cancer	>30%	37%	>30%
Radiotherapy			
Number of patients who completed radical radiotherapy treatment (palliative care patients not included)	4900	5200	5200
Number 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)	4410	3900	4680
% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	90%	75%	90%

** denotes Operational Plan KPI only, all others are also in National Service Plan 2018

Appendix 4: Capital Infrastructure

This appendix outlines capital projects that: 1) were completed in 2016 / 2017 and will be operational in 2018; 2) are due to be completed and operational in 2018; or 3) are due to be completed in 2018 and will be operational in 2019

Facility	Project details	Project Completion	Fully Operational	Additional Beds	Replace-ment Beds	Capital Cost €m		2018 Implications	
						2018	Total	WTE	Rev Costs €m
St Vincent's University Hospital Dublin	The provision of a PET-CT facility (PET – CT funded by UCD/SFI).	Q4 2017	Q1 2018	0	0	0.00	0.89	0	0

Appendix 5: Organisational Structure