North Eastern Health Board

Bord Sláinte An Oir Thuaiscirt

High Level Operational Plans 2002

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2002 - FINANCIAL SUMMARY - 2002

ALLOCATION BY CARE GROUP AND SERVICE

CARE GROUP/SERVICE	ACUTE HOSPITAL EURO(M)	COMMUNITY SERVICES EURO(M)	REGIONAL SERVICES EURO(M)	GOVERNANCE STRATEGIC PLANNING EURO(M)	SHARED SERVICES EURO(M)	AGENCY EURO(M)	INITIAL ALLOCATION 2002 EURO(M)
ACUTE HOSPITALS	147.640						147.640
COMMUNITY SERVICES *1		123.243				61.449	184.692
REGIONAL SERVICES *2			64.444			4.118	68.562
GOVERNANCE				1.769			1.769
SHARED SERVICES					30.593	16.797	47.390
TOTAL	**147.640**	**123.243**	**64.444**	**1.769**	**30.593**	**82.364**	**450.053**

Note 1: Community Services includes Child Care, Disability Services, Services for Older Persons (including hospitals and homes)

Note 2: Regional services includes Adult Mental Health, Ambulance Services, GP Services, Cancer Strategy and Health Promotion

The combined totals for Community Services and Regional Services in this table are the combined totals of Non-Acute Hospitals and Community Services in the Annual Financial Statement (AFS) Format (see Table 2.4. Service Plans)

The combined Governance and Shared Services budgets are included in Central Services and Centrally Administered Charges in the AFS Format (also Table 2.4. Service Plan)

A sum of €0.264m for general regional training is included in Shared Services in this table.

SECTION 3

Services

3.1 Regional Services

3.1.1 PRIMARY CARE SERVICES

Primary Care Services will continue to be developed, building on recent innovations in general practice in particular. Consultation mechanisms will be improved to actively seek the views of primary care providers. Integration with acute, community and regional services will continue to be a feature of service development.

DEVELOPMENTS 2002

The North East Doctor on Call (NEDoc) out-of-hours service will be developed in line with the recommendations of the evaluation carried out at the end of 2001. Peripheral centres for use by NEDoc GP's will be extended by using Oldcastle and Dunshaughlin health centres. A service level agreement will be negotiated with the GPs in NEDoc. A plan will be drawn up for the rolling out of additional daytime and out-of-hours services utilising the health board resources made available to the GP out-of-hours initiative. This will include the specific recommendations made in the evaluation report and will additionally consider the provision of integrated cross border services as part of a Co-Operation and Working Together (CAWT) initiative which is currently being developed.

The daytime use of the Ardee hub will be expanded to include a board wide telephony and information service to the public.

A service will be established to collect laboratory samples from general practice for delivering to the acute hospital laboratories. This service will use the existing transport network developed for the GP out of hour's service.

Standard polices and procedures e.g. hospital discharge, will be agreed and details of hospital waiting lists, times and availability will be circulated to General Practitioners. The Primary Care links with Acute Hospitals will continue to be improved through the development of local fora where issues of common interest can be discussed and actions agreed.

The new computerised immunisation system will be operational. This system will enable the Primary Care Services to provide monthly reports to all GPs on the achievement of vaccination targets. Public Health Nurses will be issued with details of children in their area who have not been immunised so that they can follow up with parents/guardians of these children and encourage the parents/guardians to avail of the vaccination programme.

The dental services will aim to examine 80% of targeted children in the region, providing oral health advice, implementing the fissure sealant programme and providing appropriate treatment

The oral health promotion for people with learning disabilities will be developed as a priority, based on agreed evidence based standards. A Senior Dental Hygienist and Oral Health Promotion staff will be recruited in 2002 to develop this service.

The Primary Care Services will work with the hospital pharmacists and community pharmacists to improve the integration between their services. Discharge mechanisms will highlight the need for appropriate information to patients in the use of prescribed medications.

The number of General Practitioner trainers in the Board's vocational training programme will be increased from 6 to 9. This will facilitate the extension of the scheme to six trainees and assist the Board in recruiting and retaining experienced and qualified General Practitioners. Additional funding will be required in 2002 to cover the additional cost of three trainers for six months. The additional cost will be met from primary care development funding.

Work will begin to implement the national primary care strategy. A county based information and discussion programme with GPs, pharmacists, dentists and opticians will begin in early 2002. An assessment of the population needs for Primary Care services will be completed following extensive consultation. Initial work will be undertaken to identify pilot primary care projects in the region, which meet the objectives of the national strategy.

A DUMP campaign - Disposal of Unwanted Medication through Pharmacy will be carried out throughout the region during 2002. The Primary Care Unit will work in conjunction with the Health Promotion Unit on this project. The public will be encouraged to dispose of medications no longer used in the home by bringing them to their local Pharmacy.

The results of the Family Planning survey "Attitudes to Family Planning" will be used to further develop family planning services within the region. This will be undertaken in conjunction with health promotion, community services and external agencies bearing in mind the findings in the Boards Health Status report. The "Directory of Family Planning Services" produced in 2001 will be reviewed, to ensure that it continues to provide accurate information about the range and availability of these services.

PERFORMANCE INDICATORS

Performance indicators will be used to monitor the primary care services against local and national performance.

Effectiveness

Performance Indicator

Percentage of GMS GP Practices in an area (excluding subsidiary contract holders);

- **Providing services as single-handed practices**
- **Operating formal out-of-hours rotas**
- **Providing services as recognised GP Partnerships**
- **Providing services as recognised GP Co-ops**
- **Employing a Practice Manager**
- **Employing a Practice Nurse**
- **Employing a Practice Secretary**
- **Employing both a Practice Nurse and Practice Secretary**
- **With female Doctors working full-time**
- **With female Doctors working part-time**

Rationale

Demonstrates the organisation and structure of GP Practices

Source of Information

Primary Care Unit

Frequency of reporting

Annually

Specific Questions to be asked:

- How many GMS GP Practices are there in your area?
- How many single-handed GMS GP Practices are there in your area?
- How many GMS GP Practices in your area operate formal out-of-hours rotas?
- How many recognised GP Partnerships are there in your area?
- How many recognised GP Co-ops are there in your area?
- How many GMS GP Practices in your area have a Practice Manager?

- How many GMS GP Practices in your area have a Practice Nurse?
- How many GMS GP Practices in your area Have a Practice Secretary?
- How many GMS GP Practices in your area have a Practice Nurse and a Practice Secretary?
- How many GMS GP Practices in your area have female Doctors working full-time?
- How many GMS GP Practices in your area Have female Doctors working part-time?

HEALTH IMPROVEMENT

Performance Indicator

Primary Immunisation Contracts

- **Percentage of GMS GP's holding Primary Immunisation Contracts (excluding subsidiary contract holders)**
- **Percentage of known Private GP's holding Primary Immunisation Contracts (excluding subsidiary contractors)**

Rationale

Indicator of access to Primary Immunisation scheme

Source of Information

Primary Care Units or Community Services

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- How many GMS GP's are there in your area?
- How many known Private GP's are there in your area?
- How many GMS GP's in your area hold Primary Immunisation Contracts (subsidiary contract holders should be excluded)?
- How many known Private GP's in your area hold Primary Immunisation Contracts (subsidiary contract holders should be excluded)?

EFFICIENCY

Performance Indicator

Information Technology

- **Percentage of GMS GP practices that have a computer**
- **Percentage of GMS GP's who have undertaken the ICGP IT Training Course**

Rationale

Computer literacy and computerisation is a development tool for primary care services and is a reflection of efficiency potential

Source of Information

Primary Care Units

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- How many GP Practices are there in your area?
- How many GP Practices in your area have a computer?
- How many GP's in your area have completed the Irish College Of General Practitioners IT training course?

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- Potential for accessing hospital based test results by electronic means

EQUITY

Performance Indicator

Number of Dispensing Doctors in each Health Board Area

Rationale

Indicator of equity of access to pharmacy services

Source of Information

Primary Care Units.

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

How many Dispensing Doctors are there in your area?

EFFICIENCY

Performance Indicator

Number and Percentage of Pharmacies making pharmacy claims electronically through the GMS

Rationale

Indicator of efficiency and accountability of pharmacy claims.

Source of Information

GMS Payments Board

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- How many Pharmacies are there in your area?
- How many Pharmacies make claims electronically through the GMS?

DENTAL SERVICES:

EFFECTIVENESS / HEALTH IMPROVEMENT

Performance Indicator

Number of public water fluoridation schemes in your area.

Percentage of water fluoridation schemes within statutory limits

Rationale

Indicator of good practice for statutory fluoridation schemes.

Source of Information

Principal Dental Surgeons

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- How many public water fluoridation schemes are there in your area?
- How many Public water fluoridation schemes, tested this quarter, are within statutory limits?

EQUITY

Performance Indicator

Percentage of school children in designated classes covered by dental screening

Rationale

Indicator of equity of access to dental screening services.

Source of Information

Principal Dental Surgeons

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- How many children are in designated classes at national schools in your area?
- How many children, in designated class at national schools in your area, have received dental screening?

INTEGRATION

In 2002 Primary Care Service will liaise with other Health Care services in relation to the provision of out-of-hours services including Child Care, Disability, Services for the Elderly etc.

It is proposed that Primary Care in conjunction with Community Care and Public Health will carry out a review of recording methods for immunisation uptake, and vaccine supply and delivery to General Practices

The GP Vocational Training Scheme will continue to work with the Primary Care Services, General Practice, ICGP, the National Association of Programme Directors and the Department of Health and Children to provide the highest standard of training to GP Trainees.

The Dental Services in order to pursue their own service aims and objectives are committed to inter-collaborative and multi-agency working across all services within the NEHB. In 2002 the Dental Services will work cooperatively with regional and community disability services, the Department of Public

Health, the Environmental Health Department, the Health Promotion Unit, Local General Dental Practitioners and the I.T. Department.

The Primary Care Service Pharmacy Section will develop an interface between primary and secondary care to smooth the transition for clients who are on unusual medication.

Cardiac Rehabilitation Programmes will be rolled out across the region.

It is important that the same messages are used to cross the secondary and primary care interface to disseminate important lifestyle issues to improve cardiovascular health. Multidisciplinary training programmes will be an important aspect of this work.

Greater liaison will be developed between Community Care, Public Health and Primary Care Services in relation to immunisation programmes, vaccines etc and management of the immunisation scheme will be reviewed on a regular basis, by Primary Care Services.

The Primary Care Services will work with the hospital pharmacists and community pharmacists to improve the integration between their services.

The Primary Care links with Acute Hospitals will continue to be improved through the development of local forums where issues of common interest can be discussed.

The Primary Care Services will work in conjunction with Health Promotion Department to target areas of poor uptake in DTSS

ADDITIONAL POSTS 2002

PRIMARY CARE SERVICES - POSTS 2002	NUMBER OF POSTS
Call Centre Development including Telephony	
Grade VII (Call centre)	1
Grade IV (Call centre)	1
Grade III (Call centre)	1
Drivers (NE Doc)	5
Telephonists* (Call centre)	5
CNM1 (NE Doc)	2
Information Technology Support	
Grade VI (Extranet)	1
Human Resources	
Grade III	1
Hi-Tech Drugs Scheme	
Grade III	1
Cardiovascular	
Grade III	1
Accounts	
Grade V	1
Immunisation	
Grade III	2
TOTAL	**22**

Includes 8 posts, which will be determined based on funding and approval to follow in separate letter.

3.1.2 ADULT MENTAL HEALTH

Mental Health developments continue to be guided by the mental health strategy agreed by the Board in 1999. The strategy and achievement of its action plan will be reviewed in 2002.

DEVELOPMENTS 2002

In order to support the innovative approaches for the rehabilitation of people with mental health problems, a new 16 bed staffed hostel will be completed in late 2002 in Monaghan Town. This development will facilitate the transfer of all remaining long stay patients excluding elderly patients from St. Davnet's Hospital to community placement.

Six residential places for people with mental health problems will be available in Navan, in cooperation with the Navan branch of the Mental Health Association of Ireland, who have accessed Dept. of the Environment funding

for the capital requirement.

A new mental health team will be fully established in the North Louth area, to respond to the high level of mental health requirements highlighted in the Health Status Report. The Consultant Psychiatrist's post is currently with the Local Appointments Commission for advertising.

A consultant led psychiatry of old age service will begin in County Louth by the recruitment of a consultant for the county. Applications for this post will be made immediately.

The new psychiatry of old age team in County Meath will be fully operational towards the end of 2002. Funding for this service was provided as development funding in 2001 and forms part of base line funding in 2002. The Consultant Psychiatrist's post is currently with the Local Appointments Commission for advertising. The remaining members of the team will be recruited in 2002.

The mental health service for the elderly in Cavan/Monaghan will be further developed with the recruitment of a Senior Registrar in old age psychiatry to meet the assessed needs of the local population. A senior registrar post will be recruited to support home-based treatment in Co. Monaghan.

A Senior Registrar will be recruited for the mental health service in Co. Meath to meet increased demand for services and support existing consultant led teams.

A new multi disciplinary rehabilitation psychiatry service will be established in the Louth-Meath area. The new service will be staffed by the following personnel: 1 x Senior Physiotherapist, 1 x Senior Occupational Therapist, 1 x Social Worker, 1x Clinical Nurse Manager 2, 1 x Clerical Officer.

Mental Health services in the Virginia area will be enhanced by the provision of the new local healthcare unit. This will allow for the expansion of home-based treatment services to the East Cavan area.

The Board will continue to participate in the CAWT group in mental illness. Important links were made with services from across the border in 2001 and the training exchanges agreed will be carried out in 2002.

Funding will be made available to voluntary organisations working with people with mental health problems. A regional mental health coordinating group will be established. Voluntary organisations have an important role to play in the mental health services. In 2002 specific funding will be made available to Schizophrenia Ireland, for the recruitment of a co-ordinator; GROW, the Community Health Movement, for the recruitment of two development officers and the Mental Health Association of Ireland (MHAI), for the recruitment of an additional field worker to cover the Cavan/Monaghan area. Each organisation will be required to submit a detailed service plan prior to the funding being made available.

Advocacy services will be developed in conjunction with the Irish Advocacy Network and other voluntary agencies. The NEHB will act as the conduit for national funding to Irish Advocacy Network (IAN) on behalf of all the health boards.

The pilot self-harm project in Dundalk will be evaluated in 2002. Early indications show extensive and effective use of this service.

The Board will work with the Mental Health Commission to ensure a smooth implementation of the new Mental Health Act. To assist this process a resource person will be seconded in 2002 to provide information and train relevant health board and other agency personnel.

Various mental health quality initiatives have been undertaken in the region, in particular the achievement of the Q Mark by the Dept. of Psychiatry in Navan. A national conference will be held during 2002 to explain these initiatives.

The work of the regional suicide prevention group has highlighted a number of further initiatives, which will be implemented in 2002.

Additional Allied Health professionals will be recruited. It is proposed to assign the new staff as follows: 1x Occupational Therapist in the Cavan/Monaghan area and 2 x Social Workers in the Louth area. The recruitment of the additional allied health professionals will further enhance the service offered to clients.

An additional psychiatric nurse will be recruited to support day services in Trim.

Discussions will be held with Tabor House Ltd, to provide six places to the board for clients who are recovering from alcohol addiction

PERFORMANCE INDICATORS

The Performance Indicators, which have initially been identified, relate to the following areas:

- Suicide;
- Community Services;
- Acute Services;
- Continuing Care;
- Consumer Satisfaction;

Some of those identified have been highlighted as developmental Performance Indicators for 2002, which are dependent on systems being put in place before they can be reported on (such as the roll-out of the National Suicide Research Foundation parasuicide registry).

At the outset it was considered that the area of mental well being would be best covered by the indicators developed within the health promotion area.

SUICIDE

HEALTH IMPROVMENT: Note: The information on rates indicates health status - improvement will only be shown when strategies are implemented within boards.

Performance Indicator

Suicide rate per 100,000 population by:

a) Male b) Female

c) Age d) County of residence

Rationale

Suicide is not solely positioned in the domain of mental health services. This indicator will provide information to prompt questions regarding the effectiveness of Health Boards in establishing mechanisms to pursue the implementation of measures aimed at high-risk groups i.e. the provision of information and training on suicide prevention to professionals and organisations; the improvement of services which would benefit those at risk of suicide and those who attempt suicide as outlined in the Report of the National Task Force on Suicide (1998).

Source of Information

Central Statistics Office

Role for Directors of Public Health and Health Board Resource Officers to interpret the data behind the rate.

Needs to be a mechanism for updating progress on suicide prevention strategies as part of the ongoing review and evaluation of service plans.

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

Suicide rate per 100,000 population by:

a) Male b) Female

c) age d) county of residence

COMMENTS

This indicator needs to be considered in parallel with an annual assessment of the implementation of the recommendations of the Taskforce on Suicide in each board area.

PARASUICIDE

HEALTH IMPROVMENT - HEALTH STATUS

Performance Indicator

- **Number of individuals presenting with parasuicide per 100,000 in Accident & Emergency, assessed by the mental health services (Acute Hospital Services)**
- **Number of those individuals assessed, referred for further intervention (Mental Health Services)**

Rationale

This indicator will assist services in assessing the resources that they need to put in place to support individuals who have attempted suicide. It will also help drive quality improvement initiatives in the area of suicide prevention.

Source of Information

Mental Health Services - e.g. liaison psychiatry/crisis intervention teams

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number presenting to Accident & Emergency services with parasuicide (acute hospital services)
- Number of those who have presented to Accident & Emergency services with parasuicide, referred for assessment (acute hospital services)
- Number who presented to Accident & Emergency services with parasuicide, referred to mental health services, who have been assessed (mental health records)
- Number of those assessed, who have been referred for further intervention (mental health records)

COMMUNITY SERVICES

EQUALITY/ACCESS

Performance Indicator

Number of community residential (adult mental health service) places per 100,000 population for:

- **High support;**
- **Medium support;**
- **Low support;**

  (high: 24 hour supervision by trained staff; medium: day staff provision; low: visiting staff)

  - **Provided by Health Board**
  - **Provided by Other**

Number of day centre attendances per 100,000 population

Number of day hospital attendances per 100,000 population

Number of out-patient attendances by diagnosis (based on ICD diagnostic groups)

Rationale

Indicator provides baseline data on the availability of facilities per health board area.

To monitor progress on achieving strategic objectives as outlined by the Department of Health (1984)

Source of Information

Health Board data already provided to the Inspector of Mental Hospitals

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Number of community residential places divided by population x 100,000
- Number of day centre attendances divided by population x 100,000
- Number of day hospital attendances divided by population x 100,000
- Number of out-patient attendances, by diagnosis, divided by population x 100,000

DRUG AND ALCOHOL SERVICES

The performance indicators identified by the National Drugs Strategy are being considered by the social inclusion group.

EFFECTIVENESS

Performance Indicator

- **Admission rate for alcohol disorder by primary diagnosis- into acute mental health services**
- **The number of people attending community based alcohol programmes**

Rationale

These indicators identify how services for persons with alcohol disorders are being provided and will monitor the reduction in admission rates for those with alcohol disorders to our acute mental health services.

Source of Information

Acute mental health units

Community based programmes

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Number of people admitted to acute mental health services, with a primary diagnosis of alcohol disorder divided by total number of admissions
- Number of people attending community based alcohol programmes

ACUTE SERVICES

EFFECTIVENESS/EFFICIENCY

Performance Indicator

- **Number of in-patient places by 100,000 population**
- **Admission rates to acute units, per 100,000 population**
- **First admission rates to acute units (that is first ever admission), per 100,000 population**
- **Occupancy rates of acute units (bed days)**
- **In-patient re-admission rates to acute units per 100,000 population**
- **Average length of stay**

(information required by age, diagnosis) - already being furnished to HRB

Rationale

Numbers of inpatient places monitor progress on achieving strategic objectives outlined by DOH (1984). 0.5 beds per 1,000 total population for short-stay and medium-stay patients combined.

First admission rates are a proxy measure of the effectiveness of community based services. When analysed by age group, they also indicate the appropriateness of intervention with various care groups. Trends over time would be an indicator of improvement.

Re-admission rates to inpatient acute units can be an indicator of the effectiveness of inpatient interventions and integration with community services.

Source of Information

Health Board to the Health Research Board

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Import data from H.R.B.

DEVELOPMENT P.I. FOR 2002:

To expand further on the Performance Indicator on In-Patient re-admission rates identified above:

In-patient re-admission rates, within one month of discharge, per 100,000 population. (This is viewed as being very important but dependent on systems being put in place to collate information / track people individually through our services).

EFFECTIVENESS AND EFFICIENCY

Performance Indicator

Number of people within:

i) acute units

ii) intensive care units

awaiting placement in a rehabilitative setting appropriate to their need (i.e. those awaiting discharge who can not currently be discharged due to a lack of a suitable alternative placement - this may include: day care services, day hospital, day centre, drug rehab day care, drug rehab residential, community residential; physically disabled unit, community nursing unit, step down / rehab ward, continuing care; home)

Rationale

Will identify if there are delays in discharge.

Source of Information

From discharge plans in acute units and intensive care units

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Total number of people within acute units who could be discharged, who are not discharged
- Total number of people within intensive care units who could be discharged, who are not discharged.

EFFECTIVENESS

Performance Indicator

Rate of people admitted involuntarily per 100,000 population

Rationale

Reflects the profile of admissions - will highlight if there is an over reliance on traditional responses

Source of Information

Health board data already provided to the Health Research Board.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

Number of people admitted involuntarily, within the period divided by the total population x 100,000

NEW LONG-STAY

EFFECTIVENESS

Performance Indicator

Rate of new long stay inpatients per 100,000 population

Rate of new long stay clients in community settings per 100,000 population

Rationale

Will highlight those people who are becoming new long stay

Source of Information

In-patient returns

Community residence returns

Frequency of reporting

Once a year

Specific Questions to be asked:

- Total number of new long stay inpatients, within the period, divided by total population x 100,000
- Total number of new long stay clients in community settings, within the period, divided by total population x 100,000

EFFECTIVENESS

Performance Indicator

Number of suitable long-stay patients transferred from old psychiatric hospitals to more appropriate care facilities in the community by discharge destination (home; private nursing home; community residential place; learning disability centre; community nursing/elderly care centre; centre for physically disabled)

Rationale

This reflects progress against plan in the implementation of national policy to close long stay institutions.

Source of Information

Long-stay inpatient records - as part of annual statistical returns to DOHC and Inspector of Mental Hospitals

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Total number of suitable long-stay patients in psychiatric hospitals
- Total number of these suitable long-stay patients, transferred to more appropriate care facilities by destination (home; private nursing home; community residential place; learning disability centre; community nursing/elderly care centre; centre for physically disabled)

CONSUMER SATISFACTION

PATIENT SATISFACTION/CONSUMERS

Performance Indicator

The role of consumer experience in the evaluation of our services

Each service will need to report on how they are involving consumers in both service development and assessment of services.

Rationale

This approach will assist in the further development of this performance indicator, as the nationally agreed approach identified in (b) below will be influenced by the learning achieved.

Source of Information

Mental Health services

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Performance Indicators assigned for developmental work for 2002 as agreed at the Care Group meetings (that included representation from the Care Group, Chairman of the National Project Team, Department of Health and Children) and signed off by the National Project Team at the meeting on 12/13th November.

PARASUICIDE

Health Status - (to be completed by acute services)

Performance Indicator

Rate of parasuicide per 100,000 (by male/female; age and county of residence)

Rationale

This indicator will assist services in assessing the resources that they need to put in place to support individuals who have attempted suicide. It will also help drive quality improvement initiatives in the area of suicide prevention.

Source of Information

National Suicide Research Foundation

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

Data sourced from NSRF

Comment

Development P.I. for 2002 - Linked to the rollout of the National Suicide Research Foundation parasuicide registry

Performance Indicator

The role of consumer experience in the evaluation of our services

Rationale

Elucidating the experiences of clients who utilise mental health services provides valuable information for the management of services. Enables comparison of mental health services at regional, national and international levels.

Source of Information

A nationally agreed approach to this needs to be considered.

Frequency of reporting

Annually - to be reported by 30th September.

DEVELOPMENT PI'S BEYOND 2002

It should be noted that the areas outlined below were also identified as being very important in the context of Performance Indicators. However, these are dependent on I.T. systems being put in place in order to record activity data:

Performance Indicator

- **Number of patients discharged without follow-up and whose episode is closed, to care of their G.P. after 6 months; after 12 months; after 24 months.**
  (discharge - no Community Psychiatric Nurse or other support services - considered to be no longer on 'books')
- **Number of patients discharged to care of their GP and a community mental health service, after 6 months; after 12 months; after 24 months.**

(this would measure shared care).

Rationale

Will measure the effectiveness of our mental health services - shift of focus within our mental health services

Performance Indicator

Number of patient contacts with:

- **community nursing services**
- **psychology services**
- **nurse led therapy services**
- **occupational therapy**
- **social work etc**

and in respect of these:

- **Numbers requiring services**
- **Numbers receiving services**
- **Numbers awaiting services**

Rationale

Measures the availability and accessibility of our mental health services

Performance Indicator

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Availability of specialist services per catchment area:

- **Services for homeless**
- **Child and Adolescent Psychiatry (16 - 18 years)**
- **Adolescent Psychiatry (16 - 18 years)**
- **Crisis Intervention (after hours also)**
- **Rehabilitation**
- **Old Age Psychiatry**
- **Liaison Psychiatry**
- **Forensic Psychiatry**

Rationale

Measures the availability and accessibility of our mental health services

Performance Indicator

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Response time - from referral to access to service.

Example: set targets for crisis (2 hours); urgent (24 hours); routine (3 weeks).

Rationale

Demonstrated access to health care, efficiency of services, patient satisfaction. Measure the time from original assessment by mental health team to time they are seen by consultant.

Source of Information

Outpatient referral letters to access to service.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Performance Indicator

Drug and Alcohol Services

- **Admission rates for detoxification**
- **Readmission rates**
- **Contact with addiction counsellor prior to admission**
- **Numbers on discharge who see an Addiction Counsellor**
- **Admission rates to community based alcoholism programmes**

Rationale

These indicators assist in the assessment of the success of community based drug and alcohol services.

Performance Indicator

Prescribing practices

- **Length of usage of benzodiazopines**
- **Co-prescribing of anti psychotics**

ADDITIONAL POSTS

General Psychiatry Posts 2002	Number of Posts
Senior Registrar - Meath	1
Senior Registrar - Monaghan	1
Occupational Therapist	1
Social Worker	2
CNMs	1
TOTAL	**6**

Old Age Psychiatry	Number of Posts
Consultant Old Age Psychiatrist - Louth	1
Senior Registrar - Cavan/Monaghan	1
TOTAL	**2**

Rehabilitation Psychiatry	Number of Posts
Senior Occupational Therapist	1
Senior Physiotherapist	1
Social Worker	1
CNM2	1
Clerical/Administrative Support	1
TOTAL	**5**
TOTAL POSTS MENTAL HEATLH SERVICES	**13**

3.1.3 AMBULANCE SERVICES

The activity levels in the ambulance service continue to increase. The level of emergency calls continues to rise and the demands on the service are increasingly complex. In 2001, emergency calls increased by 7% across the region and as high as 23% in certain locations; urgent GP calls increased by 15% across the region but in specific areas by 30%; inter-hospital transfers increased by 5% regionally and by as much as 24% in specific areas. Developments have been planned to address the growing demands on the ambulance service.

DEVELOPMENTS 2002

It is recognised that a coordinated integrated response to emergency planning is critical. The Board will appoint an emergency planning officer to coordinate this work and liaise with both statutory and non-statutory providers of emergency response services. The Board's revised emergency plan and supporting plan will be published.

Cross border initiatives around emergency planning will continue to be supported and submissions for funding in 2002 have been made through the respective government departments. Phase 2 of a planned upgrade of the ambulance communication system will be installed in 2002. This will allow for improved information storage and retrieval, the more appropriate deployment of resources and a more effective response to emergencies.

10 additional EMTs will be employed to meet growing demand for services.

Due to the expanding service, increasing demands and the increase in the numbers of personnel employed in the ambulance service over the past five years, it is necessary to enhance the senior management structure in 2002. Accordingly, an Assistant Chief Ambulance Officer with responsibility for day-to-day operations will be recruited. Funding for this post will be met from development monies 2002.

The number of calls on the Ambulance service continues to increase year on year and it is proposed to recruit 2 additional Emergency Medical Controllers during 2002 to ensure effective night time and relief cover. Funding from the 2002 development monies.

A planned programme of improvements to the Board's ambulance stations will continue with the finalisation of the project brief for the new Monaghan ambulance station. Work will continue on planning a new ambulance station in the centre of the region.

The pilot patient transfer service established in 2001 between Dundalk and Drogheda will be evaluated. Until recently all levels of transfers between hospitals were carried on Accident and Emergency ambulances. This level of resource is not necessary on all occasions. A new type of vehicle has been identified to carry out this duty on a trial basis and will be monitored during 2002 as to its effectiveness and benefits. Staff operating these vehicles will be appropriately trained but will not be Emergency Medical Technicians. The recruitment of two additional Patient Transport Services personnel to this service will help reduce the pressure on the A&E crews.

An additional Grade three administrative support person will be required to provide the required secretarial and administrative support for the expanding service. Funding will be from the 2002 development allocation.

EFFICIENCY

Performance Indicator

The percentage of AS1 (emergency) and AS2 (agreed response) calls for which a patient report form has been completed by ambulance personnel.

Rationale

A patient report form completed by ambulance personnel provides valuable information regarding the hospital care provided.

Source of Information

Chief Ambulance Officer's department. This information needs to be collected proactively by the ambulance service. If information is not currently available, commentary should be provided on efforts being undertaken to ascertain the information.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Number of AS1 and AS2 ambulance calls received during the period?
- Number of ambulance calls with completed patient report form?

HEALTH IMPROVEMENT

Performance Indicator

The percentage of ambulances (Emergency Response Vehicle) with a defibrillator monitor.

Rationale

The equipping of ambulances is considered fundamental to the appropriateness of care provided at pre hospital level.

Source of Information

Chief Ambulance Officer.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- How many ambulances (Emergency Response Vehicles) are there?
- How many ambulances have a defibrillator monitor?

EQUITY

Performance Indicator

The percentage of ambulance personnel who have completed approved standard training per Pre Hospital Emergency Care Council (P.H.E.C.C.)

Rationale

Ambulance service management considers that all current qualified staff should complete approved training and development courses.

Source of Information

Chief Ambulance Officer's staff training record.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- How many ambulance personnel are there?
- How many ambulance personnel have completed approved training and development courses.

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Performance Indicators assigned for developmental work for 2002 as agreed at the Care Group meetings (that included representation from the Care Group, Chairman of the National Project Team, Department of Health and Children) and signed off by the National Project Team at the meeting on 12/13th November.

EFFECTIVENESS

Performance Indicator

Exceptions to the response time norms.

Rationale

Regular monitoring is necessary to assess the adequacy of resources and performance.

Source of Information

Ambulance control bases and control centres.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Call Time
- Activation Time
- Response Time - arrival time at hospital

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Include consultation with the relevant bodies e.g., PHECC, Medical Advisers Group and the National Ambulance Training School. Working group in consultation with the Chief Ambulance Officers to establish agreed national norms. Identify core activity data in respect of response times based on miles from base, urban location, rural location etc.

PATIENT SATISFACTION/EXPERIENCE

Performance Indicator

The percentage of ambulance services assessing "user" satisfaction through an agreed study method

Rationale

Details of service users experience provides useful management information.

Source of Information

Service users; including patients.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December.

Specific Questions to be asked:

To be agreed in 2002

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Review survey material across care groups.

To be developed in consultation between the working groups and Office for Health Gain.

Additional Posts

Ambulance Services 2002	Number of Posts
Emergency Planning Officer	1
Asst. Chief Ambulance Officer	1
Emergency Medical Controllers	2
Emergency Medical Technicians	10
Patient Transport Service Driver	2
Clerical Officer	1
TOTAL	**17**

3.1.4 HEALTH PROMOTION

DEVELOPMENTS 2002

Smoking amongst young people continues to be a major health problem. Initiatives to discourage smoking and to encourage individual smoking cessation will continue during 2002.

Smoking prevention will be achieved through the development and launch of a comprehensive information programme for parents of Primary School children on how to prevent their children from starting to smoke. It will be targeted through the Health Promoting Primary Schools initiative. All Primary schools will be targeted in 2002.

In order to increase the number of sporting organisations that are actively implementing smoking policies, it is planned to extend the Voluntary No Smoking Code to all sport clubs in the region during 2002.

Specific smoking cessation initiatives will be developed in at least six schools with the training for teachers around smoking cessation techniques and support for stop smoking groups in schools. Youth workers will be provided with information for young people who wish to quit smoking. Smoking cessation support for pregnant women and their partners will be offered through increased numbers of smoking cessation clinics, which will be advertised widely across the region.

A post to co-ordinate tobacco control initiatives has been provided for in 2002. The officer appointed will enforce the tobacco legislation in the region in conjunction with environmental health offices and working with health promotion

Nutrition and Dietetic Services, working with general practice, will be further developed, with additional clinics across the region. Nutrition services delivered to older people in the community and long-term care will be improved with the introduction of a training pack for Public Health Nurses and training courses for staff working in centres for long-term care. An additional 2 dieticians will be appointed.

The physical activity programme will be expanding by the training of 30 additional health board staff as walking leaders. This will encourage a more physically fit workforce. Sli na Slainte routes will continue to be developed on health board premises.

Physical activity programmes for older people will be expanded through partnerships with older people groups, Age and Opportunity and the health board.

A new pilot lifestyle programme for health board staff will commence under the workplace initiative and in conjunction with Occupational Health.

The substance abuse and the Social Personal Health Education programmes in both primary and post-primary schools will be extended to all schools in the region.

The recommendations of the National Drugs Strategy will be implemented.

An additional counsellor and two out-reach workers will be recruited in 2002. They will supplement the existing teams and develop initiatives to improve the health and well being of drug misusers in the region. A service user charter will be produced and a range of treatment and rehabilitation options, as part of a planned programme of progression for each drug misuser, will be put in place.

The Regional Review Group on Suicide has prepared costed proposals which will be implemented in 2002. These will form the basis for further developments in the coming years. Four areas have been identified:

1. Enhancing protective factors aims to target initiatives to young people, communities and families. A range of positive mental health programmes in schools will begin and local communities will be encouraged to develop knowledge and awareness of suicide.
2. Reducing risk factors will aim to educate and develop professionals and staff to identify those at potential risk of suicide because of drug or alcohol use or mental health problems. Assisting communities at times of traumatic stress e.g. foot and mouth disease, will be a further key response to be actioned.
3. Service Provision will be optimised by applying evidence based research findings to our suicide initiatives. Information and training packages for staff and the public will continue to be developed.

4. Those at highest risk will be targeted, including those who have attempted suicide. Protocols will be developed to assist those staff responding to emergencies or crisis.

The working group developing a sexual health strategy will report on its work and in particular will aim to improve sexual health awareness amongst young people and vulnerable groups.

Educational programmes based on accepted cancer prevention models will be delivered to GP trainees, primary healthcare professionals, women's groups, cancer sufferers and their carers.

Health promoting work with asylum seekers will be undertaken to raise their awareness of health risk factors and suggest preventative measures, which can be taken.

In conjunction with the board's dental services, a school based oral health promotion initiative will begin using trained oral health promoters.

HEALTH PROMOTION - PERFORMANCE INDICATORS

EFFECTIVENESS

Performance Indicator

A) Percentage of primary and post-primary schools in each Health Board designated as health promoting.

B) Percentage of primary and post-primary schools in each Health Board working towards this designation.

Rationale

The World Health Organisation states that every child has the right to study in a health-promoting school, which goes beyond the curriculum into the school environment. The effects of studying in a health-promoting environment extend into later life health and lifestyles.

Source of Information

Health Promotion Departments

Frequency of reporting

Annually - to be reported by 30th September.

EFFECTIVENESS

Performance Indicator

Percentage of post-primary schools with at least one health-related policy agreed and published.

Rationale

To address school practices and procedures in relation to health issues e.g. drugs, sexual health, bullying

Source of Information

Health Promotion Departments

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- How many post-primary schools are there in the Health Board Region?
- How many post-primary schools have at least one health-related policy agreed and published?
- What are the health-related policies?

Effectiveness

Performance Indicator

A) Percentage of Band 1 and 2 hospitals that are full members of the Health Promoting Hospitals Network

B) Percentage of Band 1 and 2 hospitals that are associate members of the Health Promoting Hospitals Network

Rationale

The concept of a Health-promoting Hospital is to impact on the health of patients and staff and related quality issues.

Source of Information

Irish Network of Health-promoting Hospitals.

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number of Band 1 hospitals in the Health Board region?
- Number of Band 2 hospitals in the Health Board?
- Number of Band 1 hospitals that are full members of the Health Promoting Hospitals Network?
- Number of Band 2 hospitals that are full members of the Health Promoting Hospitals Network?
- Number of Band 1 hospitals that are associate members of the Health Promoting Hospitals Network?
- Number of Band 2 hospitals that are associate members of the Health Promoting Hospitals Network?

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Percentage of psychiatric and Band 3/smaller hospitals that are members/associates of the Health Promoting Hospitals Network

EFFICIENCY

Performance Indicator

A) Days of professional training provided per year (excluding conferences).

B) Numbers of professional staff trained per year.

Rationale

Health promotion is a development profession, building capacity for other professionals.

Source of Information

Director of Health Promotion/Health Promotion Manager.

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number of days of professional training provided this year?
- Number of staff trained in Health promotion principles and practices this year?

DEVELOPMENTAL PIS 2002

- Number of workplaces requesting support for Health at Work programmes.
- Number of workplaces receiving support for Health at Work programmes.
- Number of new partnerships initiated during the year
- Number of new products produced during the year as a result of a partnership?

TOPICS

These could be used as Health Improvement measures - frequency of collection: Every 2-3 years.

- Percentage of 20-year olds who are current smokers Rationale: By age 20 more than 90% have established the habit of smoking.
- Percentage of adults (18yrs+) taking regular moderate exercise. Rationale: More adults are stopping taking exercise.
- Percentage of 15-18 year old girls taking regular moderate exercise. Rationale: More adults are stopping taking exercise.
- Percentage of adult men drinking less than 21 units of alcohol per week
- Percentage of adult women drinking less than 14 units of alcohol per week
- Percentage of adults who are obese

- Percentage of 16 year olds who have never used an illegal substance other than alcohol. Rationale: 16 year-olds are on the cusp, between experimenting and developing habit
- Waiting time to access smoking cessation service. This could be used as a proxy measure for Patient Satisfaction
- Each Health Board has an agreed Mental Health Promotion Strategy

ADDICTION SERVICES - PERFORMANCE INDICATORS

Performance Indicator

The percentage (%) of all drug misusers (including under 18s) who are assessed within three working days and offered treatment as deemed appropriate not later than one month after assessment.

Rationale

Drug misusers should have immediate access to professional assessment and counselling by Health Board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment.

Source of Information

Health Boards.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December (broken down on a monthly basis)

Specific Questions to be asked:

- Number of initial client assessments undertaken by each service.
- Average time between first presentation at the centre and completion of the assessment.
- Average time between completion of assessment and commencement of methadone treatment.
- Average time between completion of assessment and commencement of counselling or other appropriate treatments.

- Number of clients commencing methadone treatment not later than one month following completion of assessment.
- Number of clients commencing counselling or other appropriate treatment not later than one month following completion of assessment.
- Number of clients failing to take up methadone treatment following completion of assessment and offer of treatment.
- Number of clients failing to take up counselling or other appropriate treatment following completion of assessment and offer of treatment.

Performance Indicator

% of drug misusers under 18 years of age who are assessed within 3 working days and offered treatment as deemed appropriate not later than one month after assessment.

Rationale

The extent of drug misuse in the under 18 age group has grown and this area needs to be addressed in its own right.

Source of Information

Health Boards

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December (broken down on a monthly basis.)

Specific Questions to be asked:

- Number of initial client (under 18 years of age) assessments undertaken by each service.
- Average time between first presentation at the centre and completion of the assessment for clients under 18 years of age.
- Average time between completion of assessment and commencement of methadone treatment.
- Average time between completion of assessment and commencement of counselling or other appropriate treatments for clients under 18 years of age.

- Number of clients (under 18) commencing methadone treatment not later than one month following completion of assessment.
- Number of clients (under 18) commencing counselling or other appropriate treatment not later than one month following completion of assessment.
- Number of clients (under 18) failing to take up methadone treatment following completion of assessment and offer of treatment.
- Number of clients (under 18) failing to take up counselling or other appropriate treatment following completion of assessment and offer of treatment.

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

ADDICTION SERVICES

Incorporating alcohol services into the Addiction Performance Indicators.

Addressing the remainder of the performance indicators laid down in the National Drugs Strategy.

Increase the number of (methadone) treatment places to 6,000 by end 2001, and to minimum of 6,500 places by end 2002.

Have in place, in each Health Board area, a service user charter by end 2002.

Have in place in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002.

ADDITIONAL POSTS

Health Promotion 2002	Number of Posts
Tobacco Control Officer	1
Drugs Controller	1
TOTAL	**2**

INTEGRATION

Integration with other service elements is a key feature of Health Promotion. Specific instances include: -

The Department of Health Promotion will support the department of Primary Care re the DUMP initiative and training of pharmacists and GPs, the ambulance service regarding CPR training, the department of Public Health and Services for the Older Person regarding Continence Promotion initiatives and hospitals and GPs around Cardiac Rehabilitation.

The Activity at Work Programme engages with staff across a range of settings on an interactive basis.

Links with Disability Services will continue to ensure broadly based Health Promotion Strategies to the specific needs of their clients.

The Youth Service works with Community Staff around formulation and delivery of training programmes.

The Nutrition Service works in conjunction with GP practice staff in terms of cardiovascular and general dietetic services and actively engages community staff (PHNs, social workers etc.) in the implementation of Cook It Programmes.

3.1.5 CANCER SERVICES

Cancer Services will continue to be developed in line with national and local strategies.

DEVELOPMENTS 2002

The symptomatic breast disease service will be developed in line with national and local strategies and within the funding provided for 2002.

Additional funding will be provided to support the increasing oncology drugs budget utilised by specialist consultants working in the region.

The report of the National Advisory Committee on palliative care will inform the development of local services. A new consultant led palliative care service will commence in 2002. This service will be developed to meet palliative care needs in primary care, community services and acute hospitals. Links with the voluntary agencies providing palliative care services will be strengthened through the development of regional consultative committee structures. A regional coordinator for palliative care will be established to assist this process. A review of the plan and resulting posts approved in 2000, by the DoH&C will be undertaken to ensure effective use of the resources.

A local needs assessment for palliative care will be undertaken. This will identify current services and resources and lead to the production of a local strategy that will be used to further develop palliative care services in the region.

In line with the national health strategy and in response to the particular needs of men, information, prevention and treatment initiatives regarding testicular and prostate cancer will be developed.

HEALTH IMPROVEMENT

Performance Indicator

Cancer Survival: Standardised survival rates for breast and colorectal cancer to 5 years

Rationale

Survival rates are an indication of the effectiveness of treatment programmes. The National Cancer Registry will be able to provide 5-year data in 2002.

Source of Information

National Cancer Registry

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

What are the standardised survival rates for breast and colorectal cancer to 5 years in the region (data is available in this format from the NCR)

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

DoHC has suggested that this indicator may not be appropriate as a Performance Indicator; this may need to be reconsidered for 2003.

ADDITIONAL POSTS

Palliative Care Posts	Number of Posts
Grade VII	1
Grade III	1
Cancer Posts	
Grade V (Coordinator)	1
TOTAL CANCER/PALLIATIVE CARE	**3**

3.1.6 CARDIOVASCULAR STRATEGY

Developments will continue to mirror the approach recommended in the national strategy and in line with the regional cardiovascular strategy.

DEVELOPMENTS 2002

PRIMARY CARE

The NEHB will expand and develop the Cardiovascular Primary Care Initiatives to a further 30 GP's. Training and education to the staff associated with the initiative will continue. A further Primary Care Dietician will be recruited to facilitate the dietetic needs identified by the Primary Care practitioners.

The Pharmacy Training initiative is ongoing. A patient held card detailing medications and risk factors has been developed for those patients involved in the Primary Care initiative which will flag hospital staff, should the patient be admitted. These shared care initiatives between Primary Care and Hospital Services will be explored and developed further during 2002.

Evidence based best practice and adherence to agreed procedures and protocols will be facilitated through the development of patient register/database in general practice settings.

HEALTH PROMOTION

One Specialist Dietician will be recruited to develop a project for disadvantaged groups to assist them in the provision of healthy eating options.

Continued implementation of the regional physical activity strategy will take place in 2002 in the community, schools and workplace settings.

GP exercise referral training will be assessed and plans developed for funding in future years.

The appointment of a Health Education Officer will facilitate the education regarding and prevention of alcohol misuse.

PRE HOSPITAL CARE

The Ambulance Service currently has a paper based clinical audit system. The NEHB intends to upgrade the current paper based clinical audit system to a computerized system. This will improve the response to cardiac emergencies in the pre-hospital setting and allow ambulance staff to provide receiving hospitals with better information.

The Ambulance service plans to introduce a Computer Aided Dispatch System (CAD), which categorises and prioritises emergency service calls.

The evaluation of the 12 lead ECG Defibrillator Project will be finalised. This project commenced in 2001 and will be extended in 2002. Each front line ambulance has been equipped with a 12 Lead ECG Defibrillator, which assists, in the early diagnosis of a Myocardial Infarction and fast tracking to Coronary Care Units.

The Ambulance service will link across disciplines such as Health Promotion in order to promote public awareness that early access to emergency medical services for clients experiencing chest pain is essential to ensure best outcome.

Administration of Aspirin training will continue. Following national legislation in relation to the administration of cardiac drugs by emergency medical technicians, continuous training will be undertaken by staff involved with patients with a suspect Myocardial Infarction

LIFE SUPPORT PROGRAMMES

The recruitment of Resuscitation Training Officers will facilitate the development of training suites and programmes for continuous education in cardiovascular resuscitation management and the extension of advanced cardiac life support training (ACLS).

The Ambulance service will continue to develop and implement community Cardio Pulmonary Resuscitation (CPR) programmes.

Ongoing development of protocols in the pre hospital and emergency setting will continue to ensure evidence based best practice.

Links between community CPR training schemes and first responder defibrillation schemes will be improved.

HOSPITAL LIFE SUPPORT PROGRAMME

Some patients with cardiac arrest require further medical support through the advanced cardiac life support teams. This service will be enhanced at Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda.

Provision of ACLS/BLS training and equipment is required to further develop the life support programme in the hospital setting for hospital personnel, health professional groups and relatives of patients.

Continuation of Cardio Pulmonary Resuscitation training programmes for staff and relatives of patients who have sustained myocardial infarction or have high risk factors for heart disease.

HOSPITAL SERVICES

NURSE LED SERVICES

Specialized nurses are required to develop specialist clinics to undertake comprehensive management in the areas of heart failure, chest pain and risk assessment. Recruitment will continue to meet the ratios suggested in the national strategy.

CARDIAC REHABILITATION

The NEHB were successful in recruiting a Cardiac Rehabilitation Coordinator at each site in 2001 and in obtaining three places on the Rehabilitation Coordinator's course in Beaumont Hospital. The Cardiovascular Strategy Team will continue to support and develop comprehensive and structured rehabilitative care in each of the Acute Hospitals involving a multi-disciplinary team in 2002. This service will be achieved in 2002 at each site through established sessions with pharmacy, stress management, nutrition and exercise.

CONTINUING EDUCATION

The NEHB, in consultation with the Institute of Public Administration (IPA) and the Royal College of Surgeons of Ireland (RCSI) undertook a needs assessment in relation to training and further education requirements, in order to enhance the existing skills of the network of staff involved in the work of the strategy. This report will form the basis for planned provision of continuing cardiovascular education to the multi-disciplinary cardiology teams and is in response to identified need for up-skilling, refresher courses and release of staff as a matter of urgency.

The decision to recruit Consultant Physician/Cardiologist rests with Comhairle na nOspideal and the strategy programme in the Board will develop in line with that decision. In 2002, the recruitment of one Consultant Cardiologist is planned to assist in the development of diagnostic techniques, non-invasive assessment and permanent pacing.

An assessment of the facilities available will be undertaken to consider the development of day case and chest pain investigation areas.

Echocardiography services will continue to be developed with the recruitment of technical support staff.

A regional Cardiology Pacing Centre will be developed in Our Lady of Lourdes Hospital, Drogheda. To facilitate patients in the NEHB area to assist in this development, an additional Radiographer will be recruited.

Implementation of the Cardiovascular Health Strategy-Building Healthier Hearts

ADDITIONAL POSTS

Cardiovascular Posts 2002	Number of Posts
Primary Care	
Dietician	1
Health Promotion	
Specialist Dietician	1
Health Education Officer	1
Hospital Services	
Consultant Cardiologist	1
Cardiology Nurses	10
Cardiology Dietician	1
Radiographer	1 (0.5 WTE)
Rehabilitative Coordinator	1
Information Systems, Audit & Research	
Research Officer	1
Audit Support Staff	1
TOTAL	**19**

INTEGRATION INITIATIVES

In order to combat the prevalence of cardiovascular disease in the Board, the Cardiovascular Strategy Team works in collaboration with the Cardiovascular Strategy Implementation Committee and its established local sub groups, Health Board service providers and inter-agencies, such as CAWT, County Development Boards, Women's Health Network, Advisory Group of external agency representatives, Irish Association of Cardiac Rehabilitation, Sli na Slainte, the Irish Heart Foundation and target groups identified in the Health Status Report.

3.1.7 WOMENS HEALTH

Developments will take place against the actions agreed in the local women's health strategy.

DEVELOPMENTS 2002

Assess the national pilot schemes being undertaken on teenage pregnancy issues for their applicability to the North East. The Health Status Report has identified a significant need in Co. Louth. Actions will be taken to begin to address this issue in 2002.

A conference on women's health will be held in early 2002 to discuss evidence-based approaches to improve women's health status and to obtain the views of a wide range of women.

A peer health education-training programme will be developed in Drogheda in conjunction with a local women's group. The effectiveness of this programme will be evaluated later in the year.

The needs of women asylum seekers will be identified and proposals brought forward to respond to cultural and gender issues.

EQUITY

Performance Indicator

TEENAGE PREGNANCIES:

Percentage of live births to females aged 15 - 19 per 1,000 population who are aged 15 - 19 years

Rationale

Teen births are an indicator of social/health need.

Source of Information

Economic and Social Research Institute/Central Statistics Office

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- What is the number of females aged 15 - 19 in the health board area?
- What percentage of live births occurs in the age group 15 - 19?

ADDITIONAL POSTS

Women's Health Posts 2002	Number of Posts
Clerical Officer	1
TOTAL	**1**

3.1.8 MEN'S HEALTH

Following the appointment of a Men's Health Development Officer, the recommendations of the Board's document "Men Talking" will begin to be implemented.

DEVELOPMENTS 2002

In conjunction with health promotion a comprehensive awareness programme, embracing a range of components including the media, resource material and leaflets will be developed to raise awareness about men's health issues and to encourage men to seek screening and timely medical help.

Linkages will be developed with community groups, including sports clubs, to enable men to maintain and promote their own health. Self help and men's groups will be contacted to establish a men's health network, providing mutual support and strategy development.

Local measures to support male victims of domestic violence will continue. No additional posts in 2002.

ADDITIONAL POSTS

AGENCY SERVICES: MENTAL HEALTH

Agency Posts 2002	Number of Posts
Schizophrenia Ireland	
Coordinator	1
GROW	
Development Worker	2
MHAI	
Field Worker	1
Irish Advocacy	3
TOTAL	**7**

POSTS FUNDED BUT NOT INCLUDED IN THE SERVICE PLAN 2001- NEED POSITION NUMBERS:

Service Area	Number of Posts
Cardiovascular	16
Primary Care	20
Ambulance	1
TOTAL	**37**

3.2 Community Services

3.2.1 CHILD HEALTH

The child health service is provided through health promotion and illness prevention, screening, child health surveillance and immunisation. A co-ordinated approach to service delivery is provided by the development of inter-sectoral collaboration with statutory and voluntary organisations. The objective is to provide a comprehensive, equitable, accessible and responsive range of services to ensure that all children have the opportunity to realize their full potential.

INFLUENCING DOCUMENTS/LEGISLATION

- Health Strategy, "Quality and Fairness", 2001
- Children First, 1999
- ISO Dental Quality Policy
- Children Act 2001
- Best Health for Children"
- Health Promotion Strategy
- National Breast Feeding Policy for Ireland"
- Communicating Quality (Speech and Language)
- Targets "21", WHO
- National Immunisation Programme
- NEHB Health Status Report 2000

DEVELOPMENTS 2002

SERVICE LEVELS

The priority for child health services in 2002 will be to ensure that posts critical to the delivery of this service are recruited and retained. The level and range of service delivered in each Community Care Area will be dependant on the availability of key staff, particularly Public Health Nurses (PHN's) and Area Medical Officers. Where gaps in service are identified it will be necessary to develop alternative care options.

'BEST HEALTH FOR CHILDREN'

To continue work at local, regional and national level to support changes and devise action plans where staffing and resources permit, to implement the guidelines in the "Best Health for Children' document on a multidisciplinary basis.

To present findings of the completed consumer satisfaction survey.

ANTENATAL EDUCATION -RESEARCH

This research commenced in December 2001 and is planned for completion within a nine month period. Integration with physiotherapy and community groups will be a feature of this work.

POST NATAL DEPRESSION

Multidisciplinary training in the Edinburgh post natal depression screening tool will be rolled out to a section of PHNs during 2002.

BREAST FEEDING POLICY

To evaluate the pilot of the introduction of a standardized Birth Register to enable PHNs to collate details of births in their areas in a uniform manner and facilitate them in providing updated and accurate statistics on Performance Indicators as required by the Dept. of Health & Children. This is being done on a regional basis before full documentation is printed.

To participate in a follow-up study (Qualitative & Quantitative Research) by Dept. of Public Health, to evaluate progress on implementation of Board's Breast feeding policy.

NATIONAL READING INITIATIVE - REVIEW 2001

PHNs will again be involved throughout 2002 with the above initiative in liaison with the Dept. of Education and Science and the County Libraries. They will issue a 'book reading pack' to mothers for their children, when they attend for their babies' nine month development check at Child health clinics.

CONTINENCE PROMOTION/ENURESIS CLINICS 2002

GPs and Practice Nurses to be informed of clinics and linkages to be established with Paediatricians in Lourdes Hospital regarding follow up on alarms at clinic.

VACCINATION PROGRAMME

To complete the Meningococcol C vaccination campaign and commence the MMR immunisation programme in 2002.

TRAINING

Training as planned in 'Best Health for Children' report

- Management development
- Updating in child development
- Record keeping
- Audiology training
- Enuresis

PERFORMANCE INDICATORS

EFFECTIVENESS

Performance Indicator

Percentage of new born children contacted by a Public Health Nurse (PHN) within 24 hours of hospital discharge

Rationale

Public Health Nurses play a very important role in the support of parents and their newborn baby. Contact (either telephone or visit) by the Public Health Nurse in the early post natal period involves alleviating any parental concerns, support around infant feeding, immunisation, accident prevention, and post natal depression.

Source of Information

PHN Records

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Number of births in the period?
- Number of newborn children contacted by a PHN within 24 hours of hospital discharge?

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- Percentage of birth notifications received by Community Care Services within 24 hours of birth needs considerable development work if it is going to be a robust performance indicator.
- Recommend the setting up of an Inter-Board working group to develop a new discharge form, pilot in health boards, then review and implement in all Boards.

EFFECTIVENESS

Performance Indicator

Number and percentage of boys with undescended testicles undergoing orchidopexy by age of 5 years as a percentage of all boys with undescended testicles undergoing orchidopexy by age of 16 years

Rationale

The U.K. Department Of Health published a document in 1993, which suggested that early surgery (orchidopexy) for undescended testes (cryptorchidism) could be used as a proxy for favourable outcome. Crytporchidism is one of the most common congenital conditions in males. Without surgery, irreversible histological changes are evident by 2-3 years of age. (14) Undescended testes are associated with infertility. Malignant changes occur in undescended testes at least 12 times more frequently than in scrotal testes.

Patients with untreated cryptorchidism or those who undergo surgery during or after puberty are at greatest risk. Other consequences of this condition include complications associated with inguinal hernias, torsion of the undescended testis and the possible psychological effects of an empty scrotum.

Screening for undescended testes is an important part of child health surveillance. Referral for a surgical opinion should take place before the age of 18 months, and undescended testes should be surgically placed in the scrotum by the age of 5 years. The effectiveness of this surgery in reducing the degree of infertility is unclear but it facilitates ease of access of testicular examination for tumour development in later life.

Source of Information

HIPE.

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

- Number of boys with undescended testes undergoing orchiopexy 0-5 years divided by number of boys with undescended testicles undergoing orchidpexy by age of 16 years.

EFFICIENCY

Performance Indicator

Percentage of children under 16 years admitted to hospital with a primary diagnosis of asthma who require hospitalisation for longer than 72 hours, per 10,000 population under 16 years of age.

Rationale

Asthma is the commonest chronic childhood illness with an estimated ten percent of children affected at some time in their childhood. Admission of children to hospital with a diagnosis of asthma generally indicates a severe attack which good preventive management in primary and secondary care aims to prevent. Shared protocols of care between primary and secondary service providers have been developed in recent years. The period of 72 hours was chosen to exclude short stay admissions, which might be treated as outpatients in some facilities.

Source of Information

HIPE

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

- Number of children admitted to hospital with a primary diagnosis of asthma admitted for more than 72 hours divided by the total population 0-16 years x 10,000

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Development work on the following Performance Indicator will take place with the National Metabolic Screening Centre.

a) Age on diagnosis of the following specified metabolic screening disorders in infants under one year:

- Phenylketonuria (PKU)
- Galactosaemia
- Maple Syrup Test
- Homocystinuria
- Hypothyroidism

b) The percentage of infants screened within 72 to 120 hours of birth.

EFFICIENCY

Performance Indicator

Children under 16 years admitted as day cases for

- **Myringotomy (Insertion of grommets)**
- **Hernia repair**
- **Squint correction**

as a proportion of all children under 16 years of age admitted for these operations.

Rationale

The British Paediatric Association considers that the majority of these procedures can be performed safely as day cases. Suitability for day surgery may be determined by the application of the following criteria (9);

- Absence of medical contraindications
- Home circumstances e.g. access to telephone, car
- Distance from the hospital
- Likelihood of postoperative complications

Day surgery is cost effective. Furthermore, admission to hospital for longer periods can be stressful for children and their families. Studies have demonstrated high levels of parental satisfaction with paediatric day surgery. However, parents must be supported by information and appropriate therapeutic agents to enable them to cope with anticipated postoperative symptoms such as pain, vomiting, fever and sleep disorders.

Source of Information

HIPE

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

Total number of myringotomy, hernia repair and squint correction procedures carried out on all children 0-16 years divided by number of above procedures carried out as day cases

HEALTH IMPROVEMENT

Performance Indicator

- **Percentage Uptake of DTaP/DT/Hib/Polio and Meningococcal C vaccinations at 12 months of age**
- **Percentage Uptake of DTaP/DT/Hib/Polio and Meningococcal C vaccinations at 24 months of age**
- **Percentage Uptake of MMR at 24 months of age**

Rationale

The World Health Organisation recommends an uptake rate of at least 95% to ensure that immunity is achieved in a community and to protect. Information on childhood immunisation rates will indicate if this target is being achieved. It will also be useful in predicting outbreaks of disease and projecting the need for special immunisation programmes.

Source of Information

Regional Vaccination Systems/National Disease Surveillance Centre

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

For Number of Children who have reached 24 months

- Quarter 1 - Number of Children born between 1st January 2000 to 31st March 2000
- Quarter 2 - Number of Children born between 1st April 2000 and 30th June 2000
- Quarter 3 - Number of Children born between 1st July 2000 and 30th September 2000
- Quarter 4 - Number of children born between 1st October 2000 and 31st December 2000
- Number of eligible children in an area?
- Number immunised for DTaP, DT, Polio, HIB and Men C?
- Number immunised for MMR?
- Percentage immunised = (Number immunised/ Number of eligible children) x100

For Number of Children who have reached 12 months

- Quarter 1 - Number of Children born between 1st January 2001 to 31st March 2001
- Quarter 2 - Number of Children born between 1st April 2001 and 30th June 2001
- Quarter 3 - Number of Children born between 1st July 2001 and 30th September 2001
- Quarter 4 - Number of children born between 1st October 2001 and 31st December 2001
- Number of eligible children in an area?
- Number immunised for DTaP, DT, Polio, HIB and Men C?
- Number immunised for MMR at 24 months
- Percentage immunised = (Number immunised/ Number of eligible children) x100

* Please note: Number of eligible children = Number of children born + Number moved in -(Number deceased + Number moved out)

** In relation to Men C, uptake figures should relate to those children who have completed the course, which could be 1 or 3 doses depending on the child's age when he/she presented for immunisation

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

In July 2001, the Department of Health and Children made two changes to the childhood vaccination schedule. Oral Polio vaccine was replaced by inactivated polio vaccine, which is given by injection. The "3 in 1" vaccine given at 2, 4 and 6 months which provided immunity against diphtheria, tetanus and whooping cough (DTaP) is now combined with Polio and Hib vaccines all of which are delivered as a "5 in 1" vaccine or "Pentavacî, and is given as a single injection. The main benefits of these combination vaccines are the reduction in the number of injections necessary and dispensing with the need to give oral polio so eliminating the risk of Vaccine Associated Paralytic Polio (VAPP). It is expected that all health boards will move to the new vaccination schedule during 2002.

** Development work will also take place on developing performance indicators and standardised reporting for BCG and Booster immunisations.

EQUITY

Performance Indicator

Percentage Uptake of Child Health Core Screening Programme as outlined in "Best Health for Children" (1999)

- **Developmental Screening**
- **Audiology Screening**
- **Vision Screening**

3.2.2 CHILD CARE AND FAMILY SUPPORT

INFLUENCING DOCUMENTS/LEGISLATION

- Children Act 2001
- Neglect Research, NEHB, 2000 - Implications
- Foster Care Working Party & NEHB Review
- Youth Homelessness Strategy, 2001
- Section 8, 2000
- Children First, 1999
- National Standards Residential Care/ISSI reports
- Review of cases
- Learning from Springboard Final Evaluation
- Health Strategy, 'Quality and Fairness', 2001
- DeLoitte & Touche VFM Report, 2001

FAMILY SUPPORT

To further develop the family support worker service with a specific remit to work with vulnerable children and families with welfare needs.

Adoption by the NEHB of the policy framework for family support services and to support the implementation of the policy throughout the region.

To host a workshop to disseminate the findings of the consultation carried out by the NEHB Family Support working group with voluntary and statutory agencies.

To develop agreed Board wide indicators of need, including the needs of children with disabilities and children from cultural minorities and to map needs throughout the region based on the agreed indicators.

PRE-SCHOOL

To conclude the development of a regional pre-school database and commence operation.

SPRINGBOARD PROJECTS

To mainstream the two Springboard family support projects in Navan and Dundalk.

CAWT

Arising from the consultation process with key stakeholders the Child and Family subgroup will progress identified priorities in the following areas

Child care information and planning

Joint approaches to the development of foster care

Best practice in Residential Care

Publish and disseminate the materials produced by the "Protecting Children with Disabilities" Project.

CULTURAL MINORITIES

As part of the Board's diversity agenda, to assess the needs of children from ethnic minorities in order to develop appropriate culturally sensitive responses to vulnerable children and families.

SERVICES FOR ADOLESCENTS

To develop an integrated model of service to meet the needs of vulnerable adolescents and their families.

TEEN PREGNANCY PROJECT

To progress the planned pilot project in Co. Louth to provide a specialist support service for teenage mothers during pregnancy and two years post-natally.

VIOLENCE AGAINST WOMEN

The Regional Planning Committee for the Prevention of Violence against Women will continue its work in the following areas:

- Evaluate the Local Area Network Model established in Co. Monaghan.
- Monitor the implementation of the guidelines for hospital staff on violence against women within the Lourdes hospital.
- Assist and support the ongoing development of the community based response to women who are victims of violence in the Cavan area.
- Pilot the policy document "Working Together for Effective Change" in Co. Cavan.
- Commission research which will map and evaluate the existing services for violence again women in the North Eastern Health Board in order to ensure the delivery of an equitable regional co-ordinated service.
- Commence the preparatory work in developing a database for quality inter-agency information pertaining to violence against women.
- Advance the work initiated in 2001 on the development of criteria for evaluating funding proposals.

CHILDRENS ACT 2001

To advance the establishment of a family welfare conference project in the North Eastern Health Board in partnership with an external provider(s) and within the framework outlined in the Children Act 2001.

To develop youth support programmes and a time-out service in partnership with Extern West as part of the Board's response to the Childrens" Act, 2001 in order to meet the needs of family and young people who are experiencing serious behavioural and emotional difficulties.

CHILD PROTECTION AND TREATMENT SERVICES

To review the operation of Child Protection Case Conferences in line with the North Eastern Health Board policy document.

To provide additional administration support to identified heads of discipline in order to strengthen the capacity of the Board to deliver information requirements, to standardize the recording of information, and to meet its obligations under Freedom of Information legislation.

To develop a model of service delivery for family therapy services across the Board's programmes which provide an integrated, equivalent high quality service to families throughout the region.

To pilot the assessment framework developed from the neglect research and evaluate its applicability.

Advance the development of a pilot project to provide an integrated response to both the parents and the children in families with adult mental health difficulties

To continue to implement the recommendations identified in the NEHB neglect research particularly in the areas of thresholds, supervision, voice of the child, standardisation of files and record keeping and values/ attitudes.

To continue to implement the phased work plan agreed by the conjoint national advisory group on the Implementation of Children First: National Guidelines for the Protection and Welfare of Children, in the following areas:

The establishment of the Regional Child Protection Committee and the continued development of the local Child Protection Committee.

To support the introduction of the national standard reporting form and the national initial assessment form.

To develop a post for child advocate, to progress the development of a pilot advocacy service for children and families and Child Protection case conferences

To continue the development of discipline specific protocols to support the implementation of the North Eastern Health Board child care supervision policy.

To develop a post with responsibility to quality assure the child protection service and to progress an audit of the system

ALTERNATIVE CARE

Work will commence on the monitoring of standards and quality placements in residential and foster care services.

A database for children in care will be further advanced.

A care planning proforma will be agreed regionally and implemented in the Board's care services.

Work will be undertaken to plan for the development of a professional foster carers project.

The recommendations from the North Eastern Health Board's review of foster care services will be incorporated into a three year strategy.

RESIDENTIAL CARE

Work will commence, in conjunction with the Young People in Care organisation, to consult with children in care to ascertain their priority issues in order to strengthen the involvement of children in decisions about their care.

- To work jointly with Our Lady of Lourdes children's ward to formulate a protocol for the admission and care of children while in the care of the Board.
- To progress the development of a short -term respite and assessment unit in the Cavan/Monaghan area.
- To identify a replacement site for one of the residential care services in Co. Louth and establish a project team to advance the plan.
- To continue the progress of the Lifeskills development group.
- To research and develop a proposal for the most appropriate response to traveller children who are in both residential or foster care in the Board.

Financial management training to be provided to local management teams to advance the accountability for budgetary control.

The Castleblayney Children's Centre, a 12 bedded high support unit which is a four Board conjoint project, will become operational in mid 2002.

ADOPTION

To continue to advance the implementation of the National Standards for Inter Country Adoption in line with the recommendations of the National Implementation Group.

- To set up a database for inter country adoption statistics.
- To address the waiting time for search and reunion clients by strengthening the administrative capacity and organising information meetings for groups of applicants.

AFTERCARE

A three year strategic plan will be developed in 2002 to underpin the policy document produced by the after-care service in 2001.

A cost benefit analysis will be carried out on the proposal to standardize entitlements for all young people leaving care.

A programme of assessment of the independent living abilities of young people leaving care will be piloted so that their specific needs can be identified and met.

A promotional event will be held to increase awareness of the needs of young people leaving care, to promote best practice in aftercare services and to promote interagency and multidisciplinary understanding and working.

TRAINING

A training needs analysis will be carried out in early 2002 and priority training needs will be identified in line with organisational requirements.

Children First training will continue with particular focus on the delivery of Foundation courses, Garda/Health Board training for newly appointed staff and Family support training.

Training courses will be provided for staff on the responsibilities of the Children's Act, on care planning, staff supervision and management development for senior managers in child and family services.

RESEARCH

The following pieces of research will be progressed in 2002 to ensure that the service is developing in line with evidence based practice with emphasis on reviewing existing services and developing new practice.

Thresholds for Children in Care - research to explore and compare the thresholds for children entering the care system in the NEHB will be designed.

Review of case conference - the NEHB policy document has been in use for two years and requires an evaluation to guide any required changes, developments etc.

Research will be commissioned to develop Board wide indicators of need for Family support services and to map needs throughout the region based on the agreed indicators.

To commission research which will map and evaluate the existing services for violence again women in the North Eastern Health Board in order to ensure the delivery of an equitable regional co-ordinated service.

To complete phase two of the NEHB Neglect Research commissioned in 2001 which will focus on multi-disciplinary contributions to assessment and decision making in child neglect.

The commissioned three year conjoint research project with two other Health

Boards, the University of Sheffield and Trinity College, Dublin into the development of a framework for the assessment of vulnerable children and their families will begin in January 2002.

A model for ensuring feedback from service users, adults and children will be progressed.

QUALITY

The NEHB's five year Children's Strategy, which commenced in 2001, will be completed accompanied by an implementation strategy.

Additional investment will be made in enhancing the capacity of the service to develop the systems in order to provide the information required in line with Department of Health & Children requirements and the National Information Management Project.

A quality assurance post will be developed with a focus on the child protection service in line with National Children First targets.

The supervision policy document will be put into operation with discipline specific protocols to support it.

The review of social work services, initiated in 2001 will be completed in 2002 and a plan for implementation will be developed.

A framework for the standardization of service agreements will be developed following a consultation and research process.

RIAN COUNSELLING SERVICES

To continue to deliver an accessible and quality service to adults who have experienced abuse in childhood across the North Eastern Health Board region by the provision of initial appointments within one month of referral, continuing to encourage self-referral to the service and the full development of the national database.

To ensure that services remain responsive to client's needs a mechanism will be put in place for evaluating the impact of the service and to obtain feedback from service users.

To contribute to the prevention of child abuse by establishing formal links with the family support managers in each community care area. To evaluate the child protection reports made by the service in conjunction with the child protection services in the Board.

To provide a safe and healthy working environment for the staff of Rian by the continued provision of regular supervision, supporting staff with workload management and the implementation of individual training programmes.

Developments Further to Letter of Determination	Proposed Development
Foster Care Services	To be agreed with DoHC
Springboard	Mainstream Navan and Muirhevnamor projects.
Special Arrangements	Unfunded Placements. Database for children in care
Children First	0.2 x Training and Development Officer 1 x Child Advocate 1 x Quality Assurance Officer 3 x Grade 1V (1 in each C.C. area) 1 x Grade 1V Regional
Intercountry Adoption	0.5 x Grade 111
Management Information Project	1 x Support for Information Officer
Youth Homelessness	Implementation of Strategy
Family Support Services	6 x Family Support Workers.Family Support Research
Children Act, 2001	Extern West. Family Welfare Conference. Upgrading from Team Leader to Project Manager Post

PERFORMANCE INDICATORS

EFFECTIVENESS

Performance Indicator

What is the % of children in:

a) Residential care

b) Foster care

c) Foster care with relatives

for whom a written care plan as defined by child care regulations 1995 has been

- **Drawn up prior to placement**
- **Reviewed within 2 months of placement**
- **Reviewed every six months for the first two years**
- **Reviewed annually**

What is the % of children in care (a), (b), (c) who have an allocated social worker?

What is the % of children in care (a), (b), (c) who have had two or more placements?

Rationale

Care planning is an important component for the provision of services to children in care. It is important that the plan be reviewed regularly to take account of changing circumstances and the needs of the child.

Source of Information

Child care records

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

ASK ALL OF THE QUESTIONS BELOW FOR FOSTER CARE, FOSTER CARE WITH RELATIVES, RESIDENTIAL CARE

- How many children were in care during the collection period?
- Of that number, how many had a written care plan drawn up prior to placement?
- Of that number Q1, how many who were in care longer than 2 months had their care plans reviewed within two months of placement?
- Of that number Q1, how many who were in care up to 2 years had their care plans reviewed every six months?
- Of that number Q1, how many who were in care longer than 3 years had their care plans reviewed annually?
- Of that number Q1, how many children have an allocated social worker?
- Of that number Q1, how many have had two or more placements?

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

The % of children entering care in the previous 12 months who have been in care longer than six months by care type.

Performance Indicator

FOSTER CARE

What number of children are awaiting a foster care placement?

- **% of approved carers with an allocated social worker?**
- **% change in the availability of approved foster carers since the last collection period?**
- **Total number of new approved foster carers during the previous 12 months**
- **How many foster carers left the service during collection period?**

Rationale

The recruitment of foster carers is vital to the well being of children requiring this service.

Source of Information

Foster care records

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

TO ANSWER QUESTION 1.

- How many children are on the waiting list for foster care placement during the period under review?

TO ANSWER QUESTION 2.

- How many approved foster carers are there during the period under review of that number? How many have an allocated Social Worker?

TO ANSWER QUESTION 3

- How many approved foster carers were there during the period under review
- How many approved foster carers are there during the period under review

TO ANSWER QUESTION 4

- How many foster carers were recruited and approved during during the period under review?

TO ANSWER QUESTION 5

- How many foster carers left the service during the period under review?

EFFICIENCY

Performance Indicator

What is the number of operational pre-school centres which were notified in accordance with the pre-school regulations 1996.

% of the above which were inspected in accordance with the regulations.

Rationale

Inspection of pre school centres ensures compliance with the child care regulations 1996. Regular inspections ensure that high quality care is provided in a safe environment.

Source of Information

Health Board annual review of the adequacy of child care and family support services

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

- Number of operational pre-school centres which were notified in accordance with the pre-school regulations 1996
- How many were inspected in accordance with regulations during the period?

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- There are many services offered under the heading of Family Support. The Working Group on Child Care will work during 2002 to measure the remainder of these services.

Performance Indicator

How many of the Inter Country Adoption (ICA) assessments performed in the previous year were completed within 18 months of receipt of application?

Rationale

Best practice indicates that 18 months is the optimum time from receipt of application to completion of process.

Source of Information

ICA records

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- How many of the Inter Country Adoption (ICA) assessments performed in the previous year were completed within 18 months of receipt of application?

3.2.3 SERVICES FOR OLDER PERSONS

SERVICE OVERVIEW

Services for older people are an integral part of the health and social services provided by the Board. Service settings include acute hospitals, residential units, day care and day hospital services, community and older people's own homes. According to the 1996 Census there are 34,812 older persons aged 65 years and over living in the North East Region. The growing number of people aged 75 years and older contribute to the challenge of planning and providing appropriate health and social services for this population. A key objective of the service is to support 95% of the elderly population to continue to live in their own homes for as long as possible in accordance with their personal choices.

POLICY INFLUENCES

- Healthy Ageing -A Secure Future (NEHB)
- The Years Ahead 1988 and Review 1997
- Adding Life to Years and Years to Life
- Cancer Strategy
- Cardiovascular Strategy
- Primary Care a New Direction 2001
- Quality and Fairness A Health System for You 2001
- Deloitte & Touche VFM Report, 2001

MISSION

To promote and support the health and quality of life of older people, carers and their communities, by utilising the resources at our disposal to provide the most appropriate care in the appropriate setting at the appropriate time.

DEVELOPMENTS 2002

Healthy Ageing -A Secure Future

SERVICE PILLAR ONE - MAINTAINING HEALTH AND WELLBEING

Preparation for implementation of NEHB five year strategy Healthy Ageing - A Secure Future

Development of Database of older people over 65 years

Development of a Standard Assessment Instrument

DEVELOPMENT OF AN ADVOCACY PROGRAMME FOR OLDER PEOPLE.

Roll out of support for community and voluntary development throughout the region by the appointment of a Community Development Officer in both Louth and Meath and a Community Support Worker which will assist in the current development phase in Cavan/Monaghan.

In line with the National Health Strategy - Quality and Fairness, a key worker will be appointed to progress an integration of service provision across all service sites.

Programmes to foster volunteerism will be undertaken.

Access to day services will be further supported by the appointment of two additional transport drivers.

Health Promotion initiatives such as Go For Life and Smoking Cessation programmes will be progressed.

SERVICE PILLAR TWO - COMMUNITY SUPPORTS

A transport initiative will be undertaken in Cavan/Monaghan to facilitate access to social services.

Day services for Dementia Patients will commence in association with the Alzheimer's Society of Ireland.

A dementia home care service will commence in the Louth area in partnership with the Alzheimer's Society of Ireland.

A regional structure for the provision of Social Worker services to older people will be developed.

The board will continue to support voluntary organisations in the provision of social day services to older people.

A multidisciplinary rehabilitation outreach service will be developed in North Meath.

The multidisciplinary rehabilitation service will be progressed in Louth.

A needs analysis of the aids and appliances required by older people living in the community will be identified.

A training course for Care Assistants will be undertaken as part of a cross border CAWT initiative.

SERVICE PILLAR THREE - ACUTE CARE

The integration of primary, secondary and tertiary care will be progressed. Discharge planning processes will be standardised throughout the region.

SERVICE PILLAR FOUR - CONTINUING CARE

To progress the quality assurance of the nursing home subvention process three RGN's and three administrative support officers will be appointed.

A number of home based subvention initiatives will be undertaken when funding from the Department of Health and Children becomes available during the year.

A Regional Inspection Unit will be developed which will undertake inspections of private nursing homes and the board's residential units.

The care and process review study of NEHB Residential Services will be completed.

Service agreements will be developed with NEDoc for service provision to residential services.

Virginia Residential Unit will become operational in 2002.

A multidisciplinary rehabilitation outreach service will be established in Virginia.

A multidisciplinary rehabilitation community service will be established in Meath.

Proposals for the development of specialist services unit for dementia patients with challenging behaviour will be developed in association with Mental Health Services.

A Speech and Language Therapist will be appointed to Louth Services.

CONSOLIDATION

Appropriate funding for 2001 staffing levels and activity in Residential Services and Day Care Services will be allocated

Funding requirement to provide Home Help Services to activity level achieved in 2001 will be addressed within the 2002 allocation.

INTEGRATION

Acute Hospital/ Residential Services - ensure/support the appointment of a Clinical Nurse Specialist Elderly, in all settings and develop integrated care protocols.

Development of a comprehensive geriatric assessment in acute care will be progressed.

Mental Health development of specialist services unit for dementia patients with challenging behaviour.

Risk Management - Develop an integrated care planning assessment, referral and risk management protocol for access to residential care.

Develop joint initiatives with disability services for older people including the progression of the proposal for a new home help/home support structure.

In line with the National Health Strategy - Quality and Fairness, a key worker will be appointed to progress an integration of service provision across all service sites.

Partnership and Integration - Support the strengthening of the recently established Regional Consultative Forum for Services to Older People.

Further develop the partnership approach to service provision with the private nursing home sector.

KEY ISSUES IN SERVICES TO OLDER PEOPLE

Implementation of NEHB's five year strategy - Healthy Ageing - A Secure Future.

Access to Information on services and entitlements for services to older people.

Quality Assurance of a number of processes i.e.

- Access to residential services including Subvention Process.
- Nursing Home Inspection Process. A regional inspection unit will be established which will also undertake inspections in the boards twelve residential units.
- Standards for day services will be agreed and set relative to service provision levels.
- Benchmarking will be undertaken in residential services and standards agreed.
- Assessment for service provision.
- Needs analysis - Provision of Aids and Appliances.
- Integrated approach to service delivery which necessitates integrated care planning and evaluation process. This will involve the appointment of key workers.

Preliminary development of outreach multi disciplinary teams from day services to surrounding areas across the region

Development of Community and Voluntary Organisation Support throughout the region - appointment of Community Development workers in Louth and Meath.

Programmes to foster voluntarism will also be undertaken.

Community support initiatives will be undertaken to support older people to continue to live in their own communities

QUALITY INITIATIVES

Complete baseline assessment of standards of care and care processes in residential services to inform standard setting, - mid 2002.

Health Promotion initiatives - Fire Safety, Personal safety, Active living.

Pilot RGN and Care Assistant on call NEDOC (Primary Care Strategy dependent)

Home Care Management Pilot with Alzheimer's Society- Dundalk

Introduction of Sonas programme in Dementia services

Pilot subvention at home

REGIONAL OFFICE

Development of a database for 65 years and over which will include older people with disability.

Progress the regional Implementation of Healthy Ageing - A Secure Future.

Commencement of development of standard assessment tool.

Discussions will be undertaken with the Department of Health and Children in regard to new community support initiatives.

Progress development of home help/home support service structure.

Progress integration agenda through key worker.

Develop Advocacy Programme.

Progress current national and develop appropriate Performance Indicators relative to NEHB services to older people.

Undertake review of services and processes as appropriate with a view towards progressing quality service delivery.

PROPOSED ACTIVITY 2002

Funding is allocated to ensure that service levels are at a minimum maintained at 2001 levels which are significantly up on 2000 levels in most cases.

North Eastern Health Board	2000	2001	% Increase
Subvention			
Number of Nursing Home Applications	479	682	42.41%
Number of Nursing Home Approvals	264	363	37.51%
Number in Receipt of Subvention	403	512	27%
Number in Receipt of Enhanced Subvention	100	244	144.1%

Day Services	
Number of New Day Services Commenced	2
Number of New Day Places	381
Estimate Number who availed of Day Services	3386

Home Help			
Activity: Number of Hours	610,667	783,078	28.2%
Number of Home Help Recipients	2402	2928	21.8%

Residential Services			
Number of Health Board Beds	987	979	- 1%
Number of Nursing Home Beds	1,037	1244	19.9%
Total Number of Admissions	2614	2716	3.9%
Total Number of Discharges	2154	2309	7.2%

Developments - New Posts 2002

	BASE	No. Posts
Nursing Home Subvention		
RGN's	M/L/C/M	3
Grade III	M/L/C/M	3
Community Support Structures		
Comm Supports Dev Officer	Regional	1
Grade V	Regional	1
Grade III	Regional	1
Voluntary Supports and Service Contracts		
Driver	C/M/M	2
Community Development Officers	L/M	2
Virginia Community Nursing Unit		
Medical Officer	C/M	1
Grade III	C/M	2
Physio Snr	C/M	1
Physio	C/M	0.5
OT Snr	C/M	1
Chiropodist Snr	C/M	0.5
S&L Snr	C/M	0.5
Dietician/Sessional		
Directorate	**Regional**	
Establishment of Database		
Research		1
Grade VII		1
Grade III		1
Integration Key Worker	Regional	1
Grade III		1

Assessment Tool		
Project Officer	Regional	1
Grade III	Regional	1

Regional Inspection Unit	Regional	6

Community Outreach Team	**Meath**	
Physio Snr	M	1
Occupational Therapist Snr	M	1
RGN	M	2
Attendant	M	2
Grade III	M	1
PHN	M	1

INFORMATION/PERFORMANCE INDICATORS/RESEARCH

Implementation of agreed activity data collection template.

Implementation of standard service agreements and evaluation processes.

Strengthen systems and processes.

Home Help/Home Care activity templates to be developed.

Further develop performance indicators in line with quality initiatives development.

PERFORMANCE INDICATORS

EFFICIENCY/EFFECTIVENESS

Performance Indicator

The number of re-admissions for the same complaint/condition, by specialty:

- **orthopaedics**
- **medicine**
- **surgery**
- **obstetrics & gynaecology**
- **ophthalmology**
- **ENT**

to acute hospitals within:

a) one week of discharge

b) one month of discharge

per thousand admissions of those aged over 65 years.

Rationale

High rates of re-admissions to acute hospitals for the same complaint/condition could indicate that service effectiveness may be compromised.

Source of Information

HIPE (re-admission data will need to be tagged)

Frequency of reporting

Six monthly - for the period from 1st January to 30th June and 1st July to 31st December

Specific Questions to be asked:

The number of re-admissions for the same complaint/condition within:

a) one week of discharge

b) one month of discharge

by specialty (orthopaedics/medicine/surgery/obstetrics/gynaecology/ophthalmology/ENT,) per 1,000 admissions of those aged over 65 years.

EQUITY/ACCESS

Performance Indicator

The number of patients, over 65 years on the waiting list for

a) Cataract surgery

b) ENT surgery

(c) Orthopaedic Surgery

The number of cataract procedures completed on

i a day case basis

ii an in-patient basis

Rationale

Older persons quality of life may be enhanced significantly by the above procedures. Clinical best practice indicates that cataract surgery may be performed as a day case procedure, although issues such as travel distance/ underlying medical conditions should also be taken into account. Day case procedures may minimise disruption for the patient and result in improved bed utilisation.

Source of Information

Waiting list information systems.

Day case information/ HIPE

Frequency of reporting

Six monthly - for the period from 1st January to 30th June and 1st July to 31st December

Specific Questions to be asked:

- The number of patients over 65 years on the waiting list for; cataract surgery; ENT surgery; orthopaedic surgery as at the last date of the reporting period.
- The number of cataract procedures completed on a day case basis within the 6 month reporting period
- The number of cataract procedures completed on an inpatient basis within the 6 month reporting period.

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- Certain waiting lists may be outside of the individual Boards control. This information may be sourced from the host health authority.

EFFICIENCY/ EFFECTIVENESS

Performance Indicator

The percentage uptake of influenza vaccine among the GMS population aged over 65 years

Rationale

Effectiveness of influenza campaign. Immunisation with the influenza vaccine can prevent respiratory complications and save lives.

Source of Information

GMS (Payments) Board

Frequency of reporting

Annually (by 1st quarter - 31st March - of the following year.)

Specific Questions to be asked:

- The GMS Population aged 65 years and over
- The number of persons aged 65 years and over who have received the Influenza vaccine.

Performance Indicator

The number of people aged over 75 years in continuing residential care, i.e. Health Board and Private Nursing home care as a percentage of the total population over 75 years.

Rationale

Current health policy states that not less than 90% of the total population over 75 years should be able to continue to live at home.

Source of Information

Private Nursing Home (legislative requirement) records and Health Board records.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- The total number of people over 75 years in private nursing home care
- The total number of people in Health Board continuing residential care
- The total population aged over 75 years per Health Board area.

Performance Indicator

Following assessment, what percentage of people over 65 years of age are in receipt of the following services:

- **Number of people in receipt of home help services**
- **Hours of service provided**
- **Day Care or Respite Care**

Rationale

Volume of service provision.

Source of Information

Public Health Nursing records, Payroll reports.

Frequency of reporting

Quarterly - for the period to 31st March, 30th June, 30th September and 31st December

Specific Questions to be asked:

- Total Number of people over 65 years assessed for home help services each month
- Total Number of people over 65 years in receipt of home help services each month
- Total Number of people assessed over 65 years for home help services each month
- Total Number of hours of services provided per month each month
- Total Number of people assessed for day care or respite care each month
- Total Number of people in receipt of day care respite services each month

OLDER PERSONS - AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

Performance Indicators for Paramedical & Associated Services provided to older persons to be developed in 2002.

Regarding Public Health Nursing Services, there is currently a difficulty in distinguishing public health nursing services provided to older persons and other services as this information is currently collected globally. This is an area that will be developed in 2002.

The following are also suggested as priorities for 2002:

- Database development
- Staff ratios
- Social Inclusion/management
- Palliative Care
- Stroke Management

3.2.4 DISABILITY SERVICES

INFLUENCING DOCUMENTS

- Needs and Abilities - Report of the Review Group on Mental Handicap Services (1990)
- Services for People with Autism, Department of Health (1994)
- Towards an Independent Future - Report of the Review Group on Health and Personal Social Services for People with Physical and Sensory Disabilities (1996)
- A Strategy for Equality - Report of the Commission on the Status of People with Disabilities (1996)
- Employment Challenges for the Millennium - Report of the National Advisory Committee on Training and Employment (1997)
- New Health Strategy - "Quality and Fairness" 2001
- Deloitte & Touche VFM Report, 2001

The principle, which underpins policy, is to enable each individual with a disability to achieve his or her full potential and maximum independence, including living within the community as independently as possible.

ISSUES IN DISABILITY

Access to information on services and entitlements for people with disabilities

A standard for delivery of rehabilitative training has been recently agreed and is in place.

A more structured policy framework covering all aspects of the provision of sheltered work for people with disabilities is required.

The forthcoming Disabilities Bill will outline a statutory framework for the assessment of need and provision of services for people with disabilities.

Review of the wide range of existing allowances and concessions for people with disabilities.

An integrated approach to care planning for individuals will become a consistent feature of the system. This will include the appointment of key workers in the context of care planning for children with disabilities.

Programmes to foster voluntarism and community responsiveness to local needs will be undertaken

The remit of the Social Services Inspectorate will be extended to include residential care for people with disabilities.

National standards for residential care for people with disabilities will be prepared.

Service agreements between the health boards and the voluntary sector will be extended to all service providers and associated performance indicators will be introduced.

Investment to provide appropriate support services for people with autism; an information system to provide accurate data on the numbers of persons with autism and their service needs .

An action plan for rehabilitation services .

All reasonable steps to make health facilities accessible .

National implementation of the Physical and Sensory Disability Database is a priority

INTELLECTUAL DISABILITY

CHALLENGING BEHAVIOUR

Progress the development of the Regional Service for Adults with Severe Challenging Behaviour, including teams, support facilities and assessment of need and resource required.

Conduct an assessment of model and resource required to meet the needs of children.

AUTISM

In conjunction with parents/carers and voluntary sector, review the needs resource requirements and management structures required to deliver a quality, equitable and people centred autism service.

REHABILITATIVE TRAINING AND WORK SERVICES

Progress the development of Rehabilitative Training and Work Services including;

The establishment of Regional NEHB/FÁS Liaison Group.

Implement an interim monitoring protocol for board and agencies.

Commence review of sheltered work services in the region.

Maintain, develop and update National Rehabilitative Training Database.

Commence an Occupational Advisor Service.

Establish approval of training programme specification and monitoring to ensure agreed standards are met.

Ensure equitable/fair distribution of additional Rehabilitative Training Whole Time Equivalent places to include new programmes/Agencies.

Examine implications and appropriate service response re former FÁS/CE scheme.

INTELLECTUAL DISABILITY

Develop a Statement of Strategy and complete a 5 Year Plan for Intellectual Disability

Progress the transfer of those with Intellectual Disability inappropriately placed in Psychiatric Hospitals, to appropriate accommodation, including requirements with residence

Conduct an audit of Intellectual Disability Database, and a plan to complete the programme

Operationalise the Guidance Documents on Relationships and Sexuality, accompanied by a Training Programme for Board and Voluntary Organisations

Implement the Personal Outcomes system of Quality in selected sites across the region in conjunction with a baseline assessment and appointment of regional and local support staff.

Devise a protocol for the funding and management of emergency placements

Advance the appointment of a consultant in the Psychiatry of Intellectual Disability, Challenging Behaviour and Autism.

Plan for Annual Disability Conference 2002/2003 incorporating Special Olympics and European Year of People with Disabilities.

A number of service agreements will be completed with voluntary agencies.

A framework for development of Service Agreements will be developed through the establishment of a reference group and implementation group.

A guidance for the development of Service Agreements will be devised in conjunction with a training and support programme.

Discussions will be undertaken with Department of Health and Children and the voluntary sector, regarding resources allocated against voluntary sector providers under-resourcing.

Discussions will be held with Department of Health and Children regarding the implications for mainstreaming of FÁS/CE schemes.

Undertake discussions with the Voluntary Sector to advance the piloting of "Micro-Board" model for person centred planning

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

Conduct an external review of development plan for Physical Disability and Sensory Impairment - "Mapping the Shape of Future Services" with particular reference to adult services.

Provide a range of flexible supports to individuals with disability, families and carers including Personal Assistants where appropriate.

A post designed to empower, enable and progress the interface between the Health Board and the Voluntary Section will be piloted (in partnership with MHB).

Progress the services commenced in 2001 to the blind and visually impaired, for the provision of Information Technology, Training Specialist, respite services, peer counselling, insight services and rehabilitation worker.

Enhance services provided to the deaf and hearing impaired with the provision of additional resource worker, and the development of tinnitus clinics in the region.

Further progress services provided to people with Multiple Sclerosis in the region, with provision of additional resources towards the second post of family support case worker.

Continue to expand home support and personal assistant services, and in particular ring-fencing dedicated resources for the development of these services to children with disabilities

Undertake discussions with the Voluntary Sector to advance the piloting of "Micro-Board" model for person centred planning .

Plan for Annual Disability Conference 2002/2003 incorporating Special Olympics and European Year of People with Disabilities.

A number of service agreements will be completed with voluntary agencies.

A framework for development of Service Agreements will be developed through the establishment of a reference group and implementation group (This applies in both Intellectual and Physical and Sensory Disabilities).

A guidance for the development of Service Agreements will be devised in conjunction with a training and support programme.

Discussions will be undertaken with Department of Health and Children and the voluntary sector, regarding resources allocated against voluntary sector providers under-resourcing.

Discussions will be held with Department of Health and Children regarding the implications for mainstreaming of FÁS/CE schemes

Undertake discussions with the Voluntary Sector to advance the piloting of "Micro-Board" model for person centred planning.

To strengthen the interface between the Statutory & Voluntary Sector particularly in relation to their advocacy function a Post will be established (Co-funded with the Midland Health Board)

INFORMATION/RESEARCH/PERFORMANCE MEASUREMENT

Progress the development of a system for the collection of core activity data, for all aspects of services including voluntary sector

Collect, analysis and report on Performance Indicators.

Further develop Performance Indicators for 2003 Service Plan.

Strengthen systems and processes, including administration support.

DATABASE

INTELLECTUAL DISABILITY

- Develop a standard for information access and provision in relation to Intellectual Disability
- Arrange Disability specific awareness training in relation to F.O.I.
- Appoint a Database Assistant (Grade IV) with regional remit to support the development and implementation and quality assurance of Database.
- Contribute to the development of a database specific to Autism
- Conduct an audit of Intellectual Disability Database re needs in particular those recorded as having no service
- Maintain, develop and update National Rehabilitative Training Database

PHYSICAL & SENSORY

- Advance the National Implementation of Physical Disability & Sensory Impairment Database
- Appoint a Database Assistant (Grade IV) with regional remit to support the development and implementation and quality assurance of Database.

INTEGRATION

Risk Management Child Care

INTELLECTUAL DISABILITY

CHILDREN WITH DISABILITIES

Develop an Integrated Care Planning Assessment, referral and Risk Management Protocol for planned and emergency placement

Describe, establish and co-fund with Childcare Services a post of one key worker in the Region

Family support and agreed needs indicators and mapping exercise will include the needs of children with disabilities

PHYSICAL & SENSORY

CHILDREN WITH DISABILITIES

Develop an Integrated Care Planning Assessment, referral and Risk Management Protocol for planned and emergency placement

Describe, establish and co-fund with Childcare Services a post of one key worker in each community services area

Family support and agreed needs indicators and mapping exercise will include the needs of children with disabilities

Mental Health & Child and Adolescent Psyciatric Services

INTELLECTUAL DISABILITY

In conjunction with Mental Health Services organise a regional planning seminar on dual diagnosis, Intellectual Disability, Challenging Behaviour and Mental Health Needs. Develop recommendations through a Regional Working Group.

Acute Hospitals Voluntary Sector

INTELLECTUAL DISABILITY

Begin the introduction of a Disability awareness programme, to include the training of key staff to provide interpreter services

PHYSICAL & SENSORY

Begin the introduction of a Disability awareness programme, to include the training of key staff to provide interpreter services

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Acute Hospitals, Community Services, Mental Health, Primary Care, Voluntary Sector,

PHYSICAL & SENSORY

Develop a needs assessment and a service proposal for a regional neurological response to include assessment, rehabilitation, transitional living, residential and respite services

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Primary Care Voluntary Sector

INTELLECTUAL DISABILITY

Revise and update "Include Me In" a guidance to G.P.s in dealing with people with disabilities

Extend pilot North East Doc. Service to include community residences for Intellectually Disabled

PHYSICAL & SENSORY

Revise and update "Include Me In" a guidance to G.P.s in dealing with people with disabilities

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Health Promotion

INTELLECTUAL DISABILITY

"Around the Corner" Reference Section 6 - Health Promotion Service plan

PHYSICAL & SENSORY

"Around the Corner"

Services for Older People/Voluntary Sector Service for Older People

INTELLECTUAL DISABILITY

Develop a protocol to promote equity and continuity of assessment, access and provision of Technical Aids & Appliances. Examine the service planning implications (residential and day care) of the ageing profile of the Intellectually DisabledDescribe and advance the post of Home Support Co-Ordinator co-funded in 2001

PHYSICAL & SENSORY

Carry out an assessment of the numbers and needs of people with disabilities inappropriately placed in residential services for older people

Describe and advance the post of Home Support Co-Ordinator co-funded in 2001

Human Resource Department and Occupational Health Department

INTELLECTUAL DISABILITY

Advance a draft Code of Practice on Disability Employment Policy incorporating guidance on Disability profiling and "reasonable adjustment"

PHYSICAL & SENSORY

Advance a draft Code of Practice on Disability Employment Policy incorporating guidance on Disability profiling and "reasonable adjustment"

Child & Adolescent & Psychiatry Childcare

INTELLECTUAL DISABILITY

Identify needs and supports required for children and teeenagers with intellectual disaability who also have Mental Health Need

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Widening/Enhancing the Partnership

INTELLECTUAL DISABILITY

Service Agreements will be developed with the voluntary agencies providing services to people with disabilities, according to an agreed framework.

Regional Development and Consultative Co-Ordinating Committees will be established.

Move forward on foot of a service agreement with Enable Ireland, the establishment of an integrated, co-ordinated approach to early intervention services

PHYSICAL & SENSORY

Service Agreements will be developed with the voluntary agencies providing services to people with disabilities, according to framework agreed.

Regional Development and Consultative Co-ordinating Committees will be established

The operation and membership of the Regional Co-Ordinating Committee for people with physical disability and sensory impairment will be reviewed

Move forward on foot of a service agreement with Enable Ireland, the establishment of an integrated, co-ordinated approach to early intervention services

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Management Services Community Welfare

INTELLECTUAL DISABILITY

Reformat and update Networks North East information pack

Enhance the design format and range of information on Disability Services - NEHB Website

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Technical Services/NDP

INTELLECTUAL DISABILITY

Support and advise project managers in advancing the concept of "Design for All"

PHYSICAL & SENSORY

Support and advise project managers in advancing the concept of "Design for All"

Quality Initiatives-Integration

INTELLECTUAL DISABILITY

Commission a baseline assessment of residential service with a view to the development of a standard of care

Health promotion training department

INTELLECTUAL DISABILITY

Conduct an evaluation of social care course jointly delivered by the NEHB and UCG

Nursing and Midwifery Planning & Dev. Unit

INTELLECTUAL DISABILITY

A review of existing and required Nursing Structures in intellectual disability for the management and delivery of a quality nursing services will be conducted

PHYSICAL & SENSORY

A review of existing and required Nursing Structures in disability for the management and delivery of a quality nursing services will be conducted

Health Promotion (Voluntary sector)

INTELLECTUAL DISABILITY

Disability awareness in schools Information leaflets on services - child facilities

SERVICE DEVELOPMENTS 2002

INTELLECTUAL DISABILITY

Residential Services

NO. OF PLACES 8

Development	Group Home, Meath Rathaldron
Places	3
Comments	Development commenced

Development	Louth Residential, (Fees uplift - Service Development)
Places	2
Comments	Simon Residential, St. Brigids Group Home (Rehabcare) Magedaline St. Drogheda (Rehabcare) Service agreement per agreed framework prior discussion RDSU, Pin No's required.

Development	Cavan / Monaghan
Places	3
Comments	Enhancement service delivery/changing clients needs, Arches Group Home (CMX P&F), Manderley 2 Care attendants Millbrook 1 Care attendant

Development	Castleblayney Group Home
Places	5

Location	Meath - St Olivers
Places	10 WTE + Day Service
Comments	1 Unit Manager, 4 Care Staff. Service agreement per agreed framework previously discussed RDSU

Location	Louth - Childrens Residential/Respite (St John of God/NEHB)
Places	4 WTE
Comments	St. John of Gods service agreement

Location	Cavan/Monaghan Interim Service pending provision of purpose built unit.
Places	3 WTE
Comments	Progression of 2nd facility, plans to be clarified, interim service ongoing.

Location	Order of Malta
Places	4
Comments	Baseline funding for Day Activation programme. Service agreement per agreed framework prior discuss RDSU, Pin No's required.

Location	Day Services Hope
Places	4
Comments	Service agreement per agreed framework prior discuss RDSU, Pin No's required.

Location	Errigal/Truagh Clones Day Services
Places	2 + 2
Comments	Enhancement/expansion of services. Service agreement per agreed framework previously discussed RDSU, Pin No's required.

Location	Day Services, Monaghan
Places	4
Comments	DTC + Day Activation Unit enhancement of services. Pin No's required.

Location	Day Service provision challenging behaviour - Kavanagh Unit
Places	4
Comments	Regional behaviour support service, day, unfunded

Location	Day Services, Carrickmacross
Places	3
Comments	Support development of new day facility, enhance standards of services.

Location	Meath Sheltered Workshop
Places	2
Comments	Commence the development of person centred planning, provision of additional Job coach, Care Attendants posts. Service agreement per agreed framework prior discuss RDSU.

Location	St. John of God Services, New work centre, Drogheda
Places	No. to be confirmed
Comments	Service agreement per agreed framework previously discussed RDSU.

Health Related Supports for Children With Intellectual Disability and Autism

Res/Respite Unit for children with Intellectual Disability

Service Agreement with provider, 2003 requirement.
NEHB/St John of Gods

Home Support for children

Meath	number of places to be agreed
Louth	number of places to be agreed
Cavan / Monaghan	number of places to be agreed

Transfers from Inappropriate Setting

Location	Cavan/Monaghan,Lisdarragh Hse, Monaghan
Places	6
Comments	Redeployment of Nursing Staff from C.H. Res. Centre.

Location Louth 2001/2002 Programme:

	Places
Additional funding for Point Rd/Ravensdale	5
Carngrove, Newry	1 Place
Additional funding for St. John of Gods package	5

Comments Service agreement per agreed framework to be prior discuss RDSU, Pin No's required.

Regional Specialist & Additional Supports

Regional Challenging Behaviour Support Service

Progress the development of Behavioural Support Services/Autism Services (Establish post of regional Clinical Co-ordinator)

Kavanagh Unit To be reviewed

Specified Funding

Camphill	€25,000	Cavan/Monaghan €20,000 Meath €3,000 Louth €2,000 Towards enhanced placement costs.
St. John of Gods	€254,000	Existing Services

Quality Assurance - Implementation of Personal Outcomes,approach to Quality

Regional Implementation Officer

Establish post in each Community Service Area, Contract/Project Basis, initial 18 months

PHYSICAL DISABILITY & SENSORY IMPAIRMENT

Service Details St. Christopher's Centre, Cavan

Particulars Completion of Phase III

Service Details Multi-Agency Resource Centre - Louth/South Monaghan

Particulars Interim service in place. Capital Project for development in 2002

Service Details P.A. Services, Regionally

Particulars For further expansion in 2002

Service Details Home Support/Respite Packages

Particulars Adult services - further expansion

Service Details Full Year Costs on Clinical Co-ordinator of Early Intervention Services 1 Post Cavan/Monaghan - Enable Ireland.

Particulars There will now be a Clinical Co-ordinator post in each CCA

Service Details Acquired Brain Injury

Particulars Project Management plus initial Team.

Service Details N.C.B.I.

Particulars Full year costs on Information Technology Training Specialist., Respite Services, Peer Counselling - Service Agreement, Insight Service, Rehabilitative Worker.

Service Details M S Society

Particulars Full year Cost on 2nd Post of Family Support/Case Worker. 11 Service Agreements.

Service Details	Posts Associated with Adult Community Teams
Particulars	Full Year Costs

Service Details	Progress additional service Regional Child Assessment Treatment & Rehabilitative Service
Particulars	Service Agreement Enable Ireland, Commencement of Enable Ireland Service Monaghan.

Service Details	Micro boards
Particulars	Consultation with Voluntary Sector to advance the piloting of "Micro Board" Model of person centred planning.

Database Physical & Sensory

Service Details	Support to Board & Voluntary Agencies in supporting roll out of National implementation
Particulars	Details will be agreed with Regional Database Committee

Revenue Consequences of NDP

Service Details	Resource Centre Meath
Particulars	Existing/completed payments To Be Agreed.

Home Support Services - Ring fenced for children with disabilities plus complex needs.

Service Details	Home Support Packages of Care (Incl. Respite) - Children
Particulars	Further Expands services in each CCA

Service Details	P.A. Services - Children
Particulars	Further Development

Therapy Services

Details	Completion of existing Teams. Commencement of New Posts - Early Intervention, 6-18 yrs & Specific Language.
Particulars	Describe, Establish, Develop & Co fund with Child Care Services on a pilot basis post of one key worker to promote integrated care planning for children.

Priorities identified by the Regional Co-Ordinating Committee

Details	National Association for the Deaf
Particulars	Informative Administration & Agreement Minor Repairs
Details	Day Resource Centre Drogheda (IWA)
Particulars	Detailed proposal received from IWA/Drogheda Disability Intellectual Group
Details	Resource Centre Navan (IWA)
Particulars	Expansion of Day Service to 5 Day service
Details	Provided at Na Driseoga to provide for High Support Clients
Particulars	Enhancement of Respite Service
Details	Disability Federation of Ireland
Particulars	Co fund post within Midland Health Board.
Details	Neurofibromatosis
Details	Regional Child Assessment Treatment & Rehabilitative Service
Particulars	Progress development

INTELLECTUAL DISABILITY SERVICES

EFFECTIVENESS

Performance Indicator

The Percentage of Clients in Residential Care for whom a written person centred plan is in place.

(An individual support plan is a statement of the person's vision for the future and the services designed to assist the person to move towards that future. The Plan is a tool used to document specific information about individualised supports for each person. It also communicates priorities to all support personnel and provides a point of reference for reviewing progress and change.

Plans are based on information from the person, the person's primary support network and other service personnel who know and interact with the person. It reflects discussions and decisions about services and supports during planning sessions. The plan provides a road map for the achievement of personal outcomes.)

Rationale

Care Planning is an important component of the provision of services for clients with intellectual disability. The presence of a person centred plan will ensure the needs of users will be identified and implemented

Source of Information

Clients files

Frequency of reporting

Annually by 31st December

Specific Questions to be asked:

- Number of clients in residential care
- Percentage of those for whom a written person centred plan is in place

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- This PI will be expanded on in 2003 following further consultation throughout 2002.

HEALTH IMPROVEMENT

Performance Indicator

- **The percentage of clients (by organisation) in Residential Care including Group Homes who have been vaccinated against Hepatitis B.**
- **The percentage of clients (by organisation) who declined the vaccination**
- **The percentage of staff (by organisation) in Residential Services who have been vaccinated against Hepatitis B.**
- **The percentage of staff (by organisation) who declined the vaccination**

Rationale

Hepatitis B is an important cause of serious liver disease. The Immunisation Guidelines for Ireland (1999) recommend immunisation for the above mentioned at risk groups.

Source of Information

Organisation Records

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number of clients in an individual organisation
- Number of those who have been vaccinated against Hepatitis B
- Number of those who declined the vaccination
- Number of staff in an individual organisation
- Number of those who have received the vaccination
- Number of those who declined the vaccination

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- Year 2 (2003) will look at Day Services following further consultation throughout 2002

EQUITY

Performance Indicator

- **The percentage of clients on the intellectual disability database assessed as requiring Day Services for whom funding has been received who are receiving the service.**
- **Percentage of these clients requiring a further Day Service**
- **The percentage of clients on the database who are assessed as requiring residential services for whom funding has been received and who are receiving the service.**
- **Percentage of these clients requiring further Residential Services**
- **The percentage of clients who have been assessed as needing to be transferred from psychiatric hospitals and large institutional settings for whom funding has been received**

Rationale

Access to service is a strategic objective

Source of Information

Intellectual Disability Database/Agencies

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number of clients on the Intellectual Disability Database
- Number of clients assessed as requiring day services
- Number of clients assessed as requiring day services for whom funding has been received
- Number of clients assessed as requiring day services for whom funding has been received who are receiving the service
- Number of clients requiring a further day services
- Number clients assessed as requiring a residential service
- Number of clients assessed as requiring residential service for whom funding has been received

- Number of clients assessed as requiring residential service for whom funding has been received who are receiving the service
- Number of clients requiring a further residential service
- Number of clients who have been assessed as requiring transfer
- Number of clients who have been assessed as requiring transfer for whom funding has been received
- Number of clients who have been assessed as requiring transfer for whom funding has been received who have been transferred

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

In 2003 explore assessing waiting times for Day and Residential Services by incorporating extra entries on the Database in 2002.

In 2003 Performance Indicators will be devised for Home Support, Respite and Inappropriate Placements. Length of time from assessment to actual receipt of service will also be looked at.

PATIENT SATISFACTION/EXPERIENCE

Performance Indicator

Percentage of services that employ a methodology to seek the views of the Residential Service Users, their parents, family members and/or advocates.

Rationale

Elucidating the experience of service users provides valuable information for the management of services

Source of Information

Residential Services

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

- Number of Residential Services
- Number of those that employ a methodology to seek the views of users

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

In year 2 (2003) this indicator will be extended to other services such as Day and Respite Services.

PHYSICAL & SENSORY DISABILITY SERVICE

EFFICIENCY/EFFECTIVENESS

Performance Indicator

Percentage of clients who have applied to be included on the Physical & Sensory Disability Database who have been interviewed

Rationale

The Physical & Sensory Database will provide a list of the specialised health and personal social service needs of people with a physical and sensory disability. This performance indicator will monitor the implementation process for the database.

Source of Information

Database Administrators

Frequency of reporting

Annually by end of third quarter (30th September)

Specific Questions to be asked:

- Number of people who have applied to be included on the physical & sensory disability database
- Number of those who have been interviewed

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

This PI will be expanded on in 2003 following further consultation throughout 2002.

EQUITY/ACCESS

Performance Indicator

- **Number of people who have applied for a personal assistant**
- **Percentage of those assessed as being in need of a personal assistant**
- **Percentage of people who require additional hours**
- **Percentage of personal assistants who have received training**

Rationale

Personal Assistant Service is pivotal to the independent living of people with physical disabilities. This indicator will assess how effective we are in addressing this need

Source of Information

Manual Records. Please provide commentary detailing type of training received.

Frequency of reporting

Half Yearly - 30th June and 31st December.

Specific Questions to be asked:

- Number of people who have applied for a personal assistant
- Percentage of those assessed as being in need of one
- Percentage of people who require additional hours
- No. of Personal Assistants employed
- Percentage of those who received training

CLIENT SATISFACTION/EXPERIENCE

Performance Indicator

Percentage of services that employ a methodology to seek the views of the Residential Service users, their parents, family members and/or advocates.

Rationale

Elucidating the experience of service users provides valuable information for the management of services.

Source of Information

Service Providers. Please provide commentary on the methodologies utilised.

Frequency of reporting

Annually - to be reported by 30th September.

Specific Questions to be asked:

Number of residential services

- Percentage of those that employ a methodology to seek the views of users

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

- In Year 2 (2003) this indicator will be extended to other services such as day and respite.

3.2.5 TRAVELLERS HEALTH OVERVIEW

The Board will work within the framework of the new National Health Strategy and National Travellers Health Strategy in partnership with the travellers' community, statutory and voluntary agencies. The objective of the Board is to improve awareness among the travelling community of health issues, in partnership with the travelling community.

OVERVIEW

INFLUENCING DOCUMENTS

Health Strategy, "Quality and Fairness", 2001

National Traveller's Health Strategy (due to be launched early in 2002.)

WOMENS HEALTH

To develop and deliver a health information programme which will cover breast examination, cervical smear testing, family planning and maternity services (ante natal, post natal, breast-feeding), healthy eating and exercise.

To follow up and explore ways of meeting the requested need of traveller women for a free cervical smear service which will be delivered by female staff.

To complete the follow-up tracking of Anti D recipients among the traveller women in County Louth.

To develop and deliver "traveller friendly" information on the Primary Immunisation Programme.

To recruit and train community health care workers from the travelling community for the implementation of the Primary Health Care Project for travellers.

CHILD HEALTH

To increase the uptake of the Community Childhood Accident Prevention Programme to 75% of the target group.

To develop and deliver a Junior 'Cook-it'

To develop a 5 module training pack for community health workers on the new Primary Immunisation Programme .

All families with babies under two years in Co. Louth to be visited with this information, following the delivery of the training.

To develop a response from a request by traveller teenagers in Dundalk for a Physical Activity and Personal Development Programme, in consultation with the Health Promotion Department.

DENTAL

A visit from "Dodger the Donkey" to be continued and expanded to the Drogheda area.

DISABILITY

To compile a register of all travellers who have a disability, to facilitate liaison with Disability Services, and to monitor the movements of transient travellers with a disability, with a view to delivering services to them.

TRAINING

Training for Staff on traveller culture "Dealing with Difference" will continue.

Training and development of the existing traveller community health workers through the principles of Primary Health Care will include drugs awareness, immunisation, group dynamics, personal development and record keeping.

Cook-it Programme will run in Dundalk, Drogheda and Dunleer.

PERFORMANCE INDICATORS

Performance Indicator

Number and % of key health board personnel who have completed cultural awareness and sensitivity training programmes which have been developed in partnership with traveller organisations.

Rationale

Regional Health Boards in partnership with Traveller organisation should have in-service training courses for all health professionals on the circumstances, culture of, and discrimination practised against Travellers. The focus for this training should ensure the development of skills necessary to provide an inter-cultural service and ensure an anti-racist context. This training should also include a focus on Travellers" perspective on health and illness.

Source of Information

Health Boards.

Frequency of reporting

Twice Yearly by 30th June and 31st December

Specific Questions to be asked:

Number and % of *key health board personnel who have completed cultural awareness and sensitivity training programmes which have been developed in partnership with traveller organisations.

*key staff = Health service staff and especially functional staff who come into periodic or regular contact with travellers.

i.e. Reception/security staff.

Environmental Health staff.

Community Welfare.

Dental Nurses.

Public Health Nurses.

Doctors.

A & E Medical staff.

Maternity Unit staff.

AREAS IDENTIFIED FOR DEVELOPMENT WORK DURING 2002

TRAVELLING PEOPLE

Performance Indicators will need to be developed next year in line with Traveller Health strategy.

Indicators will need to be drawn up around the following areas:- Identification of travellers on health data sets, number of health plans developed and monitored using the desegregated data on travellers, participation of travellers and traveller organisations, development of equality policies and anti-racist codes of practice and development of culturally appropriate information and education materials.

Indicators will be further developed in line with the Traveller Health Strategy which will be launched soon.

INTEGRATION

Involvement with the new Traveller Women's Group in Drogheda to be maintained and increased.

Links with other Traveller Primary Health Projects nationally to be strengthened. Multi-dimensional and inter-disciplinary collaboration in the delivery of services to the traveller community will be promoted by liaison with:

- Health Promotion Department
- Hospital Services
- General Practitioners
- Voluntary groups, local and national and statutory agencies.

3.2.6 ENVIRONMENTAL HEALTH SERVICES

OVERVIEW

The objective of the Environmental Health Service is to control those environmental health factors which may adversely affect health and to promote good environmental health standards.

The Environmental Health Service is the Health Board's key agent in food control structures established in conjunction with the Food Safety Authority of Ireland (FSAI). The Authority has the statutory responsibility for all food control and has contracted with all those agencies involved in food control, including health boards, local authorities, and Government Departments for the delivery of food control functions. This ensures that there is a national approach to food safety protection. The Boards' Environmental Health Service will work closely with the Food Safety Authority on a range of health issues including gathering relevant data on human and animal infections, establishing health priorities and establishing control measures which are targeted appropriately.

The Service will also enforce the Board's statutory responsibilities in the area of tobacco control as well as contributing to the Board's strategy on combating smoking in the region.

The promotion of good environmental health standards generally will continue with the enforcement of appropriate legislation, advice and education.

DEVELOPMENTS 2002

The Food Control Programme will give priority to visits to high risk food premises in the Board's area. An increasing emphasis will be placed on the requirement for all businesses to introduce hazard analysis [HACCP] and any systems in place will be audited for compliance with legislation. This will involve some 2500 visits to high and medium risk operations. Dealing with the investigations and assessments of applications for registration of food businesses will be within legal time limits

Food sampling will continue at the 2000 level viz. 946 samples (645 for microbiological analysis and 301 for compositional analysis)

Training of food workers will continue to concentrate on those in high risk businesses. Training has been updated to include an introduction to HACCP. A target of bringing 800 trainees to certificate level using the Primary Course in Food Hygiene will be set for 2002 with, once again, the emphasis on high risk catering, retailing and food manufacturing. Liaison with private trainers will continue. In line with the EU strategy on HACCP implementation the focus on the Board's Institutions will continue. With the cooperation of the Hospital General Managers the aim is that all catering operations in these Institutions will have progressed significantly towards having HACCP systems by end 2002.

All food alerts received from the FSAI and complaints of unfit food with the minimum practicable delay and food poisoning will be responded to within 24 hours where possible.

Liaison with the organisers of outdoor events will continue to ensure an agreed programme of environmental health is implemented. These are an ever-increasing feature of the Summer period. Some 50 outdoor events will require to be controlled. A target of minimum one inspection of each food outlet during the event plus necessary follow-ups will continue to be set.

Enforcement of the restrictions on smoking in catering premises and food outlets will be carried out during visits. There are some 560 catering premises subject to the no-smoking regulations and these will receive at least 1 visit each. In addition the Environmental Health Service will cooperate with Health Board anti-smoking initiatives. The enforcement of no-smoking regulations in non-food premises will continue.

A post will be established during 2002 to co-ordinate tobacco control initiatives.

Monthly monitoring of all fluoridated water supplies will continue with some 300 samples being taken. Implementation of drinking water sampling programmes will continue in cooperation with local authorities including investigation of complaints of poor quality. Complaints regarding contaminated drinking water will be responded to as a matter of urgency. Advice to consumers on quality matters will continue.

The Environmental Health Service operates as part of the pre-school and nursing home inspection teams which will continue to visit in 2002 in accordance with statutory duties. This will involve some 250 pre-school inspections and 120 nursing homes inspections.

Activities with regard to statutes in the areas of housing, planning, environmental hazards, pest and poisons control will continue. A response-time target of l0 days to complaints of environmental hazards/nuisances will be set. Urgent complaints of health hazards will be responded to immediately and remedial action initiated, in conjunction with the appropriate local authority where necessary. A response-time of 21 days to each planning application referred continues to be our target.

An additional 3 EHOs have been approved by the DoH&C for food control which will increase the surveillance and inspection capacity.

A regional SEHO post specialising in the Flare system has been approved by the DoH&C. When in place the post will improve the management and further development of the system. The system is central to management of our food control activities as well as providing statistical and other information to the Board, the DoH&C and the FSAI.

3.2.7 HOMELESS SERVICE

OVERVIEW

The Health Boards responsibilities for the delivery of services to homeless persons were clarified and developed in "Homelessness - An Integrated Strategy" produced by the Department of Environment in 2000. Health Boards are responsible for the health and in-house care needs of homeless persons; the provision of emergency, hostel and temporary accommodation being the responsibility of Local Authorities. The Youth Homeless Strategy was published by the Department of Health in late 2001.

ESTABLISHMENT OF HEALTH BOARD HOMELESS CO-ORDINATION COMMITTEE

Membership will come from the following service areas :

General hospital, psychiatric hospital, disability service , care of the elderly, environmental health and community welfare. The committee will work with the Director of Homeless Services to ensure:

The implementation of the homeless integrated strategy in the region

The quality assurance of care provided by existing homeless services

The development of appropriate linkages between existing homeless services and health board hospital, residential and community services.

The development of co-operation between the health board, the local authorities, FAS and voluntary organisations to develop services for homeless people.

PARTICIPATION IN THE WORK OF HOUSING FORA ESTABLISHED BY LOCAL AUTHORITIES

The health board will participate actively in the work of the housing fora established by local authorities. Each local authority in the region is developing within the housing fora a strategy for the delivery of services by statutory and voluntary agencies to homeless people.

The housing fora will consider new proposals for services. Among the services due to commence year 2002 are :

Homeless Persons Centre, Navan - Meath Co Council and the NEHB propose to open a centre which will promote the following services for homeless people :

- To provide early assessment of customer needs particularly in relation to accommodation, housing and welfare needs
- To provide advice information and support to people on housing and accommodation option
- To link homeless people to a range of basic living facilities and personal services including washing, laundry, medical assistance and social contact.
- To provide a social centre for recreational activity
- To provide access to primary health care by assuring that all homeless people obtain quickly a medical card
- To provide access to community services such as dental, welfare, social work and counselling services.

Drogheda Women's Centre - Hostel for Homeless Women: Drogheda Women's Centre, on behalf of Drogheda Corporation and the NEHB is going to open a hostel that will accommodate up to five homeless women and their children. Referrals will be taken from Co Louth and Co Meath. Drogheda Corporation is purchasing a premises suitable for use as a hostel and the NEHB is contributing to the cost of employing care staff.

CONSOLIDATION AND DEVELOPMENT OF EXISTING SERIVCES

The NEHB is increasing the grant allocations to the following organisations to enable them to employ additional staff to improve the level of care provided:

- Dundalk Simon Community
- Drogheda Homeless Aid
- Castleblaney Trust for Homeless, Needy and Unemployed People
- St Vincent de Paul Night Shelter, Cavan

Additional staffing will enable the above organisation to prepare care plans for homeless people in the expectation that many homeless people will be settled into supported independent living.

EVALUATION OF PROJECTS

In year 2001 the ten health boards established national working groups to devise agreed performance indicators to be used by all health boards. The social inclusion working group has devised performance indicators which will be used to evaluate services provided for homeless people. In year 2002, it is intended to apply three performance indicators to existing services for homeless people in the NEHB region :

Performance Indicator

1. Access of Homeless people to primary health care

Rationale

All persons are entitled to receive appropriate primary health care services.

Mechanism for Measurement

To check that all users of existing services for homeless people possess an up to date medical card.

Performance Indicator

2. To provide a range of services to homeless people with addiction problems which addresses all their needs in a holistic manner.

Rationale

Homeless people require easy access to additional counselling services

Mechanism for Measurement

To find out :

- Number of staff in homeless hostels who are trained in addiction awareness.
- Number of users of homeless hostels who have been assessed for alcohol and other addiction.
- Number of users of homeless hostels who have been referred to a key worker in an addiction counselling service.

Performance Indicator

Homeless People should have support system to enable them to deal with problems that have caused homelessness.

Rationale

The development of a care plan/key worker system within homeless hostels is essential to supporting homeless people.

Mechanism for Measurement

To look at care protocols of homeless hostels to ensure that a key worker system is in place.

YOUTH HOMELESS SERVICES

The Youth Homeless Strategy was launched on 31st October 2001 by Mary Hanifin T.D. Minister for Children.

The goal of the strategy is:

To reduce and if possible eliminate youth homelessness through preventative strategies and where a child becomes homeless to ensure that he/she benefits from a comprehensive range of services aimed at re-integrating him/her into his/her community as quickly as possible.

The health board is required to prepare a two year implementation plan and to submit it to the Department of Health and Children by 28th February 2002.

Proposals include:

SUPPORTED LODGINGS SERVICES

In each Community Care area, a Supported Lodgings Service will be developed.

This will be targeted at young people aged thirteen to eighteen who are experiencing serious difficulties in their lives and are in need of a new care arrangement.

A Supported Lodgings family will provide accommodation for a referred young person as well as providing personal help. Supported Lodgings may be provided for the following group of young people:

- Young people leaving care on a planned basis who require transitional accommodation until they are able to live independently.
- Young people whose care placement has broken down and need supported living arrangements.

- Young people who have recently become homeless and require emergency accommodation.
- Supported accommodation will be provided on the principle of `localisation`. This promotes the placement of children in settings as close as possible to their family of origin and their cultural background.

DEVELOPMENT OF LEAVING CARE SUPPORTS

Three after care workers were employed by the NEHB in year 2001. Research undertaken on behalf of Focus Ireland has indicated that a large number of young people leaving care experience homelessness within a short time of leaving care. The after care workers will provide personal and financial support to young people leaving care to enable them to establish themselves in supported, independent living arrangements.

DEVELOPMENT OF COMMUNITY BASED PROJECTS TO PREVENT YOUNG PEOPLE FROM BECOMING HOMELESS

Within the NEHB region, one interagency project, the Youth Initiative Partnership, Dundalk has developed a detailed range of services for at risk young people.

The project was established by the health board in 1997 as a response to community pressure about alleged child exploitation and serious risk behaviour of young people in the Dundalk area. An Garda Siochana and the Probation Service are represented on the project Board of Management as well as their voluntary services.

The work of the project is based on an approved EU working model for undertaking work with unattached young people : The Comprehensive Pathway Approach

The two main requirements for developing this approach are :

- Statutory and voluntary organisations within a given location agree to co-operate with one another in their work with young people.
- No one organisation can undertake every required task to turn around the life of a vulnerable young person. Each organisation undertakes its work in accordance with one or more of the four stages of the model.

In year 2002 it is hoped to secure the future of the Youth Initiative Partnership Project and to encourage some other organisations in the region to replicate it's model of work in their activities.

3.2.8 COMMUNITY WELFARE SERVICES

OVERVIEW

The Community Welfare Service seeks to relieve social distress and where possible, help to prevent its recurrence by informing people of the statutory income maintenance services that are available and assisting them to avail of the services and to provide financial support, where necessary through the Supplementary Welfare Allowance (SWA) Scheme.

Community Welfare Services also help determine eligibility for health and welfare services administered by the board and funded by the Dept. of Health and Children.

DEVELOPMENTS 2002

Development of the services will continue to be a priority. The "Review of the S.W.A. Scheme and the Future Role of Community Welfare Services" has been completed. It is anticipated that the recommendations of this Review will greatly enhance the structure and delivery of Community Welfare Services.

Staff training and development programmes will be developed to assist staff in dealing with the increasing numbers of multi ethnic groups and also C.P.I. awareness.

A database capturing the activity of Asylum Seekers/Refugees will be established.

CWO's accommodation will be up-graded regionally. This will enhance services to the clients and also provide a safer environment as recommended by the Health & Safety Authority

ACTIVITY STATISTICS

DSCFA RELATED ACTIVITIES:

Supplememtary Welfare Allowances:

(Projections 2001)

	Louth	Meath	Cavan/Mon	Totals
Basic Cases:	4851	2575	2361	9787
Supplements	2384	927	1410	4721
Except. Needs Pmts	3542	4738	1872	10152
Totals	**10777**	**8240**	**5643**	**24660**

(Projections 2002)

	Louth	Meath	Cavan/Mon	Totals
Basic Cases	5336	2833	2597	10766
Supplements	2622	1020	1551	5193
Except. Needs Pmts	3896	5212	2059	11167
Totals	**11854**	**9065**	**6207**	**27126**

Back to School Clothing And Footwear Scheme 2001:

	Louth	Meath	Cavan/Mon	Totals
Applicants	3075	1800	1682	6557
Payments made	2574	1580	1422	5576
Refusals	501	220	260	981

Back to School Clothing and Footwear Scheme (Projected 2002).

	Louth	Meath	Cavan/Mon	Totals
Applicants	3382	2000	1850	7232
Payments Made	2831	1750	1564	6145
Refusals	551	250	286	1087

HEALTH BOARD RELATED ACTIVITIES:

Medical Cards 2001(Projections)

	Louth	Meath	Cavan/Mon	Totals
Number Assessed	4770	4740	4050	13560
Number reviewed	6256	6500	5900	18656

Medical Cards 2002 (Projections)

	Louth	Meath	Cavan/Mon	Totals
Number Assessed	4770	4740	4050	13560
Number Reviewed	6256	6500	5900	18656

Other Allowances and Schemes (Projections 2001)

	Louth	Meath	Cavan/Mon	Totals
Blind Welfare Allowance	48	41	58	147
Mobility Allowance	11	20	92	123
Motorised Transport Grant	15	9	22	46
Nursing Home subvention	0	201	290	491
Extended/Respite Care and Inst. Assist	314	125	185	624

PERFORMANCE INDICATORS:

As SWA is a demand led service, all customers who turn up during clinic and out of hours periods, must be dealt with.

There are currently no National Performance Indicators within Community Welfare Services, but the issue is attempting to be addressed.

Community Welfare Services have been under review by DSCFA for a number of years. The outcome of this review is awaited so that key issues may be addressed.

3.2.9 CHILD AND ADOLESCENT PSYCHIATRY

OVERVIEW

To provide a comprehensive psychiatric service to children, adolescents and their families, through assessment, consultation and therapeutic intervention. The remit of the service extends to children who suffer from "childhood psychiatric disorder" and this defines a group of children and adolescents whose problems are qualitatively and quantitatively distinct from those with milder difficulties and whose problems are characterised by their persistence and severity.

DEVELOPMENTS 2002

OUTPATIENT ACTIVITY

The level of service provided in 2001 (an increase of 13% on previous years activity)will be maintained.

	1999 No.	2000 No.	2001 No.
Cavan/Monaghan	118	132	143
Meath	107	150	172
Louth	165	172	196
Total	**390**	**454**	**511**

The number of new appointments will be maintained at 2001 levels with particular attention being paid to the reasons for non-attendance.

	1999 - 2000	2000 - 2001
New Patients appointments given	315	694
Follow-up appointments	2466	3809
New patients who Did Not Attend	No data	140

EXPANSION OF MULTI DISCIPLINARY TEAMS

Post for scarce grades which were not filled in 2001 will be redesignated to improve the potential to recruit.

The multi-disciplinary teams will be strengthened by the addition of Senior Registrars in Meath and Louth.

PAEDIATRIC LIAISON SERVICE will be further developed

ACCOMMODATION TO BE PROVIDED FOR CHILD PSYCHIATRIC SERVICE.

New accommodation for the multi-disciplinary teams will be provided in Cavan, Monaghan and Meath

SERVICE INTEGRATION

A number of key worker posts are being developed to improve the level of integration across services with particular emphasis on addressing the needs of children of parents with mental illness.

ANTI BULLYING PROJECT

The Project has been divided into two categories, as follows:

a) Ongoing work with schools,

b) Work with persistent bullies.

ONGOING WORK WITH SCHOOLS

CO. MEATH

In schools where one full day of training has been delivered, further meetings with Anti-Bullying Co-ordinators and teams will be arranged. These will concentrate on issues such as: ways of investigating bullying, encouraging disclosure and individual work with parents (six schools).

In schools where one half day of training has been delivered, further training will concentrate on developing Whole School Policy, and achieving agreement amongst staff about procedures (four schools).

Three schools have set dates for a full training day.

Four schools are currently planning for full training days.

Three schools remain at the pre-planning stage.

CO. LOUTH

All schools in Co. Louth have been contacted and have received an information pack about the programme. Planning meetings to be scheduled in each school.

Data collection in each school to determine the extent of bullying and to provide a focus for work.

In-service to be timetabled and initiated.

CO. CAVAN AND CO. MONAGHAN

All schools to be contacted with a view to providing information and planning.

WORK WITH PERSISTENT BULLIES

PROPOSED RESEARCH

Research on developing assessment procedures for children who are

involved in serious and persistent bullying. This work will look at attitudes to aggression, theory of mind development, and school related behaviour, with a view to developing an intervention.

GROUP THERAPY

A Health Professional will be sourced and will be involved with the development of an intervention and the delivery of this in group therapy with the persistent bullying group.

Further Group therapy for victims of bullying is also proposed for early 2002.

PUBLICATION OF MATERIALS

The following materials will be finalised for publication Sept2001-Sept2002.

Bullying in School - Advice for Parents.

Responding to bullying - Guidelines for Teachers.

Investigating bullying - Guidelines for teachers.

3.3 ACUTE HOSPITAL SERVICES

INTRODUCTION

The Board will consolidate in 2002, the many developments which commenced in 2001. It is anticipated that the main areas of service pressures experienced in the past year will continue and these will need to be responded to. These include A&E, Maternity, Paediatrics and Neonatology services and are largely due to the changing demographics in the region. Significant service pressures can also be expected in Cavan Monaghan in respect of the care and treatment of older persons.

Developments and proposals at national level will have a profound influence on the provision and development of acute hospital services throughout the country. Proposed action points in the National Health Strategy for 2002 include the provision of additional bed capacity (No 78), establishment of a National Hospitals Agency (No 80) and the introduction of a treatment purchase fund (No 81). A committee of Comhairle na nOspideal is expected to report to the Minister for Health and Children in the near future on the provision of Accident and Emergency services nationally. Medical manpower implications arising from changing requirements of the registration and training bodies are currently being reviewed.

DEVELOPMENTS - 2002

SYMPTOMATIC BREAST DISEASE SERVICE

The Board will continue to implement its Symptomatic Breast Disease Strategy with the appointment of key professional staff. This will be subject to full year funding being agreed and approved by the Department of Health and Children. Consultation will be required with the Symptomatic Breast Cancer Implementation Group and the Department of Health & Children before the implementation of any new aspects of service.

CANCER SERVICES

A key development in the provision of cancer services will be the proposed appointment of a Consultant Haematologist with a regional responsibility. The special needs of patients with serious blood diseases will be given priority along with the development and quality assurance of blood policies in the interest of patient safety.

PALLIATIVE CARE

Specialist palliative care services will be developed throughout the Board with the appointment of a Consultant in Palliative Care Medicine. Based at the Louth/Meath Hospital Group, this Consultant will play a lead role in the future direction and development of Palliative Care services in the region as a whole.

CARDIOVASCULAR STRATEGY

Developments in 2002 will be in accordance with those identified by the Board's Cardiovascular Strategy Steering Group and subject to available funding. Training will continue to be provided in CPR, ACLS, and PALS in line with the Cardiovascular Strategy. It is hoped further appointments will take place in nursing and allied health professions.

OBSTETRICS

Based on bookings for the initial three months of 2002, it is anticipated that births in the Louth/Meath Hospital Group will increase on 2001 figures due to continued demographic changes in the area.

It is anticipated that there will be an increase in births in the Cavan/Monaghan Hospital Group in the order of 3% in 2002.

Resources may have to be diverted from elective services to support obstetric services should the need arise.

The Task Force recommended by the Report of the Review of Maternity Services established in 2001 will continue with its work through 2002 including an implementation plan which is due by early summer 2002.

PAEDIATRICS/NEONATOLOGY

As a consequence of the increase in the number and complexity of births in Our Lady of Lourdes Hospital in 2001 and following the advice of the Review Group on Maternity Services, the Board applied to Comhairle na nOspideal for approval to the appointment of two Consultant Neonatologists. Pending the filling of these posts in a permanent capacity, both posts have been filled in a temporary capacity with effect from the beginning of 2002. These appointments will be reviewed in the light of service needs and resource availability in Dublin hospitals.

Paediatrics services will be enhanced in Cavan Monaghan with the appointment of a third Consultant Paediatrician in early 2002. This post will have specific responsibilities for community child health and will focus on the requirements of the Monaghan catchment area.

RENAL SERVICES

It is planned to enhance the Renal Service based at Cavan General Hospital by seeking Department of Health and Children approval and funding to the appointment of a Consultant Physician with a special interest in Nephrology to replace the retiring medical officer. This proposed appointment will also assist the Board in planning the future direction of renal services at regional level. Patients from this Board will continue to receive renal dialysis services at Daisy Hill Hospital, Newry.

WAITING LISTS

Waiting List Management at specialty level will focus on ensuring equity of access for public and private patients. Subject to resources being available, additional procedures in orthopaedics and ENT will be carried out during the year. Waiting list activity will be based on the following projections for 2002: a further 350 orthopaedic and additional140 ENT procedures will be carried out.

ORTHODONTICS

An additional trainee specialist Orthodontist will be appointed. The waiting period for urgent orthodontic care will continue to be monitored and prioritised. It is projected that there will be 2,480 patients receiving treatment in 2002.

ACCIDENT AND EMERGENCY SERVICES

It is expected that the report of Comhairle na nOspideal's review of A&E services will be published in early 2002. This will inform the future direction of A&E services and it is envisaged that a number of A&E Consultants will be appointed to the Board's hospitals in the coming years. The Board will seek Department of Health and Children approval to the funding of these new posts.

Continued emphasis will be placed in 2002 on the provision of appropriate training for staff. Consultants will manage and support the staff dedicated to A&E services across the region.

DAY SERVICES

There will be continued movement from in patient to Day Services in line with best practice, focusing where appropriate on the development of care processes to minimise inconvenience to patients. The further integration of day services with Primary Care and Community services will improve the service from the patients prospective.

PATHOLOGY AND LABORATORY SERVICES

The phased implementation of the recommendations of the Pathology and Laboratory Services Review will continue. The accreditation of laboratory services will ensure an enhanced quality safer service.

The projected activity levels are set out below:

	2000	2001	Projected for 2002
Activity Levels			
Cavan Monaghan Hospital Group			
Laboratory Samples	245000	296299	297000
Louth Meath Hospital Group			
Laboratory Samples	567443	673403	675000

Please note: these services cover acute hospitals, primary care and community services.

RADIOLOGY /DIAGNOSTIC IMAGING SERVCIES

The CT service located in Our Lady of Lourdes Hospital will be phased up to a 24 hour service subject to funding and staff being available.

The projected activity levels are set out below:

	2000	2001	Projected for 2002
Activity Levels			
Cavan Monaghan Hospital Group			
Radiology Examinations	58280	63536	64000
Louth Meath Hospital Group			
Radiology Examinations	129006	141913	142000

Radiology and diagnostic services contribute in a significant way to the care of patients in community settings.

PHARMACY

A review of pharmacy services will be undertaken regionally to examine the configuration of services procurement procedures and drug formularies.

PERFORMANCE INDICATORS

Eight performance indicators for acute hospitals agreed by the national group on performance indicators will be implemented. It is planned to develop further indicators following consultation with staff.

ACCREDITATION

The NEHB will commence participation in a DOHC sponsored national project on accreditation (Irish Health System Accreditation Scheme), the central focus of which is on safety for patients, staff and the public, within a continuous quality improvement framework.

QUALITY INITIATIVES

Specific quality initiatives planned for 2002 will focus on the following:

- Development of staff induction and mentorship programmes
- Improved provision of information to patients on service availability, accessibility, aftercare, etc
- Increasing emphasis on multi disciplinary team working
- Increased emphasis on health promotion for staff
- Use of HACCP protocols to review food production and distribution in both hospital group in the interests of food safety and quality
- Continued focus on the provision of training for care assistants and support staff
- Implementation of Maximum Surgical Blood Ordering Schedule (MSBOS)
- Continuation of Risk Management pilot projects
- Each hospital group will complete a range of initiatives in the area of patient centredness
- The Pre Hospital Emergency Care (PHEC) project will continue to identify initiatives and develop protocols in the interest of patient safety and care .A methodology for quality assuring A/E service activity will be introduced in early 2002.This project is due to complete by mid-summer 2002.
- The Clinicians in Management project will report in early 2002.

CASEMIX

The casemix adjustment is based on a comparative analysis with like hospitals. It is clear that Cavan, Navan and Dundalk hospitals are improving their clinical efficiency.

The trend in Our Lady of Lourdes Hospital, Drogheda indicates that further work needs to be done to improve its clinical efficiency.

Monaghan General Hospital is losing significant monies and this will need to be addressed by the clinicians and management of the hospital.

MANAGEMENT

Accountability will be further strengthened in 2002 by the greater involvement of clinicians in the management process in each of the hospital group. Management processes and information systems will be improved as resources permit.

Activity will be managed on the basis of differentiating between emergency and elective services.

A more integrated approach will be taken to admission/discharge planning with primary care and community services to ensure the most productive use of scare valuable resources.

Service provision will continue to focus on developing evidence based protocols and best practice in the interest of patient safety and on a safe working environment for staff. By early 2002 both hospital groups will have Risk Advisors operating to facilitate and support service providers.

Further improvement will be made in both clinical and financial information systems to assist the management process in each hospital.

ACTIVITY REVIEW - 2001

The following tables show the activity levels in each hospital group for 2001 together with 2000 figures for comparison purposes. These indicate a considerable increase in certain areas, which has resulted in significant pressures on resources. Underlying these figures is a substantial change in intensity, complexity and cost of services

CAVAN MONAGHAN HOSPITAL GROUP

	2000	2001	Increase/ Derease	Projected 2002 Activity
Admissions				
Surgical	4497	4687	(+4.2%)	4700
Medical	4974	5193	(+4.4%)	5200
Paediatrics	1606	1594	(-0.7%)	1600
Obstetrics	1737	1733	(-0.2%)	1750
Gynaecology	829	792	(-4.4%)	800
Psychiatry	93	50	(-46%)	50
TOTAL	**13736**	**14049**	**(+2.3%)**	
Births	1177	1219	(+3.5%)	1250
Day Cases	**6715**	**9046**	**(+34%)**	**9200**
A&E Depts				
New	**18763**	**19651**	**(+ 4.7%)**	**20000**
Total	**24192**	**24148**	**(- 0.2%)**	

LOUTH MEATH HOSPITAL GROUP

	2000	2001	Increase/ Decrease	Projected 2002 Activity
Surgical	7031	6763	(-3.8%)	7000
Medical	11574	11623	(+0.4%)	11500
Paediatrics	3066	3189	(+4.0%)	3500
Obstetrics	4942	6424	(+30%)	7000
Gynaecology	1821	2091	(+14.8%)	1800
Orthopaedics	3167	3515	(+11%)	3500
ENT	235	271	(+15.3%)	310
TOTAL	**31836**	**33876**	**(+6.4%)**	
Births	**2666**	**3095**	**(+14%)**	**3000**
Day Cases	**15012**	**13811**	**(-8%)**	**16000**
A&E Depts.Newd	61374	62259	(+1.5%)	6000
Total	73238	72356	(-1.2%)	

In 2002 activity levels will be regularly reviewed to ensure the funded level of activity is adhered to in both Hospital Groups.

A range of in-patients, outpatients, day and emergency services will be provided at both Hospital Groups. Clinical, Diagnostic and other support services will support the Acute Hospital Services and Primary/Community Services.

Each specialty and department within each hospital group will be expected to sign off and agree to projected targets for their specialty and department.

It will be necessary to review and alter activities in the light of service pressures, which arise during the year. It will be necessary to carry out a full review of staffing levels in both hospital groups in early 2002. Pending the outcome of the review, restrictions will be placed on staff recruitment except in situations of extreme necessity.

NATIONAL PERFORMANCE INDICATORS

The following suites of performance indicators were agreed at national level to monitor service provision with regard to accessibility, equity and efficiency.

OUT-PATIENT DEPARTMENT CLINICS

EFFICIENCY

Performance Indicator

Waiting times for Out-Patient Department appointments by specialty (percentage seen within 13 or 26 weeks of referral by General Practitioner (GP).

PATIENT SATISFACTION/EXPERIENCE

Performance Indicator

Waiting times in Out-Patient Department (Percentage (%) seen < 30 minutes).

USE OF ACUTE SECTOR BEDS

EFFICIENCY

Performance Indicator

The number of patients who have been assessed as clinically fit for discharge but are still in hospital awaiting appropriate placement at

(a) over 65 years of age, and

(b) under 65 years of age

as a percentage of total in-patient discharges at (a) and (b) above.

Performance Indicator

Average Length of Stay (ALOS) (with changes on previous year for set of Diagnostic Related Groupings (DRGs).

ACCIDENT & EMERGENCY

PATIENT SATISFACTION/EXPERIENCE

Performance Indicator

Waiting times in Accident & Emergency for triage, consultation and admission.

IN-PATIENT WAITING LISTS

EQUITY/ACCESS

Performance Indicator

Success in achieving waiting times targets (<12 months for Adults, < 6 months for Children) for in-patient admissions for the following target specialties - ENT, Orthopaedics, Cardiac Surgery, General Surgery, Gynaecology, Opthalmology, Plastic Surgery, Urology, Vascular Surgery.

HAEMOVIGILANCE

Performance Indicator

The number of times in the last year the Hospital Transfusion Committee has convened.

OUT-PATIENT DEPARTMENTS

EQUITY/ACCESS

Performance Indicator

Number of patients, by specialty, who are seen by a Consultant at their first Out-Patient Department clinic appointment.

ACCIDENT & EMERGENCY

EFFICIENCY/EFFECTIVENESS

Performance Indicator

Percentage (%) of re-attendances at Accident & Emergency.

IN-PATIENT ACTIVITY

EFFICIENCY/EFFECTIVENESS

Performance Indicator

The number of emergency re-admissions by specialty:

Performance Indicator

Percentage of Cataract surgery procedures performed on a day case basis.

Performance Indicator

Surgery rates for Dilatation and Curettage (D&C) in women under 40 years per thousand female population 15-40 years.

Performance Indicator

In-Patient /Day Case ratio for a given range of procedures

Draft set of procedures: Inguinal Hernia, Excision of Breast lump, Varicose Veins Procedures. Cystoscopy, Arthroscopy, Myringotomy, Correction of Squint

Performance Indicator

Surgery rates for:

(i) primary elective hip replacement and

(ii) knee replacements

for those aged 65 years or over per 1,000 population over 65

Performance Indicator

Age standardised surgery rates per 1,000 population for:

(i) Coronary Artery Bypass Graft (CABG) and

(ii) Percutaneous Transluminal Coronary Angioplasty (PTCA)

by Health Board of Residence

Performance Indicator

The percentage of live births to females aged under 19 years per 1,000 females population who are aged 15-19 years.

INTEGRATION INITIATIVES

Integration will continue to be fostered throughout the Board region. Linkages outside the acute services are both formal and informal and cover a wide range of services, voluntary agencies and cross border working.

- Direct Access Services will continue to be developed with Primary Care, Community and General practitioners actively involved.
- Geriatric and Rehabilitation services and out patient and day hospital units continue to involve consultants, GPs, hospital and community based specialist nursing staff.
- The Paediatric Service in Cavan/Monaghan and Louth/Meath will continue to work in an integrated way to support children and adolescents in their journey through our service.
- Palliative care services, community, hospital and voluntary will operate in a cohesive manner in the region to support the terminally ill. A new regional advisory group and development committee will be established in 2002
- Integration between community, hospital and primary care and the private nursing home will be firmly established to service the needs of elderly patients to continue to improve admission and discharge planning processes for patients.
- Other initiatives that enhance the level of integration in the Board area include CAWT/Cross Border. A telemedicine link exists between Louth Meath Hospital Group and Craigavon Area Hospital. In addition a Cross Border Working Group meets to examine the issue of discharge planning.
- There is a close relationship between both hospital groups and a large number of educational establishments e.g. the nursing programmes from Dundalk Institute of Technology and the medical programmes from Royal Colleges of Surgeons, Medicine and Obstetricians and Gynaecologists.
- At local level all units within each hospital group will place emphasis on multidisciplinary approach to their day to day working. This happens at all levels and across disciplines and is increasingly becoming part and parcel of the way work is done.

APPENDIX A - POLICIES - ACUTE HOSPITAL SERVICES

A New Direction in Acute Hospital Services - 1993

The Next 5 Years - A Framework for Continued Development -1998

Speciality Development and Consultant Manpower Plan, 2001-2006

Review of Maternity Services (Kinder Report) - 2001

National Health Strategy 2001-Quality and Fairness-A Health System for You.

Primary Care -A New Direction 2001.

3.4 GOVERNANCE AND STRATEGIC PLANNING

OVERVIEW

The Governance and Strategic Planning Department is responsible for promoting good governance practices throughout the organisation. The department underpins and supports the operational activities of the Board through strategic management, service planning, corporate governance, organisation development, quality, risk management, health and safety, working together in partnership, customer services including freedom of information and consumer affairs. The department is also responsible for liasing with the Ombudsman in relation to appeals and complaints.

Governance provides a framework through which the Board is accountable for continually improving the quality of services and safeguarding high standards of service delivery by influencing and creating an environment in which excellence in service delivery is promoted. Governance provides the essential context in which methods and means of accountability are devised and managed at all levels including financial, organisational and professional. Governance is about supporting good management practice within an organisational framework where the structures, strategies and policies reflect these requirements.

The Governance and Strategic Planning Department is developing and evolving based on the core guiding principles/foundations as outlined in the diagram on page 143.:

KEY ROLES OF GOVERNANCE AND STRATEGIC PLANNING

The key roles of Governance and Strategic Planning are to:

- Act as an internal resource to the organisation,
- Promote integration and linkages across the whole organisation,
- Support organisation-wide, regional, and team level initiatives and
- Link strategic and service planning/evaluation with overall corporate goals and priorities ensuring organisational alignment.

Key functions within this Department will adopt a facilitating and enabling role to support the organisation to develop and perform more effectively. The Department will also provide an advisory and guidance role while promoting best practice in the development of the organisation and services. In addition, Governance and Strategic Planning has a monitoring, measurement and evaluation role as part of its remit in ensuring best governance practices throughout the organisation.

Communication is a key factor in supporting the role of Governance and Strategic Planning, and mechanisms to support better communication will be developed in consultation with key personnel in the Board.

Partnership working is recognised as the preferred means of delivering improvements in effectiveness for clients and in improving the quality of the workplace for staff. The Board is committed to adopting a partnership approach to service delivery and to improving organisational effectiveness.

The details outlined below indicate areas for priorty consideration within Governance and Strategic Planning

Framework for Governance and Strategic Planning

	Strategic effectiveness	Corporate & clinical effectiveness	Quality	Risk mgt.	Patient and staff experiences	Resource Effectiveness	Communication	Learning Effectiveness
Communication Systems	Development of a Corporate Strategy Strategic Planning Initiatives	Review of Accountability Structures and Systems in line with the Health Strategy	Development of a Strategic Framework for Quality, Research and Evaluation	Strategic framework for Risk Management and Health & Safety	Development of Consumer Services, including measures of Client/ Patient Satisfaction	Monitoring & reporting structures and systems	Review of Organisational structures /systems /policies	Development of a Learning organisation
Partnership Working	Measures to improve organisational effectivness.	Development of the Service Planning Process	Staff and client involvement in consultation processes to improve the quality of services		Development of measures to determine staff satisfaction	Value for money initiatives	Partnership and working together to improve communication, service planning and development	Development of ethos of Research, Evaluation, and Feedback
		Development of performance indicators			Involving staff in decision making and consultation processes			Development of learning ethos within the context of risk management
Supporting integration	Development of Strategy, Policy Advisory Forum (SPAF)	Development of ethos of Evaluation & Outcome Measurement Risk Mgt Health & Safety			Complaints Procedeures FOI			

The key priority areas identified below will therefore be developed through an ethos of working together.

PRIORITY DEVELOPMENTS 2002

Governance and Strategic Planning is committed to the following key priority developments in 2002.

Health Strategy "Quality and Fairness, A Heath System for You" and the Primary Care Strategy.

Governance and Strategic Planning will play a lead role in supporting the analysis of these strategies and in planning and guiding the implementation of the actions required to bring about the required changes to support organisational development and reform. This work will be done in close collaboration with the Senior Management Team, senior managers and clinicians in the Board and will ensure a partnership approach to include staff in the process.

CORPORATE STRATEGY

One of the principles of good governance highlights the need for the establishment of a mission statement for service provision in line with the interests of all stakeholders and in line with legal and ethical considerations. The Board is committed to developing a Corporate Organisation Development Strategy in 2002. This process will be led and directed by Governance and Strategic Planning.

STRATEGY FOR GOVERNANCE AND STRATEGY PLANNING

The role and function of Governance and Strategy Planning will be reviewed in 2002 in light of the Health Strategy and taking into account how this internal resource can best meet the needs of the organisation.

ONGOING DEVELOPMENT OF THE STRATEGY POLICY ADVISORY FORUM (SPAF)

The Management Team and senior managers in the Board are aware of the need to focus on policies, strategies and plans in addition to operational matters. The Board is committed to ensuring that its strategies, policies and planning processes can meet the requirements of the National Strategy. Governance and Strategic Planning will take the lead role in the ongoing development of the Strategy Policy Advisory Forum that was established in 2001. This forum aims to facilitate the process of formalising and standardising the approach to the development and ratification of strategies and policies in an integrated manner throughout the region.

DEVELOPMENT OF KEY STRATEGIES

The Governance and Strategic Planning Department will provide appropriate support and guidance to the development of key strategies planned for 2002 by working with key strategic planners in the Board to ensure organisational alignment between the Board's vision and new strategic developments. In particular the development of the human resource strategy is seen as a key enabler to improving organisational effectiveness. The Director of Human Resources will lead the development of this strategy and appropriate support will be provided by Governance and Strategic Planning. Involvement in other strategic initiatives within childcare, disability services, primary care etc. will also be supported.

LINKAGES

Governance and Strategic Planning will continue to have a lead role in developing and supporting key external linkages and partnerships. In particular it will aim to support the development of better linkages between the Board and national/external agencies through improved communication, organisational representation/mandate, better use of internal resources/reference groups, to support shared learning and development.

There will be a continued emphasis on developing linkages with voluntary and community bodies/agencies in the form of service level agreements and to ensure that appropriate corporate strategic linkages are forged.

Ongoing linkages will be strengthened with a number of national bodies including the National Partnership Forum, the Centre for Partnership and Performance, the Office for Health Management, Office for Health Gain, Health and Safety Authority, the HSEA, and the newly formed Health Information and Quality Authority.

There will also be ongoing efforts in 2002 to enhance the Board's appeals process for Supplementary Welfare Allowances and other appeals. In particular external and internal communication processes with all key stakeholders in relation to appeals will be further developed e.g. patients / clients, Ombudsman, Department of Social, Community and Family Affairs, Community Welfare Officers, and Community Services.

In addition the need to continue to forge stronger linkages with all relevant government departments will be prioritised.

SERVICE PLANNING AND ANNUAL REPORT

Service planning is recognised as the most significant means of working together to develop services and to promote consultation and involvement. It is also recognised as a significant enabler to organisation development. The potential to increase the involvement of more staff in the service planning and evaluation process will be explored in 2002 and this work will involve close consultation with the regional and local partnership committees. The ongoing development of the service planning process will therefore be a priority in 2002. In particular an evaluation of the process and model o

service planning will be carried out in line with regional and health strategy requirements. The revised template and timetable for the service planning process for 2003 will be communicated and disseminated following the evaluation process.

Based on the outcome of the evaluation of the service planning process and in line with national guidelines, the utilisation of resources to support the ongoing development of the service planning process will be prioritised.

Governance and Strategic Planning will also be responsible for the co-ordination of the Board's annual report.

STRATEGIC FRAMEWORK AND QUALITY

The Board is concerned that appropriate systems (both corporate and clinical) are in place to meet its obligations and comply with law and regulation. In the context of health care, good governance clearly implies taking responsibility for systems to provide quality of care and the monitoring of same. The health strategy places a high level of emphasis on quality, evaluation and continuous improvement. Improving quality in the health system requires implementation of internationally recognised evidence based guidelines and protocols and ongoing education and commitment from health care organisations and all staff.

The development of a quality culture that is embedded into the values of the organisation is a real challenge for all health service organisations. The process of setting evidence-based standards and developing an interdisciplinary approach to the continuous evaluation of the system is also demanding of dedicated time and resources. Progress has been made in the development of quality systems and evaluation processes in parts of the system. The challenge in 2002 is to share this learning and provide an overall framework to support the integration of the development of better quality services for our population.

These areas will be addressed in 2002 within a framework of developing an overall quality strategy for the Board. In particular Governance and Strategic Planning in collaboration with the Public Health Department will consider the development of measures to assess client/patient experiences of services. A commitment has been made to the setting up of a dedicated project (one post allocated), to support developments in the area of consumer/patient satisfaction and Freedom of Information based on national guidelines. This work will build upon some of the initiatives already commenced throughout the region, and will also link in with appropriate initiatives in the Office for Health Management.

The acute hospital accreditation process will be led within the acute hospital sector and appropriately supported within Governance and Strategic Planning.

RISK MANAGEMENT AND HEALTH AND SAFETY

Within the context of developing better quality health care the Board has outlined its commitment to developing a systematic approach to risk management in the Board. Within 2002 the risk management function corporately will be strengthened (2 posts), and risk management teams will be established in each acute hospital group (6 posts), community services group (9 posts) and regional services (3 posts). A commitment has also been made to completing the risk analysis of community and regional services. Areas where policy development is necessary will be identified and a policy formulation process will be commenced both in relation to risk management and health and safety. A review of records management systems with the cooperation of local managers throughout the Board will be carried out.

The Health and Safety team will continue to support and provide guidance to managers in meeting their legal obligations under relevant legislative requirements. Joint initiatives will be developed between risk management and health and safety to develop and implement standardised approaches to risk assessment and incident reporting. These approaches will enhance integrated working at different levels. A submission has been made to the Department of Health and Children to support developments in the areas of health and safety and occupational health for 2002.

EVALUATION AND MONITORING

The Governance and Strategic Planning Department will support the development of an ethos of research and evaluation particularly in relation to service and organisation developments. This work will be carried out in close collaboration with the Directors of Care Groups and the Public Health Department. Dedicated research resources (2 posts) will be appointed in 2002 to help build research capacity, to support organisation development-based research and the further development of evaluation measures.

The ongoing development of performance indicators in liaison with key senior personnel within the Board and the national working group will be a priority area in 2002. The ongoing development of the integrated reporting mechanism with appropriate communication systems will also be targeted.

Governance and Strategic Planning will also continue to support the work of the Board's ethics committee in 2002. A review of appropriate publications in relation to the Board's requirements under Freedom of Information legislation will also be carried out, in addition to the extension and development of the FOI database to all locations within the region.

TRAINING AND DEVELOPMENT

The Board is committed to the development of a learning organisation ethos and to supporting staff in developing the competencies and skills required to meet the increasing demands in the health services.

Many of the change and organisation development initiatives identified within the context of Governance and Strategic Planning for 2002, will require a dedicated learning and development response to support the desired changes. These include developing the competencies of staff to work in a team based way to support partnership working, development of core competencies in the areas of service planning, needs identification and service evaluation, training specific initiatives to support the ongoing development of risk management approaches and training specific to the legislative requirements of health and safety. The development of a programme to support a customer service ethos is planned in conjunction with the Training Department for 2002. There will also be a focus on training needs to meet the requirements of the Freedom of Information Act.

In addition there will be a strong emphasis on the need to align organisation development issues with appropriate individual, team, management and leadership development responses. In this regard there will be a need to closely align the work of the Governance and Strategic Planning Department, the Organisation Development Unit and the Human Resources Department.

SECTION 4

Functional Support

4.1 FINANCE DEPARTMENT

The Finance Department will continue to provide financial services to the Board and all its units in 2002. The use of the SAP system will be further extended to costing and budgeting. The integration of the Finance Department in one premise will enhance teamwork, workflow and efficiency.

The 2001 Annual Financial Statements must be prepared in punts, resulting in an additional workload and complexity.

The devolution of the finance functions in the Board, which commenced in 1998 with the introduction of the SAP financial systems, will be reviewed. Linkages with service managers will be strengthened.

PAYROLL

The links with the National PPARS project will be enhanced and planning for the transfer to the SAP payroll will continue.

The rollout of direct access to payroll date by local centres will continue.

The paypath method of staff payment will be expanded to our home help staff.

ACCOUNTS PAYABLE

Planning for the use of electronic funds transfer (EFT) for non-pay will continue and it will be introduced during the year.

The use of purchasing cards for low-cost items will be expanded.

MANAGEMENT ACCOUNTS

The level of information from the finance systems will be enhanced and close-working relationships will be established in the finance function throughout the Board. The level and volume of information now available needs to be analysed in great depth.

Conjoint work with other health agencies will be carried out to agree costing and benchmark levels.

ESTATE MANAGEMENT

The estate management function deals with the acquisition and disposal of assets. It provides information to the Board, and its property committee, on all relevant issues.

DEVELOPMENTS 2001

In 2001, the Board purchased six properties at a cost of £554,000, while agreement was reached to sell one property for £21,000. Leases for twenty-nine premises were arranged with annual rents of £694,000. The advice of the Valuation Office was used extensively and this contributed significantly to our negotiations.

DEVELOPMENTS 2002

The development of services and the ongoing National Development Plan will require the acquisition / lease of further properties. The Boards Property Committee will be advised of progress and recommendations sought for Board approval on appropriate issues.

INSURANCE MANAGEMENT

The level of claims and awards against the Board continue to rise. We will work with one insurer to identify areas where risks can be reduced and insurance premiums contained as a result.

The service level agreement with our insurers will continue.

STAFF

Four additional staff will be recruited to implement the development outlined above.

MATERIALS MANAGEMENT

Material Management will continue to work nationally and in the region to enhance value for money in the Board. A number of developments are planned for 2002:

- A full review of the supplies and materials management systems and procedures will be undertaken by external consultants
- stock inventory management will be introduced and stock turnover levels will be improved
- the quality of available information will be improved with enhanced reporting
- the use of procurement cards will be extended
- a quality initiative for the regional management service will be undertaken

INTERNAL AUDIT

The increase in the level and complexity of services being delivered by the Board, together with the continued devolvement of responsibilities and accountability, requires the appointment of one additional post in the Internal Audit section. The staffing levels will then be in line with the guidelines set out in the Report of the Review Groups on Internal Audit

4.2 MANAGEMENT SERVICES DEPARTMENT

The vision for ICT is to provide the Board's personnel with modern, integrated computerised information systems that use Information Communication Technology (ICT), where appropriate, to achieve and sustain healthcare professional excellence and to underpin high-quality patient care.

DEVELOPMENTS 2002

The implementation of the Board's ICT strategy will continue with initiatives aimed at progressing the vision of the Integrated Patient Record throughout the Board. This involves the maximisation and consolidation of existing IT systems, continuing the process of improving electronic communication and integration of information within the Board.

One of the key initiatives in this regard is the Community Care Information System (CCIS) for which a vision statement and business plan will be created and presented to the DOHC for their approval and support by the third quarter of the year. A feasibility study will be carried out during the first quarter on the practicalities of implementing a document management system for the Board. The use of Electronic Funds Transfer to pay suppliers and development of data integration and quality projects will be undertaken during the year.

Continued rollout and increased usage of existing systems will see the IT user base continue to increase in 2002. This will mean that the greater proportion of the Department's resources (in excess of 70%) will be devoted to supporting the users and the systems already in place. New software to assist the department monitor and track support calls was introduced in December 2001. The implementation will be completed during the first quarter of the year. This software will allow the department to manage and measure our response times to support queries.

The remaining percentage of the departments" resources will be devoted to developing and upgrading our fifty existing systems.

The Boards IT department moved part of its central Data Centre last year to the new complex at Kells Business Park. The second part of this move is due to be completed by the third quarter of the year.

The continuing demand for additional services and systems will see the extension of our IT Infrastructure and communications networks. The department will prepare a specification for the procurement of network and infrastructure services by the second quarter of the year. The monitoring and pro-active management of the quality and resilience of this network will be a key objective.

With eight of the other Health Boards, we will continue in the conjoint procurement process for a new Hospital Information System. This system will replace our existing system that is almost 10 years in use. The decision on the outcome of this process is expected by the third quarter.

In collaboration with all the Health Boards we will be implementing a performance indicators (PI) system to link with the national PI system in the first quarter of the year.

A review and evaluation of the Central Client Eligibility Index (CCEI) project will be carried out during the year. As the pilot board for this project, the Management Services Department will have an ongoing role in advising and supporting other Health Board's on our implementation strategy and lessons learned.

This Board will be leading the process of developing the national specification for an interface between local Health Board systems and the national CCEI system. It is envisaged that the interface will be implemented during the third quarter of the year.

Within Community Services, the Community Services Information System (CSIS) will become the primary IT system. A prototype has been completed to enable end-users to standardise business processes. The Management Services Department will work in conjunction with Community Services to assess the business impact of the prototype and requirements prior to the implementation of the system. Based on positive internal outcomes and Department of Health and Children funding and support implementation will commence in the fourth quarter of 2002.

A number of E-Health initiatives, including e-forms will be undertaken during the year. In conjunction with Community Services Management Services will be developing electronic forms, such as E111's, that will allow the public access services via the use of the Internet and other technologies.

Completion of projects started in 2001 such as Computed Radiology, Digital Radiology and 24 hour CT and the upgrade of the Radiology Information System will be a priority.

Thin Client Computing (provision of a windows environment) is being installed in the Board's main sites. This will facilitate greater access to, and provide resilience to clinical and administrative systems.

Feasibility studies will be carried out into a number of new developments such as, Regional Call Center/Central telephony and a central booking system for outpatient appointments. The second phase of the Computer Aided Dispatch System for the Ambulance Service will be completed by the end of the third quarter. A project will commence during the first quarter to prepare for implementation of Mental Health into the Boards shared information systems model.

Management Services in conjunction with the Primary Care services Department will be involved in the consolidation and enhancement of a number of existing I.T. developments that were commenced during 2001.

The development of a new Immunisation/Vaccination system will continue during 2002. It is being developed in accordance with a specification produced by a project team consisting of members from Primary Care, Public Health, Public Health Nursing and General Practice.

Consolidation and enhancement of the Primary Care Extranet project will also continue. This will involve further linkages between the NEHB and GP Practice systems.

An automatic payment interface between the local primary care systems and the SAP financials system will also be developed during the first half of the year. This will significantly reduce the manual overhead in processing claims for clinical procedures by General Practitioners.

It is also anticipated that in the second and third quarters the Board will begin the implementation of the new national system for electronic recording of the registration process surrounding Birth's, Deaths and Marriages (Civil Registration Modernisation Programme).

Two additional staff will recruited in 2002 as follows :

- 1 Grade V to provide IT support in Kells
- 1 Grade IV to provide Reception and Administration duties for the Kells Business Park complex.

EVALUATION

The Senior Project Managers and Local IT officers within the department meet on a monthly basis for purposes of planning and reviewing projects. Monitoring of our service plan will take place at these meetings.

4.3 HUMAN RESOURCE DEPARTMENT

INTRODUCTION

The Human Resource Department has a major role to play in promoting and supporting organisational change and reform envisaged in the recently published Health Strategy Quality and Fairness - A Health System for You. Our prime objective is to contribute to the creation of a learning organization where staff are enthusiastic partners in delivering quality services to our clients and customers. We will work with line managers to create an organisation that is committed to achieving excellence, continuous improvement and employee involvement. We will achieve this by:

- Selecting and retaining the best people;
- Creating a climate of continuous learning and improvement;
- Developing future and current leaders;
- Promoting health and wellness within the organisation;
- Promoting good relationships through open communications.
- Partnership Working

All activities undertaken by the H.R. Department will be underpinned by the following values:

- Respect for individuals;
- Dedication to satisfying the Board's customers/clients;
- Integrity;
- Innovation and team working.

During 2002 priority will be given to putting in place a strategy for human resources aimed at harnessing and fully recognising the contribution of all staff. In this context the H.R. Department will work within a partnership model and will provide leadership and direction in promoting an inclusive, participative and positive work environment aimed at recruiting, retaining and developing staff with the objective of providing quality services to patients and clients.

The H.R. Strategy will inform and empower line areas in developing and delivering a structured and quality approach to all aspects of human resource management through the alignment of H.R. practices with the goals and action plans set out in the national and primary care strategies. Best employment practices will be developed and promoted across all services. Further development of the P.P.A.R.S. system will facilitate greater integration of the H.R. function across all line areas within the Board and will support the achievement of both service delivery and staff objectives through the availability of enhanced data and reporting facilities.

RESOURCING & RECRUITMENT

The service developments of the various care groups proposed in this operational plan will require the creation of 330 posts during 2002. The Resourcing & Recruitment Section will work with service managers in developing an action plan and time frame for recruitment to these posts.

The Section, in collaboration with HeBE, will explore alternative approaches and initiatives aimed at recruiting staff in scarce grades to ensure the Board has the capacity within its workforce to meet the objectives of the Health Strategy. This initiative will include maximising the utilisation of ICT. The Section will commence work with local service managers to assess the workplace needs arising from the national and primary care strategies and will liaise with the Department of Health & Children to ensure needs are met from the proposed increase in training places.

A priority for 2002 will be to provide quality information to candidates, the Board's management and line managers through introduction of the following initiatives:

"Intention to Recruit Pack" - aimed at improving manpower planning, job analysis and greater efficiency in the recruitment process.

"Application Pack" - aimed at providing relevant information to prospective candidates.

A Customer Satisfaction Survey and quality assurance process will be undertaken in respect of a number of competitions. This initiative will also examine costs associated with recruitment and selection to individual posts within the Board and will form the basis for future benchmarking.

A Recruitment "Free Phone" Number will be introduced to facilitate candidates seeking application forms. The emphasis will be on customer service and maximising valuable advertising space.

The Section will undertake continuous audit of the recruitment process together with evaluation of the Board's recruitment advertising campaign in order to maximise opportunities for attracting and recruiting staff and to measure internal customer satisfaction with the process.

A programme of Exit Interviews will be introduced with the long-term objective of retaining staff within the Board. This programme will initially pilot 50 interviews in selected sites throughout the Board.

LEARNING & DEVELOPMENT

In early in 2002 work will commence on the task of researching, co-ordinating and further enhancing an Induction Programme for the Board aimed at corporate and line level.

A structured and enhanced evaluation system will be introduced in order to carry out an impact assessment of the training received by staff within the Board. This will be aimed at Prospectus Courses, training initiatives and third-level courses.

The Board will develop and strengthen links with Third Level colleges with the objective of supporting staff development and quality assuring training from a health and social care perspective.

A Training Needs Analysis Programme will be introduced to gain an overall picture of the training needs of staff. This will ensure that training and development programmes will be aligned with objectives outlined in the Health Strategy and with the Board's service plan thereby ensuring that staff have the key skills and competencies necessary to deliver excellent services. This initiative will be supported by the development of the PPARS Training Module.

The Learning & Development Section will work within the partnership model to identify and develop training programmes for staff aimed at facilitating partnership working.

A programme of Personal Development Plans will be piloted within the H.R. Department. This will enable staff to plan and work towards a rewarding career within the Board and will lead to the acquisition of the necessary competencies to enhance performance.

The Section, in consultation with the library services, will continue to evaluate the provision of reading material and computer access throughout the Board's libraries with the objective of consolidating and improving on the success of medical databases and reading material in relation to nurse training and healthcare programmes.

NURSING & MIDWIFERY PLANNING & DEVELOPMENT

A Forum for Continuing Nursing Education is planned to include all disciplines of nursing and midwifery, for the purpose of identifying and targeting training needs in line with national strategies and operational/service plans. In addition the Training Needs Analysis Programme for Nurse Managers will be further developed and evaluated.

An Initiation Course for First-Time Managers specifically targeting the CNM1 grade will be delivered in the region and will provide places for 45 participants.

Manpower Planning & Forecasting of Nursing & Midwifery will commence within the Board in line with nationally agreed strategies. This will include the development of the minimum data set for nurses and midwives.

OCCUPATIONAL HEALTH

The Occupational Health Unit became fully operational in 2001. The Unit will continue to make an important contribution to the wellbeing of all staff. Its main objective will be to work across all services to secure a healthier, safer and more attractive workplace.

2001 saw the introduction of Pre-Employment Health Screening, a comprehensive immunisation programme for all staff and the provision of staff education programmes aimed at safer work practices. In order to consolidate these developments one additional nursing post will be created during 2002.

Additional clerical support will be appointed to facilitate the establishment of an occupational health database with the objective of providing analysis aimed at reducing work-related morbidity.

Staff Counselling & Support Services will be developed in order to lead out positive health initiatives within the Board.

Occupational Health services will continue to provide medical advice in relation to sickness, absence management, return to work, disability, rehabilitation, ill-health retirements, etc. Services will be provided on site in three acute hospitals in 2002 - Cavan General Hospital, Lourdes Hospital, Drogheda and Our Lady's Hospital, Navan. These outreach services will be in addition to the Central Unit at Ardee.

In consultation with Health Promotion Unit, a Life Style & Health Profile Project for staff will be piloted with the aim of increasing awareness of health activities among staff.

SUPERANNUATION

The Section will continue to examine ways of improving established practice to ensure the provision of a quality and timely superannuation and retirement planning service to all staff. In addition the Section will work in partnership with the Board's Induction Co-Ordinator to provide newly appointed staff with appropriate superannuation information.

New legislative change providing for superannuation arrangements for temporary/part-time staff and for the provision of Annual Benefit Statements will come into effect during 2002. These developments will be supported by the appointment of two additional staff.

P.P.A.R.S.

PPARS is a fully integrated computerised H.R. system which will provide a standardised approach for all Boards in areas such as reporting, staff numbers, policy and procedure interpretation, etc. The objective of the system is to provide accurate and timely information in areas such as work force planning, costing, training analysis, etc.

A HR - Payroll interface will be introduced during 2002. The reporting function of the system will be developed and enhanced to meet the statistical requirements of service managers and relevant external agencies in the planning and monitoring of resources.

EMPLOYEE RELATIONS

The main objectives in 2002 will be to provide advice, assistance and support to managers and employees in all areas of employee relations.

The Section will work closely with the partnership process to ensure provision of a better staff relations system and to improve the working environment. This approach will involve identifying employee relations trends and issues with a view to resolving matters within a partnership model. This approach will also include working with the Training & Development Section to provide training for line managers in the area of staff relations and joint problem solving.

During the year a suite of H.R. Policies/Procedures will be developed at corporate level designed to support the H.R. Strategy and communicate best employment practice throughout the organisation.

The Section will work with staff and their representatives in a positive and proactive manner in implementing National Agreements and Guidelines issued from the Department of Health & Children and the Health Services Employers Agency.

It is proposed to strengthen activity in relation to the PPARS function with the objective of ensuring data integrity to facilitate future use of data for workforce planning, statistical returns and costing. Access to live data and decentralised data input will commence on a phased basis supported by a Help Desk. These developments will be facilitated by the appointment of three support staff.

ACTIVITY DATA

	2001 Position	2002 Proposed
OCCUPATIONAL HEALTH		
Medical Examinations	225	350
Health Screening (incl. Pre-employment)	988	1,200
Health Interview (Advisory)	91	150
Health Investigations	210	350
Immune Status Investigations	1,295	2,000
Immunisations	456	800
LEARNING & DEVELOPMENT		
I.T. Courses		
Number of Courses	84	70
Number of Participants	692	750
Management Skills		
Number of Courses	36	40
Number of Participants	514	600
FUNDING FOR THIRD LEVEL COURSES		
Certificate	52	50
Diploma	18	15
Degree	9	10
Masters	9	10
SUPERANNUATION		
Lump Sums/Pensions	65	60
Notifications Issued in Respect of Previous Service	210	250
Benefit Statements Issued	400	600
Pre-Retirement Seminars		
Seminars held	3	3
Attendance	68	70
Early Retirement Seminars		
Seminars held	2	2
Attendance	20	30

EMPLOYEE RELATIONS

Calculation/Payment of Incremental Credit to temporary and part/time staff	1,000	1,000
Applications under Flexible Working		
Time Agreement introduced February, 2001	213	213
Mid-Probation Assessments	250	250
Final Probation Assessments	250	250
Applications for career breaks and		
leave without pay.	200	230
Applications for maternity leave	210	210
Freedom of Information Requests	10	10

NURSING & MIDWIFERY PLANNING & DEVELOPMENT

Continuing Nurse Education		
Prospectus Courses:		
Number of Courses	22	25
Number of Participants	570	625
Funding for Third Level Courses		
Certificate	7	8
Higher Diploma	20	15
Degree	74	65
Masters	9	5

Local initiatives supported:

- Integrated Care Pathways (Louth/Meath Acute Hospital Services)
- Documentation Project (Cavan/Monaghan Maternity Services)
- Solution Focused Brief Solution Therapy (Cavan/Mon. Mental Health)
- Person Centered Dementia Care (Louth Care of the Older Person)

RESOURCING & RECRUITMENT

Panels Formed	320	320
Staff Appointed/Promoted	900	900
Internal Promotions		
Number of Applications Received	3,600	4,500
Application of incremental credit to permanent staff	300	300

PERFORMANCE INDICATORS

During 2002 the H.R. Department will put in place a number of performance indicators aimed at ensuring the work of the Department is efficient and effective in terms of supporting organisational objectives and providing a customer focused service. Performance indicators will include:

- Conduct an Audit and Customer Satisfaction Survey in respect of a number of competitions during 2002 and evaluate findings.
- Number of Line Managers attending Staff Relations Courses
- Percentage of course places filled
- Number of staff attending retirement courses and percentage of course places filled.
- Number of Superannuation Benefit Statements issued to staff.
- Number of H.R. policies completed.
- Personnel/Payroll Interface completed.
- Percentage of all new staff starting who have pre-health screening completed.
- Number of Nurse Managers attending The Initiation Course for First Time Managers.
- Number of Exit Interviews completed.

EVALUATION

The H.R. Department will meet on the second Tuesday of each month for purposes of monitoring progress on the service plan and written evaluation of progress will issue to the Director of H.R. at the end of each quarter.

INTEGRATION

The activities of the Human Resource Department by their nature aim to support the objectives of the Health Strategy and the operational plans of service managers. The Department will promote policies and practices that support a culture of team working and the provision of integrated services. In addition sections within the Department will work across all services to promote a positive work environment aimed at recruiting, retaining and developing staff with the objective of providing a better quality service to patients and clients.

4.4 PUBLIC HEALTH DEPARTMENT

INTRODUCTION

The Public Health Department is principally concerned with the determination of the health status of the population, monitoring and evaluation of outcomes of health services, development of information systems, promotion and encouragement of healthy lifestyles and health orientated public policies and surveillance and control of communicable diseases.

DEVELOPMENTS 2002

The Public Health Department will continue to facilitate the implementation of national health strategies focusing on improving the health of the population in the region.

As part of the Board's overall strategy to deal with the issue of alcohol and drug misuse among young people, a study will be undertaken to identify the levels of such misuse and associated factors in 2002. This study will have two elements with research taking place on children attending second level schools and also early school leavers. Previous research has shown that early school leavers are most at risk. The results of this research will be compared to the study completed by the NEHB in 1997.

The Public Health Department will continue to work with the Health Promotion Unit in the further development of the Health Promotion Schools Project. The Public Health Department will continue to facilitate the implementation of the Best Health for Children and Best Health for Adolescents reports. The second phase of the demonstration project, under the auspices for Best Health for Children, which will look at the views of staff concerning the provision of services, will be undertaken. The Public Health Department will be represented on the Child Care Advisory Committee and will be involved in developing a regional strategy for children and families.

The Public Health Department will continue to work with the health development officers for women's health and men's health groups in order to achieve the targets set out in the National Strategy.

The Public Health Department will undertake the internal research required by the Health Research Board as part of a pilot project in an attempt to quantify the level and quality of research being undertaken within health board units. In addition it will facilitate the implementation of the Health Research Strategy, "Making Knowledge Work for Health" and will recruit a researcher to support the implementation.

The Public Health Department will continue to work with the Pre-Hospital and Emergency Care Project in facilitating the analysis required for completion of the project and in arriving at solutions for the future.

Research will be undertaken in association with the Violence Against Women Officer, assessing A&E staff perceptions of guidelines for managing victims of such violence and the perception of/satisfaction with NEHB services for women who are victims of such violence.

In 1996 the Public Health Department in partnership with the Public Health Nursing services undertook a detailed analysis of the breast-feeding rates within the region. Following on from the results of that analysis a policy document on breast-feeding was developed and widely distributed within the relevant units in the board. It was envisaged that a follow up study would be carried out to evaluate progress. It is now appropriate; given the importance of breast-feeding and that it has been identified as a specific target area within the new health strategy, to revisit this area. It is planned to carry out a review of the implementation of the board's policy in this area and to carry out quantitative and qualitative research on breast-feeding in 2002.

As the number of older persons living at home increases it is important to identify and reduce any risk factors that may result in accidents or hospitalization. In 2002 the Public Health Department will facilitate a study to identify risk factors in the homes of older person's with a view of reducing risks and subsequent injury or illness.

The Report of the National Advisory Committee on Palliative Care 2001 recommended that each health board undertake a needs assessment for palliative care services. The national health strategy has identified this as an initiative to be undertaken in 2002. The Public Health Department will work with the service managers to complete this piece of work, which will guide the development of services for people in the region who require palliative care.

The Public Health Department will continue to provide an input for the development of symptomatic breast services through membership of the regional breast services implementation group. Following the introduction of Phase One of the National Cervical Screening Programme, consideration is being given to the extension of the programme nationally. The Public Health Department will undertake a review of the capacity requirements for the NEHB to participate in the programme.

The requirement to address the health needs of asylum seekers/refugees has been identified in the national health strategy. The Public Health Department will undertake an assessment of the impact of this new client group on the health services in the NEHB and advise on the issues arising.

The Public Health Department will work with the Primary Care Unit to examine the requirements for the primary care teams as indicated in the Primary Care Strategy.

In the area of communicable diseases, a better monitoring system will be put in place through the introduction of two surveillance scientists. This will improve the effectiveness of information systems and improve the quality of data obtained from laboratories, hospitals, Community Care and Primary Care. Further initiatives to improve the infectious disease database will be introduced with the aim of preparing for the introduction of a national system in coordination with the National Disease Surveillance Centre. A regional infrastructure to provide data on antimicrobial resistance, monitor the use of antimicrobials and develop measures to reduce the emergence of resistant organisms will be established. The views of hospital, community care, pharmacists and laboratory staff are being taken into account while devising these measures. Initiatives aimed at reducing the inappropriate use of antibiotics through education, provision of infection control and prescription guidelines will be introduced. This will be facilitated by the appointment of a new clinical microbiologist. In the area of bio-terrorism new measures are being introduced to prepare for the consequences of a biological weapon being used. These include the preparation of a cross border multi-agency educational meeting for dealing with bio-terrorist incidents and increased surveillance of infectious disease to ensure early detection of unusual outbreaks, which may be related to a covert bio-terrorist incident.

Enhanced surveillance of Hepatitis B infection will be initiated from January 2002 and a detailed survey of Meningococcal infection in the NEHB, which began in 2001, will be completed in 2002. The Public Health Department will develop vaccination programmes to meet the objectives of the new childhood infant vaccination schedule including a catch-up MMR programme in all primary schools as well as the introduction of Tetanus/reduced dose Diphtheria vaccination in 2nd level schools. Influenza pandemic planning will be initiated, using the guidelines supplied by the National Influenza Pandemic Committee report 2001. Methods to improve storage, distribution and uptake of vaccines within the board will be formulated and the 2002 Immunisation Guidelines for Ireland will be disseminated among all relevant health-care groups in order to facilitate their implementation.

The Public Health Department, in recognition of the need for quality information to be made available in a timely manner, will publish regular updates on mortality, morbidity and related public health issues throughout the year.

This plan will result in the recruitment of three additional posts; 1 research and development officer, 1 surveillance officer and 1 clerical officer.

INTEGRATION

The Public Health Department works with all service areas in achieving service plan objectives. In addition the department works with other sectors (voluntary, local authority, educational, universities) in trying to ensure health gain and social gain for the NEHB population.

4.5 TECHNICAL SERVICES DEPARTMENT

DEVELOPMENTS 2002

Develop the property maintenance structure throughout the Health Board. This will require the appointment of 5 Maintenance Supervisors (regraded posts) and 9 Assistant Maintenance Supervisors (new posts).

Develop new environmental management section to review the energy management and waste management policies of the Health Board and to introduce new monitoring and reporting systems to ensure that best practices are followed. This will require the appointment of an environmental manager at Chief Assistant T.S.O. grade.

Review and evaluate the effectiveness of the current Fire Safety Training Programme. It is planned to carry out 220 fire safety training sessions in 2002 and these sessions will be evaluated.

Promote the awareness of the Construction Health and Safety Regulations and monitor their implementation throughout the Health Board. This will require Health and Safety training for maintenance staff.

Implement the Board's Capital Development Programme as outlined in the Board's NDP Plan 2000-2006.

4.6 OFFICE OF THE CHIEF EXECUTIVE OFFICER

INTRODUCTION

The role of the office of the Chief Executive Officer is to provide administrative support to the CEO, the management team, the Board and a number of its committees to ensure the efficient and effective management of the corporate affairs of the Board. The office also provides administrative support to the CEO in his roles as Chairman of the national CEO group, Director General of CAWT, Chairman of the Pre-hospital Emergency Care Council and other tasks that arise from time to time. The office also carries out a number of accounting functions for the above external agencies. The Senior Administrative Officer chairs a group of the senior managers in Head Office to ensure the timely co-ordination and dissemination of information relating to the workings of the Board. The office is also responsible for the day-to-day upkeep and maintenance of the Headquarters building.

A communications department was established within the CEO's office in 2001 under the direction of the Communications Co-ordinator. This department is responsible for both internal and external communications of the Board. It is also responsible for ensuring timely and accurate replies to Parliamentary Questions and the co-ordination of the publication of the various reports of the Board during the year.

DEVELOPMENTS 2002

In 2002 the office will continue to provide the administrative support required to the CEO, the Board and its committees in order that they can continue to function in an efficient and effective manner.

The work of the office will also be influenced by the implementation of the actions contained in the National Health Strategy.

An audit committee will be established as recommended in the report of the review group on internal audit in Health Boards.

A number of initiatives will also improve the services provided by the office in conjunction with other departments, agencies and external bodies in 2002 including;

- A local HeBE office will be established in March 2002
- A free-phone service for Board members will be provided in conjunction with the Management Services Department and the Board's Customer Care Office
- The Board's intranet will be further developed
- The staff magazine will be further developed and an editorial board will be appointed
- In conjunction with the Management Services Department the Board's web-site will be updated
- In order to improve our external communications a Press Officer will take up duty early in 2002
- The office will facilitate the election of Board members in accordance with the Health Board (Election of members) Regulations 1972

The above developments will result in the employment of 3 additional staff. A number of caretaking positions will also be regularised in 2002.

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