Value for money assessment: review of allocation and utilisation of funding in acute services in the southern hospital group: final summary report.

Talbot Associates
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ERNST & YOUNG
Quality In Everything We Do

VALUE FOR MONEY ASSESSMENT: REVIEW OF ALLOCATION AND UTILISATION OF FUNDING IN ACUTE SERVICES IN THE SOUTHERN HOSPITALS GROUP

FINAL SUMMARY REPORT

27 NOVEMBER 2007

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GLOSSARY AND ABBREVIATIONS

AEP: the Appropriateness Evaluation Protocol is a tool designed to assess bed utilisation. The AEP determines whether a particular patient was appropriately admitted to an acute bed in the first instance, and also to assess whether a patient is appropriately occupying an acute bed on a given day.

AFS: the Annual Financial Statement is a document that gives the Health Service Executives' financial status, stating profits and losses, for the year.

ALOS: Average Length of Stay is the average time spent by an inpatient in an acute hospital.

AR-DRG: Diagnostic related groups a system to classify hospital cases into one of approximately 665 groups, also referred to as DRGs, expected to have similar hospital resource use.

CME: Continuing Medical Education.

CMU: Case mix unit is a system that classifies people into groups that are homogeneous in their use of hospital resources. It takes account of case complexity.

CPD: Continuing Professional Development refers to the continuous updating of professional knowledge.

CUH: Cork University Hospital.

DOHC: The Department of Health and Children.

ED: the Emergency Department in an acute hospital.

HCAI: Healthcare Associated Infections refers to infections that occur as a result of contact with a healthcare system.

HIPE: Hospital Inpatient Enquiry Scheme is a computer-based health information system designed to collect clinical and administrative data on discharges and deaths from acute hospitals in Ireland.

HSE: Health Service Executive refers to the management body responsible for providing health and personal social services in Ireland.

MUH: Mercy University Hospital.

MRSA: Methicillin-Resistant Staphylococcus Aureus is a form of healthcare associated infection.

Network 2: comprises the eight hospitals in the Southern Hospitals Group and is made of the six statutory hospitals and the two voluntary hospitals.

NHO: the National Hospitals Office is a division of the Heath Service Executive with responsibility for the management of acute hospitals in Ireland.

NTPF: the National Treatment Purchase Fund is a monetary fund set aside to finance the treatment of public patients who are waiting more than three months on a public hospital in-patient waiting list for an operation.

Occupancy: occupancy refers to the percentage of hospitals beds occupied by patients. Bed occupancy is typically measured on an annualised basis.

OECD: Organisation for Economic Cooperation and Development.

OPD: Outpatients Department.

Patient Treatment Register: Patient Treatment Register is a register for public in-patient and day-case hospital waiting lists. The Patient Treatment Register is managed by the National Treatment Purchase Fund.

PCCC: Primary, Community and Continuity Care Services refer to the provision of health and personal social services in health facilities and communities. This includes primary care, mental health, disability, child, youth and family, community hospital, continuing care services and social inclusion services.

PMU: Performance Management Unit is a division within the Health Service Executive responsible for the monitoring of data relating to acute hospitals in Ireland.

SHG: Southern Hospitals Group refers to a group of eight acute hospitals operating within the Health Service Executive southern area. The SHG is a division of the National Hospitals Office.

SHG+: includes the eight hospitals in the Southern Hospitals Group plus acute services provided by St. Finbarr's Hospital (St. Finbarr's is not classified within the Southern Hospitals Group).

SHG Level 1: Level 1 refers to the Southern Hospitals Group organisational layer in the Health Service Executive. Strategic planning for the Group occurs at this level. Business plans formulated at Level 1 are directly informed by HSE Corporate plans and are also used to drive local hospital business plans.

SIVUH: South Infirmary Royal Victoria University Hospital.

VFM: Value for Money.

WTE: Whole-Time Equivalent is the equivalent number of combined part-time and full-time staff resources operating on a full-time basis.

1. EXECUTIVE SUMMARY

This Value for Money (VFM) study has been conducted by Ernst & Young, in association with Talbot Associates. The consultants were asked to provide a systemic analysis of the allocation and utilisation of funding for expenditure in the Southern Hospitals Group (SHG) in 2006 under the Government's Value and Policy Review Initiative.

The overall objective of the review is to:

- assess the VFM achieved from money allocated and utilised in the (SHG), and
- inform the scope for alternative approaches.

The SHG includes the following hospitals – Cork University Hospital, Mallow General, Erinville (Cork Unified Maternity Hospital), St Mary's, Kerry General, Bantry General, Mercy University and South Infirmary Victoria University Hospital.

1.1 Conclusions

Efficiency & Economy

The SHG did not provide optimum VFM in 2006. The evidence is:

- Productivity declined with the introduction of new staff over the period 2004-2006. Each staff member is on average serving fewer patients.
- Costs have increased in real terms. Real costs per patient/CMU have both increased by 3% in 2006 relative to 2004 which reflects inefficient use of staff and other non pay resources.
- Costs for inpatients and day patients are greater than national norms in certain hospitals.
- Utilisation is up to 13.5% below Australian practice.

We believe that costs per CMU could be held constant or reduced, in real terms, through a series of actions, including:

- Holding real costs constant through improved staff deployment and other related measures, including reductions in day-patient costs, and increased use of shared services. If real costs and productivity had remained at the 2004 level then the savings in 2006 would have amounted to over €15m.
- Improving productivity through progressive reductions in length of stay, the increased transfer of treatment to day patient settings and elimination of costs associated with unused facilities arising from these measures.
- Improvements in budgetary control.
- Alignment of incentives.

At the same time improved patient service can be achieved through reduction in waiting times, shorter length of stay and improved quality control.

Effectiveness

At SHG level, our review confirms that:

- Outpatient volume targets were met, the proportion of day cases as a proportion of total cases increased, and average length of stay is lower than the national average.

- Targets were not achieved for day patients, inpatients or emergency departments. Three out of the four main settings targets were missed. Missing an individual target is not necessarily a sign of ineffectiveness. However, missing a number of targets when other metrics such as occupancy, ED waiting times, medical and surgical waiting times and ALOS are average by comparison to national and international benchmarks suggests a higher level of effectiveness can be achieved.

- Target-setting was very limited in scope and not integrated with resource planning. Only 22% of actions had identified targets, while a further 41% had inferred or implied targets.

Outcomes

There are no comprehensive set of objectives or targets in terms of population need, patient groups to be served, or outcomes. This is a critical requirement in focussing the efforts of management, in assessing performance and in the evaluation the VFM achieved.

Key Finding

There is significant opportunity for the achievement of improved VFM in terms of:

- Increased and lower cost day case activity.
- Shorter length of stay.
- Lower cost per CMU.
- Improved staff management.

1.2 Recommendations

The challenge is to deliver on the opportunities for greater efficiency which exist. The business planning framework at both hospital level (Level 2) and SHG (Level 1) can be used to manage progress against the recommendations in this report.

Setting Targets – Key Metrics

At both SHG and hospital level, targets should be defined:

- To achieve policy results in terms of patient care and outcomes.
- To reduce average length of stay to international best practice.
- To increase day case activity based on a basket of appropriate day cases defined at HSE level.
- For elective work which can be achieved in a day setting.
- To reduce the cost per case to an agreed target.

These targets are specifically designed to address the most significant areas for improvement which were noted above. Other performance measures are recommended as part of the overall set of VFM indicators.

Measurement of Targets and Management

At both hospital and SHG level, VFM targets must be measured, monitored and managed against. Hospital targets must be reported to the SHG. The development of budgeting, costing, performance or quality related management systems should support the process, at hospital and SHG level, of:

- Achieving best patient outcomes.
- Defining appropriate targets.
- Providing relevant, high quality data, and,
- Measuring against targets to inform management decisions.

Below and overleaf, we present a short summary of all recommendations under three headings of:

- Efficiency and effectiveness.
- Management processes and systems.
- Further study.

Likely effect, level of priority, time and lead responsibility are also summarised.

Effectiveness and Efficiency Recommendations

Recommendation	Effect	Priority	Timing	Lead Responsibility
Set Targets for Key Metrics	High	High	2008 Q1	HSE /NHO (Network 2 Office)
Set Targets – Hospital Level (agree with NHO/HSE)	High	High	2008 Q2	Hospitals
Collect Data	High	High	2008 Q3 on	NHO (Network Office /Hospitals
Manage Performance	High	High	2008 Q4 on	Hospitals/NHO (Network Office)
Manage against	High	High	2009 Q1 on	NHO (Network Office) /Hospitals

Management Systems Recommendations

Recommendation	Effect	Priority	Timing	Lead Responsibility
Integrate business systems	High	High	2008	HSE
Strengthen and deepen budgetary control systems	High	High	2008	HSE
Improve data gathering and information provision	High	High	2008 Q4	HSE/ NHO (Network Office /Hospitals
Implement Balanced Scorecard - Design/agree - Rollout	High	High	2008 Q2/Q3 2008 Q4	HSE/NHO (Network Office) /Hospitals
Introduce Enhanced Quality Management	High	High	2008 Q4	HSE/ NHO (Network Office /Hospitals
Improve Structure	High	High	On going	HSE/ NHO (Network Office /Hospitals

Issues for Further Study

We recommend that the following areas are studied.

Recommended areas to study	Effect	Priority	Timing	Lead Responsibility
Budgetary control systems	-	High	Mid 2008	HSE
Quality management	-	High	Mid 2008	HSE
Structural change and integration	-	High	Mid 2008	HSE/ NHO (Network Office /Hospitals
Incentives for efficiency	-	High	Mid 2008	HSE/ NHO (Network Office /Hospitals

While there is a need to invest at HSE level in appropriate systems and support for the full implementation of these recommendations, the costs are likely to be significantly outweighed by the benefits. We do not see specific additional costs at a hospital level, other than the cost of normal management time which should be directed to these matters in any event.

Accounting Issues

The 2006 Revised Estimate Volume (Appendix 2 to Vote 40 for the HSE) showed estimated expenditure attributable to Network 2 (SHG) as €664.2m. This is considerably higher than the actual expenditure of €590.1m shown by the Annual Financial Statement (AFS) for SHG. There are two issues – first, it has not been possible to obtain a reconciliation of the €664.2m to the actual expenditure within the SHG. Thus, it is not possible to say whether all of the funding attributed to Network 2 in the appendix to the Estimate was used for the provision of services to or by Network 2. Secondly, HSE structures, which are based on national pillars (of which NHO is one pillar), are not aligned to the Vote. As a result, managers at network level are not in a position to affect the VFM obtained for all of the expenditure attributed to Network 2 in the appendix to the Estimate.

2. Introduction

2.1 Objectives of Review

As stated in the terms of reference, "the purpose of the review is to provide a systematic analysis of the allocation of funding for expenditure in the SHG in 2006 under the Government's Value and Policy Review Initiative."

The Terms of Reference specified that the review "will focus specifically on the €664m allocated to the Southern Hospitals Group". The financial analysis set out in this document relates to SHG actual net expenditure of €531.8m (gross €590.1m) in 2006, as reported in the AFS for 2006. The difference of approximately €41.9m gross represents funding that was set out in the 2006 estimates (Appendix 2) as relating to Network 2 but was not subsequently or formally allocated by HSE directly to Network 2.

2.2 Scope of Review

The scope of the review included:

- A review of financial and accounting policy only.
- Detailed consideration of the allocation process to hospitals.
- Detailed analysis of expenditure by specialty across the hospital group.
- Detailed analysis of expenditure is required by Diagnostic Related Groups (Case mix) where available.

In-scope hospitals

The table overleaf presents a brief profile of each of the hospitals reviewed for this report. While St Finbarr's Hospital is not part of the eight hospitals in the SHG, for consistency and completeness, data relating to acute services for this hospital was also reviewed.

Figure 2.1 – SHG Hospitals

Hospital	Location	No. of Beds (Inpatient/Day)*		Statutory/Voluntary
CUH	Cork	556	55	Statutory
Mallow General	Mallow	76	5	Statutory
Erinville	Cork	N/A	N/A	Statutory
St. Mary's	Cork	123	0	Statutory
Kerry General	Tralee	377	0	Statutory
Bantry General	Bantry	118	0	Statutory
Mercy University	Cork	230	59	Voluntary
SIVUH	Cork	200	58	Voluntary

*Source: HSE web-site, 19 November 2007: http://www.hse.ie/en/FindaService/HealthServices/County/

Hospitals in the SHG have undergone a number of changes in recent years. This change has arisen at both national, group and hospital level. Significant issues which have impacted on the operation of the SHG include:

- Winding up of the Southern Health Board and the establishment of the HSE under the Health Act 2004.
- Realignment of Primary, Community and Continuity Care (PCCC) services.
- Establishment of the National Hospitals Office to manage acute hospital care and ambulance services.
- Consolidation of maternity services into a specialised maternity hospital setting within the CUH group.

Estimates for 2006

The Project Proposal for the "Review of Allocation and Utilisation of Funding in Acute Services in the Southern Hospitals Group" specified that the review would "focus specifically on the €664m allocated to the Southern Hospitals Group". This sum was the expenditure attributed to the provision of services by the Network 2 hospitals as shown in Appendix 2 of the Revised Estimates for 2006. The total net expenditure for the SHG, as per the 2006 Income and Expenditure Account, was approximately €507m against a final budget of approximately €505m.

The consultants were required to examine the difference between the Estimates amount and actual expenditure and to assess the VFM of all funds expended within the SHG only. Based on information available we have identified the following:

1. Gross expenditure (€664,228) attributable to Network 2 in 2006 Estimates, excluding central overhead €629.377m
2. Gross expenditure (including €507,106) per AFS €590.081m
3. Unexplained difference €39.296m

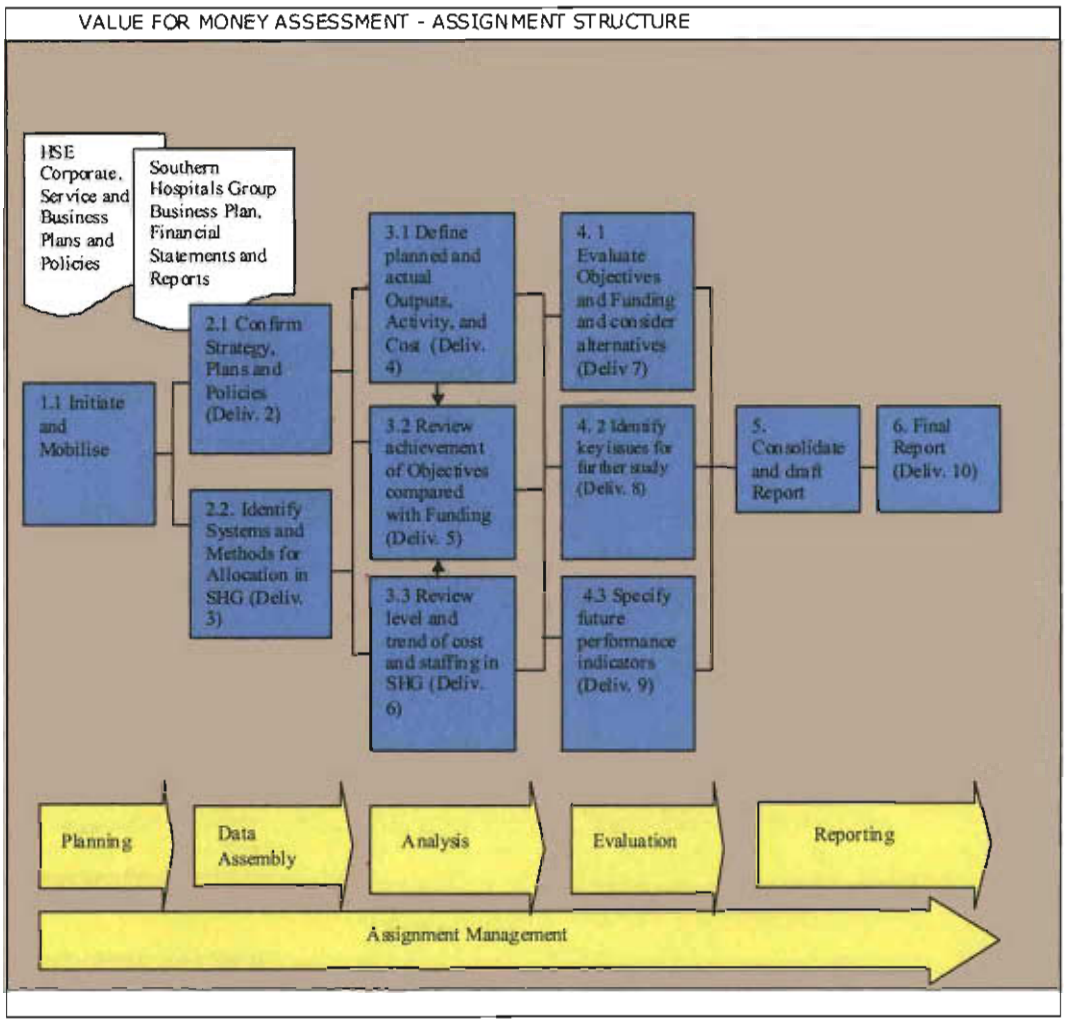
We have not been able to obtain from HSE a reconciliation of this difference or data that might enable us to the carry out such reconciliation. Some part of the difference will be attributable to the fact that the Estimates are prepared on a vote, or cash, basis, while actual expenditure, per the Annual Financial Statements, is accounted for on a Income and Expenditure, or accruals, basis. It is possible that a full reconciliation may not be available at network level, given the necessary level and difficulty of estimation in relation to the 2004 position, which, through the 2005 estimates, underlies the expenditure attributed to Network 2 in the 2006 estimates. The VFM assessment has been carried out on the funding actually made available to, and controllable by, the SHG.

2.3 Approach and Report Structure

Our Approach

Our approach to this review is illustrated below. The five key phases of the project are outlined with tasks completed at each stage also identified. The key deliverables are identified.

Figure 2.2 – Approach for Report Completion



International best-practice

As specified in the terms of reference, and where appropriate, international best practice data is used to compare SHG activity data. Sources for data comparison across international settings included OECD and Eurostat (the statistics division of the European Commission), as well as case mix data for Australian healthcare settings. Generally, international data is not directly comparable. However, Australian and Irish case mix weightings are comparable and a more detailed comparison of SHG and Australian activity data is presented in the report.

Structure of Summary Report

The structure of this report has been informed by Department of Finance guidelines on VFM report writing[1]. The body of this report contains seven key sections. These are:

- ***Strategic objectives of the SHG*** – this section examines the validity of the objectives for funding allocation and utilisation for acute services within the SHG. These objectives are also assessed for their overall compatibility with NHO/HSE strategy.

- ***Inputs*** – this section identifies the systems and methodologies used for the allocation of funding to and within the SHG.

- ***Outputs*** – this section identifies SHG output activity and trends and assesses these against the level of funding provided. This section also examines the extent to which objectives have been achieved and the effectiveness with which they have been achieved. Finally, the level and trend of costs and staffing resources associated with the SHG is examined and the efficiency with which objectives have been achieved is commented on.

- ***Results*** – this section evaluates the degree to which objectives warrant the allocation of public funding on a current and ongoing basis.

- ***Scope for alternative approaches*** - this section examines the scope for alternative policy/organisational approaches towards achieving objectives on a more efficient or effective basis.

- ***Opportunity for improvements in management processes*** - this section examines key processes where change is required to support value driven initiatives. Potential future performance indicators which may be used to better monitor the allocation and utilisation of funding to and within the SHG are also identified.

- ***Conclusions and recommendations*** – This section presents the conclusions and recommendations and specifically addresses key issues for further study, including factors which adversely impact on efficiency.

2.4 Background to Establishment of SHG

It is worth noting that this review relates to a period of great change in the Irish public healthcare system. The HSE was established in 2005 under the Health Act, 2004. The HSE replaced the previous system of regional health boards and was formed to act as a single entity with responsibility for delivering health and social care needs in Ireland. The NHO is a sub-division of the HSE and has responsibility for delivering acute hospital services nationally.

[1] *'Value for Money and Policy Review Initiative Guidance Manual'*, Value for Money and Policy Reviewers' Network Central Expenditure Evaluation Unit, Department of Finance, March 2007.

2.5 Acknowledgements

Ernst & Young would like to acknowledge the contribution of the Steering Committee, chaired by Mr. Tom Finn, Assistant National Director – NHO, and particularly Ms. Sandra Daly and Ms. Noelle Dineen for their helpful work throughout the review process.

3. Strategic Objectives of SHG

3.1 Introduction/Section Objectives

The objectives of this section is to examine the current validity of the objectives in relation to the allocation and utilisation of funding of Acute Services in the SHG and their compatibility with the overall strategy of NHO/HSE, from within which the SHG operates.

3.2 Evaluation of Objectives

The key corporate objectives of the SHG for 2006 are as follows:

1. "We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice.
2. We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion.
3. We will empower staff to deliver responsive and appropriate services, making effective team-working a priority.
4. We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders."

Under each specific corporate objective the following are included and confirmed by the network as focus areas:

Figure 3.1 – Corporate Objectives

Objective 1	Objective 2	Objective 3	Objective 4
Equitable Access	Emergency Planning	CME/CPD	Feedback mechanisms
Waiting Times	Breastcheck/Cervical Screening	Clinical practice training	Clinicians in Management
Integration	Cardiovascular	Violence in the Workplace	Monitoring mechanisms
Reorganisation of Services	Cancer		Uniform Data Standards
Primary Care *	Health Promoting Hospitals		Performance Improvement Initiatives
Community and Continuing Care Services *	Obesity		
ED Services	Breast Feeding		
Quality, Safety & Risk Management			

* These areas are not acute services and are not considered as part of this review.

Each focus area contains a number of identified actions as being required to improve or develop the focus area. The objectives, focus areas and actions mirror exactly those outlined in the HSE National Corporate Plan 2005 – 2008 and the HSE Service Plan 2006 and the SHG Level 1 Business Plan has therefore cascaded the agreed national objectives and actions appropriately.

The SHG has confirmed that the objectives and action areas are rational and are the most effective choices in addressing national and Network level strategy.

Each action lists between one and twenty tasks (typically 7-10). These tasks are region and hospital specific initiatives. The following example illustrates the hierarchy of the stated objectives and actions.

Figure 3.2 – Hierarchy of the Stated Objectives and Actions

Origin		Example
HSE Corporate Plan 2005 – 2008 & Network 2 Business Plan 2006	Objective	We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice
HSE Corporate Plan 2005 – 2008 & Network 2 Business Plan 2006	Focus Area	Waiting Times
HSE Service Plan 2006 & Network 2 Business Plan 2006	Action	Work with the National Treatment Purchase Fund (NTPF) to target a reduction in waiting times
Network 2 Business Plan 2006	Tasks	Agree a service level agreement with NTPF (CUH) (KGH) (MUH) (SIVUH)
Network 2 Business Plan 2006		Pilot a number of outpatient initiatives with NTPF (CUH) (KGH)
Network 2 Business Plan 2006		Initiate and participate with the Patient Treatment Register (CUH) (KGH) (MUH) (SIVUH)

It was not clear from the HSE Corporate Plan 2005 – 2008 or the HSE Business Plan 2006 what was required of Networks at the action level in terms of performance or areas for attention. This allowed Networks the flexibility in selecting tasks appropriate to their area and setting targets and metrics which are suitable and achievable in their area.

3.3 Context in 2005/2006

The National Corporate Plan 2005 – 2008 was developed by the initial management team assigned to the HSE on its creation in 2005. The plan was subsequently revised by members of the current HSE management team in a short timeframe (as requested by the Department of Health and Children) and accepted by the Board of Directors in December 2005.

The Network 2 business, Level 1, plan for 2006 was completed at the end of June 2006. Although the plan was not confirmed until June 2006, a network manager was in place and dealing with individual hospitals directly and had approved Level 2 (hospital level) plans. Budgets, WTE ceilings and the activity targets were also set by January 2006.

3.4 Review of SHG 2006 Targets

The following points are relevant to the issue of targets:

- Targets were generally not identified or quantified for the actions or tasks in the Level 1 business plan.
- Some actions cannot be measured against targets for one of two reasons:
  - The action is not something that can be quantified with a specific and measurable target.
  - If a target has been identified, sufficient data may not exist or be available to measure progress against the target.
- HSE does not include specific financial or monetary commitments or budgets to actions or objectives in the business plan.
- A number of actions relate to national objectives or initiatives for which Network responsibility or specific funding may not be readily apparent.
- Without specific assigned targets for all actions, the 2006 (network) business plan could not be effectively utilised by SHG management to report at a national or corporate level. However, the Network Office did report against specific targets (where defined) as requested by the National Hospitals Office.
- Locally, formal quarterly service plan review meetings are held with hospital CEOs to review progress.

We have reviewed the 70 actions included in the Level 1 business plan and evaluated the extent to which targets were present or identifiable. The following categories were utilised to grade the actions, and examples have been included to illustrate the distinction.

- Defined target – a target was specifically enunciated in the business plan.

Emergency Planning	Continue to participate in the Major Emergency Planning activities of the HSE	Major Emergency plans finalised and adopted Review of helicopter landing facilities 4 SEVESO exercises completed FLU Pandemic plan collated for each hospital

- National inferred target – a target can be inferred for this action based on national communications, strategies or plans published or finalised during 2006.

Waiting times	Work with the National Treatment Purchase Fund (NTPF) to target a reduction in waiting times	No adult waiting longer than 6 months and no child longer than 3 months (Health Strategy)

- Implied target – a target can be implied from the working of the action, so whilst lacking specificity or an exact metric, the action could be crudely measured or evaluated.

Obesity	Identify priority actions for hospitals to implement the Report of the National Task Force on Obesity	Actions identified

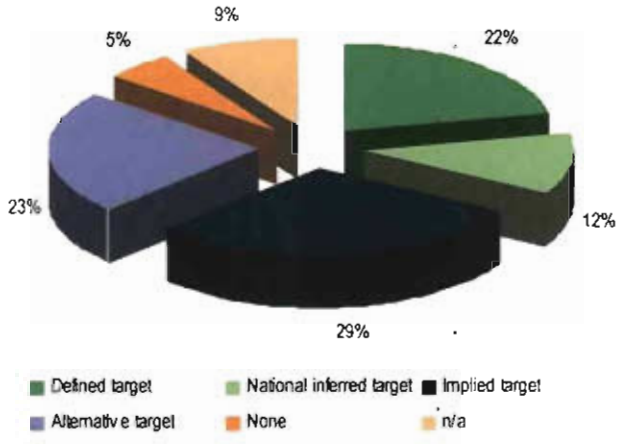
- Alternative target – a target, if identifiable, could not be said to belong to any of the above categories, however it is likely that a target could have been identified.

CME/ CPD	Continue to support Continuous Medical Education (CME) and Continuous Professional Development	No of staff with required CPD hours

- None – it is unlikely that a meaningful target could be identified (i.e. the target does not have at least 2/3 of the features of a SMART target).
- Not applicable – the action relates to national level actions or focus areas not relevant to the NHO.

It can be seen from Figure 3.3 below that only 22% of actions could be said to have defined targets. However, a further 29% of actions had an implied target which indicates half of the identified actions could have had SMART targets identified and managed against.

Figure 3.3 – Actions related to defined targets



A complete listing of the actions and their categorisation is included in Appendix 2.

3.5 Conclusions

- The objectives, focus areas and actions mirror exactly those outlined in the HSE National Corporate Plan 2005 – 2008 and the HSE Service Plan 2006 and the SHG Level 1 Business Plan has therefore cascaded the agreed national objectives and actions appropriately.
- The SHG has confirmed that the objectives and action areas are appropriate (rational).
- 2005/2006 was a period of great change. New plans were being agreed for the HSE which was formally established in 2005. Planning at SHG took place within this context.
- Only 22% of actions have identifiable targets, while a further 41% of actions have either inferred or implied targets.

4. Inputs

4.1 Introduction

Inputs to the SHG come in two forms, monetary inputs used to finance and fund its operations and staff inputs employed to carry out and implement the day to day running of the SHG. This section examines both of these inputs.

We also examine the systems and methodologies currently used for allocating funding to and within the SHG, including the comparison of actual versus budgetary expenditure. We also highlight the management processes for delivery of allocations to hospitals.

4.2 Monetary Inputs

Funding for the SHG

Total costs incurred by the SHG in 2006, as per the AFS, were €590.1m. This total includes some items, e.g. superannuation in respect of retired staff and costs/income in respect of certain research projects, which are outside of normal day-to-day operations and are excluded from operating costs as reported on the SHG Income and Expenditure statements. These latter statements show gross operating costs of €564.5m for the year, representing own income of €57.4m and net expenditure of €507.1m. The detailed Value for Money assessment has been carried out in relation to the allocation and utilisation of those funds under the control of SHG management.

The 2006 Revised Estimate Volume (Appendix 2 to Vote 40 for the HSE) showed estimated expenditure attributable to Network 2 (SHG) as €664.2m. This is considerably higher than the actual expenditure of €590.1m shown by the AFS for SHG. Although the appendices to the Estimates are not formally part of the Vote, it is believed by the Steering Committee that the Oireachtas, in approving the Vote, is informed by the level of costs attributed in those appendices to specific services. The consultants were therefore required to examine the difference between the Estimate amount and actual expenditure.

There are two known elements that would contribute to the difference of €74.1m:

1. The Estimate is prepared on a vote, or cash, basis while the AFS is prepared on an accruals basis, which takes account of items of income earned and expenditure incurred which were not received or paid as at the date of the accounts. The difference arising from the utilisation of these two different bases would equate to the movement in the level of accruals/prepayments over the accounting period.
2. The Estimate figure will have included an allocation of central overheads, e.g. in respect of shared central services which provide support to operational areas such as SHG. The amount included in the 2006 Estimates for allocation of central overheads to SHG was, we understand, €34.9m.

We understand from the HSE Finance Directorate that the HSE budget is based upon the Estimate as published and is reconciled and maintained nationally within the Directorate. We also understand that Vote and accrual accounting are reconciled monthly at a national level. These reconciliation activities reflect the difficulty of operating with legacy systems that are not appropriate to a national organisation and

also of reporting on two different accounting bases. That being said, we have not, as at the date of this report, been able to obtain from HSE a reconciliation of the difference between the Estimate and AFS expenditures for 2006 at Network 2 (SHG) level.

An underlying issue is that the structure of the Vote, with sub-heads aligned to former health board regions, does not reflect the current organisational structure of the HSE, which is based on national pillars. Voted funds are managed on a national basis. Managers at local network level work solely with, and are responsible for, the funds allocated through the budgeting system. They are not in a position to affect the VFM obtained for all of the expenditure attributed to Network 2 in the appendices to the Estimate.

Allocation to HSE South

The overall allocation to the HSE for the year is voted to the Accounting Officer by the Oireachtas on the basis of the HSE vote included in the Revised Estimates for Public Services.

The estimates are entered into the HSE's Rosetta web-based budgeting system which records and communicates the budgets being made available to the operational areas.

HSE South is regarded as one area entity, broken down into 13 categories:

1. Cork Dental.
2. South East Area – PCCC.
3. South Eastern Statutory Hospitals (Network 1).
4. South East Area Corporate.
5. South Area PCCC.
6. Southern Statutory Hospitals (Network 2).
7. Southern Area Corporate.
8. Mercy University Hospital (Network 2 voluntary).
9. South Infirmary – Victoria Hospital (Network 2 voluntary).
10. Regional Acute Services (South).
11. Regional Acute Services (South East)
12. Network Manager's HQ (South).
13. Network Manager's HQ (South East).

Categories 6, 8 and 9 together constitute Network 2, the SHG.

The allocations within hospitals are represented by the hospital budgets. Each month, actual expenditure is reported together with forecasts to the end of the year. During the financial year decisions may be made by hospital management in discussion with the Network Manager on the utilisation of available funds to meet service priorities.

Budgets are assigned on the same bases as for the estimates process that is:

Pay	Element 1 of pay budgets (basic pay) is based on approved funded whole-time equivalents, using a 'zero base' approach, adjusted for pay awards

	Elements 2-9 (other pay costs) are 'rolled', utilising prior-year actuals adjusted for inflation
Non-pay	Based on 'rolled' budgets plus adjustments for inflation
Income	Based on 'rolled' budgets plus adjustments for inflation, plus adjustments for known changes in charges.

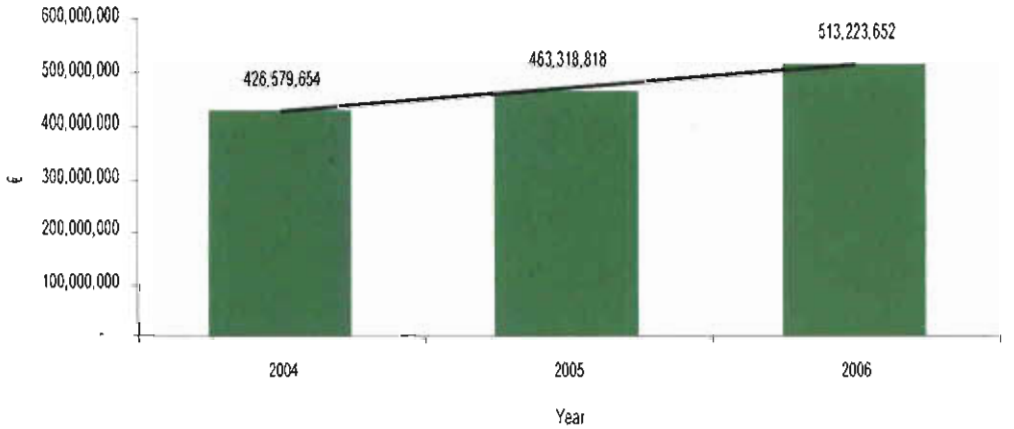
Allocations are, effectively, based on the core recurring budget (allowing for inflation) *plus* the cost of new developments *plus* pay awards.

Analysis of Net Expenditure in SHG

SHG net expenditure, as reported in the AFS, rose from €397.4m in 2004, to €437.5m in 2005 and to €534.8m in 2006. Because, however, of changes in structures over that period and the related changes in accounting, direct comparison of total net expenditure between the years is somewhat misleading. In order to enable analysis of cost trends, some cost elements that were not common across each of the three years have been excluded. Details of these adjustments are included as Appendix C. The adjusted expenditures are used as a basis for inter-year comparison.

Figure 4.1 below shows the trend of costs over the period 2004-2006.

Figure 4.1 – Total Net Expenditure 2004-2006



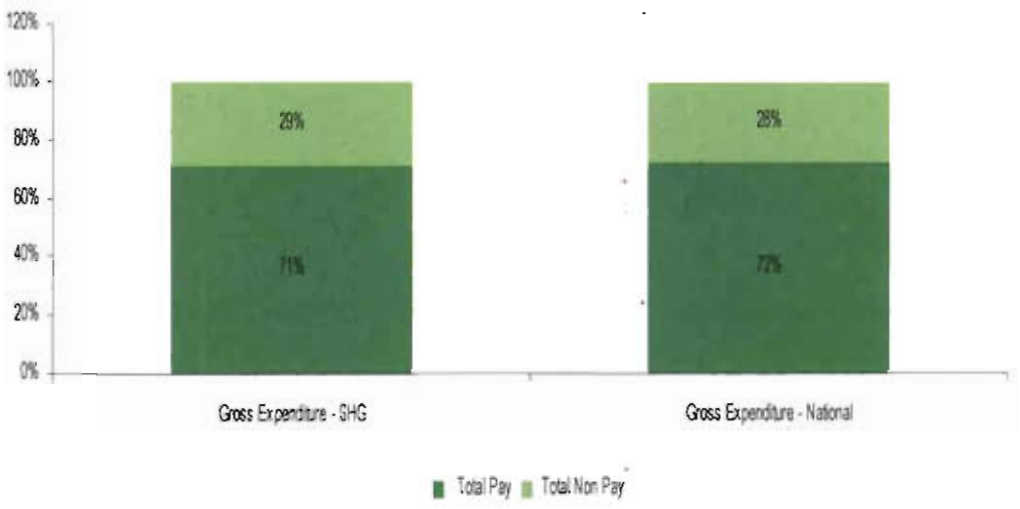
This shows that SHG net expenditure increased from € 426.6m in 2004, to €463.3m in 2005 and €513.2m in 2006. This represents an increase of 20.3% over the period.

Pay versus Non-Pay Expenditure

Figure 4.4 compares the proportion of gross expenditure that is spent on pay versus non-pay for SHG (non-voluntary hospitals) to the national (non-voluntary hospitals) level for 2006[2]. This shows that SHG spent a 71% of its gross expenditure on pay and 29% on non pay which is broadly in line with national spend for NHO non voluntary hospitals.

[2] Voluntary Hospitals have been excluded from the above comparison to national figures. This is because the AFS does not permit a distinction between pay and non pay spends for these hospitals.

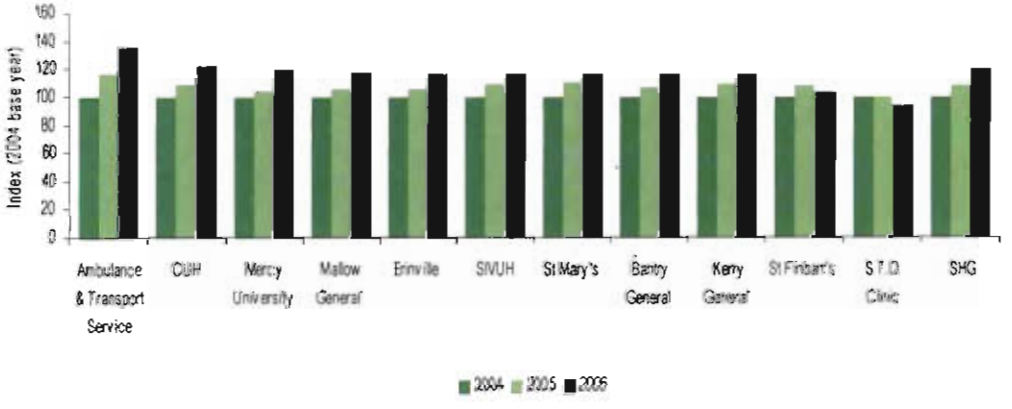
Figure 4.2 – Proportion of spend on Pay versus Non Pay-2006



Real increase in expenditure

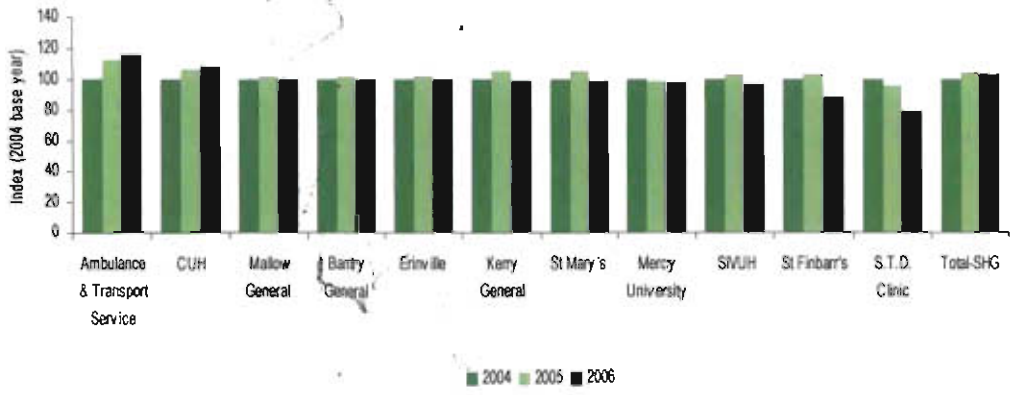
Indexed net expenditure by hospital is shown below in nominal terms. All hospitals and services show increases in funding over the period. Ambulance and Transport Service, CUH and the Mercy University Hospital had the highest increases with St. Finbarr's Orthodontic Unit and the S.T.D. Clinic having the lowest increases.

Figure 4.3 – Indexed Total Net Expenditure 2004-2006



While total net expenditure increased by 20.3% in 2006 when compared to 2004 as highlighted in Figure 4.3, this is a nominal increase which ignores the effect of medical inflation. Deflating net expenditure in an attempt to take into account medical inflation shows with the exception of the Ambulance Service and CUH, all other hospitals/services had a static funding position or decline in funding over the period.

Figure 4.4 – Indexed Total Net Expenditure 2004-2006 deflated using specific category deflators[3]



Expenditure on New Developments

New Developments are monies received for specific projects during the fiscal year. The table below compares monies received by SHG for new development as a proportion of the AFS compared to the national percentage spend.

Figure 4.5 – SHG New Developments as a proportion of AFS spend compared to national spend

	SHG	National
2006 AFS	531.8 m	4.41 bn
Spend on New Developments	8.2 m	89.78 m
% of AFS	1.54%	2.03%

Figure 4.5 shows that SHG received a proportionally lower amount of monies for new developments when compared to the national spend.

Figure 4.6 shows monies received by SHG for new developments by service area. It highlights that only 30% of the monies received were actually spent on the designated projects. Monies that were not used for new developments were used to cover overruns elsewhere in SHG.

[3] It should be noted that there is no one official rate available for medical inflation, neither is there any agreement as to what the rate might be. Figure 4.6 uses deflators that combine elements of the CPI and pay award inflation. Pay increments, which are separate to any national pay awards, are believed to add about 1% per annum to the pay bill. The central point to embrace is that while the nominal increase in net expenditure from 2004 may be 20.3%, the reality is that real increases have been considerably less and show a marginal increase.

Figure 4.6 – Use of New Developments Monies within SHG

AREA	Amount Received (€ M)	Amount Spend on New Development (€ M)	Amount Spent on overruns (€ M)
Day Procedure Unit	3	0	3
New Maternity Unit	4	2	2
Cancer Services	.4	0	.4
Obesity	.4	.3	.1
Neurology	.4	.2	.2
Total	8.2	2.5	5.7

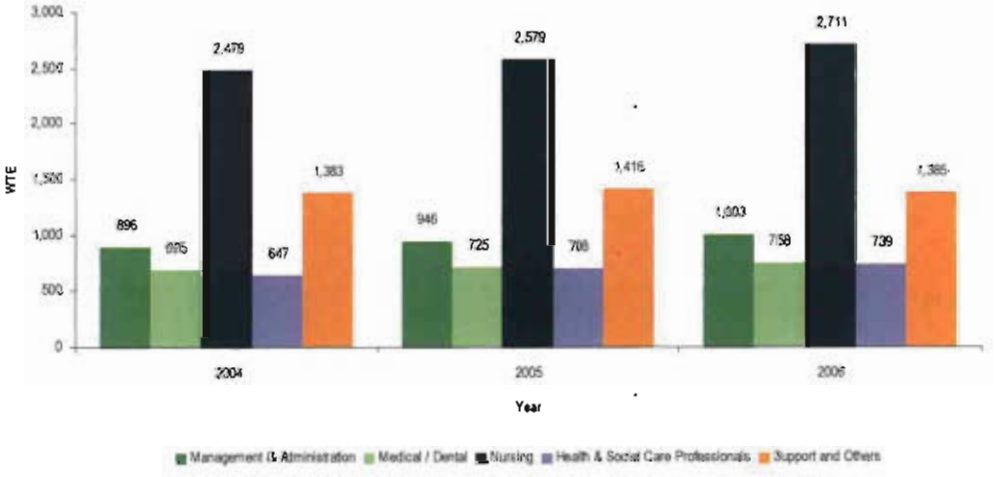
4.3 Staff Inputs

Staffing levels are reported in terms of Whole Time Equivalents (WTEs), a measure which takes account of the different bases of employment and/or of hours worked by individual staff members. Only employees of the HSE are included as WTEs. Agency personnel are excluded. SHG currently has approval for approximately 6,543 WTEs.

Level of staffing resources[4]

Between December 2004 and December 2006, total staffing in the SHG rose from 6,100 to 6,595[5], an increase of approximately 8.1% over the period[6]. Figure 4.7 below shows the numbers of staff in each main category over the period 2004-2006.

Figure 4.7 – Actual WTE by Grade



[4] Year-end census WTE data has been used for all of section 4 when discussing staffing levels. The census data was chosen as the most appropriate as it is derived from the formal reporting processes.

[5] It should be noted that these WTE figures include the Regional Acute category which comprises of STD clinic, Regional Laundry and other ancillary services which accounted for 83.98 WTEs in 2006. It also includes the Network Manager's Office which accounted for 3WTEs in 2006.

[6] Employment Monitoring Unit - Network 2 Stat Dec 04 05 06 WTEs and MUH/SIVUH Dec 04 05 06.

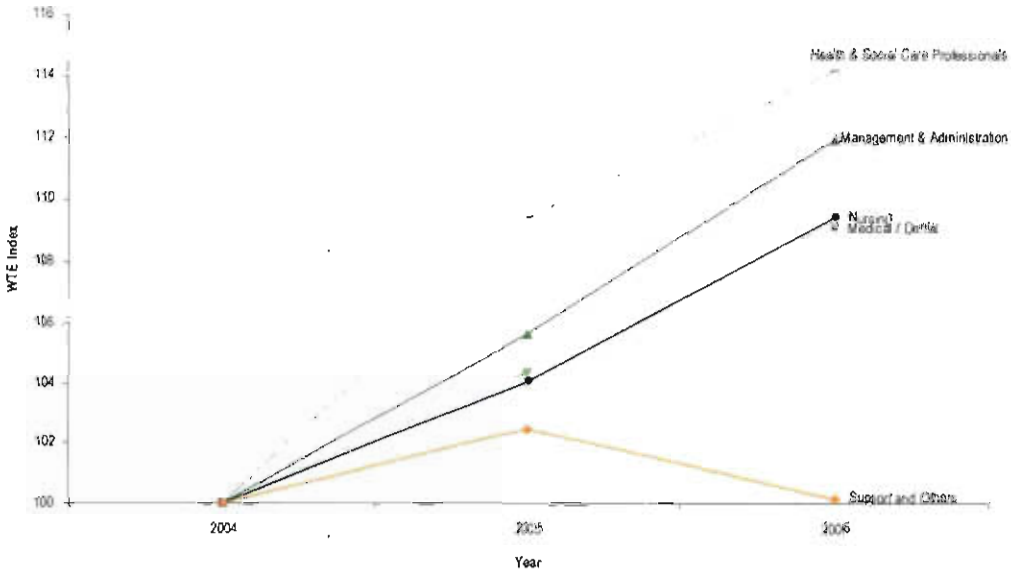
Nursing is the predominant category, compromising approximately 40% of total staffing. Support Staff is the next largest category, at approximately 21% of total staffing. These two are followed in close order by Management and Administration (15.2%), Medical and Dental (11.5%), and Health & Social Care Professionals (11.2%).

It should be noted that WTEs do not include Nursing Agency Costs, while WTE data for this category is not readily available, it is estimated that there was approximately 27 WTEs in 2006 directly relating to Nursing Agency Costs.[7] The reliance on agency nurses more than doubled over the period 2004 to 2006.

Trend of staffing resources

Total growth in staff numbers over the period the period 2004-2006 was 495, an increase of 8.1%. Within this overall increase, however, there was considerable variation in the rates of increase in different categories of staff and in different locations or services. Figure 4.8 below shows the relative growth in the different categories of all SHG staff.

Figure 4.8 – Growth in WTE by Category

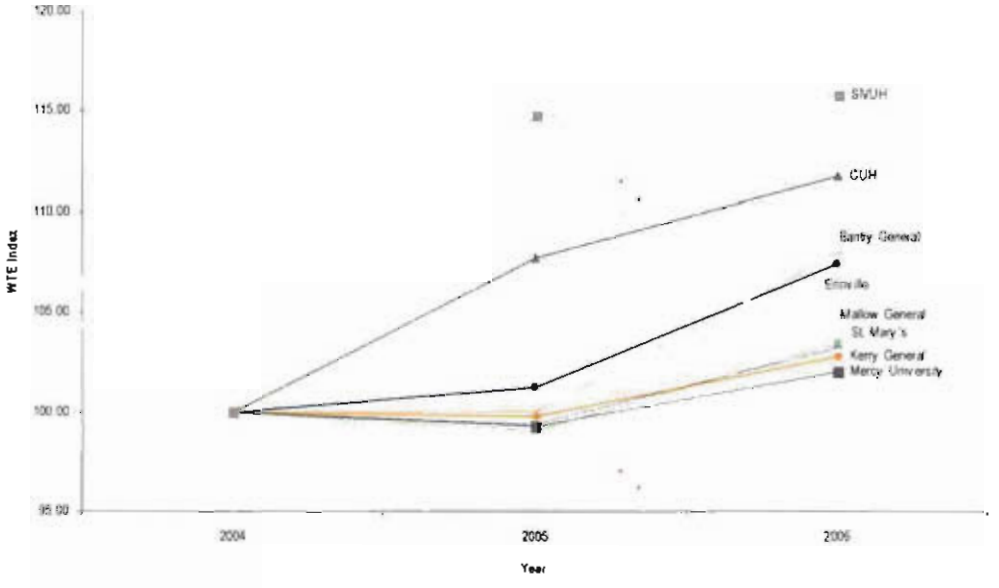


The highest rates of growth were in Health Social Care Professionals and Management and Administration, both categories showing growth rates of approximately 14% and 12% respectively over the period 2004-2006. These were followed by nursing (9.03%) and Medical and Dental (9%). The category Support Staff & Other was effectively static over the period.

[7] WTE for Nursing Agency Costs are calculated by totalling the 2006 agency costs, for CUH, Kerry General, SIUVH and Mercy University Hospital, of €2,157,359 and dividing by an estimated cost per WTE of €80,026. The average cost of such WTEs are derived based on the SIUVH 2006 nursing agency costs of €202,467 and dividing by 2.53WTEs.

Figure 4.9 shows the changes in numbers in WTEs by hospital, over the period 2004-2006.

Figure 4.9 – Growth in WTE by Hospital



4.4 Conclusions

Monetary input

SHG had a gross expenditure of €590m in 2006. Because, however, of changes in structures over the period 2004 to 2006, and the related changes in accounting, direct comparison of total gross and/or net expenditure between the years is somewhat misleading. In order to enable analysis of cost trends, an analysis was carried out to take into account these differences and shows that there has been an increase of 20.3% in net expenditure in 2006 when compared to 2004. In real terms, the increase was marginal as, with the exception of the ambulance service and CUH, all other hospitals/services had a static funding position or a decline.

Staff Input

SHG had 6,595 staff by the end of 2006. This represents an 8.1% increase when compared to 2004 staff levels. Within the various categories of staff, the Social Care Professionals/ Management and Administration categories have seen the largest increase (14.13% and 11.9%, respectively, on 2004), while Medical and Dental staff increased by 8.7%.

5. Outputs

5.1 Section Objectives

The principle objectives of this section are threefold. They are:

- To define the outputs associated with SHG activity and identify the level and trend in those outputs for the level of funding provided.
- To examine the extent that the objectives of the SHG have been achieved, and comment on the effectiveness with which they have been achieved for the level of funds provided; and,
- To identify the level and trend of costs and staffing resources associated with the SHG and thus comment on the efficiency with which it has achieved its objectives.

This section is presented in two sections: Effectiveness and Efficiency. The effectiveness section focuses on activity within key areas and settings across the SHG and at hospital level.

The efficiency section assesses the relationship between outputs and the inputs used to achieve them. Efficiency is assessed through a number of metrics, including: expenditure per patient; expenditure per CMU; patients per WTE; and CMUs per WTE.

5.2 Effectiveness

This section assesses the effectiveness of SHG output. To achieve this comparisons of activity across settings, against targets, across years and against national and international best practice where appropriate, are made. Hospital settings include inpatients; day cases; emergency department; and outpatient departments (OPD) activities. Other output information is presented in this section including hospital occupancy; surgical and medical waiting times; and emergency department waiting times.

5.2.1 Overall Output

Figure 5.1 sets out the key high level activity indicators for the SHG and nationally, for the period 2004-2006 inclusive. The data shows:

- Inpatient activity has remained relatively constant in the SHG.
- Day patient activity has increased, both nationally and in the SHG.
- Emergency Department presentations have fallen in the SHG and are up nationally.
- Outpatient numbers have increased in the SHG and nationally.

Specifically, outputs are defined, trends examined and progress against objectives measured.

Figure 5.1 – Macro Data and Trends – 2004-2006

	2004*		2005**		2006**	
	SHG	Nationally	SHG	Nationally	SHG	Nationally
Inpatients	80,619	576,473	80,029	575,120	80,414	592,269
Average Length of Stay	6.34	6.5*	6.39	6.6*	6.2	6.3****
Day Cases	80,835	480,565*	83,441	512,344	88,144	554,512
Emergency Department Presentations	160,491	1,242,686	154,091	1,238,790	158,490	1,146,244
Emergency Department Admissions	n/a	n/a	33,788	290,284	35,418	294,020
Outpatients	257,172*****	n/a	303,897	2,594,883	330,014	2,854,768

Sources *Department of Health & Children
**HSE PMU
***Network Manager's Office
****HSE PMU
*****Combined sources: Department of Health & Children; Network Manager's Office/2006 Level 1 Business Plan; and directly from hospitals.

n/a = Not available

5.2.2 Inpatient Activity

5.2.2.1 SHG Data

Under inpatients, we set out for the period 2004-2006:

- Levels of activity (basic outputs).
- Average length of stay (ALOS).

Below, we examine performance against SHG/SHG+ level and hospital targets.

Figure 5.2 – Inpatient Data and Trends - SHG & National 2004-2006

	2004 Outturn*	2005 Outturn**	2006 Target***	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
SHG	80,619	80,029	81,271	80,414	×	⇑	⇓
SHG+	82,524	81,113	85,686	81,290	×	⇑	⇓
National	576,473	575,120	580,963****	592,269	√	⇑	⇑

Sources: *Department of Health & Children
** HSE PMU
***Network Manager's Office/2006 Level 1 Business Plan (This is the business plan for SHG)
****HSE National Service Plan 2006

The data shows that:

- Outturn figures have fallen marginally, from 80,619 in 2004 to 80,414 in 2006.
- The SHG target was not exceeded – outturn was approximately 1% below target. The national target was exceeded – outturn was approximately 2% above target.
- In 2006, inpatient outturn activity in the SHG+ of 81,290 represented approximately 13.7% of the actual national outturn of 592,269, while the 2006 SHG target was set at approximately 14% of the national total.

The following highlights the key outputs for the period under review at a hospital level[8]:

Figure 5.3 – Inpatient Data and Trends – SHG Hospitals 2004-2006

Hospital	2004 Outturn*	2005 Outturn**	2006 Target***	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
CUH	26,352	26,962	27,000	27,548	√	⇑	⇑
Mallow General	4,427	4,574	4,346	4,592	√	⇑	⇑
Erinville	9,409	8,921	9,388#	9,601	√	⇑	⇑
St. Mary's	2,292	2,280	2,398	2,564	√	⇑	⇑
Kerry General	14,961	15,304	14,710	14,501	×	⇓	⇓
Bantry General	2,857	2,882	3,050	2,940	×	⇑	⇑
Mercy University	10,826	9,702	10,978	9,641	×	⇓	⇓
SIVUH	9,495	9,404	9,400	9,027	×	⇓	⇓
St. Finbarr's	1,905	1,084	2,013	876	×	⇓	⇓

Sources: *Department of Health & Children
** HSE PMU
***Network Manager's Office/2006 Level 1 Business Plan (This is the business plan for SHG)
****HSE National Service Plan 2006

- Over the period 2004-2006, 5 hospitals increased inpatient activity and 3 reduced inpatient activity (i.e. excluding St. Finbarr's). The trend is similar for 2005-2006.
- Four out of eight SHG hospitals exceeded their targets in 2006 by an average of 2.8%, while the remaining four hospitals fell below their targets by approximately 5.3%. Specifically Mallow General and St. Mary's both exceeded their targets by approximately 5%. The Mercy University fell below its target by approximately 13.5%.

Inpatient Output Case Mix

The inpatient activity reported above is based on actual patient numbers. However, for the purpose of a uniform comparison, taking account of case mix complexity and resource intensity, inpatient discharges are also reported within HIPE in terms of case mix units[9] of output. The following figure illustrates the results for the SHG and individual hospitals for 2004-2006.

Figure 5.4 shows that the inpatient case mix units decreased from 2005 to 2006. From 2004 to 2006, there was a decrease of 4.2% in inpatient case mix units in the SHG.

[8] St. Finbarr's is not classified by the HSE as an acute hospital, although it caters for some acute patients. While we have presented acute patient data for St. Finbarr's, we have excluded it from our subsequent commentary. HSE data generally includes St. Finbarr's within the SHG data where an acute service is being provided. The data for St. Finbarr's has been shown so that the overall total is consistent with published data for the SHG.

[9] Case mix Unit - a measure of the complexity of a hospital workload relative to other hospitals in the Case mix budgeting system. A value of 1 for a particular case indicates an average level of complexity. Values less than and greater than one indicates workloads of lesser or greater complexity respectively.

Figure 5.4 – Inpatient Case Mix Units – 2004-2006

Hospital	CUH	Mallow General	St Mary's	Kerry General	Mercy University	SIVUH	SHG
2004	31,859	3,687	3,453	11,985	12,206	8,417	71,340
2005	30,465	3,363	3,702	11,733	11,327	8,738	69,328
2006	31,299	1,997[10]	3,648	11,736	11,507	8,298	68,485

Source: HSE Case Mix Unit, Case mix Units, which reflect case complexity, are based on 2005 relative values as 2006 relative values are not yet available. The 2006 figures are not audited. The audit is currently being completed.

Average Length of Stay

Average lengths of stay (days) for inpatients has fallen year on year as illustrated below:

Figure 5.5 – Length of Stay Data and Trends - SHG & National 2004-2006

Hospital	Average '04*	Average '05**	Average '06**	2006 % Average Change
SHG+	6.57	6.69	6.0	-10.3
SHG	6.34	6.39	6.11	-4.4
National	6.5	6.6	6.3	-4.5

Sources: *Department of Health & Children
**HSE PMU

- The ALOS for SHG patients in 2006 was 6.11 days. This has fallen by approximately 4.4% from 2005, and by 3.6% from 2004.
- We have noted that the SHG ALOS is in line with the national average length of stay.

Figure 5.6 – Length of Stay Data and Trends – SHG Hospitals 2004-2006

Hospital	Average '04*	Average '05**	Average '06**	2006 % Average Change
CUH	6.8	6.7	6.3	-5.9
Mallow General	5.1	5.3	5.1	-3.8
Erinville	3.7	3.9	3.5	10.3
St Mary's	10.2	10.3	8.3	-19.4
Kerry General	6.7	6.5	5.9	-9.2
Bantry General	8.5	8.1	8.9	9.9
Mercy University	6.6	6.9	6.9	0.0
SIVUH	5.8	5.9	6.0	1.7
St Finbarr's	16.2	3.1	1.9	-38.7

Sources: *Department of Health & Children
**HSE PMU

[10] The accuracy of CMU's and costs for Mallow cannot be established because of a lapse in HIPE coding and failures to adhere to case mix procedures and deadlines

- St. Mary's Orthopaedic had the largest decrease in ALOS in 2006 for SHG hospitals with a drop of 19.4% from 2005. Conversely, Bantry General had the largest increase in ALOS in 2006 with an increase of 9.9%.
- In 2006, five hospitals reduced their ALOS from 2005 including Cork University Hospital, Mallow General, St. Mary's Orthopaedic, Kerry General and St Finbarr's.
- In 2006, three hospitals increased their ALOS from 2005 including Erinville, Bantry General and South Infirmary/Victoria University Hospital[11]. ALOS remained the same in Mercy University in 2006.

Occupancy

In 2006, occupancy in the SHG at 82.3% was lower than the national average.

Figure 5.7 – Occupancy SHG & National 2004 and 2006

	Bed Days Used 04*	Bed Days Used 06**	2004 Occupancy %*	2006 Occupancy %**
SHG+	542,180	484,439	79.8	82.3
National	3,853,172	3,739,483	86.2	90.0

Sources: * Department of Health and Children
** HSE PMU

- The overall occupancy rate improved as the comparable occupancy rate in 2004 was 79.8%.
- Bed days used in 2006 totalled 484,439 (including St. Finbarr's), an approximate decrease of 11.9% from 2004.

Occupancy rates for individual hospitals in the SHG are presented below. In 2006 the largest hospital in the group, CUH, had an occupancy rate of 94.3%, while St. Mary's had the lowest occupancy rate at 47.6%.

Figure 5.8 – Occupancy SHG Hospitals 2004 and 2006

Hospital	Bed Days Used 04*	Bed Days Used 06**	2004 Occupancy %*	2006 Occupancy %**
CUH	180,499	172,642	88.5	94.3
Mallow General	22,591	23,209	81.2	83.7
Erinville	34,540	33,693	62.1	73.3
St Mary's	23,304	21,196	50.9	47.2
Kerry General	99,542	85,075	82.7	86.9
Bantry General	24,246	26,299	87.2	90.1
Mercy University	71,394	66,216	81.3	80.8
SIVUH	55,137	54,440	78.9	78.6
St Finbarr's	30,927	1,669	76.8	19.0

Sources: * Department of Health and Children
** HSE PMU

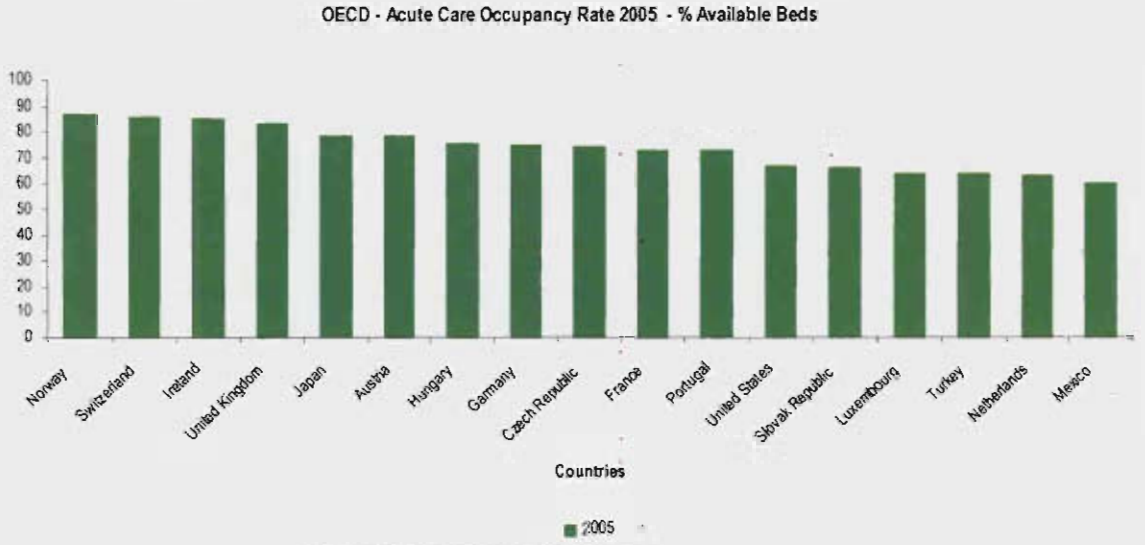
[11] The increase in the ALOS at SIVUH can be explained by the opening of a Medical Rehabilitation Unit for the Elderly where the ALOS was 30.8 days per patient.

5.2.2.2 International Comparison

Occupancy

Average occupancy in the SHG hospitals in 2006 was 82.6%. This compares with a national occupancy rate of 85.5% in 2004 (fourth highest in OECD reported countries) and 85.4% in 2005 (third highest in OECD reported countries).

Figure 5.9 – Acute Care Occupancy Rates by Country

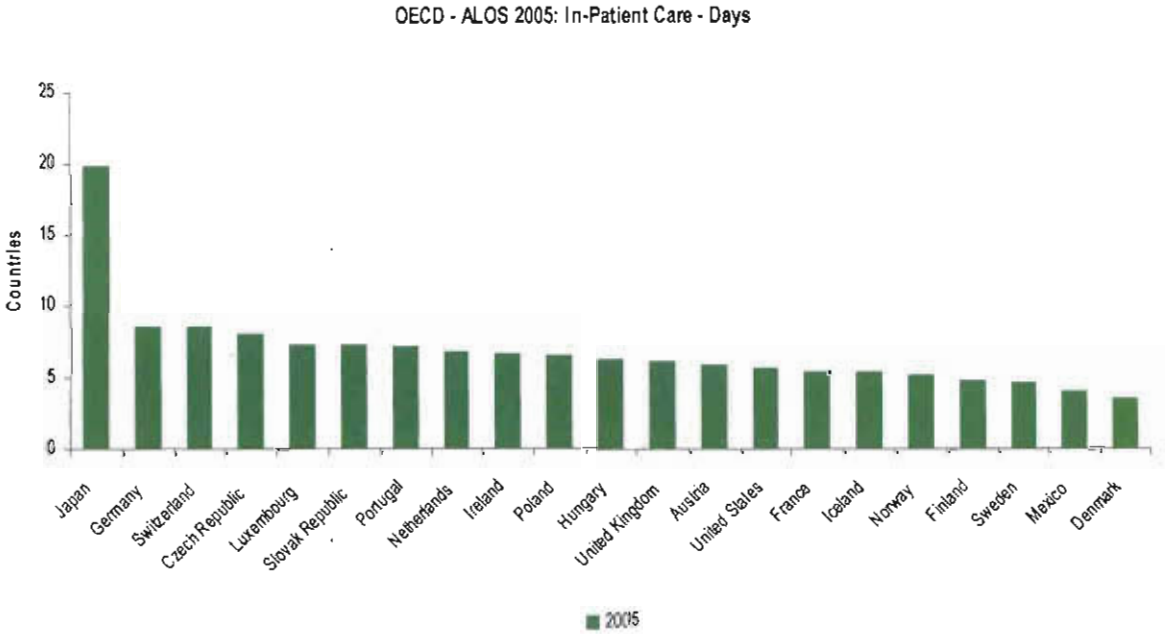


Source: OECD Health Data 2007, July 2007

Length of Stay

The shorter the length of stay, the potentially greater throughput a hospital can achieve. The average Length of Stay in SHG hospitals was 6.11 days. This compares with National Length of Stay of 6.5 days. Patient length of stay is impacted by current internal hospital processes such as patient review and assessment, admission too early and delayed discharge. When compared internationally, Length of Stay in Ireland, on a simple average days' basis, is relatively low by international standards. However, when compared on a more detailed DRG level with comparable countries, a somewhat different picture emerges as discussed in Section 7.

Figure 5.10 – Average Length of Stay by Country



Source: OECD Health Data 2007, July 2007

Length of stay is, of course, determined by the complexity of the treatment involved. Case mix adjustments take this complexity into account when comparing hospitals. On a case mix adjusted basis, SHG Length of Stay is 5.73.

5.2.3 Day Case Activity

Figure 5.11 highlights the key day patient outputs for the period under.

Figure 5.11 – Day Patients Data and Trends SHG & National Level 2004-2006

	2004 Outturn*	2005 Outturn**	2006 Target***	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
SHG	80,835	83,441	88,350[12]	88,144	√	⇧	⇧
SHG+	80,835	83,441	88,350	88,144	×	⇧	⇧
Total Nationally	484,557	512,344	532,185****	554,512	√	⇧	⇧

Sources: *Department of Health & Children
** HSE PMU
***Network Manager's Office/2006 Level 1 Business Plan
****HSE National Service Plan 2006
n/a = not applicable

- Day case activity outturn for the SHG in 2006 was 88,144. Measured against the target of 88,350, this was less than 1% below the 2006 output target.

[12] The targets for day cases do not sum to the total for SHG/SHG+ as the HSE did not revise individual hospital targets having revised the overall target.

- The SHG day case outturn for 2006 of 88,144 was approximately 16% of the total national activity output. The target figure for SHG output as a proportion of the national outturn was also approximately 16%.
- At a national level in 2006, activity output was 554,512 which exceeded the target figure of 532,185 by approximately 4.2%.
- The number of day case patients increased in the SHG during 2006 and over the period 2004-2006.

The following highlights the key outputs for the period under review at a hospital level:

Figure 5.12 – Day Patients Data and Trends SHG Hospitals 2004-2006

Hospital	2004 Outturn*	2005 Outturn**	2006 Target***	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
CUH	40,996	42,600	43,992	43,508	×	⇑	⇑
Mallow General	2,111	2,077	2,088	2,153	√	⇑	⇑
Erinville	0	12	n/a	2,316[13]	n/a	⇑	⇑
St. Mary's	1,672	1,421	1,585	1,205	×	⇓	⇓
Kerry General	5,945	6,149	6,310	6,149	×	⇔	⇑
Bantry General	1,254	1,270	1,475	1,094	×	⇓	⇓
Mercy University	13,473	14,846	13,474	15,384	√	⇑	⇑
SIVUH	15,384	15,066	14,856	16,335	√	⇑	⇑
St. Finbarr's	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Sources: *Department of Health & Children
** HSE PMU
***Network Manager's Office/2006 Level 1 Business Plan
****HSE National Service Plan 2006

- Three out of the eight hospitals exceeded their target outturns for 2006, while four out of eight fell below their target outturns.
- Five hospitals increased their patient day case numbers in 2006, two decreased and one remained constant. The trend over the period 2004-2006 is similar with six hospitals showing an increase and two a decrease, namely Bantry General and St. Mary's.

Day Case Output Case Mix

The following figures illustrate the results for the network and individual hospitals for three years. Figure 5.13 shows that the day case case mix units increased from 2005 to 2006. For 2006 Cork University Hospital and The South Infirmary/Victoria University Hospital have recorded increases in case mix units when compared to 2005. From 2004 to 2006, there was an increase of 10% in day case case mix units in the SHG.

[13] This is due to a reclassification of coloscopy from an OPD case to a recognised day case procedure.

Figure 5.13 – Day Case Case Mix Units – 2004-2006

Hospital	CUH	Mallow General	St Mary's	Kerry General	Mercy University	SIVUH	SHG
2004	32,971	2,242	2,308	9,224	14,768	7,388	68,901
2005	35,746	1,925	1,962	9,870	17,253	8,229	74,985
2006	36,500	1,056[14]	1,700	9,768	17,200	9,556	75,780

Source: HSE Case Mix Unit, Case mix complexity is based on 2005 relative values as 2006 relative values are not yet available. The 2006 figures are not audited. The audit is currently being completed.

5.2.4 Outpatient Activity

Figure 5.14 shows key outpatient outputs for the period under review.

Figure 5.14 – Outpatient Data and Trends SHG & National – 2004-2006

Hospital	2004 Outturn	2005 Outturn**	2006 Target*	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
SHG	257,172	303,897	297,482	323,597	√	⇑	⇑
SHG+	257,172	308,868	303,397	325,058	√	⇑	⇑
National	n/a	2,594,883	2,610,323***	2,854,768	√	⇑	[ ]

Sources:* Network Manager's Office/2006 Level 1 Business Plan
** HSE PMU
***Direct from hospital
****HSE National Service Plan 2006
#Classified under 'Unified Maternity'
~May or may not include St. Finbarr's

- Overall activity for 2006 was 323,597 (excluding St. Finbarr's), which was approximately 8.8% in excess of the target figure of 297,482.
- National activity of 2,854,768 exceeded target outturn of 2,610,323 by approximately 6%.

At a hospital level trends are generally positive and trends achieved.

[14] The accuracy of CMU's and costs for Mallow cannot be established because of a lapse in HIPE coding and failures to adhere to casemix procedures and deadlines.

Figure 5.15 – Outpatient Data and Trends SHG Hospitals – 2004-2006

Hospital	2004 Outturn	2005 Outturn**	2006 Target*	2006 Outturn**	Target Exceeded	2005-06 Trend	2004-06 Trend
CUH	127,704*	134,673	129,824	140,275	√	⇑	⇑
Mallow General	n/a	7,889	8,279	8,076	×	⇑	
Erinville	n/a	24,412	25,523#	26,282	√	⇑	
St. Mary's	n/a	2,035	1,013	5,211[15]	√	⇑	
Kerry General	41,062*	41,310	43,775	45,381	√	⇑	⇑
Bantry General	8,260***	8,762	8,200	11,638	√	⇑	[ ]
Mercy University	30,370***	35,770	32,033	35,608	√	⇓	⇑
SIVUH	49,776***	49,046	48,835	51,126	√	⇑	⇑
St. Finbarr's	n/a	4,971	5,915	1,461	√	⇑	n/a

Sources:* Network Manager's Office/2006 Level 1 Business Plan
** HSE PMU
***Direct from hospital
****HSE National Service Plan 2006
#Classified under 'Unified Maternity'

- Activity grew in 2006 against 2005 in seven out of the eight hospitals in the SHG.
- St. Mary's had the largest proportional increase in outpatient activity growing to 156% of its 2005 outturn, translating in real terms to an increase in outpatients from 2,035 to 5,211.
- Seven out of eight hospitals exceeded their 2006 outturn targets, while the remaining hospital fell below their target levels. In real terms CUH had the largest excess in outturn against target, with an excess figure of 10,451. Proportionally, St. Mary's had the largest excess in outturn against targeted outturn of 414%.

5.2.5 Emergency Department

Figure 5.16 shows the ED admission data for 2005 and 2006.

Figure 5.16 – Emergency Department Admission Trends SHG & National 2005-2006

	2005 Outturn*	2006 Outturn*	Target Exceeded	2005-06 Trend
SHG	33,788	35,418	n/a	⇑
National	290,284	294,020	n/a	⇑

Source: HSE PMU

2006 targets not provided.
n/a = not available

[15] Capacity in St Mary's utilised for CUH specialities (minor plastic surgery procedures, pain service) i.e. transfer of some services during 2006.

- SHG activity in 2006 accounted for almost 12% of the national total emergency department admissions activity.
- Activity for the SHG grew by almost 5% in 2006 against 2005.

At a hospital level, the trends are varied.

Figure 5.17 – Emergency Department Admission Trends SHG Hospitals 2005-2006

Hospital	2005 Outturn*	2006 Outturn*	Target Exceeded	2005-06 Trend
CUH	13,004	14,469	n/a	⇑
Mallow General	3,091	2,970	n/a	⇓
Kerry General	7,854	8,424	n/a	⇑
Bantry General	n/a	n/a	n/a	n/a
Mercy University	5,153	5,230	n/a	⇑
SIVUH	4,686	4,325[16]	n/a	⇓

Source: HSE PMU

2006 targets not provided.
n/a = not available

- Activity increased in 2006 against 2005 in three out of the five hospitals in the SHG and fell in the two other hospitals.
- The largest increase (in real terms and proportionally) occurred in Cork University Hospital with an 11% increase in emergency department admissions in 2006.

ED Waiting Times

Waiting times data for July – December 2006 has been provided for four out of the five hospitals in the SHG with an emergency department. Of these, CUH has the largest number of patients waiting, while Kerry General has the lowest.

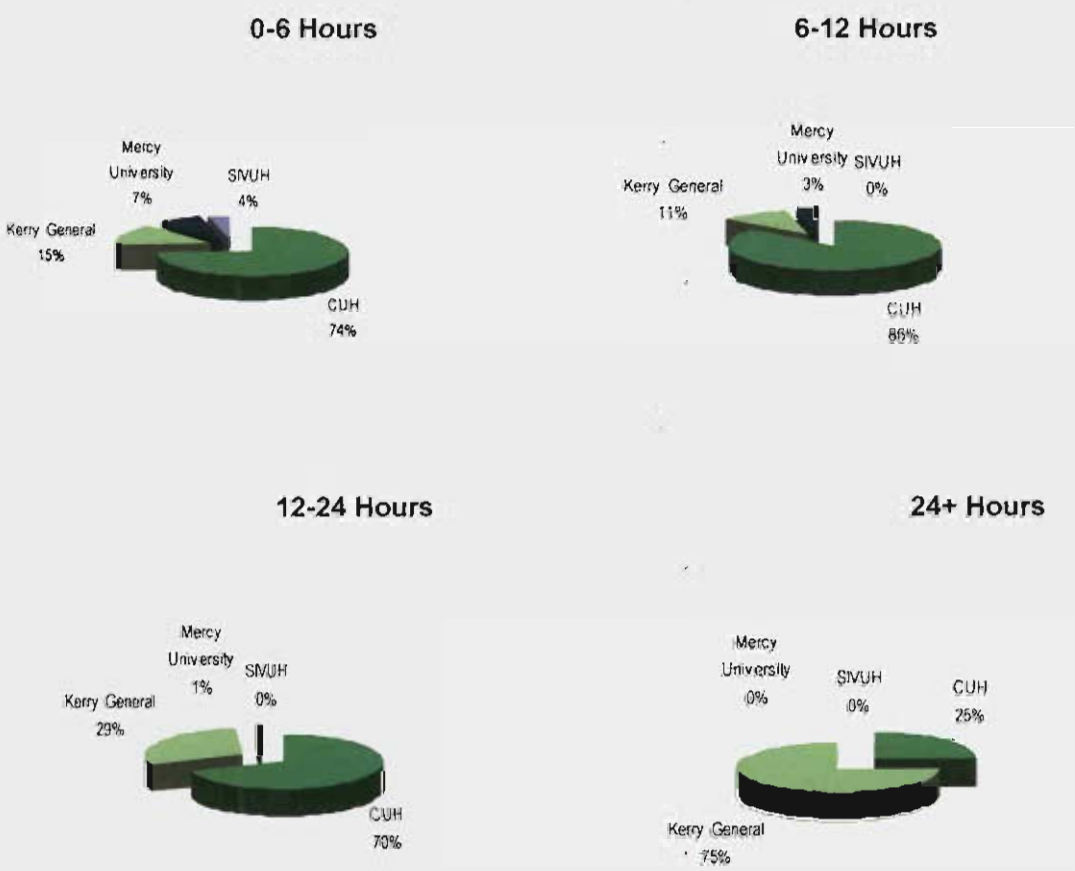
The average daily number of patients waiting for admission from the emergency departments in the SHG, over the period July-December 2006, was 5.95[17]. CUH accounts for 75% of those waiting i.e. 4.53 people waiting on average daily.

Emergency department patient waiting times are classified into four categories, as illustrated overleaf. Of the patients waiting in Cork University Hospital, almost 51% waited for a period greater than 6 hours. The corresponding figure for the Mercy University and South Infirmary/Victoria University Hospital is approximately 60% and 20% respectively. All patients in Kerry General emergency department were admitted within 6 hours. Of the remaining three hospitals, there were no persons waiting longer than 24 hours for admission.

[16] This reduction can be partly explained by the opening of a new Chest Pain Assessment Unit which accounted for 956 patients during 2006 (Source – SIVUH). These patients would previously have attended the Emergency Department.

[17] We have not been provided with data for Mallow General.

Figure 5.18 – Percentage Waiting by Hospital by Length of Wait, July-December 2006



Source: HSE PMU

5.2.6 PCCC

PCCC and Acute Hospital Capacity

The role and future direction of PCCC services in Ireland was outlined in the Primary Care Strategy which was launched in 2001. The strategy envisioned a role where PCCC healthcare would indirectly relieve pressure on acute hospitals through the provision of 'one-stop-shop' community based health services, including, for example, general practitioner support, home help, physiotherapy, social care and a range of other health services.

The primary care strategy was rolled out in 10 pilot sites prior to a planned widespread roll out. Difficulties arose in the implementation of the strategy and primary care teams have not yet been initiated as was envisioned by the strategy.

Lack of front-line provision of in-place PCCC services is likely to be impacting on capacity pressures on acute hospital services.

5.3 Efficiency

Efficiency in the context of this study is the relationship between the outputs of the SHG and the inputs, or resources, used to achieve those outputs. The key inputs[18] are funding and staff, and the level and trend in the use of these resources has been outlined in the previous sections.

Two sources of output data were available:

1. Activity data provided by the HSE PMU.
2. Workload data derived from HIPE reports.

Neither of these sources fully reflects the outputs of SHG. In particular, the data does not include outpatient activity, which has increased proportionately within SHG. They do however enable the calculation of high level indicators which is useful in identifying overall trends in performance.

Relating the outputs for SHG to the two key inputs provides indicators of efficiency expressed in terms of:

(a) Costs, which reflects the overall use of funding, and
(b) Productivity which reflects the use of staff.

5.3.1 Cost indicators

Figure 5.19 shows that the average cost (in real terms) per patient[19] has risen in 2006 by 3% relative to 2004. Figure 5.20 shows that the average cost (in real terms) per case mix unit rose in 2006 by 3% relative to 2004[20]. The Mercy University Hospital and The South Infirmary Victoria University Hospital have been excluded as their net expenditure is not available from the AFS. This is because the AFS shows only the grant paid from HSE to those hospitals without any income they receive.

[18] Outputs can really only be linked to costs at a macro level.
[19] See note 25 overleaf.
[20] A day case CMU is not equivalent to an inpatient CMU. Expenditure per CMU is macro type indicator which is helpful in assessing the overall trend.

Figure 5.19 – Expenditure per patient

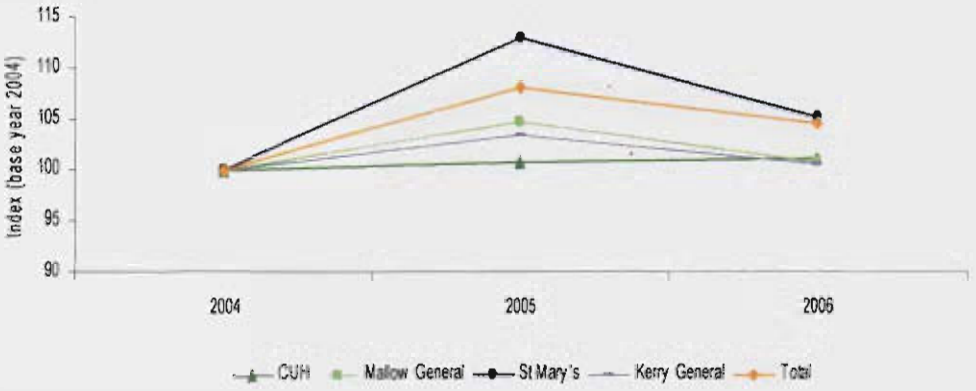
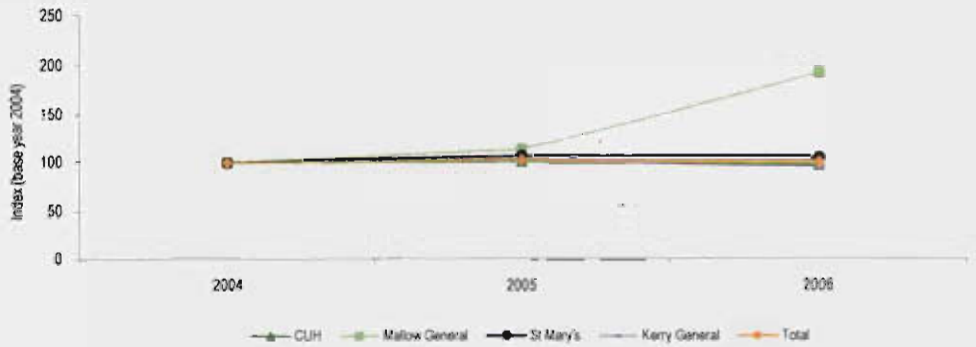


Figure 5.20 – Expenditure per CMU



Case mix costs for inpatients and day cases

The tables below illustrate preliminary results[21] for case mix cost-per-case for inpatients and day cases:

Inpatient Cost per Case

Based on the case mix units, we have calculated the cost per case, presented overleaf. The cost per case has risen (in nominal money) in all hospitals and is similar to relevant Group 1 and Group 2 averages. CUH is a Group 1 hospital. All other SHG hospitals are Group 2. The accuracy of costs for Mallow cannot be established because of a lapse in HIPE coding and failures to adhere to case mix procedures and deadlines.

[21] Preliminary results are 98.5% coded.

Figure 5.21 – Cost per Inpatient – 2004-2006 (€)

Hospital	CUH	Mallow General [22]	St Mary's	Kerry General	Mercy University	SIVUH	SHG Case Mix Total	Group 1	Group 2
2004	4,025	3,687	4,301	3,633	3,533	3,370	3,795	4,265	3,713
2005	4,411	4,220	4,309	4,212	4,091	3,713	4,197	4,637	4,114
2006*	4,856	7,400	4,615	4,235	4,531	4,161	4,672	5,059**	4,488**

** Unaudited*
*** Assumes 9.1% increase in 2006. This is in line with previous year on year increases.*

Day Case Cost per Case

Based on the case mix units, we note that the cost per day case has risen (in nominal money) in all hospitals (with the exception of CUH and St. Mary's).

Figure 5.22 – Cost per Day Case – 2004-2006 (€)[23]

Hospital	CUH	Mallow General	St Mary's	Kerry General	Mercy University	SIVUH	SHG Case Mix Total	Group 1	Group 2
2004	603	455	400	539	575	647	582	582	539
2005	727	303	656	563	588	759	664	587	588
2006*	628	573	517	669	665	927	676	640**	642**

** Unaudited*
*** Assumes 9.1% increase in 2006. This is in line with previous year on year increases.*

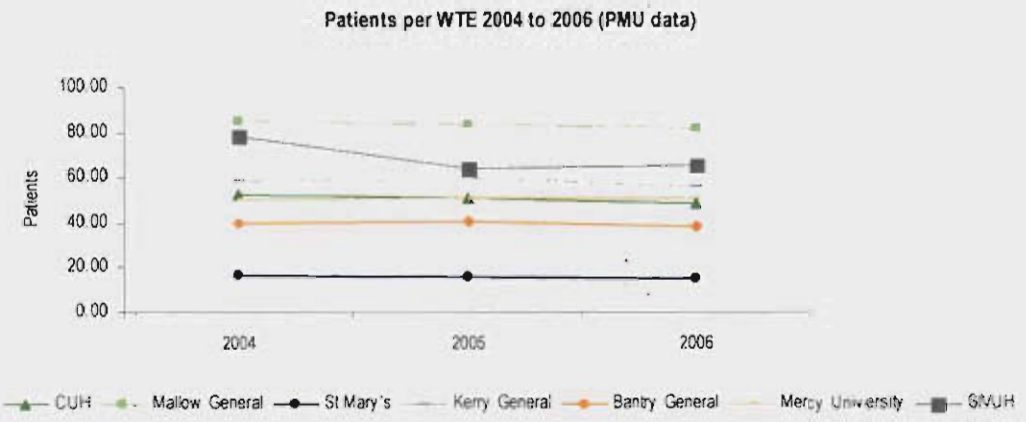
5.3.2 Productivity indicators

Measures of staff productivity attempt to identify changes in the volume of services provided by each member of staff. While they must be used with care they can, however, be useful indicators of trends which can be used to identify areas for more detailed examination.

Figure 5.23 shows, for individual SHG hospitals, the number of patients treated[24] per WTE in each of the years 2004 to 2006.

[22] The accuracy of CMUs and costs for Mallow General cannot be established because of a lapse in HIPE coding and failures to adhere to case mix procedures and deadlines.
[23] These costs have not been adjusted for inflation.
[24] Source: Performance Monitoring Unit (PMU) and Board reports. Patient activity includes data for Inpatient, day Patient and A&E presentations. Data does not include outpatient activity for which 2004 data was not available. Staff numbers include all staff with the exception of the Erinville.

Figure 5.23 – Patients per WTE



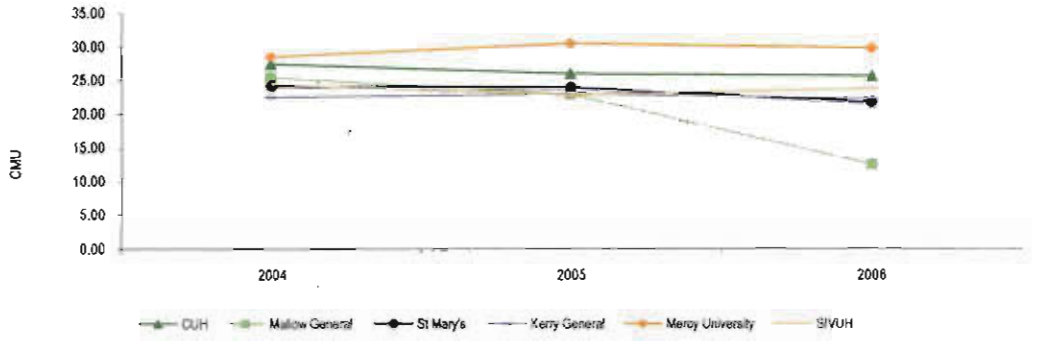
This indicates that the numbers of patients treated per WTE has fallen for all hospitals, with the exception of the Mercy, which is static. CUH shows the greatest fall in the number of patients per WTE. The above trend excludes agency nurses whose number has been increasing. This further reinforces the conclusions drawn in relation to productivity.

It is recognised that this measure assumes a constant mix of patients and complexity of case. Utilising case mix data for those hospitals for which they are available addresses these issues to some extent by taking account of complexity and reducing activity to the common denominator of case mix units (CMU)[25]. It does not, however, take into account either A&E or outpatient activity.

Figure 5.24 shows, for each of the SHG hospitals, the number of CMUs per WTE in those hospitals that are included in case mix for each of the years 2004 to 2006. There are certain limitations when comparing CMU and WTE data. While WTE data relates to the entire hospital, CMU data refers exclusively to inpatient and day case patients. While productivity for all staff in a hospital including management and administration and other support staff who cannot be directly associated with patients of any category, needs to be assessed, the figures illustrated in Figure 5.24 are valuable indicators.

[25] Source: Case Mix Unit for 2004 and 2005 data; Case Mix Unit for preliminary 2006 data, adjusted to utilise un-audited hospital data where considered more appropriate. Data does not include Erinville or Bantry which are not in Case mix . Data also does not take into account either outpatients or A&E.

Figure 5.24 – CMUs per WTE



This indicates that the output of CMUs per member of staff decreased in all hospitals with the exception of the Mercy University where it remained static.

Overall, the indicators suggest static or declining WTE productivity, while recognising the possible impact of greater outpatient activity in the patient mix on the indicators, this area requires further examination.

5.4 Conclusions

The overall summary of performance for the SHG can be summarised as follows:

Efficiency:

- Inefficient use of staff – productivity falling with new staff not resulting in appropriate increase in the volume of service.
- Real costs per patient/CMU increased by 3% in 2006 relative to 2004.

Effectiveness:

- Outpatient volume targets were met, the proportion of day cases as a proportion of total cases increased, and average length of stay is lower than the national average.
- Targets were not achieved for day patients, inpatients or emergency departments. Missing an individual target is not necessarily a sign of effectiveness, however, missing a number of targets when other metrics such as occupancy, ED waiting times, medical and surgical waiting times and ALOS are average by comparison to national and international benchmarks suggests that a higher level of effectiveness could be achieved.
- The target-setting process was ineffectual which undermined the approach of assessing effectiveness in greater detail. We have, however, examined a number of other aspects in Section 6 under Results (Outcomes) which should be read in conjunction with this section.

6. Results (Outcomes)

6.1 Introduction

When considering the outcomes of the SHG for 2006, we have used the approach of comparing actual outcomes with targets. It should be noted however, that on many occasions, targets for the SHG were generally not identified or quantified for the actions or tasks in the SHG Level 1 business plan. Where targets did exist they were often either aspirational, lacking a measurable outcome or did not have sufficient data to make it possible to measure progress against the target.

Outcomes are examined under the following headings;

- Delivery of service to patients.
- Day case activity trends.
- Public Private mix.
- Waiting times.
- Delayed discharges.
- Quality and risk.

6.2 Outcomes

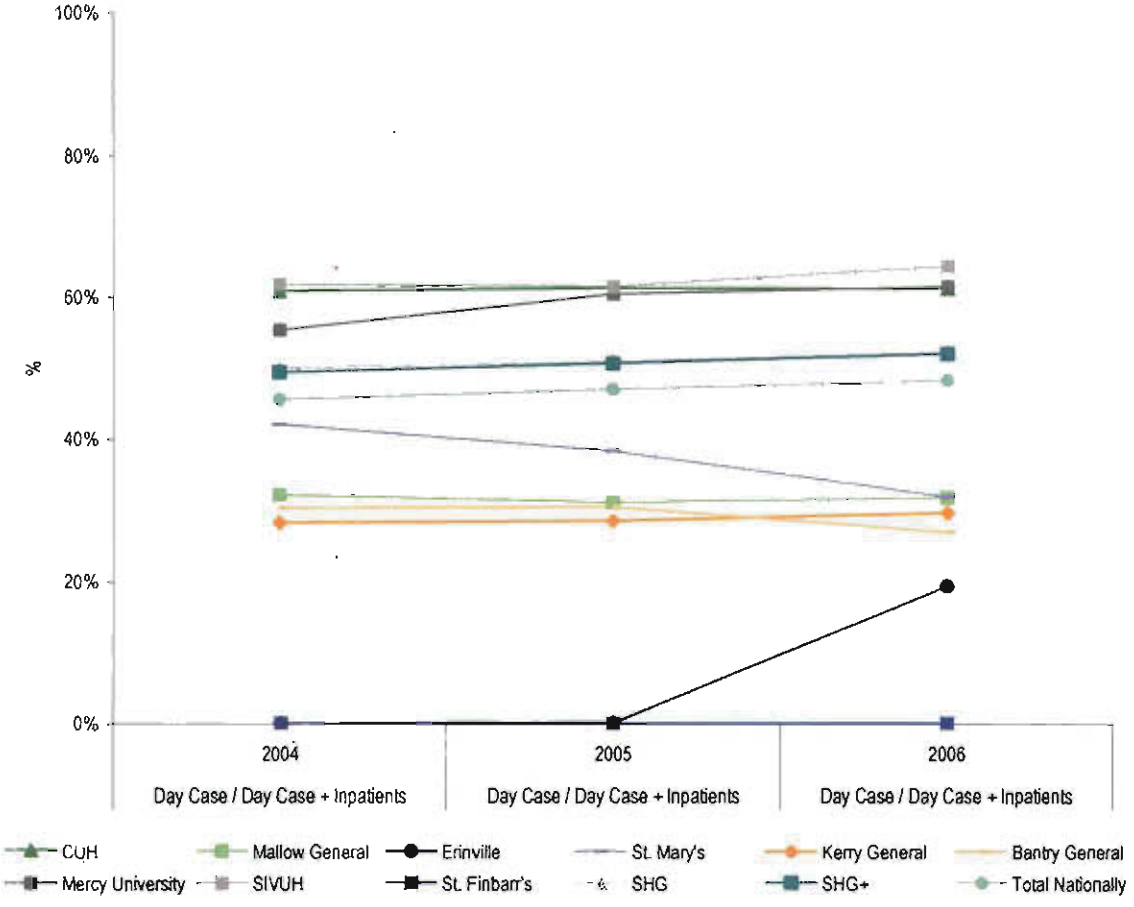
Delivery of service to patients

There are no objectives or targets in terms of population need, patient groups to be served or outcomes. This is a critical requirement in focussing the efforts of management, in assessing performance and in the evaluation the VFM achieved.

Day Case Activity Trends

Figure 6.1 overleaf illustrates the proportion of day case activity of the total day case plus inpatient activity over the period 2004-2006. Data is presented at hospital, SHG and national level.

Figure 6.1 – Day Case Activity % of Day Case & Inpatient Activity 2004-2006

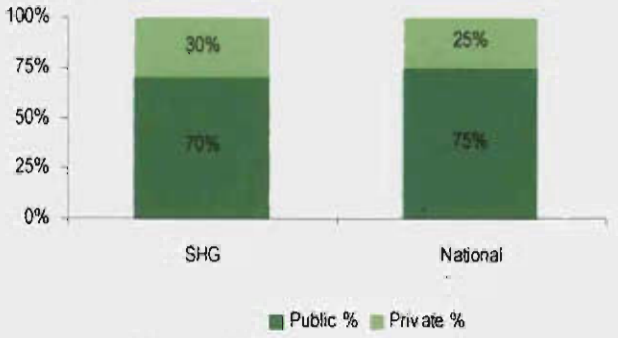


Source: HSE PMU.

Public Private Mix

The mix of public versus private patients is a focus area within objective 1 of the Level 1 business plan. The overall goal is a split of 80:20 in favour of public patients treated within public hospitals. Data is available for inpatients, day cases and overall. In 2006 the target of 80% was not met on either a national basis or at the level of the SHG for inpatients. However, the 80:20 target is being met for day cases.

Figure 6.2 – Public versus Private Patient Split 2006 - Inpatients



Source: HSE Board Report 2006

The SHG has a smaller proportion of emergency admissions (59%) vis-à-vis the national average (67%). This should have a positive impact on both (1) public and private mix of patients as there is more control over the public private mix in relation to elective procedures and on (2) surgical and medical waiting times.

Waiting Times

The Health Strategy (2001) stated that no adult should wait more than 6 months and no child more than 3 months for treatment. These targets have not been achieved in the SHG.

However, the trend in SHG surgical and medical waiting times is one of improvement as shown by the figures below.

Figure 6.3 – Adult Surgical Waiting Times

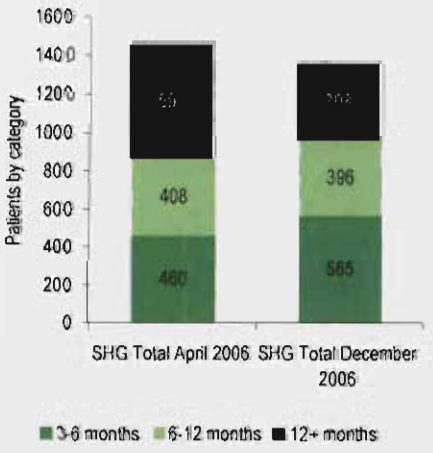


Figure 6.4 – Child Surgical Waiting Times

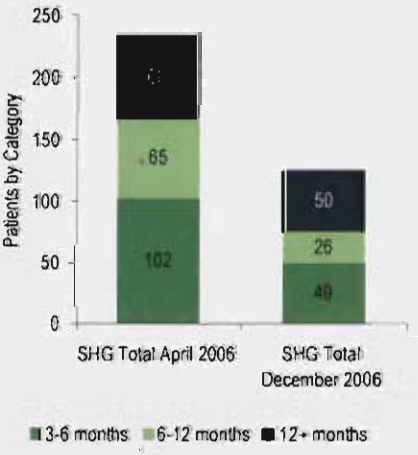


Figure 6.5 – Adult Medical Waiting Times

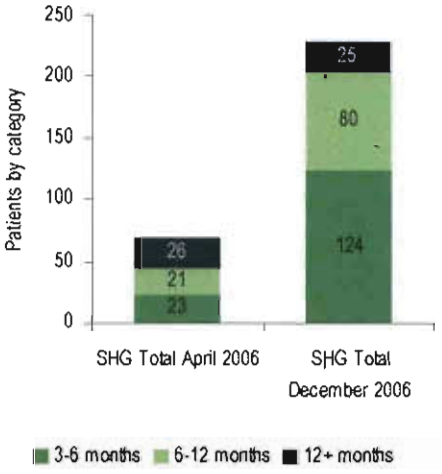
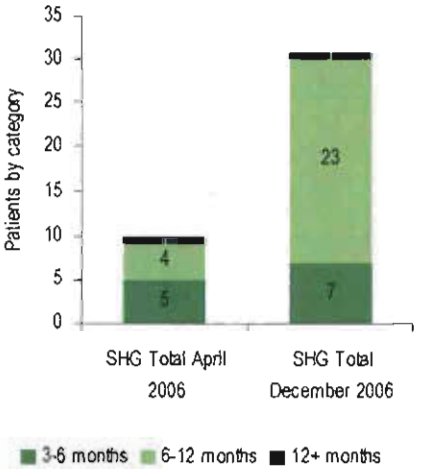


Figure 6.6 – Child Medical Waiting Times



It should be noted that the potential lack of step down facilities that would help the freeing up of beds could be a factor impacting on waiting times. However, assessments of the funding of such facilities is not within the scope of this study.

Quality & Risk Management

Where the measures discussed above are useful indicators as to the effectiveness and quantity of services delivered, the quality and risk management focus area of objective 1 point to the quality of those services. Hospital acquired infections, audited hygiene scores and the more general customer survey scores can be used as guides to the effectiveness of SHG actions in addressing quality and mitigating risk.

Hygiene Audits

All SHG hospitals improved their hygiene audit scores in 2006 compared to 2005. The largest increase was by Kerry General which increased by 40%. Whilst 4 hospitals were below the national average of 74% in 2005, 5 hospitals were below the increased average of 84%. The SHG has been ±1% of the national average in both 2005 and 2006.

Under the scoring system, 4 SHG hospitals were classified as poor in 2005 but this had been reduced to 1 in 2006. The number of "excellent" scores increased from 1 to 3 over the same period.

Other Data

MRSA and customer data are expected to be available by early 2008. This information is expected to be made available in a format that will allow comparison between hospitals and networks.[26]

6.3 Conclusions

The planning process and the linking of plans to measurable objectives were not properly implemented in 2006. With no specific targets for many of the actions and no systems in place to measure performance, objective setting and reports were ineffective.

Our principal conclusions are that:

- There are no targets for population need, or patient outcomes.
- There are improvements in the proportion of patients treated as day cases rather than as inpatients.
- The SHG is failing to meet the 80:20 guidelines for the public/private mix of inpatients and is below the national average. The 80:20 target is being met for day cases.
- Waiting times for adults and children have improved on an absolute level and SHG is outperforming the national rates of improvement. However, there were 794 adults and 125 children waiting more than 6 and 3 months respectively for surgical treatment in December 2006. Therefore national targets are not being met.
- Hygiene audit scores are improving year on year but 5 hospitals are still below the national average. There is little comparable data for customer survey scores and MRSA surveys.

26 Previous MRSA or customer care surveys were either unavailable or did not facilitate appropriate comparison by hospital or network level.

7. Scope for Alternative Approaches

7.1 Individual Hospital Performance

The cost per bed-day is out of line with national norms for the following hospitals:

Figure 7.1 – Speciality Inpatient Cost per Bed-Day in selected SHG Hospitals

Hospital	National Average €	Hospital Cost 2006 €	Variance %
CUH	831	948	-14.1%
St. Mary's Orthopaedic	678	809	-19.3 %
Mercy	678	787	-16.1%
SIVUH	678	734	-8.3%

Note: Figures have not been audited. The different national averages relate to Group 1 and Group 2 hospitals respectively.

While there may, of course, be particular reasons for costs being out of line, there appear to be opportunities to review the cost structure in these individual hospitals.

Cork University Hospital

CUH is the largest hospital in the Group, having some 2,643 WTEs at the end of 2006 and consuming almost 41% of the SHG budget. Staff numbers had increased by 3.8% in 2006 after a further increase of 7.7% in 2005 and were 2% over approved ceilings. The increase in 2006 was, we understand, primarily due to the opening of the new Accident & Emergency Department giving greatly improved patient service, and pre-commissioning of the new Maternity Hospital, neither of which would have generated increased output in the period. Over the same period, case mix units increased by 2.4% in 2006 and 2.1% in 2005. This represented an overall decline in productivity in the hospital in the period. This decline is consistent with the trend in case mix budgetary adjustments for CUH. The case mix bonus declined between 2004 and 2005 from €2,704,632 to €538,572. This decline appears to be primarily due to a penalty on day-case activity of €1,895,667.

St Mary's Hospital

St Mary's Hospital had an unusually low occupancy rate of 47.6%, output, in terms of case mix units, declining by 5.5% from 5,664 to 5,348 units, but costs rose by 6.6%. Staff numbers were 13.8% over the approved ceiling.

South Infirmary Victoria University Hospital/ Mercy University Hospital

Speciality Cost per bed-day in these two hospitals is out of line with national average for Group 2 hospitals, as shown in Figure 7.1 above.[27]

[27] On the basis of the information supplied, SIVUH management do not accept that the cost per bed-day figures, for SIVUH, are correct.

It may be appropriate to consider the possibility of a shared administrative service offering by CUH to Mercy University Hospital and SIVUH to achieve greater utilisation of CUH resources and to achieve cost efficiencies in Mercy University Hospital and SIUVH.

7.2 Improvement in Utilisation

While overall Length of Stay appears reasonable at 6.11 days or 5.73 days (case mix weighted), analysis of the major diagnostic related groups (DRG's) in the SHG indicate that there is potential for significant further reduction. In the following table Southern Hospital Group Average Length of Stay for the top 10 DRG's are compared with 2005/6 data from Australia. Australia has been selected for comparison because the relative values applied in case mix assessment are broadly consistent.

Figure 7.2 – Case Mix Weighted Lengths of Stay for top 10 DRGs in SHG

Description	SHG No. of Patients	SHG Beddays	Australia	National Group 1	National Group 2	SHG	CUH	Mallow	St Mary's	Kerry	Mercy	SIVUH
OTITIS MEDIA and URI without cc	1,368	2,575	1.64	1.75	1.94	1.88	1.53	1.23		2.27	1.63	2.24
ABDMNL PAIN MESENTRC ADENTSwthotCC	1,172	2,389	1.49	2.12	2.19	2.04	1.96	2.54		2.18	1.48	2.5
CHEST PAIN	1,032	2,936	1.51	2.42	3.02	2.8	2.25	1.6		3.14	2.83	4.38
LENS PROCEDURES	874	2,843	1.24	2.91	1.55	3.3	3.25					
OESPHS GASTR and MIS DIG Agt9wthotCSCC	907	3355	1.93	2.47	3.5	3.7	3.73	3.8	2	3.42	3.7	4
APPENDICECTOMY wthot CSCC	694	2,681	2.78	3.75 HSE Target < 3.56	3.78 HSE Target < 3.56	3.86	4.19	3.69		3.54	3.99	3.68
OTHER HEAD INJURY	694	1,088	1.35	1.83	2.13	1.57	1.22	1.9		1.79	2.8	2.93
VIRAL ILLNESS Alt60 wthotCC	690	1,387	1.65	1.41	2.06	2.01	1.63	3.14		2.48	2.1	3.98
NwthotMJR ARYTHM and CONDCTN DSRDwthotCSCC	906	2,956	2.28	3.33	3.94	3.26	3.4	3.4		5.04	4.53	2.6
EXT O.R. PR UNREL to PDX	277	3,538	11.53	16.12	13.74	12.77	13.79	2.33	4.5	22.18	10.32	12.51

Note: Groups refer to the case mix budget model for hospital classification - Group1 "Teaching"; Group 2 "other"; Group 3 "Maternity"; Group 4 "Children's". This system was introduced in order that hospitals were not disadvantaged by being compared against hospitals with a lower cost base.

While SHG hospitals were not unduly out of line with national averages, both SHG and those national averages were, in general, considerably out of line with Australian norms. On this basis, if the Australian averages were applied to SHG volumes, there would be a resultant saving of 8,092 bed-days, or 1.6% of all bed days in SHG, for these ten DRGs.

If the Australian average length of stay had been achieved for inpatients treated for the top 100 DRG's in SHG, there would have been a resultant saving of 71,900 inpatient and day patient bed-days in SHG, or 13.5% of actual inpatient and day patient bed days in the group in 2006.

Without regard for international standards, as illustrated in Figure 7.3, there is considerable variation in length of stay between hospitals within SHG, and between SHG and HSE targets. For instance:

Figure 7.3 – Comparison of Average Length of Stay for Selected DRG's

	DRG			
Hospital	**Heart Failure**		**Appendicectomy**	
	Nos	**ALOS (Days)**	**Numbers**	**ALOS (Days)**
Mercy University	227	15.52	29	8.38
SIVUH	292	13.74	45	4.8
Mallow General	82	7.22	18	4.9
CUH	693	17.76	161	4.75
Kerry General	416	11.94	170	4.25
SHG Average		14.9		4.81
HSE Target		7.3		3.56

Day Case Ratios and Costs

International research suggests that procedures conducted on a day case basis can be achieved at substantially lower cost than if they were conducted in an inpatient setting. The UK Healthcare Commission[28] references a NHS Department of Health planned target that 75% of elective admissions should be completed on a day case basis. Reasons cited for promoting day case procedures include:

- Provides for shorter waiting times.
- Less disruptive and stressful to patients.
- Reduced risk of cross infection.
- Cheaper and more efficient.

Measured in relation to case mix units day cases account for 52.8% of total day and inpatient activity in the SHG in 2006. The SHG, Network 2, has historically increased its day case workload, year on year, as well as undertaking increased case complexity within day case settings. For example, CUH increased day case activity during the six years from 14,103 in 2000 to 50,023 in 2006. We understand that some of this increase arose as a consequence of transferring Radiology treatments from Outpatient to Daypatient settings.

[28] Day Surgery, July 2005.

To promote, encourage and monitor the practice of day case procedures internationally there is a trend towards publishing a list or "basket" of cases suited to day case procedures. The UK Healthcare Commission reported in 2005 that only 67% of cases from a "basket" of 25 day surgery procedures were conducted on a day case basis. Barriers to progress in the UK listed a number of factors such as:

- Day surgery theatres operated only 16 hours in a week.
- Cancelled or short running lists.
- Time gaps between patients accounted for 45% of planned hours.

We found no evidence of measures or information to identify such barriers or "day case baskets" in the SHG. However, the HSE has set a specific target that 90% of procedures for the extraction of Cataracts should be performed as day cases. (UK Target 94% upper quartile).

Consideration needs also to be given to the relative cost of day case procedures in the SHG. The average cost of day cases in the SHG is €674, compared with a national mean of €642. Day case costs in Kerry General, Mercy University Hospital, and SIVUH,, are out of line with the national mean. If the national average day-patient cost had been achieved in 2006, a saving in excess of €3m would have been achieved. The accuracy of day case costs in Mallow is difficult to assess because of a lapse in HIPE coding (<40% completed) and management failures to adhere to casemix procedures and deadlines.

Figure 7.4 – Day Patient Case Volumes and Costs (Case Mix Adjusted)

Hospital	Volume 2006	National Mean €	Hospital Mean €	Variance %	Estimated Value of Variance €
Kerry General	6,149	642	669	4.29%	307,260
Mercy University	15,380	642	665	3.65%	312,110
SIVUH	16,149	642	927	44.4%	2,570,130

Note: figures have not been audited.

Utilisation of available day-beds, assuming an average length of stay of 0.5 days per case and availability on a 5-day week basis, is 82.7%, or 56.7% on a 7-day week basis.

Staff Management

Staff numbers at the end of 2006 were above approved staff ceilings of 6,385 or by 52 or less than 0.8%. The net additional number of funded posts (not part of the ceiling) based on HSE data is 104 so it is evident the HSE was funded to recruit additional staff even though the ceiling had been adjusted[29]. While this was a relatively small excess overall, because Erinville Hospital numbers were below staff ceiling by 202, excesses in other hospitals are not fully evident in the overall figure. The percentage differences in Bantry General (14.2%), St. Mary's (13.9%), SIUVH (8.5%) and Kerry General (7.8%) are particularly notable. As staff represent over 70% of hospital costs, the control of staff costs is essential for cost effective delivery of service.

[29] The HSE has letters of determination for funded posts which are not part of the official ceiling.

Figure 7.5 – Staff Ceiling and Actual Numbers

Hospital	Staff Ceiling	Staff Numbers 31st December 2006	Difference	%
CUH	2,587	2,642	55	+2.1%
Kerry General	898	968	+70	7.8%
Erinville	632	430	-202	-31.9%
Bantry General	232	265	+33	+14.2%
Mallow General	228	241	+13	+5.7%
St Mary's	217	247	+30	+13.9%
Mercy University	965	965	0	0%
SIUVH	691	750	59	8.5%
Regional Acute[30]	89	84	-5	-0.5%
Network Manager's Office	4	3	-1	-25
Total	**6,543**	**6,595**	**+52**	**+0.8%**

Hospital Administrators can have difficulty in controlling staff numbers in a changing and dynamic environment or where increasing volumes of activity are being experienced. Equally, staffing levels are often difficult to adjust where a reduction in demand for service is being experienced. Staff ceilings, based on previous year levels with specific adjustments can be inflexible and inappropriate to the needs of a hospital. However, staff represent over 70% of hospital costs and control of staff costs is essential for cost effective delivery of service.

In the short term there would appear to be a need for an improved focus on staff cost management and control, including agency and contract staff numbers.

A more strategic approach may also be appropriate to the management of staff costs. Examples of such approaches in other environments include:

- Introduction of shared services for back office procedures between hospitals.
- Expansion of shared administrative and support services between units within hospitals.
- Increased automation.
- Outsourcing of non-core services.
- Rationalisation of services between hospitals in the same catchment area.
- Developing staffing models based on an objective assessment of the service load.
- Focus on strategies to reduce absenteeism.
- Successful staff cost management as a Key Performance Indicator for hospital administrators.

We understand that such initiatives have been actively considered over the past twelve months. Such changes will of course take time to implement and will need to be negotiated within the partnership process.

Cost of Quality

Quality management is a key responsibility of managers throughout industry. Quality improvements are driven by an awareness of customer requirements and the cost of

[30] See footnote 9 for explanation.

non-conformance, a strong system of measurement, a commitment by management and clearly defined responsibilities. Apart from clinical management, quality failures which can have a significant impact on hospital costs include such matters as:

- Cancelled procedures or clinics.
- Rework in the form of repeated tests or investigations, because of incomplete, inaccurate or missing records or a communications failure.

Measurement of the cost of quality and the cost of non-conformance is an essential element of a quality system.

Initiatives are taking place towards a comprehensive quality system amongst the SHG. CUH has achieved Pre-Accreditation Advanced Stage, the Mercy University Hospital has achieved Pre-Accreditation, Level 1, and SIVUH has achieved Pre-Accreditation Level 1 with Report. Bantry and Kerry General Hospitals are establishing Executive Boards with responsibility for the development of a robust system of clinical governance. There is systematic approach to some quality issues such as hygiene. However there is as yet, little evidence of a systematic rigorous overall Total Quality approach to setting and measuring quality standards, or on the measurement of the cost of non-conformance. In particular there were few limited outcome measures available to support a VFM assessment.

8. Opportunity for Improvements in Management Processes

8.1 Section Objectives

The principle objectives of this section are to:

- To identify areas for improvement in management processes and systems.
- Specify potential future performance indicators that might be used to better monitor the allocation and utilisation of the €664m to and within the Southern Hospital Group.

8.2 Areas for Improvement

We have identified a number of areas for improvement.

- Integration of:
  - Business planning and budgeting.
  - Cost and financial management.
- Strengthening and deepening budgetary control systems.
- Data gathering validation and reporting.
- Establishing KPIs (Balanced Scorecard and measures.)
- Quality management.
- Structural change and integration.

Improvements in systems and process will reinforce and support the achievement of efficiency gains.

Budget & Integration of Business Systems

The current budgetary process is relatively rigorous, and is monitored monthly. Service Plans are prepared by each hospital and are consolidated into the overall Network Service Plan, and further integrated into the HSE Service Plan. The planning process is built around key documents such as: Estimates (Finance and Service issues); Service Plans (Activity targets); and Budget (Financial Projections on Current Year Budget). These plans are reported on a monthly basis 'planned activity v's actual'.

The level of integration between budget allocation and delivery of the action areas in the business plan at SHG level is under developed.

Integrated Financial and Costing Systems - budgeted activity and expenditure is not integrated with case-mix cost. A number of the elements of this process are in place and a fully integrated system of budgeting as described would build on existing processes and expertise and could be implemented over a short number of years.

There is a need for greater integration between the business planning and budgetary processes. Budget elements should be specifically linked to service areas as part of the planning process so the that the input to output relationship is considered through out the two main planning processes – i.e. budgeting and development of business plan for SHG.

Strengthening and deepening budgetary control systems

In view of the level of integration of business systems, the level of growth in staff number which has not been reflected in an appropriate increase in service volume and given the range of negative expenditure variances, mainly in relation to staff budgets, at hospital level in the SHG (from 2.5% to 23.6%), particularly for statutory hospitals, further development of the budgetary control system should be considered.

A breakout of case-mix costs to cost components should be prepared, and reconciled with department costs. Case-mix costing, which is now generally accepted, should become an integral part of the budgeting and management process. Case-mix cost reports and cost adjustments should be made on a quarterly basis, in the quarter following the period of expenditure. These adjustments can be made on a provisional basis subject to review following audit. It is recognised that further systems development and information systems support will be required to implement case-mix costing at hospital level.

In addition to a strengthened budgetary and costing, a formal, methodical process of rolling expenditure reviews should be initiated, where all expenditure programmes would be formally and critically assessed every three years. The agreed recommendations from these reviews should be allocated to management for implementation and the implementation monitored.

Data Gathering, Validation & Reporting

There are a number of largely independent data gathering and reporting sources:

- The Rosetta budgeting system.
- General Ledger.
- Hospital accounting.
- HIPE.
- Specialty costing.
- Case mix.
- Performance Monitoring Unit (PMU).
- Hospital level statistics.

The current information system in the SHG is fragmented and incomplete. It is apparent that data is held in disparate forms and on different bases throughout the HSE system, and is not readily available in a timely manner to enable rapid management response e.g. patient satisfaction or MRSA data was not available in a form which would allow inter-hospital comparison or comparison with SHG or national averages. Even at this stage of writing, data for 2006 has not been finalised in the case mix area. Given the degree of difficulty for the consultants in establishing the appropriate activity numbers to use suggests that data accuracy and validation is an issue.

The HSE is in the process of developing a Decision Support System. A Decision Support System with a core objective to enable "access to internal and external data on service delivery and support processes (inputs, outputs, outcomes, etc) across the HSE, to provide integrated intelligence, feedback into the system and support effective corporate decision making." This development is consistent with our observations on the fragmentation of information.

There is a need for a coherent and efficient approach to the identification, capture, and analysis of strategic information to facilitate management of key performance measures and the examination of specific areas of operation. Reliable consistent and relevant data is essential for efficient and effective management. A programme should be put in place, building on an agreed balanced scorecard (such as described in this section) to ensure that the relevant information is assembled and reported in a consistent manner.

The value of information collection is realised in dissemination and action. As is the case in other countries, information assembled in relation to performance indicators should be made available, on a timely basis, to hospital, HSE and Public Sector management, peer hospitals, and the public:

- For information and guidance.
- To encourage the achievement of standards.
- To provide a comprehensive and balanced picture of hospital performance.
- To support community involvement and the coordination of care.
- To enable the public and their advisors to make informed choices.

Quality Management

Quality management is a key responsibility of managers throughout the healthcare industry.

Measurement of quality and the cost of non-conformance is an essential element of a quality system. While progress is being made in relation to clinicians in management, accreditation and hygiene, there is, as yet, little evidence of a systematic rigorous overall approach to setting and measuring quality standards, or on the measurement of the cost of non-conformance. In particular there were few limited outcome measures available to support a VFM assessment. The specific quality indicators within the Corporate Performance Measurement should be identified.

Structural Change and Integration

This study has not specifically focused on examining structural change and integrated planning between hospitals. Such matters are central to organising the services in the region in the most cost effective manner. The recent announcement on the merger of the Mercy University Hospital and the SIVUH confirms this point.

We have recognised that the Mercy University Hospital and the South Infirmary Victoria University Hospital could forge stronger links. They have common characteristics:

- Both are medium-sized voluntary hospitals with a proud and strong tradition of service.
- They are both based close to the centre of Cork City, with limited scope for physical expansion and have difficulties of access and parking.
- There is significant overlap in service provision, including emergency services, oncology, ophthalmology, genito-urinary and cardiology.
- They both have a full supporting range of diagnostic and therapeutic services.
- They both have the normal range of administrative functions.
- They both provide teaching facilities.

Other structural and service issues are also under consideration in the Acute Hospital Review of the SHG which is currently being prepared.

In terms of structural change, options which should be considered in light of the forthcoming HSE South Review of Acute Services might include:

- Rationalisation of services between hospitals in the same catchment area.
- Introduction of further shared services for back office procedures between hospitals e.g. CUH took over St. Mary's payroll function in October 2006, and the payroll and accounts functions of the new maternity hospital (CUMH) in April 2007. The materials management function of CUMH amalgamated with the CUH function.
- Expansion of shared administrative and support services between units within hospitals. Increased automation e.g. progress has been made in relation to business objects reporting, billing and debt management.
- Outsourcing of non-core services.

8.3 Balanced Scorecard - VFM

The terms of reference for this review specifically request that the study identify potential key performance indicators in the context of VFM. The HSE does not currently have a specific set of tailored key performance indicators for VFM. The Decision Support System which still in planning envisages a set of VFM indicators.

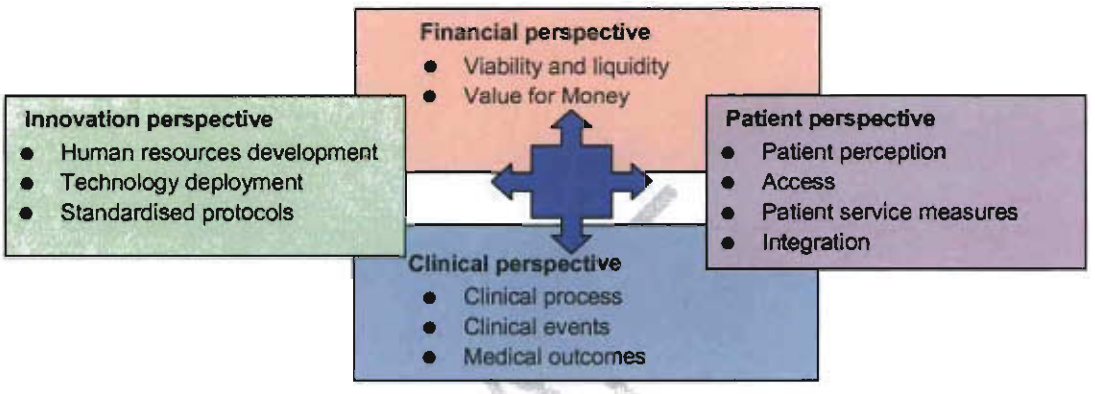
A set of potential future performance indicators should be developed which focuses specifically on monitoring the allocation and utilisation of funds. These indicators are described overleaf and set out in detail in Appendix A to this report.

Figure 8.1 – HSE SHG Potential Performance Indicators for Monitoring Allocation and Utilisation of Funds

The above performance indicators for VFM would sit within an overall SHG Balanced Scorecard which takes account of all relevant aspects of the health service. This possible overall SHG framework is outlined in Appendix A. The overall scorecard, which is suggested at SHG level reflects current and emerging international practice, utilises four perspectives:

- **Financial (including VFM)**
- Patient
- Clinical - delivery of high-quality service; and
- Innovation - the ability to learn and grow.

Figure 8.2 – Balanced Scorecard



Within each performance dimension, specific performance indicators and, below that, performance measures may be identified. Some of the key indicators, and their associated measures, are included in the HSE Corporate Performance Measurement Report[31].

It is recognised that the implementation of a Balanced Scorecard approach would be a very significant development and would require the commitment of considerable resources. It would be a strategic national issue for HSE rather than for SHG. The Balanced Scorecard would have to reflect, and be mapped to, the strategic objectives as they are cascaded down from the Department of Health and Children, through the HSE to individual services, HSE areas, hospital groups and individual hospitals. The approach would above all require senior management commitment as this approach can only work effectively if the specific Performance Indicators are selected by managers as the key measures that they will use to plan, monitor and control their areas of responsibility. It would also require their involvement in establishing appropriate, clearly defined, targets and alarm levels, and in the selection of appropriate international benchmarks. Finally, the implementation of a Balanced Scorecard approach would be dependent upon investment in, and development of, the information systems necessary to collect, integrate and report the information on which the scorecard is based. These strategic developments would have to be considered in the context of national HSE initiatives such as the current Decision Support initiative.

The indicators outlined in Figure A.1 in Appendix A.1 are not exhaustive. They are indicative of the overall framework within which indicators specifically focused on the

[31] Corporate Performance Measurement, Report one: February 2007.

allocation and utilisation of funds might operate. Within that overall framework, a hierarchy of indicators would be developed to address the specific concerns and priorities of managers. Some examples of such specific indicators might include the following:

Clinical focus:

- Comparison of medical outcomes.
- Mortality rates.
- Rate of specific procedures, e.g. caesarean sections.
- Returns to theatre.
- Medication errors.
- Reportable incidents.
- Prevalence of hospital acquired infections.
- Hygiene standards.

Staff:

- Staff retention/turnover.
- Permanent versus temporary staff.
- Employees versus agency staff.
- Absenteeism levels.

Patient focus:

- Patient satisfaction.
- Waiting times: admission to surgery.
- Waiting times: discharge to written report to primary care.
- Waiting times: referral from GP to appointment in OPD.
- Patient profile: return patients seen in A&E.
- Patient profile: return patients seen in OPD.
- Patient profile: % of patients booked for OPD who did not attend.

9. Conclusions and Recommendations

9.1 Section Objectives

The principle objectives of this section are to:

- Summarise the scope for alternative policy or organisational approaches to achieving SHG's objectives on a more efficient or effective basis.
- Identify any key issues which should be isolated for further detailed study including factors which have an adverse impact on efficiency.

9.2 Opportunity for Improvements – VFM Focus

Conclusions

Efficiency

The SHG did not provide optimum VFM in 2006. The evidence is:

- Productivity declined with the introduction of new staff over the period 2004-2006. Each staff member is on average serving fewer patients than in 2004.
- Costs have increased in real terms. Real costs per patient/CMU have both increased by 3% in 2006 relative to 2004 which reflects inefficient use of staff and other non pay resources.
- Costs for inpatients (i.e. CUH, St. Mary's, Mercy University and SIVUH) and day patients (i.e. Kerry General, Mercy University and SIVUH) are greater than national norms in certain hospitals. This conclusion is based on preliminary data.
- Utilisation is up to 13.5% below Australian practice.

We believe that costs per CMU could be held constant or reduced, in real terms, through a series of actions, including:

- Holding real costs constant through improved staff deployment and other related measures, including reductions in day-patient costs, and increased use of shared services. If real costs and productivity has remained at the 2004 level then the savings in 2006 would have amounted to over €15m.
- Improving productivity through progressive reductions in length of stay, and increased transfer of treatment to day patient settings and elimination of costs associated with unused facilities arising from these measures.
- Improvements in budgetary control.
- Alignment of incentives.

At the same time improved patient service can be achieved through reduction in waiting times, shorter length of stay and improved quality control.

Effectiveness

In terms of addressing the specific question of effectiveness, it is evident that:

- Outpatient volume targets were met, the proportion of day cases as a proportion of total cases increased, and average length of stay is lower than the national average.

- Targets were not achieved for day patients, inpatients or emergency departments. Three out of four main settings targets were missed. Missing an individual target is not necessarily a sign of ineffectiveness, however, missing a number of targets when other metrics such as occupancy, ED waiting times, medical and surgical waiting times and ALOS are average by comparison to national and international benchmarks suggests a higher level of effectiveness can be achieved.

- Target-setting was very limited in scope and not integrated with resource planning. Only 22% of actions had a specific target.

Outcomes

There are no comprehensive set of objectives or targets in terms of population need, patient groups to be served, or outcomes. This is a critical requirement in focussing the efforts of management, in assessing performance and in the evaluation the VFM achieved.

Specific Areas of Focus

Our research has demonstrated clearly that there is significant opportunity for the achievement of improved VFM in terms of:

- Increased and lower cost day case activity.
- Shorter length of stay.
- Lower cost per CMU.
- Improved staff management.

Increased and Lower Cost Day Case Activity

While there has been a slight move towards treating patients on day case basis, progress has been slow. International research suggests that procedures conducted on a day case basis, where appropriate, can be achieved at substantially lower cost than if they were conducted in an inpatient setting. To promote, encourage and monitor the practice of day case procedures internationally there is a trend towards publishing a list or "basket" of cases suited to day case procedures (e.g. UK Audit Commission). We found no evidence of measures or information to identify such barriers or "day case baskets" in the SHG.

Shorter Length of Stay

While overall Length of Stay appears reasonable at 6.11 days or 5.73 days (case mix weighted), analysis of the major diagnostic related groups (DRG's) in the SHG indicate that there is potential for significant further reduction as per the Australian example in section 7.

Lower Cost per CMU

We have noted that the cost per case (CMU/patient) has increased in real terms. At a more micro level, the cost per bed-day is out of line with national norms for the following hospitals – CUH, St. Mary's, Mercy University and SIVUH[32]. While there may, of course, be particular reasons for costs being out of line, there appear to be opportunities to review the cost structure in these individual hospitals.

Improved Staff Management

Staff numbers at the end of 2006 were above approved staff ceilings of 6,543 by 52. While this was a relatively small excess overall, because Erinville Hospital numbers were below the staff ceiling by 202, excesses in other hospitals are not fully evident in the overall figure. Excepting that it can difficult to adjust staff numbers to reflect current demand, with staff representing over 70% of costs, the need for an improved focus on staff cost management and control, including agency and contract staff numbers which have all been rising without the commensurate increase in service volumes.

Recommendations

The challenge for hospitals within the SHG is to deliver on the opportunities identified in this review. The business planning framework at both hospital level (Level 2) and SHG (Level 1) can be used to manage progress against the recommendations in this report.

Setting Targets

At both SHG and hospital level, targets should be defined:

- To achieve policy results in terms of patient care and outcomes.
- To reduce average length of stay to international best practice.
- To increase day case activity based on a basket of appropriate day cases defined at HSE level.
- For elective work which can be achieved in a day setting.
- To reduce the cost per case to an agreed target.

These targets are specifically designed to address the most significant areas for improvement which were noted above. Other performance measures are recommended as part of the overall set of VFM indicators (see Section 9 and Appendix 1).

[32] Preliminary data – analysis by Ernst & Young/Talbot Associates.

The HSE will have to factor in the impact of the existence (or lack) of PCCC facilities. Issues in relation to PCCC are not an excuse to avoid setting such targets as the negative changes in efficiency and productivity over the past few years were clearly delivered using the existing PCCC model. Targets need to be challenging and require a joint NHO/hospital initiative which is achievable within the current business planning framework. More generally, targets at SHG level must be much more specific than hitherto.

Measurement of Targets and Management

At both hospital and SHG level, targets must be measured, monitored and managed against. Hospital targets must be reported to the SHG. The development of other management systems be they costing (or case mix) related, performance indicators or quality related should support the process, at hospital and SHG level, in:

- Defining targets.
- Providing high quality data, and
- Measuring against targets to inform management decisions.

Improvements in systems, process and structures supports the achievement of efficiency gains (as per Section 8).

For example, this report identifies a number of areas for improvement.

- Integration of:
  - Business planning and budgeting.
  - Cost and financial management.
- Strengthening and deepening budgetary control systems.
- Data gathering validation and reporting.
- Establishing KPIs (Balanced Scorecard and measures).
- Quality management.
- Structural change and integration.

9.3 Opportunity for Improvements – Further Study

We have identified a number of issues through out this review. These issues relate to:

- Strengthened budgetary control/costing systems.
- Quality management.
- Structural change and integration.
- Incentives for efficiency.

While progress may be made on some of these issues as a matter of course, further detailed study, will be required.

Strengthened Budgetary Control/Costing Systems

The areas for specific study are:

- Greater integration between the business planning and budgetary processes. The relationship between SHG business plan and the budget should be more clearly identified.

- Integrated Financial and Costing Systems. Budgeted activity and expenditure is not integrated with case-mix cost. The relationship between budget (inputs) and output is not transparent and should be better understood.

Incentives for Efficiency

Incentives to meet targets – while case mix provides one mechanism to reward the more efficient hospitals and other incentive schemes are in place such as the scheme in place to reward those who exceed various target levels for waiting times in emergency departments, there is an opportunity to reward those hospitals where other agreed business plans targets are achieved. For example, if a balanced scorecard type approach as recommended in this report is introduced, then it might offer an opportunity to develop a scoring system which could add to the case mix incentive scheme. Each hospital could use such an agreed scorecard linked to core measurable objectives and in turn linked to a reward system. These questions require careful consideration.

Quality Management

We have noted that there is no overall quality management system at SHG level. Quality must not only address hygiene but could also address MRSA, customer care perceptions, clinical events and processes, mortality rates, adverse outcomes, readmissions, cost of readmissions, waiting times, etc.

Structural Change and Integration

The key challenge will be to study, plan for and deliver appropriate change arising from the HSE South Review of Acute Services.

9.4 Recommended Action Plan

In this section, recommendations are set out under the following headings:

- Effectiveness and Efficiency.
- Management Systems.
- Issues for Further Study.

In relation to the recommendations relevant to "Effectiveness and Efficiency", (see overleaf) we do not see specific costs at NHO or hospital level, other than the cost of normal management time which should be directed to these matters in any event. The planning and management of the change required can be managed through the normal budget and business planning process.

Effectiveness & Efficiency

Recommendation	Effect	Priority	Timing	Lead Responsibility
Set Targets for Key Metrics	High	High	2008 Q1	HSE /NHO (Network 2 Office)
Set Targets – Hospital Level (agree with NHO/HSE)	High	High	2008 Q2	Hospitals
Collect Data	High	High	2008 Q3 on	NHO (Network Office /Hospitals
Manage Performance	High	High	2008 Q4 on	Hospitals/NHO (Network Office)

Management Systems

Recommendation	Effect	Priority	Timing	Lead Responsibility
Integrate business systems	High	High	2008	HSE
Strengthen and deepen budgetary control systems	High	High	2008	HSE
Improve data gathering and information provision	High	High	2008 Q4	HSE/ NHO (Network Office /Hospitals
Implement Balanced Scorecard - Design/agree - Rollout	High	High	2008 Q2 2008 Q4	HSE/NHO (Network Office) /Hospitals
Introduce Enhanced Quality Management	High	High	2008 Q4	HSE/ NHO (Network Office /Hospitals
Improve Structure	High	High	On going	HSE/ NHO (Network Office /Hospitals

While there is a need to invest at HSE level in appropriate systems and support for the full implementation of these recommendations, the costs are likely to be significantly outweighed by the benefits. We do not see specific additional costs at a hospital level, other than the cost of normal management time which should be directed to these matters in any event.

Issues for Further Study

Costs incurred in relation to further study will be incurred at HSE national level. Costs in relation to these are already being incurred at a national level.

Recommended areas to study	Effect	Priority	Timing	Lead Responsibility
Budgetary control systems	-	High	Mid 2008	HSE
Quality management	-	High	Mid 2008	HSE
Structural change and integration	-	High	Mid 2008	HSE/ NHO (Network Office /Hospitals
Incentives for effjciency	-	High	Mid 2008	HSE/ NHO (Network Office /Hospitals

APPENDICES

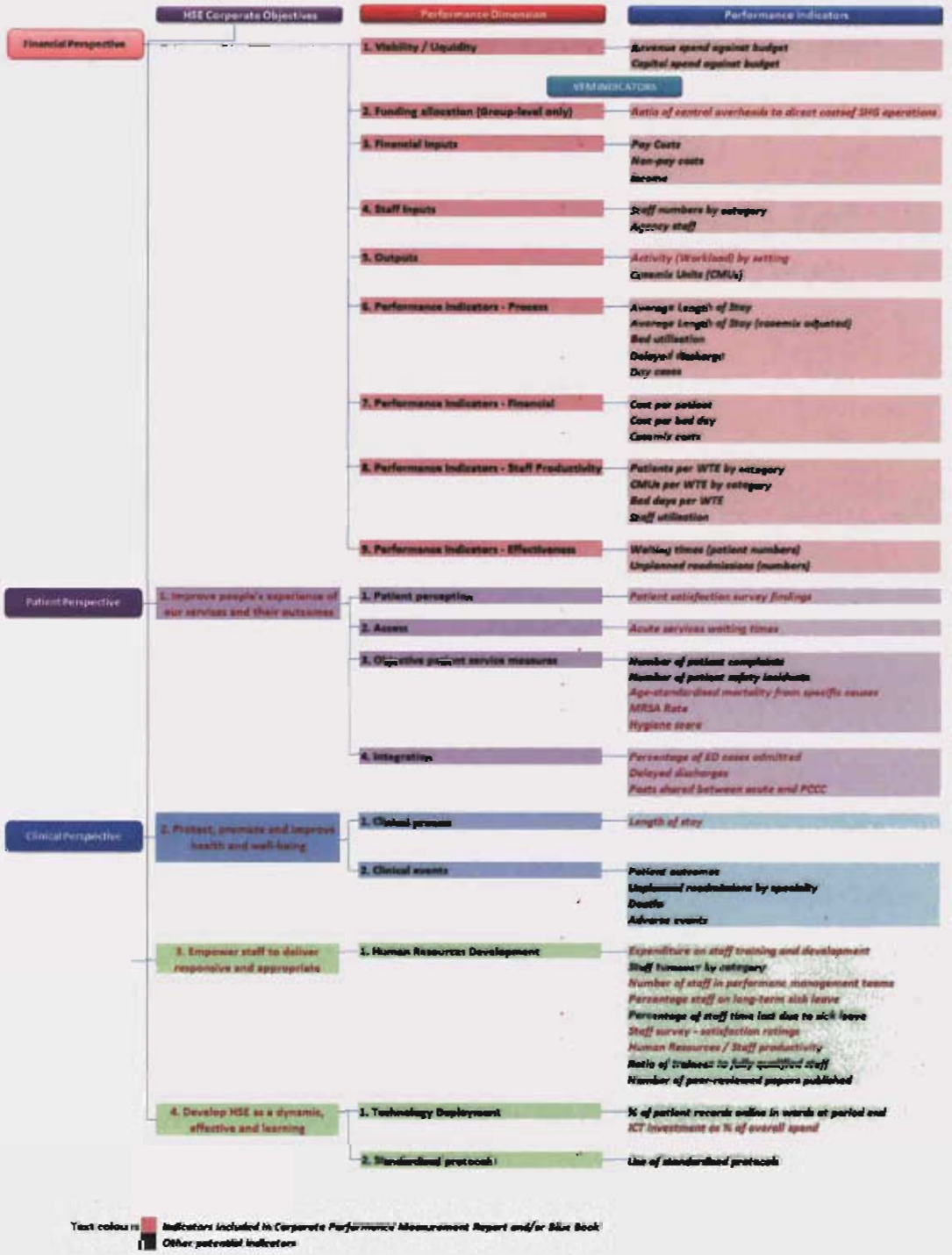
LIST OF FIGURES

Appendix A – Balanced Scorecard

Appendix A.1 – HSE Balanced Scorecard Structure

Figure A.1 overleaf shows, within the financial perspective, a sub-set of indicators that are appropriate to VFM. .These include some indicators that are appropriate also to the patient, clinical and innovation perspectives, and have also been included under those perspectives.

Figure A.1 – HSE SHG - Potential Balanced Scorecard Structure



Appendix A.2 – Potential Future Performance Indicators

Group 1: Financial inputs

Performance Indicator	***Direct funding to network as a percentage of total funding***
Focus	Degree to which total funding is focused on direct provision of services rather than on meeting overheads and other indirect costs, thus reflecting efficiency in the provision of corporate services
Calculation	Funds allocated to SHG expressed as a % of the total cost estimates for SHG
Reporting	Quarterly
Current Status (if known)	Not reported at SHG level

Performance Indicator	***Apportionment of corporate overheads to network as a percentage of total funding***
Focus	Degree to which total funding is focused on direct provision of services
Calculation	Central HSE overheads/support costs apportioned to SHG in the annual estimates expressed as a % of the total cost estimates for SHG
Reporting	Annual
Current Status (if known)	Not reported at SHG level

Group 2: Financial inputs

Performance Indicator	***Pay costs – percentage change on prior year***
Focus	Rate at which pay costs are increasing (the combined impact of pay increases and changes in staff numbers)
Calculation	Difference between current year pay costs and prior year pay costs expressed as a % of prior year pay costs
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Pay costs – percentage variance on budget***
Focus	Degree to which pay costs are in line with budget
Calculation	Difference between current year actual pay costs and current year budgeted pay costs expressed as a % of budgeted pay costs
Reporting	Monthly
Current Status (if known)	Variances reported in Income & Expenditure Accounts

Performance Indicator	***Non-pay costs – percentage change on prior year***
Focus	Rate at which non-pay costs are increasing
Calculation	Difference between current year non-pay costs and prior year non-pay costs expressed as a % of prior year non-pay costs
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Non-pay costs – percentage variance on budget***
Focus	Degree to which non-pay costs are in line with budget
Calculation	Difference between current year actual non-pay costs and current year budgeted non-pay costs expressed as a % of budgeted non-pay costs
Reporting	Monthly
Current Status (if known)	Variances reported in Income & Expenditure Accounts

Performance Indicator	***Income – percentage change on prior year***
Focus	Rate at which income is increasing
Calculation	Difference between current year income and prior year income expressed as a % of prior year income
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Income – percentage variance on budget***
Focus	Degree to which income is in line with budget
Calculation	Difference between current year actual income and current year budgeted income expressed as a % of budgeted income
Reporting	Monthly
Current Status (if known)	Variances reported in Income & Expenditure Accounts

Group 3: Staff inputs

Performance Indicator	***Staff numbers – percentage change on prior year (by staff category)***
Focus	Rate at which staff numbers are increasing
Calculation	Difference between current period staff numbers and prior year equivalent period staff numbers expressed as a % of prior year equivalent period staff numbers (staff numbers expressed as WTEs)
Reporting	Monthly
Current Status (if known)	Similar data reported in Monthly Employment Monitoring reports

Performance Indicator	***Staff numbers – percentage variance on ceiling (by staff category)***
Focus	Degree to which staff numbers are in line with approved ceiling
Calculation	Difference between current year actual staff numbers (WTEs) and current year approved ceiling (WTEs) expressed as a % of approved ceiling (WTEs)
Reporting	Monthly
Current Status (if known)	Reported in Monthly Employment Monitoring reports

Performance Indicator	***Agency staff costs – percentage change on prior year***
Focus	Rate at which agency staff costs are increasing
Calculation	Difference between current year agency staff costs and prior year agency staff costs expressed as a % of prior year agency staff costs
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Agency staff costs – percentage variance on budget***
Focus	Degree to which agency staff costs are in line with budget
Calculation	Difference between current year actual agency staff costs and current year budgeted agency staff costs expressed as a % of budgeted agency staff costs
Reporting	Monthly
Current Status (if known)	Variances reported in Income & Expenditure Accounts

Performance Indicator	***Agency staff – percentage of approved ceiling (by relevant staff category)***
Focus	Degree to which services are provided by agency staff
Calculation	Agency staff numbers (calculated WTE equivalents) expressed as a percentage of approved ceiling
Reporting	Monthly
Current Status (if known)	

Group 4: Outputs

Performance Indicator	***Workload - percentage change on prior year (by setting)***
Focus	Rate at which workload (total of inpatient, day patient and ED non-admission activity) is increasing or decreasing
Calculation	Difference between current period workload and prior year equivalent period workload expressed as a % of prior year equivalent period workload
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Workload – variance against target (by setting)***
Focus	Degree to which workload (total of inpatient, day patient and ED non-admission activity) is in line with target
Calculation	Difference between current period workload and target workload expressed as a % of target workload
Reporting	Monthly
Current Status (if known)	Workload data reported by Performance Monitoring Unit (PMU)

Performance Indicator	***Case Mix Units (CMUs) – variance against target***
Focus	Extent to which workload, case mix adjusted, is meeting target
Calculation	Difference between current period workload and target workload expressed as a % of target workload
Reporting	Bi-annual
Current Status (if known)	

Performance Indicator	***Case Mix Units (CMUs) - percentage change on same period prior year***
Focus	Rate at which workload, case mix adjusted, is increasing or decreasing
Calculation	Difference between current period workload and prior year equivalent period workload expressed as a % of prior year equivalent period workload
Reporting	Bi-annual
Current Status (if known)	

Group 5: Performance Indicators - Process

Performance Indicator	***Average Length of Stay (ALOS) - percentage change on prior year***
Focus	Rate at which ALOS is increasing or decreasing
Calculation	Difference between current ALOS and prior year ALOS expressed as a % of prior year ALOS
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Average Length of Stay (ALOS) - percentage variance against target***
Focus	Extent to which ALOS is meeting target
Calculation	Difference between current ALOS and target ALOS expressed as a % of target ALOS
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Average Length of Stay (ALOS) case mix adjusted - percentage change on prior year***
Focus	Rate at which ALOS case mix adjusted is increasing or decreasing
Calculation	Difference between current ALOS and prior year ALOS expressed as a % of prior year ALOS
Reporting	Bi-annual
Current Status (if known)	

Performance Indicator	***Average Length of Stay (ALOS) case mix adjusted - percentage variance against target***
Focus	Extent to which ALOS case mix adjusted is meeting target
Calculation	Difference between current ALOS and target ALOS expressed as a % of target ALOS
Reporting	Bi-annual
Current Status (if known)	Not Available

Performance Indicator	***Bed day variance against national average (adjusted)***
Focus	Extent to which each DRG LOS exceed DRG Group LOS (days)
Calculation	Sum of each DRG (Group LOS minus DRG LOS) multiplied by number of patients for each DRG
Reporting	Bi-annual
Current Status (if known)	Not available

Performance Indicator	***Average Bed Occupancy - percentage change on prior year***
Focus	Rate at which average bed occupancy is increasing or decreasing
Calculation	Difference between current average bed occupancy and prior year average bed occupancy expressed as a % of prior year average bed occupancy
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Average Bed Occupancy - percentage variance against target***
Focus	Extent to which average bed occupancy is meeting target
Calculation	Difference between current average bed occupancy and target average bed occupancy expressed as a % of target average bed occupancy
Reporting	Monthly
Current Status (if known)	No Targets set

Performance Indicator	***Delayed discharge - percentage of available bed days lost***
Focus	Extent to which bed capacity is lost due to delayed discharge
Calculation	Number of bed days lost due to delayed discharges expressed as a % of total available bed days
Reporting	Monthly
Current Status (if known)	Similar measure included in HSE Corporate Performance Measurement Report. Classification of causes for delay to be clearly defined & communicated.

Performance Indicator	***Day cases - percentage of discharges as against target***
Focus	Extent to which the proportion of discharges represented by day cases is in line with target
Calculation	Number of day cases expressed as a % of by total discharges (inpatient plus day cases)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Day cases - percentage of elective admissions as against target***
Focus	Extent to which the proportion of elective admissions represented by day cases is in line with target
Calculation	Number of day cases expressed as a % of total elective admissions (inpatient & day cases)
Reporting	Monthly
Current Status (if known)	Not regularly reported

Group 6: Performance Indicators - Financial

Performance Indicator	***Cost per patient (gross and net) – percentage change on prior year***
Focus	Rate at which the average cost of treating a patient is increasing or decreasing
Calculation	Difference between the current average cost of treating a patient and the prior year average cost of treating a patient expressed as a % of the prior year average cost (Average cost per patient calculated as total cost – gross and net - divided by workload)
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Cost per patient (gross and net) – variance against target***
Focus	Extent to which the average cost of treating a patient is in line with target
Calculation	Difference between the current average cost of treating a patient and the target average cost of treating a patient expressed as a % of the target average cost
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Cost per bed day (gross and net) – percentage change on prior year***
Focus	Rate at which the average cost of a patient bed day is increasing or decreasing
Calculation	Difference between current average cost of a patient bed day and the prior year average cost of a patient bed day expressed as a % of the prior year average cost (Average cost per bed day calculated as total cost divided by bed days utilised)
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Cost per bed day (gross and net) – variance against target***
Focus	Extent to which the average cost of a patient bed day is in line with target
Calculation	Difference between the current average cost of a patient bed day and the target average cost of a patient bed day expressed as a % of the target average cost
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Specialty inpatient cost per bed day***
Focus	Cost to treat and care for a patient per day
Calculation	Inpatient specialty costs divided by the number of bed days used
Reporting	Quarterly
Current Status (if known)	One year in arrears by case mix unit

Performance Indicator	***Proportion specialty cost to total revenue spend***
Focus	Degree to which hospital costs are in relation to activities within case mix
Calculation	Case mix specialty costs divided by total net costs
Reporting	Annual
Current Status (if known)	Not reported

Performance Indicator	***Average cost per case mix adjusted base price – Band 1 and Band 2 hospitals – compared to target***
Focus	As in HSE Corporate Performance Measurement Report
Calculation	As specified in HSE Corporate Performance Measurement Report
Reporting	Bi-annual
Current Status (if known)	Annually in arrears by case mix unit Included in HSE Corporate Performance Measurement Report

Performance Indicator	***Day case cost per case mix adjusted base price***
Focus	Cost per case
Calculation	As specified in HSE Case Mix Manual
Reporting	Bi-annual
Current Status (if known)	Annually in arrears by case mix unit

Group 7: Performance Indicators – Staff Productivity

Performance Indicator	***Patients per WTE (by staff category) – percentage change on prior year***
Focus	Rate at which staff productivity is increasing or decreasing as measured by the relationship between the number of patients and the number of staff
Calculation	Difference between the current average number of patients per WTE and the prior year average number of patients per WTE expressed as a % of the prior year average number of patients per WTE (Patients per WTE is calculated as total number of patients – workload - divided by WTEs)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Patients per WTE (by staff category) – variance against target***
Focus	The extent to which staff productivity, as measured by the relationship between the number of patients and the number of staff, is meeting target
Calculation	Current average number of patients per WTE expressed as a % of the target average number of patients per WTE
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***CMUs per WTE (by staff category) – percentage change on prior year***
Focus	Rate at which staff productivity is increasing or decreasing as measured by the relationship between the number of CMUs and the number of staff
Calculation	Difference between the current average number of CMUs per WTE and the prior year average number of CMUs per WTE expressed as a % of the prior year average number of CMUs per WTE (CMUs per WTE is calculated as total number of CMUs divided by WTEs)
Reporting	Bi-annual
Current Status (if known)	Not reported

Performance Indicator	***CMUs per WTE (by staff category) – variance against target***
Focus	The extent to which staff productivity, as measured by the relationship between the number of CMUs and the number of staff, is meeting target
Calculation	Current average number of CMUs per WTE expressed as a % of the target average number of CMUs per WTE
Reporting	Bi-annual
Current Status (if known)	Not reported

Performance Indicator	***Bed Days per WTE – percentage change on prior year***
Focus	Rate at which staff productivity is increasing or decreasing as measured by the relationship between the number of bed days and the number of staff
Calculation	Difference between the current average number of bed days per WTE and the prior year average number of bed days per WTE expressed as a % of the prior year average number of bed days per WTE (bed days per WTE is calculated as total number of bed days divided by WTEs)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Bed days per WTE – variance against target***
Focus	The extent to which staff productivity, as measured by the relationship between the number of bed days and the number of staff, is meeting target
Calculation	Current average number of bed days per WTE expressed as a % of the target average number of bed days per WTE
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Bed Days per Nursing WTE – percentage change on prior year***
Focus	Rate at which nursing staff productivity is increasing or decreasing as measured by the relationship between the number of bed days and the number of nursing staff
Calculation	Difference between the current average number of bed days per Nursing WTE and the prior year average number of bed days per Nursing WTE expressed as a % of the prior year average number of bed days per Nursing WTE (Bed days per Nursing WTE is calculated as total number of bed days divided by Nursing WTEs)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Bed days per Nursing WTE – variance against target***
Focus	The extent to which nursing staff productivity, as measured by the relationship between the number of bed days and the number of nursing staff, is meeting target
Calculation	Current average number of bed days per Nursing WTE expressed as a % of the target average number of bed days per Nursing WTE
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Acute bed Days per Nursing WTE – percentage change on prior year***
Focus	Rate at which nursing staff productivity is increasing or decreasing as measured by the relationship between the number of acute bed days and the number of nursing staff
Calculation	Difference between the current average number of acute bed days per Nursing WTE and the prior year average number of acute bed days per Nursing WTE expressed as a % of the prior year average number of acute bed days per Nursing WTE (acute bed days per Nursing WTE is calculated as total number of acute bed days divided by Nursing WTEs)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Acute bed days per Nursing WTE – variance against target***
Focus	The extent to which nursing staff productivity, as measured by the relationship between the number of acute bed days and the number of nursing staff, is meeting target
Calculation	Current average number of acute bed days per Nursing WTE expressed as a % of the target average number of acute bed days per Nursing WTE
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Non-acute bed Days per Nursing WTE – percentage change on prior year***
Focus	Rate at which nursing staff productivity is increasing or decreasing as measured by the relationship between the number of non-acute bed days and the number of nursing staff
Calculation	Difference between the current average number of non-acute bed days per Nursing WTE and the prior year average number of non-acute bed days per Nursing WTE expressed as a % of the prior year average number of non-acute bed days per Nursing WTE (non-acute bed days per Nursing WTE is calculated as total number of non-acute bed days divided by Nursing WTEs)
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Non-acute bed days per Nursing WTE – variance against target***
Focus	The extent to which nursing staff productivity, as measured by the relationship between the number of non-acute bed days and the number of nursing staff, is meeting target
Calculation	Current average number of non-acute bed days per Nursing WTE expressed as a % of the target average number of non-acute bed days per Nursing WTE
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Percentage of staff time spent on non-line[33] activities – change on prior year***
Focus	The extent to which staff productivity, as measured by the percentage of available staff time spent in non-line activities, is increasing or decreasing
Calculation	Actual staff time spent on each specified activity expressed as a % of total available staff time
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Percentage of staff time spent on non-line activities – variance against target***
Focus	The extent to which staff productivity, as measured by the percentage of available staff time spent in non-line activities, is meeting targets
Calculation	Actual staff time spent on each specified activity expressed as a % of total available staff time divided by target percentage
Reporting	Monthly
Current Status (if known)	

[33] Non-line activities would include e.g. training, research, etc.

Group 8: Performance Indicators – Effectiveness

Performance Indicator	***Emergency Department waiting times < 6 hours***
Focus	The % of people admitted to a hospital bed having waited for less than 6 hours.
Calculation	As set out in the HSE Performance Measurement Report
Reporting	Monthly
Current Status (if known)	Reported in the HSE Performance Measurement Report

Performance Indicator	***Inpatient waiting times > 3, 6, 9 and 12 months***
Focus	The % of people waiting for elective surgery who are waiting for periods greater than the respective target periods
Calculation	Number of people waiting more than the defined periods as a percentage of the total number of people waiting
Reporting	Monthly
Current Status (if known)	Similar data reported in the HSE Performance Measurement Report for waiting <6 months

Performance Indicator	***Outpatient waiting times > 13,17 and 21 weeks***
Focus	The % of people waiting for outpatient appointments who are waiting for periods greater than the respective target periods
Calculation	Number of people waiting more than the defined periods as a percentage of the total number of people waiting
Reporting	Monthly
Current Status (if known)	

Performance Indicator	***Unplanned readmissions - change on prior year***
Focus	Extent to which resource availability is affected by unplanned readmissions
Calculation	Unplanned readmission numbers for current year less readmission numbers for prior year as a percentage of readmission numbers for prior year
Reporting	Monthly
Current Status (if known)	Not reported

Performance Indicator	***Unplanned readmissions - variance on target***
Focus	Extent to which unplanned readmissions are increasing or decreasing
Calculation	Unplanned readmission numbers for current year less target unplanned readmissions as a percentage of target unplanned readmissions
Reporting	Monthly
Current Status (if known)	Not reported

Appendix B – Corporate Objectives and Targets

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Equitable Access	Work with PCCCD to continue and enhance measures to improve access and use of acute hospital services by people with intellectual disabilities and people with higher support needs	-	-	-	Unclear as to whether available data will provide required levels of granularity
Equitable Access	Prioritise equity of access and regional self sufficiency as key elements of the allocation of resources within the acute services	-	Additional acute beds added to the system to be designated public only (Q&F) 80:20 split	-	Number of patients from region admitted to hospitals outside the region
Waiting times	Review out-patient services nationally and begin implementation of the resulting recommendations	Implementation of recommendations	-	-	-
Waiting times	Develop specific proposals to ensure that those requiring hospital care receive it in a timely manner in accordance with defined needs	Proposals developed	-	-	Detail of proposals and effect/impact?
Waiting times	Work with the National Treatment Purchase Fund (NTPF) to target a reduction in waiting times	-	No adult waiting longer than 6 months and no child longer than 3 months (Health Strategy)	-	-
Waiting times	Use data from the National Patient Treatment Register to	-	-	-	Access to services

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
	improve both planning and access to services				measure?
Integration	Promote integrated working within and between hospital networks and between secondary and tertiary levels of acute care	-	No of shared posts with other hospitals/networks	-	-
Integration	Develop better integration and collaborative arrangements between hospitals and primary, community and continuing care services, thus ensuring continuity of care for service users in their interaction with health and personal social care services. This will build on existing models of good practice within the system, e.g. in relation to diabetes and asthma	-	-	-	Bed days lost Average Length of stay
Integration	Establish specific processes / mechanisms with PCCCD to look at the management and care of older people	-	-	-	Average LOS by age group (unlikely to be available?)
Integration	In conjunction with PCCCD and Population health, agree a national approach to the management of chronic illness and establish a number of pilot projects, initially developing integrated care pathways for the following conditions: o Chronic Obstructive Pulmonary Disease (COPD). o Diabetes	National approach agreed	-	-	-
Reorganisation	Demonstrate parity of treatment in our relationships with	-	-	-	PMU reporting

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
of services	all hospitals, based on the following principles: o *Reorganisation* Appropriate resource allocation. o Alignment of clinical decision making and accountability. o Standardised performance measurement in line with the National Performance Monitoring Framework				systems implemented
Reorganisation of services	Continue to give effect to national strategy and policy in service areas under the remit of the NHO, with particular reference to optimising the commissioning of additional bed capacity as per the Acute Hospital Bed Capacity Report	-	-	Additional bed capacity added	-
Reorganisation of services	Commence implementation of the recommendations arising from the National Renal Review, once published	Implementation of recommendations	-	-	-
Reorganisation of services	Commence implementation of the recommendations arising from the National Review of Cystic Fibrosis services	Implementation of recommendations	-	-	-
Reorganisation of services	Work with all relevant stakeholders to develop an agreed approach to the future development of national neuroscience services	Neuroscience plan completed	-	-	
Reorganisation of services	Commence implementation of the recommendations arising from the Review of Tertiary Paediatric services	Implementation of recommendations	-	-	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Reorganisation of services	Establish formal mechanisms to engage with General Practitioners on the development and delivery of hospital services	Mechanisms identified and established	-	-	-
Reorganisation of services	Develop and pilot clinical networks in relation to the following services / specialties initially: o Vascular services. (as per Comhairle Report) o Obstetrics	-	-	Networks piloted	-
Reorganisation of services	Develop a plan to spread the learning and improvements from the pilot sites to the rest of the hospital system on a phased basis	Plan developed	-	-	-
Reorganisation of services	Implement a set of targeted, evidence based interventions for patients with Acute Myocardial Infarction in three pilot sites initially	-	-	CUH launched as pilot site	-
Reorganisation of services	Review and revise of [sic] existing acute hospital beds, facilities and equipment so that patient care is optimised	-	-	Network level review of acute hospital beds completed	
Reorganisation of services	Play a key role in the negotiation of new contracts with Consultants and other key staff groups	-	National objective	-	-
Reorganisation of services	Commence the reorganisation of services arising from: o The implementation of the European Working Time Directive.	-	-		Average working time for junior doctors in CUH (CUH is a pilot

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
	o The recommendations of the Report of the National Task Force on Medical Staffing. o The introduction of revised contractual arrangements for non-consultant hospital doctors, consultants and other staff groups. o Changes to the organisation of medical education and staffing			Revised contracts introduced	site) Recommendations implemented from Report on Medical Staffing
Reorganisation of services	Lead the implementation of the National Radiotherapy plan and examine the potential for securing additional radiotherapy services, pending the full implementation of the plan	-	-	Radiotherapy plan implemented	Radiotherapy waiting lists/throughput
Reorganisation of services	Contract with the private sector providers for specific services, with particular emphasis on ensuring quality of care and value for money	Patient throughput on private contracts – MRI services (CUH, KGH), cardiac angiography services (CUH, MGH, KGH), Security & Cleaning (MUH)	-	-	-
Reorganisation of services	Establish a forum to enable the involvement of the independent hospital sector in service development, emergency planning, information exchange and the identification of potential areas for service agreements	-	-	Forum established and meeting regularly	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Reorganisation of services	Approve proposals under the 1,000 beds initiative which satisfy the assessment criteria established by the HSE	Proposals approved	-	-	-
Primary Care	Consider new models of providing diagnostic services i.e. through extending hours of service or through partnerships with the private sector. Improve access for patients referred by GPs to hospital based services e.g. outpatients	-	-	Models identified/implemented % of outpatients referred by GP	-
Community and Continuing Care Services	Building on existing good practice models of discharge planning in the system, work with PCCCD to provide appropriate outreach to ensure that patients have the support they need in the community, on discharge from hospital	n/a	n/a	n/a	n/a
Community and Continuing Care Services	Work with PCCCD to implement all relevant aspects of the Palliative Care Strategy	n/a	n/a	n/a	n/a
Community and Continuing Care Services	Collaborate with the DoHC and PCCCD to further develop plans for paediatric palliative care	n/a	n/a	n/a	n/a

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
A&E Services	Continue to implement the A&E 10-point plan and improve accident and emergency services to reduce significantly the unacceptable delays many patients encounter when they require admission, by focusing on: o reducing the time taken to treat patients in A&E. o improving hospital efficiency and discharge procedures	-	All targets as laid out in 100+ reward document - 100% of admissions < 24 hrs - 90% of admissions < 12 hrs - 70% of admissions < 6 hrs - No trolley waits for admitted patients <20% elective admissions	-	-
A&E Services	Commence implementation of the recommendations arising from the Process Mapping exercise in A&E services	-	-	Recommendations implemented	-
A&E Services	Consider the recommendations of the Paediatric Emergency Services Network once their Report is published	-	-	-	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Quality, Safety and Risk Management	In consultation with key stakeholders across our services, agree high priority areas for action to improve patient safety	-	-	Areas agreed	-
Quality, Safety and Risk Management	Pursue, develop and implement quality standards throughout our services, driving a culture of safety, review and audit at all levels	-	-	Quality standards implemented across SHG	-
Quality, Safety and Risk Management	All public hospitals will be encouraged and supported to participate in the National Accreditation Programme	-	-	-	No of hospitals accredited
Quality, Safety and Risk Management	Put in place measures for reporting of adverse incidents and events associated with blood quality and safety, in compliance with the requirements of the EU Blood Quality and Safety Directive	-	-	Measures in place and being reported against	-
Quality, Safety and Risk Management	Put measures in place for testing, labelling and traceability of blood and blood products, for quality management systems in blood establishments and hospital blood banks	-	-	Measures in place and being reported against	-
Quality, Safety	Implement EU Directive 2004/23/EC setting standards of	n/a	n/a	n/a	n/a

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
and Risk Management	quality and safety for tissues and cells for human application				
Quality, Safety and Risk Management	Establish a focus on patient safety, strengthen incident reporting and complaints management, share the learning from incidents that occur and work to develop national solutions addressing key patient safety issues	-	-	-	Communications made to staff regarding quality & safety, learnings shared
Quality, Safety and Risk Management	Using examples of best practice currently in the hospital system, develop and implement systems to support best practice in medication safety in 3 pilot sites	-	-	Systems implemented in 3 sites	-
Quality, Safety and Risk Management	Develop a plan to spread the learning and improvements from the pilot sites to the rest of the hospital system on a phased basis	Plan developed	-	-	-
Quality, Safety and Risk Management	Work with design teams and capital project teams to eliminate or mitigate design features which pose a risk to patients or staff and to incorporate features which minimise or reduce risks	-	-	-	-
Quality, Safety and Risk	Establish a strong working relationship with the Health and Safety Authority, Health Information and Quality	-	-	-	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Management	Authority (HIQA), Irish Health Services Accreditation Board, Irish Medicines Board, Medical Council, State Claims Agency and other relevant external organisations in pursuit of the quality / safety agenda to improve the safety, effectiveness and quality of our services				
Quality, Safety and Risk Management	Agree the content of and develop a standardised approach to medical records, including a retention policy	Policy developed	-	-	-
Quality, Safety and Risk Management	Review procedures and systems for risk management, infection control and waste management and develop a national plan which implements best practice	n/a	n/a	n/a	n/a
Quality, Safety and Risk Management	Reduce the incidence of hospital acquired infections through continued implementation of SARI and improved hospital hygiene	-	Results of national hygiene audits (DOHC Business Plan 2006)	-	-
Quality, Safety and Risk Management	Undertake a survey of hospital acquired infection prevalence to give validated, internationally comparative date for Ireland for the first time	-	Results of national hygiene audits (DOHC Business Plan 2006)	Survey of hospital acquired infection completed	-
Quality, Safety	Work in close collaboration with the Irish Health Services	-	-	Standards	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
and Risk Management	Accreditation Board to roll out validated Infection Control Standards and Hygiene Standards nationally			implemented	
Quality, Safety and Risk Management	Implement the recommendations of the National Hospital Hygiene Audit, including the development of a suite of relevant policies, procedures and guidelines, a public information campaign, training initiatives, and minor capital investment to improve the building and equipment infrastructure	Recommendations implemented	-	-	-
Quality, Safety and Risk Management	Conduct further national audits of hospital hygiene	-	Results of national hygiene audits (DOHC Business Plan 2006)	Survey of hospital acquired infection completed	-
Quality, Safety and Risk Management	Act on the Good Practice notes contained in the Comptroller and Auditor General's report on Waste Management in Hospitals	-	-	Recommendations implemented	-
Quality, Safety and Risk Management	Engage with Universities, third level institutions and other agencies in the conduct of research and development to inform planning, design and delivery of services	-	-	-	No of students in place in college and hospital
Quality, Safety	Work in collaboration with the Irish Medicines Board to	Guidance	-	-	-

Objective 1 – *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services, in line with best practice*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
and Risk Management	implement their guidance in relation to the Manufacturing of Medical Devices within Healthcare Institutions	implemented			

Objective 2 – *We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Emergency Planning	Continue to participate in the Major Emergency Planning activities of the HSE	Major Emergency plans finalised and adopted Review of helicopter landing facilities 4 SEVESO exercises completed FLU Pandemic plan collated for each hospital	-	-	-
Breastcheck/Cervical	Continue to support the national roll out of BreastCheck and the National Cervical Screening Programme	-	n/a	No of Cervical Screenings	-
Cardiovascular	Continue implementation of all relevant aspects of the Cardiovascular Strategy	-	-	Implementation of "relevant" aspects	-

Objective 2 – *We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Cancer	Commence implementation of the new National Cancer Strategy, once published	-	-	Strategy implementation	-
Health Promoting Hospitals	Continue to encourage hospitals to participate in the Health Promoting Hospitals initiative	-	-	-	No of hospitals involved
Obesity	Identify priority actions for hospitals to implement the Report of the National Task Force on Obesity	-	-	Actions identified	-
Breast Feeding	Work to implement the recommendations of the National Breast Feeding Committee	-	+2% after 48 hours of discharge +4% in socio-economic groups 4 & 5		-

Objective 3 – *We will empower staff to deliver responsive and appropriate services, making effective team-working a priority*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
CME/CPD	Continue to support Continuous Medical Education (CME) and Continuous Professional Development	-	-	-	No of staff with required CPD hours
Clinical practice training	Ensure compliance with regulatory and professional bodies in relation to standards of clinical practice and training	-	-	-	Study Days allowed
Violence in the Workplace	Building on best practice initiatives currently in place, develop and roll out a national training programme to address the issue of violence in the workplace	-	-	-	Courses run, numbers attending

Objective 4 – *We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Feedback mechanisms	In line with best practice, improve information access for service users and utilise their feedback effectively in the development and enhancement of services	-	-	-	Results of customer satisfaction surveys
Clinicians in Management	Focus on developing the Clinicians in Management Initiative	-	-	-	?

Objective 4 – *We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / Voluntary / Community Sector and other stakeholders*					
Sub-Area	**Action**	**Defined target**	**National inferred Target**	**Implied Target**	**Alternative Target**
Monitoring mechanisms	Participate in robust monitoring mechanisms in respect of delivery and standards of care. As part of this, we will specifically focus on case mix (increasing the blend rate to 40%* in 2006) and on management of public / private mix *This will be phased in maternity and paediatric hospitals and in A&E at lower, but continually increasing, blend rates	-	-	Blend rate	-
Uniform Data Standards	Introduce and implement a series of uniform data standards / definitions and validation procedures to ensure consistency of approach nationally and validity of information for use in planning and performance reviews	Uniform standards implemented	-	-	-
Performance Improvement Initiatives	Commence performance improvement initiatives within and between hospital networks, which recognise and reward optimum performance	-	-	A&E 100+ reward targets	-

Totals	Defined target	National inferred target	Implied target	Alternative target	None	n/a
70	17	9	23	18	4	7

Note – the sum of the categories exceeds the total number of actions as an action could have been said to have more than 1 type of target related to it.

Appendix C - Hospital Expenditure

Tables C.1 below and C.2, overleaf, outline expenditure for the SHG and individual hospitals. Table C.1 presents a schedule of net expenditure for the SHG in 2006 and is broken down by pay and non-pay expenditure.

Figure C.1 – Net Expenditure SHG 2006

Item - 2006	€
Pay expenditure - excluding superannuation	310,453,854
Superannuation	25,179,143
Total Pay	**335,632,997**
Non- Pay expenditure	254,447,705
Gross expenditure	**590,080,702**
Income	(58,233,315)
Net expenditure (AFS 2006)	**531,847,387**
Less superannuation	25,179,143
Add research projects (see note 1)	437,705
Net expenditure excluding superannuation & including research projects	**507,105,949**
less non comparable items (see note 2)	18,839,916
Comparable items excluding superannuation	488,266,033
Add back superannuation of comparable items (note 3)	24,957,618
Net Expenditure for comparable items 2006 (see note 4)	**513,223,652**

Note 1: Hand and biofinger research projects were not included in the I & E of the AFS. However they are included in the management accounts and therefore are added back to arrive at €507,105,949 which is the figure that is analysed against budget costs.

Note 2: When comparing 200 to 2005 to 2006, we need to compare like categories. Therefore categories that do not have a direct comparable figure for previous years have been deducted for trending purposes.

Non comparable items (including superannuation) are :	€
Programme administration	1,135,420
Ancillary services	16,748,409
Laundry	518,382
Research projects	437,705
Total	18,839,916

Figure C.2 – Net Expenditure 2004-2006 by Hospital

Table C.2 below, outlines net expenditure for individual hospitals in the SHG for the period 2004-2006.

Note 3: The comparison of 2004 to 2006 is done using net expenditure. The definition of net expenditure includes superannuation. Therefore to be consistent superannuation of comparable items that had previously been deducted is added back.

Note 4: A breakdown of comparable items for 2006 and for the previous two years are shown below:

NET EXPENDITURE	2004	2005	2006
CUH	177,467,091	193,300,394	218,614,196
Kerry General	66,226,302	72,790,095	76,998,554
Erinville	23,196,692	24,661,880	27,159,670
Bantry General	15,558,682	16,624,267	18,167,660
Mallow General	14,957,315	15,918,692	17,569,145
St Mary's Hospital	14,785,622	16,328,250	17,300,848
St Finbarr's	1,816,709	1,965,197	1,883,067
Mercy University	56,597,895	59,399,306	67,763,935
SIVUH	42,562,298	46,798,544	49,832,712
Ambulance & Transport Service	12,708,330	14,830,170	17,217,784
S.T.D. Clinic	702,718	702,022	716,081
Total	**426,579,654**	**463,318,818**	**513,223,652**