



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# Corporate Plan report

Report against the HSE Corporate Plan 2008-2011

July - December 2009



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# Part 1

# Introduction

## Levels of planning and performance measurement

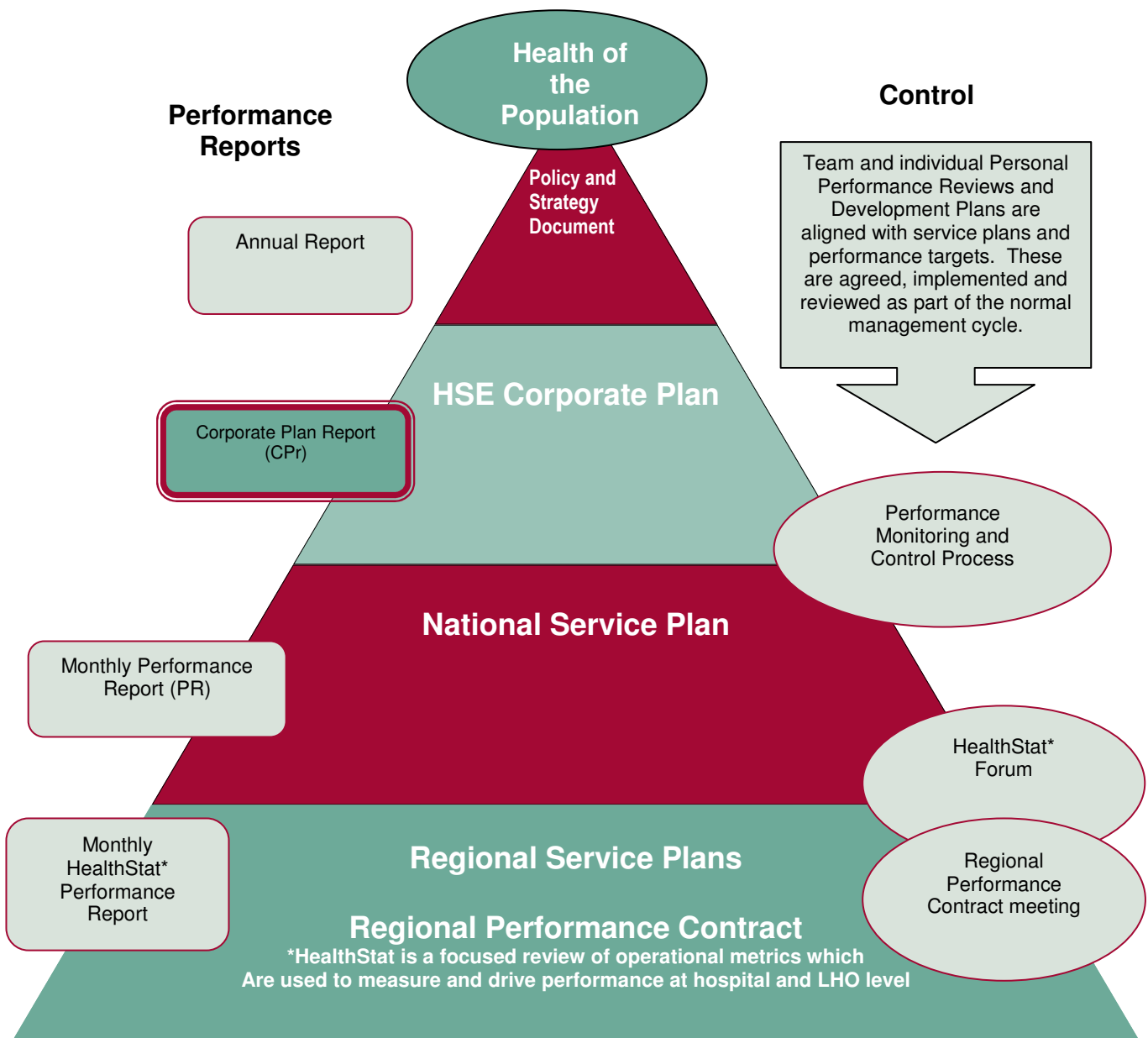
Planning takes place at several levels and takes into account internal and external guidance provided through, for example, the Department of Health Statement of Strategy, National Policy Documents, economic forecasts and clinical and quality priorities.

There are different tiers of planning and performance measurement within the HSE (see figure 1), from multi-annual corporate planning to annual service planning at a national, regional and service level.

Performance measurement reports mirror the different levels of planning and provide an oversight for managers of actual performance measured against planned performance.

The Corporate Plan report is one level in this reporting process and will provide information on trends over time at a strategic level.

Figure 1: **Levels of Planning, Measurement and Reporting**



## Performance Metrics and Performance Measurement 2009

Since the publication of the Corporate Plan 2008-2011, the fiscal environment has changed dramatically. However, the demand for healthcare has not reduced and will always outstrip supply, with public expectations remaining extremely high.

The annual service planning process is the key mechanism for setting out how funding will be used and staffing organised in any given year. The National Service Plan (NSP) is aligned with the objectives of the HSE Corporate Plan 2008-2011. Within these objectives, business and service choices must and have been made during the time period of this report, some of which will delay the achievement of some corporate objectives / targets.

For this Corporate Performance report 2009, a set of Key Performance Indicators (KPIs) were agreed with the Department of Health and Children. Defining and collecting the appropriate performance indicators is a continuous, evolving process that will develop over the period of the corporate plan. In this report 46 agreed indicators are reported on. A number of further indicators are being developed and will be included in future reports.

## Corporate Objectives and Metrics

The HSE Corporate Plan and the six Corporate Objectives provides the overarching framework within which agreed metrics are used to chart organisational progress.

### Health and Wellbeing

*We will invest in preventing illness; supporting, encouraging and empowering people to pursue independent, healthy and fulfilling lifestyles to reduce the likelihood of illness. We will ensure that early diagnosis, treatment and care options are available, if required.*

- Smoking prevalence
- Breastfeeding rates
- Orchidopexy treatment
- Influenza vaccinations
- Childhood vaccinations
  - Diphtheria
  - Pertussis (whooping cough)
  - Tetanus
  - Haemophilus influenzae type B
  - Haemophilus influenzae type B
  - Polio vaccine
  - Meningococcal C
  - MMR (Measles, Mumps, Rubella)
- Vaccine preventable diseases
  - Pertussis
  - Tetanus
  - Haemophilus influenzae (type B)
  - Hepatitis B
  - Neisseria Meningitidis serogroup (MenC)
  - Measles
- Infectious diseases
  - Salmonella
  - Cryptosporidiosis
  - Tuberculosis
  - Chlamydia
- Suicide Rate
- Deliberate self harm

### Trust and Confidence (Access)

*We will build trust and confidence in our health services through the provision of timely, well integrated, professional and accessible services. We will make it easier for people to access the right service, in the right place, at the right time.*

- Ambulance response times
- GP out of hours service
- Community Adolescent Mental Health Service (CAMHs)
- Disability Assessment
- Emergency Department Experience
- Public / private hospital activity

### Sustainable Services

*We will reconfigure our services to develop sustainable hospital and community services that provide the care people need now, and in the future. By delivering the majority of care in the community, hospitals will be able to focus on improving accessibility in order to deliver more efficient acute and planned care.*

- Primary Care Teams
- Residential Care, Older People
- Home Help Hours
- Palliative Care beds
- Children in Residential Care
- Care planning for children in care
- Average length of acute stay
- Inpatient / day case ratios
- Appropriate Use of beds

## Quality and Safety

*We will ensure the quality and safety of our services. By developing a transparent quality and safety culture and adapting our work practices, we will ensure continuous quality and safety improvement is integral to all that we do.*

- Caesarean Sections
- Cancer Survival rates
- Symptomatic breast cancer service
- MRSA
- Complaints
- Parliamentary Questions (PQs)
- Satisfaction Rates

## Operational Excellence / Unlocking our Potential

*We will achieve operational excellence using processes and systems that are efficient, easy for the service users to access and understand, evidence based, monitors performance and delivers value for money. We will actively support and encourage all staff to achieve their full potential and deliver quality care. In partnership, we will recognise and celebrate achievements and encourage staff to work responsibly, manage challenges and take pride in their contribution to the services they provide on behalf of the organisation.*

- Budget Management
- Value for Money (VFM)
- Inpatient spend per day
- Whole Time Equivalents (WTE's)
- Absenteeism
- Information Communication Technology (ICT)
- Procurement

## Relative Performance

Assessment of progress against a Corporate Plan / Corporate Objectives informs future planning and priorities. To make this assessment, it is useful to take stock of where our performance lies against national or international benchmarks.

Targets and judgement of performance may differ between those that measure the National Service Plan which ask did we do what we said we would do this year and medium term targets aligned with the Corporate Plan which ask how are we performing against the position we desire to be in within three years. This Corporate Plan report provides an opportunity to check progress against our short term targets (2009) and the desired medium performance. It reflects progress against HSE objectives and priorities as set out annually in the NSP.

The Performance Dashboard overleaf shows a selection of metrics from the suite in the Corporate Plan report. These are areas where there is a benchmark against which performance and progress can be measured and where there the data covers a time period which gives a view of current performance.

Out of the 30 metrics displayed, against 2009 targets, 17 are on target (green); 9 are within the top quartile of performance (amber); and 4 are outside the top quartile of performance (red). 12 areas have shown an upward trend in performance within 2009. This level of performance was achieved by service managers in an environment of declining budgets and staff numbers in many services.

Future reports will provide more detailed commentary on performance improvement action aligned with the results reported.

# Performance Dashboard

Performance Dashboard Corporate Plan report 2009					Performance June 2009			Performance Dec 2009			
Strategic Objectives	Key Performance Measures	target direction	Medium Term Target*		Result Jan June 2009	Performance against 2009 Target	Performance against Medium Term Target	Result July - Dec 2009	Performance against 2009 Target	Performance against Medium Term Target	Performance Trend
			2009 target	Target*							
Health and Wellbeing	Smoking prevalence	less than	23.4%	20%	23.6%	99.1%	82.0%	23.6%	99.1%	82.0%	
	Breastfeeding rates, exclusive or partial at 3 mths	equal or more than	30.0%	50%	20.5%	68.3%	41.0%	21.5%	71.7%	43.0%	
	Rate of orchidopexy: % completed < 4 years	equal or more than	70.0%	95%	61%	87.1%	64.2%	61%	87.1%	64.2%	
	Influenza vaccine % uptake > 65 years	equal or more than	75.0%	75%	64%	85.3%	85.3%	70.1%	93.5%	93.5%	
	Childhood vaccination: % uptake at 24 mths	equal or more than	94.0%	95%	92.3%	98.2%	97.2%	94%	100.0%	98.9%	
	Suicide: national rate reduction	reduce year on year by	10.0%	10%	7.8%	78.0%	78.0%	7.8%	78.0%	78.0%	
Trust and Confidence	Ambulance response times: % within 19 mins	equal or more than	76.0%	95%	73%	95.7%	76.5%	72.3%	95.1%	76.1%	
	GP out of hours service: % of pop who have access to urgent GP out of hours	equal or more than	80.0%	85%	72%	90.0%	84.7%	72%	90.0%	84.7%	
	Child and Adolescent teams: % of those seen who are within 3 months of referral	equal or more than	70.0%	100%				67.5%	96%	67.5%	new
	Disability assessment: % of ID assessments completed within timelines specified	equal or more than	100%	100%	15.3%	15.3%	15.3%	24.0%	24.0%	24.0%	
	Emergency department waiting times from registration to admission/discharge	equal or more than	100%	100%	71%	71.0%	71.0%	88.0%	88.0%	88.0%	
	Public private hospital activity: based on all acute activity	equal or more than	80.0%	80%	76.0%	95.0%	95.0%	75.5%	94.4%	94.4%	
Sustainable Services	Primary care teams: numbers in place	equal or more than	210	500	112	53.3%	22.4%	219	104%	43.8%	
	Residential Care, older people: % of > 65 pop in residential care	less than	4.5%	4%	4.6%	98.7%	86.0%	4.6%	98.7%	86.0%	
	Children in residential care as a % of all children in care	less than	8.0%	5%	7%	112.1%	59.4%	6.8%	115%	64.0%	
	Care Planning for Children: % of children in care with a written care plan	equal or more than	82.0%	100%	80.5%	98.2%	80.5%	84.7%	103.3%	84.7%	
	Inpatient/day case ratio for all activity	equal or more than	55.0%	75%	52.5%	95.5%	70.0%	53.8%	97.8%	71.7%	
Quality and Safety	Caesarean section: as a % of all births	less than	20.0%	15%	25.7%	71.5%	28.7%	25.8%	71.0%	28.0%	
	Symptomatic breast cancer services: % seen within 2 weeks	equal or more than	95.0%	95%	84.4%	88.8%	88.8%	98%	103.2%	103.2%	
	5 year survival Colorectal cancer	equal or more than	56.2%	56.2%				53.2%	94.7%	94.7%	new
	5 year survival Lung cancer	equal or more than	10.9%	10.9%				10.6%	97.2%	97.2%	new
	5 year survival Breast cancer	equal or more than	79.0%	79.0%				76.9%	97.3%	97.3%	new
	5 year survival Prostate cancer	equal or more than	77.5%	77.5%				82.9%	107%	107.0%	new
	Mrsa: as a % of total S Aureus in hospital	less than	26.3%	20%	32.5%	76.2%	37.5%	28%	93.3%	60.0%	
	Complaints: % dealt with in 30 working days	equal or more than	95%	95%	80%	84.2%	84.2%	79.2%	83.4%	83.4%	
	PQs: % dealt with in 15 working days	equal or more than	75.0%	95%	65%	86.7%	68.4%	62%	82.7%	65.3%	
Unlocking our Potential/ Operational Excellence	Budget: management of buget against planned position	equal or more than	100%	100%	75%	75.0%	75.0%	100%	100%	100%	
	Value for money: % achievement of target set	equal or more than	100%	100%	78%	78.0%	78.0%	100%	100%	100%	
	WTE numbers against approved ceiling	equal or more than	100%	100%	100%	100%	100%	100%	100%	100%	
	Absenteeism: %, of all those on payroll, absent because of sick leave.	less than	4.0%	3.50%	4.64%	84.0%	67.4%	5.5%	63.8%	44.3%	

Key to symbols

Greater than 95%

Greater than 75% and less than 95%

Less than 75%

Upward performance trend > Performance the same or < Downward Performance trend > 1%

\* the Medium Term Targets are aligned with the HSE 3 year Corporate Plan, 2008 - 2011, and are based on policy positions, evidence based benchmarks, or planned progression within the health services.

## Summary of Performance Dashboard metrics

### Health and Wellbeing

**Smoking** shows a performance at 23.6%, which is meeting the short term target of 23.4% but is falling well short of the medium term target of < 20% of the population smoking.

**Breastfeeding** results were provided in Q2 2009 based on a view from 2001 - 2007. Breastfeeding rates remain low, at 20.5% partial or exclusive breastfeeding at 3 months, and require a standardised and consistent approach across all health care settings.

**Orchidopexy**, the percentage of boys who are being treated < 4 years remains constant within 2009 at 61%, but the performance has decreased from 2006. The protocols and practice around orchidopexy will be examined in conjunction with public health service providers to increase the level of screening, reporting, referral and timely treatment.

**Influenza vaccine** for those > 65 years has improved from 59% in 2007 to 70% in 2009 and is reaching the desired coverage of 75% among those aged > 75 years.

**Childhood vaccination** at 24 months continues to improve and is now at 94%.

**Suicide** has shown a decrease in suicide numbers over the past 5 years from 497 in 2003 to 424 in 2008 (a 7.8% decrease). A focused campaign is currently being targeted at those who may be affected by the economic recession.

### Trust and Confidence

**Ambulance Response times** over 2009 remain the same and are close to the internal target set for 2009 of 76% within 19 minutes. A joint group between HIQA, DoHC and the HSE is developing appropriate ambulance response time and other targets for future use.

**GP out of hour service** 72% of the population now have access to a formal urgent out of hour service.

**Child and Adolescent mental health teams** now number 55 CAMHS, up from 47 at the beginning of the year. 50 of these are community based and progress has been made over 2009 to improve access to these teams within 3 months of referral. 67.5% of new referrals seen waited no more than 3 months in the six months July – Dec 2009.

**Disability assessments** completed within specified timelines shows a 36% improvement over 2009 but it remains low in overall terms at 24% of completed assessments being within the specified timelines. This is receiving particular focus and a performance improvement action plan is being rolled out.

**Emergency department waiting times** shows the waiting time in ED, based on a sample of all attendees, has improved over 2009. Overall 88% of this group of attendees are admitted or discharged within 6 hours of registration. There is a performance improvement project in place across 5 of the hospitals experiencing the longest waiting times. This will remain an area of focused attention.

**Public / Private hospital activity** reflects all activity in the HSE and has remained constant, below the expected performance in 2009. This will be replaced by information from the consultant's contract reporting system which will allow action to be targeted.

### Sustainable Services

**Primary care teams** holding clinical meetings have increased to 219 and surpassed the target set in 2009. The target from the Primary Care Strategy requires 400 - 600 teams to be in place by 2011.

**Residential Care older people** shows the percentage of the population aged over 65 years in residential care as being 4.6%, close to the target of < 4.5% for 2009. Services continue to be planned and organised to enable a larger number of this age group to remain in the community.

**Children in residential care** as a proportion of all children in care declined in 2009 from 7% to 6.8%, an improving performance. This was in a time where the overall numbers of children coming in to care continues to increase. The long term aim is to have no more than 5% of all children in care in residential care.

**Care plans for children** the percentage of children in care who have a written care plan is 84.7% at the end of 2009. This is above the 2009 target of 82% and is up from 80.5% in June. The target for 2010 is 100%.

**Inpatient day case ratio for acute care** shows the proportion of all acute discharges from hospital that are day cases has increased since 2008 and over 2009 to 53%. It is intended to move to a basket of day case procedures in 2010 which can be more easily compared across the hospitals and internationally. The target will move to 75% for this basket.

### Quality and Safety

**Caesarean Section as a percentage of all births** have been increasing in Ireland over the past 10 years. The percentage of Caesarean births is currently 25.8%. While this rate is around the OECD average, the rise over time in Ireland is amongst the highest in Europe. The DoHC and other stakeholders are currently reviewing this performance.

**Cancer Survival 5 year rates** show Ireland performing at the European average for cancer survival over 5 years based on the last available information.

**Symptomatic breast cancer** treatment – percentage of women seen with two weeks of referral improved over 2009 and by the end of the year all but one centre was meeting the 95% target.

**MRSA**, as a percentage of all Staphylococcus Aureus (S. Aureus) in hospitals continues to improve dropping from 34% in 2008 to 28% in 2009.

**Complaints**, the percentage completed in 30 working days remained constant at approximately 80% during 2009.

**PQs**, the percentage responded to within 15 working days declined over 2009 from 65% to 62% against a target of 75%. An action plan to improve efficiency is being rolled out within the division.

### Operational Excellence and Unlocking our Potential

**Budget management**, the HSE came in on vote in 2009.

**Value for money**, the target of €115 million saving through efficiencies was achieved in 2009. Some of the corporate targets for VFM were not reached but substitute savings allowed the overall target to be reached and surpassed.

**WTE** numbers against approved ceiling shows that the HSE managed within the approved ceiling in 2009.

**Absenteeism** shows that the rate of absenteeism, based on those on pay who were absent because of certified or uncertified illness, varied over the second half of 2009 from 4.64% in June to 5.45% in November. This has been a particular focus in HealthStat and many settings; in particular hospital settings have improved their performance. Cross learning and targeted action is now being rolled out. One of the approaches being pursued in relation to the management of absenteeism is the application of tiered financial adjustments in agencies showing a pattern of consistent variance from HSE specified targets.

# Part 2

# Health and Wellbeing

## Smoking Prevalence

### Metric Used

Smoking: Cigarette smoking national prevalence by gender and by age.

### Rationale

Tracking changes in smoking prevalence over time provides important information in aiding current primary prevention efforts and in predicting future adult disease consequences.

Accurately measuring prevalence monitors the effectiveness of cessation strategies (e.g. workplace smoking ban, taxation, labeling and packaging).

### Data Source

Office of Tobacco Control  
www.otc.ie

Research Institute for a Tobacco Free Society  
www.tri.ie

### Period Covered by Data

2003 – March 2008

### Target Information

< 23.4% of total pop >15 years NSP 2009

< 20% of the population smoking, Medium Term Target

### National Overview

23.6% - National average smoking prevalence (March 2008)

### Commentary

Tobacco is the major preventable cause of death and chronic disability in Ireland today. Tobacco related cardiovascular and respiratory diseases and cancer cause approximately 6,500 deaths per year in Ireland [www.tri.ie].

Smoking prevalence in Ireland has been decreasing since the 1980's. However, the rate of decrease is slowing since the mid-1990s. In 2000, an OECD study reported Ireland as having reduced the % of adults who report themselves as being a daily smokers from 30% (1990) to 27% (1998). The current position of 23.6% shows further improvement but further focus is required to achieve a prevalence rate of <20%.

As of March 2008, 48% of Irish smokers were female. Rates among young Irish women are higher than the international average (Health Behavior in School Aged Children HBSC 2001/02; European School Survey Project on Alcohol and Other Drugs, ESPAD 2003).

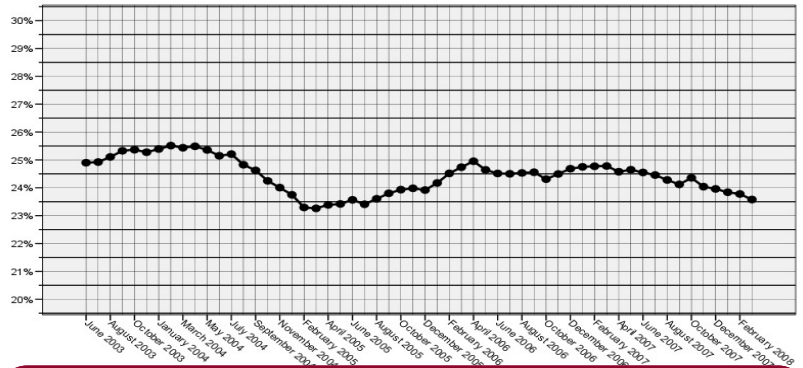
The overall national average prevalence rate highlights the fact that there is still a worrying trend in relation to the recruitment of young smokers.

The EU Council Recommendation on prevention of smoking and on initiatives to improve tobacco control, 2002, recommends that member states continue developing strategies and measures to reduce the prevalence of smoking, such as general programmes to overcome tobacco addiction.

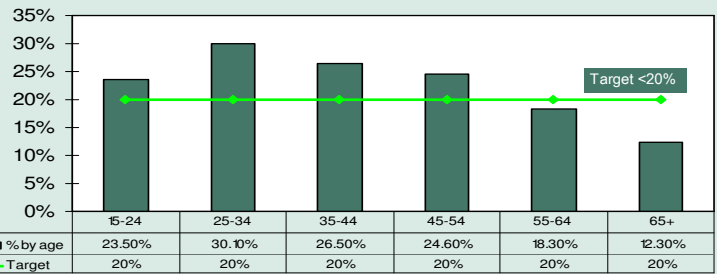
The HSE deliver smoking cessation services at area level through telephone support, group work and information support packs.

### Cigarette Smoking Prevalence

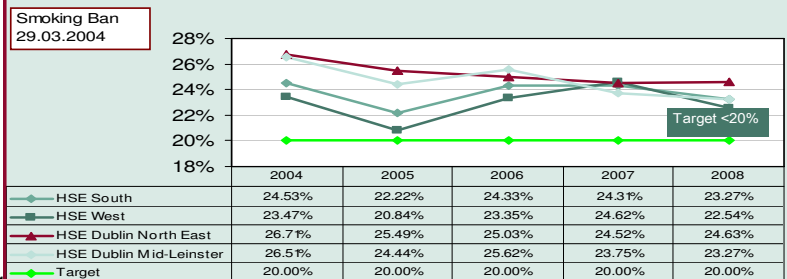
12 month moving average trend ending March 2008



### Smoking Prevalence by Age Group



### Smoking Prevalence by HSE Area



### % Adults who report being daily smokers (1990 and 2000) (OECD Health Data, 2002)



## Breastfeeding Rates

### Metric Used

Breastfeeding: the % of babies seen at the 3 month PHN assessment who are partially or exclusively breastfed.

### Rationale

HSE data requires validation to provide a baseline against which the target can be monitored. Comparison in rates achieved quarterly will feature in future reports and this will allow an analysis of the factors which contribute to an increase in breastfeeding initiation and continuation.

### Data Source

Business Intelligence Unit (Non Acute), HSE

Perinatal Statistics Report (ESRI)  
www.ESRI.ie

### Period Covered by Data

2001 – 2007: Perinatal Data  
Q2 2009: HSE Regions

### Target Information

30% 2009 - derived from Breastfeeding Strategy (2005)

50% Medium Term Target based on international benchmarks

2% increase in breastfeeding rates year-on-year in each LHO area (Strategy target) and 4% for lower SES mothers. From baseline of 2001, the 2009 target is 30% exclusive breastfeeding at 3 months. International OECD average is 50% breastfeeding at 3 months and this is used to judge performance in this report.

### National Overview

21.5% - National average number of babies partially or exclusively Breastfed (Q2 2009).

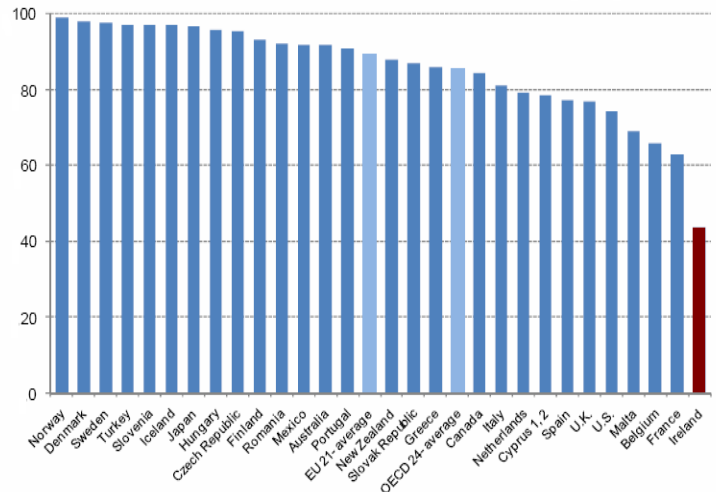
### Commentary

There are significant health benefits associated with breastfeeding. To maximize the evidence-based health advantages of breastfeeding the WHO, UNICEF, the Department of Health and Children (DOH&C) and the HSE recommend exclusive breastfeeding for the first six months and continued breastfeeding thereafter in combination with nutritious complementary foods up to two years or beyond.

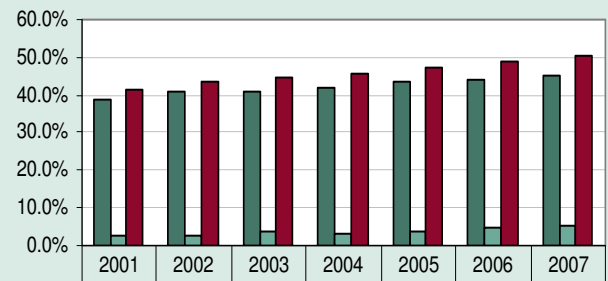
A recent (Aug 2009) OECD report places Ireland at the bottom for rates of breastfeeding in an analysis of 29 countries. The HSE is addressing this by spearheading the implementation of Breastfeeding in Ireland: A Five Year Strategic Action Plan' (DOH&C, Oct. 2005).

Whilst there is a gradual upward trend in breastfeeding rates, it is essential to have comprehensive, accurate and timely data on breastfeeding up-take and duration to evaluate the Action Plan's targets and estimate the effectiveness of its other initiatives. To address this, priority needs to be given to employing best practice in promoting, supporting and protecting breastfeeding across all health care sectors.

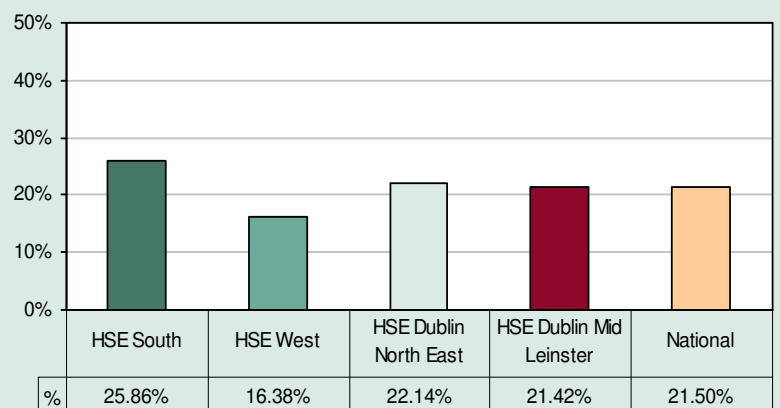
Chart CO3.1: Proportion of children who were "ever breastfed", 2005



### Breastfeeding at discharge from maternity hospital



### % of Babies aged 3 months who are partially or exclusively breastfed



## Orchidopexy Treatment

### Metric Used

Orchidopexy: the % of boys 0 - 4 years (inclusive) undergoing orchidopexy treatment as a percentage of all boys aged 0 – 14 years (inclusive) undergoing orchidopexy treatment.

### Rationale

This indicator assists with monitoring the frequency and timeliness of surgery for undescended testes (orchidopexy) in boys under 15. Undescended testes are associated with potential complications in later life such as infertility and malignancy. Timely correction (such as surgery before the age of 5) acts as a proxy for both timely detection through early childhood screening, and potential prevention of later complications.

### Data Source

Hospital In-Patient Enquiry (HIPE)  
HSE Health Atlas

### Period Covered by Data

2006 - 2008

### Target Information

70% NSP 2009 (incremental target towards benchmark of 95%)

95% Medium Term Target based on international benchmark

#### International Targets

75% surgery < 24 months

95% surgery < 60 months

### National Overview

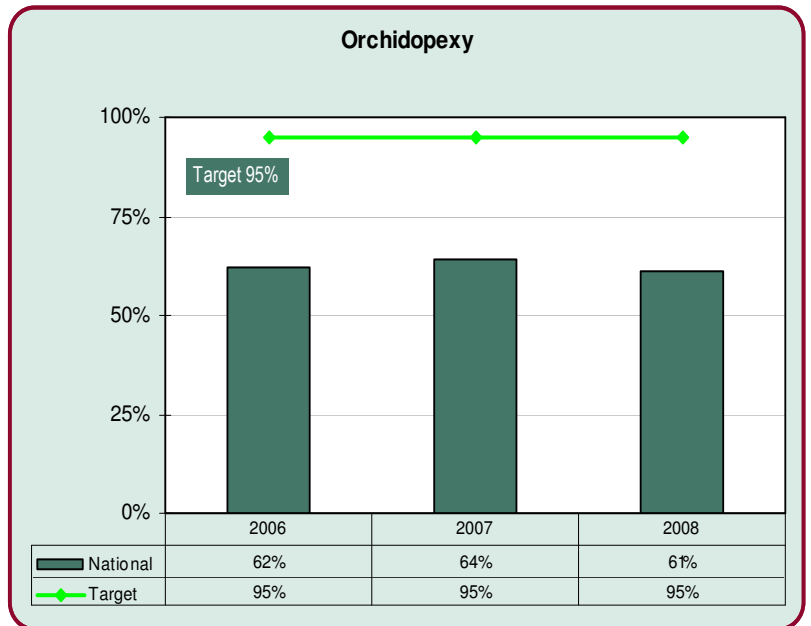
61% - National rate of Orchidopexy Treatment (2008)

### Commentary

Reported performance is not reaching the levels which international evidence suggests is required to provide an effective response to this problem. It is vital that it is detected early, by paediatricians at birth or the general practitioners (GPs) at the six-week check up. Prompt referral to a surgeon with a paediatric interest is essential in order to permit surveillance or surgery.

There is a need for continued emphasis in this area in order to ascertain the level of screening, reporting, referral and treatment to clearly see where processes and responses can be improved.

The protocols and practice around orchidopexy will be examined in conjunction with public health service providers to increase the level of screening, reporting, referral and timely treatment.



## Vaccines

## Influenza Vaccination

**Metric Used**

Influenza: the % uptake of influenza vaccine among the GMS population aged over 65

**Rationale**

In Ireland, annual influenza vaccination is recommended for all persons aged over 65 years of age. Influenza vaccination is thought to reduce influenza related morbidity by 60% and influenza related mortality by 70-80% in the elderly [WHO, *Influenza vaccines. WER 2000; 75:281-288*]

**Data Source**

Health Protection Surveillance Centre  
[www.hpsc.ie](http://www.hpsc.ie)

**Period Covered by Data**

Flu Seasons 2003 - 2009

**Target Information**

75% NSP 2009 / CP 2008 – 2011

**Note:** WHO target of 75% relates to all Older People aged over 65 years. Data presented here relates to GMS Clients (Medical Card / GP Visit Card).

**National Overview**

70.1% - National Influenza uptake rate (2009)

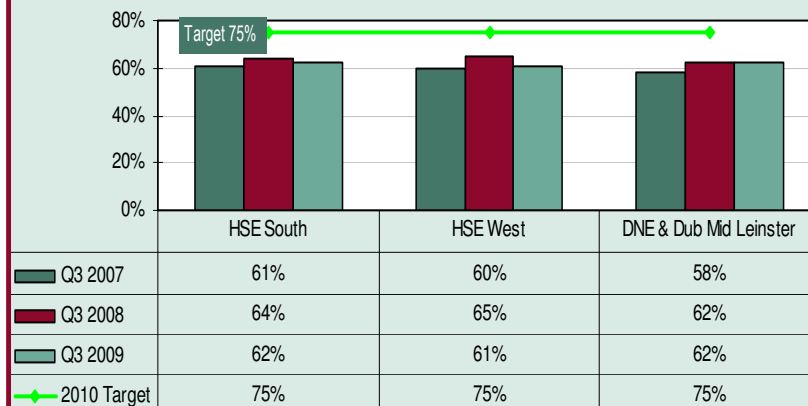
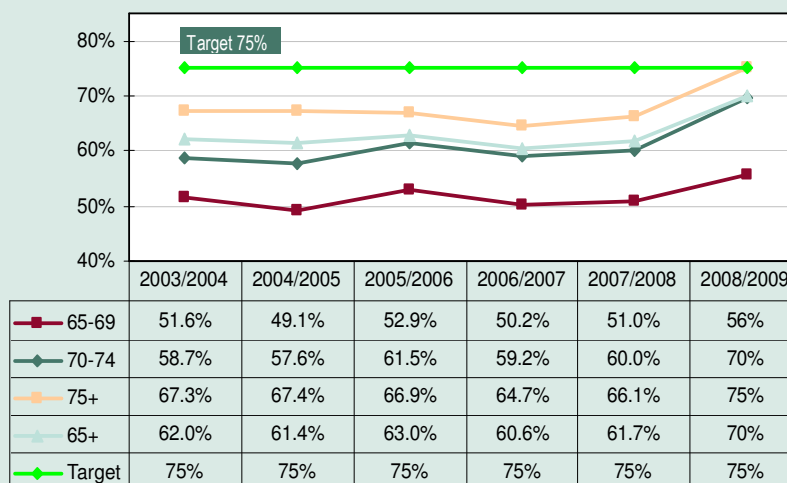
**Commentary**

In Ireland, the average influenza vaccination uptake rate for the 2008/2009 influenza season among medical cardholders and GP Visit cardholders aged 65 years of age and older was 70.1%. This is a marked increase on the reported uptake rate of 61.7% for 2007/2008. This is the highest uptake rate reported since influenza vaccine uptake surveillance was initiated during the 2003/2004 influenza season. The second highest uptake rate reported was 63.0% (2005/2006).

Variation in vaccination coverage was observed between HSE areas (ranging from 68.2%-71.7%)

The uptake for vaccination is highest in the group aged over 75 years (75.1%). As this is the group most at risk, this is appropriate.

Work on increasing awareness within the wider community about the value of influenza vaccination for those at risk of influenza complications is supported as part of efforts to increase vaccine coverage. Health professionals encourage and facilitate access to vaccination for their at-risk patients, including everyone aged 65 or older. The need for a national immunisation register is ever more relevant in order to estimate more timely and complete influenza vaccination uptake rates in risk groups, individuals aged 65 years and older and health care workers.

**Influenza Vaccination Uptake for GMS Clients****National Average Influenza Uptake by Age Group**

## Childhood Vaccination

### Metric Used

Childhood Vaccination: the % of children 24 months of age who have received 3 doses of vaccine against D<sub>3</sub>, P<sub>3</sub>, T<sub>3</sub>, Hib<sub>3</sub>, Hib<sub>b</sub>, Polio<sub>3</sub>, MenC<sub>3</sub> and MMR vaccine.

- D<sub>3</sub> = Third dose Diphtheria Vaccine
- P<sub>3</sub> = Third dose Pertussis (whooping cough) vaccine
- T<sub>3</sub> = Third dose Tetanus vaccine
- Hib<sub>3</sub> = Third dose of Haemophilus Influenzae type b vaccine
- Hib<sub>b</sub> = Haemophilus influenzae type B vaccine
- Polio<sub>3</sub> = Third dose Polio vaccine
- MenC<sub>3</sub> = Third dose Meningococcal C vaccine
- MMR = Measles, Mumps, Rubella vaccine

### Rationale

Immunisation is a proven, safe and effective public health measure that can save lives and protect against serious diseases such as measles, diphtheria and polio. The WHO recommends that immunisation uptake rates should reach at least 95% to prevent outbreaks of these and other diseases.

### Data Source

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)  
 National Immunisation Office (NIO)  
[www.immunisation.ie](http://www.immunisation.ie)

### Period Covered by Data

Q3 2009

### Target Information

94% NSP 2009  
 95% uptake by 2010 (CP 2008 – 2011)  
 >95% of children vaccinated at 24 months (WHO)

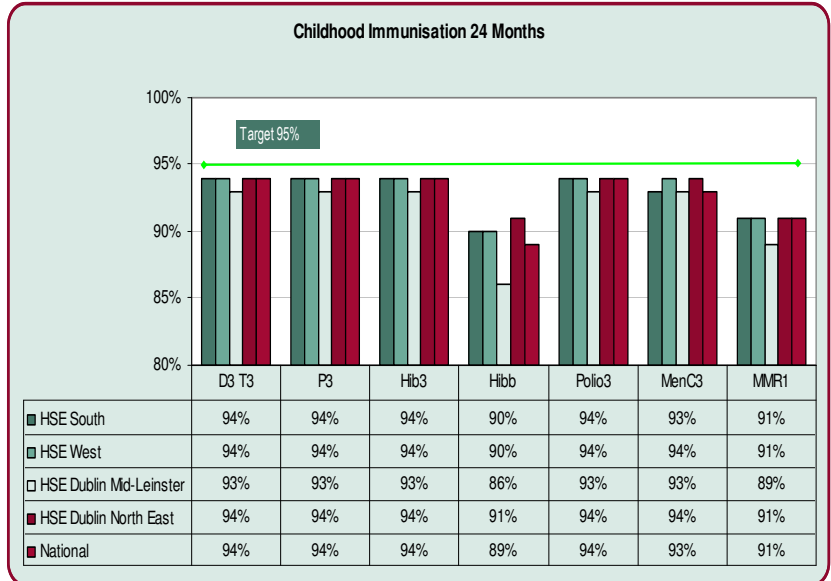
### National Overview

94% - National average immunisation rate (2009)

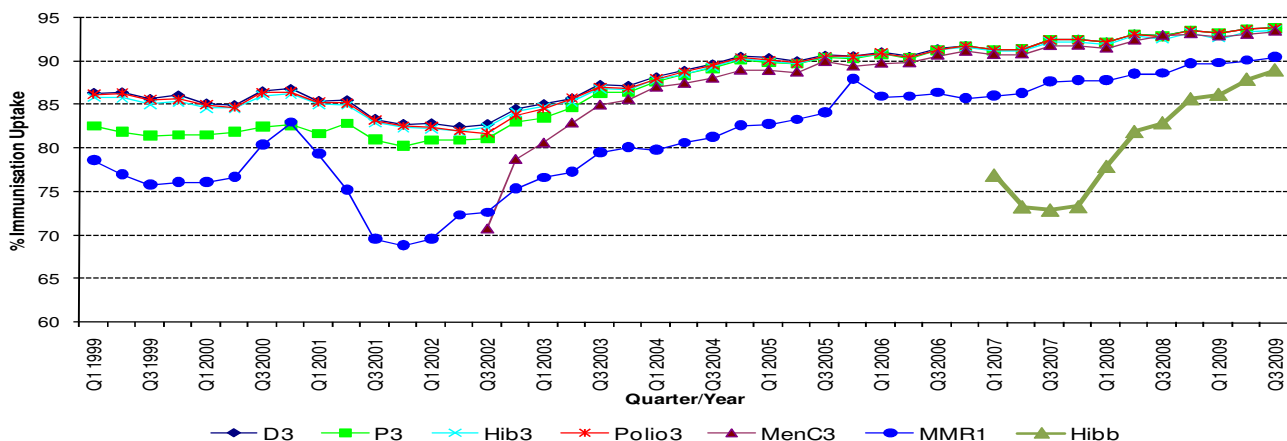
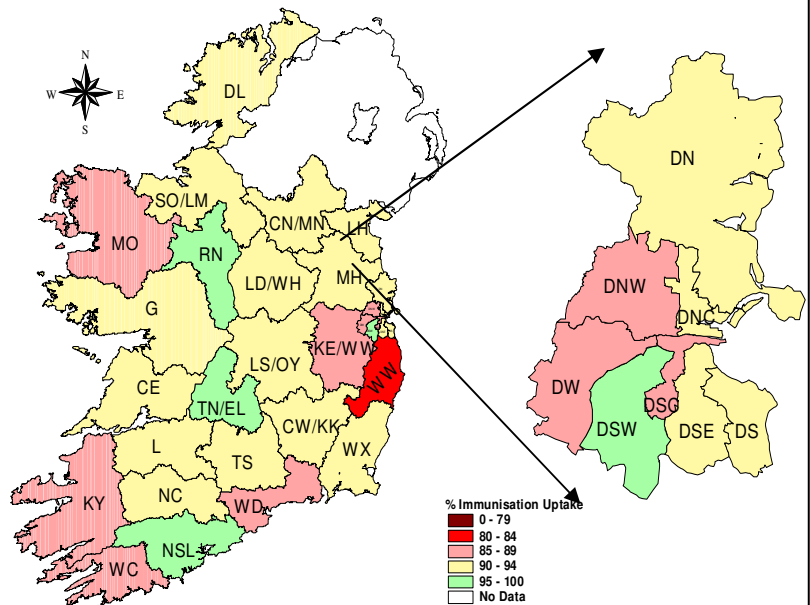
### Commentary

In Q3 2009, national immunisation uptake rates at 24 months were 94% for D<sub>3</sub>, P<sub>3</sub>, T<sub>3</sub>, Hib<sub>3</sub> and Polio<sub>3</sub>, 93% for MenC, 89% for Hib and 91% for MMR. Sixteen Local Health Offices (LHOs) had ≥95% uptake of D<sub>3</sub>, P<sub>3</sub>, T<sub>3</sub>, and Polio<sub>3</sub>. Thirteen LHOs had ≥95% uptake of Hib<sub>3</sub>, twelve LHOs had ≥95% uptake of MenC, four LHOs had ≥95% uptake of Hib<sub>b</sub> and four LHOs had ≥95% uptake of MMR.

This data is very encouraging and is a reflection of the work done by health care professionals and allied staff in promoting immunisation, following up with parents of unimmunised children to encourage vaccination and ensuring the immunisation databases have the most up to date information. These achievements need to be built on so that the 95% target rate is achieved nationally for all vaccines.



MMR Immunisation Uptake Rates (%) by LHO in those 24 months of age in Q3 2009



## Vaccine Preventable Diseases

## Pertussis

## Metric Used

Pertussis: Number of notifications and Crude Incidence Rate per 100,000 population.

## Rationale

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

## Data Source

Health Protection Surveillance Centre (HPSC)  
www.hpsc.ie

## Period Covered by Data

2000 – 2009 (2009 data provisional)

## Target Information

No target specified at this time

## National Overview

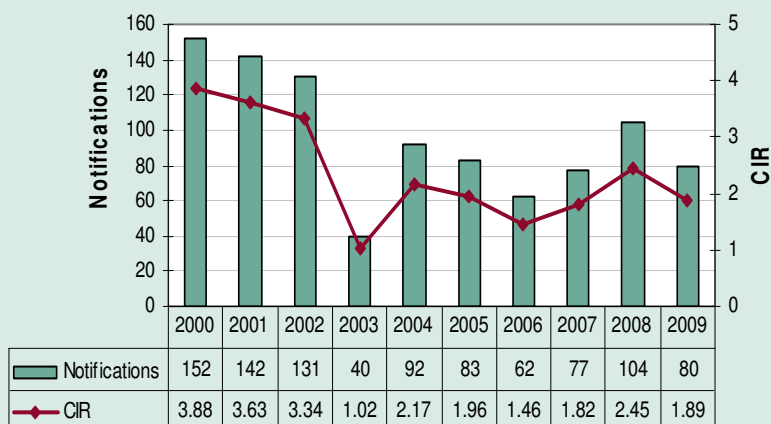
80 notifications / 1.89 CIR per 100,000 population (2009)

## Commentary

Pertussis, also known as whooping cough, is a highly contagious disease caused by the bacterium *Bordetella pertussis*. It is known to last for a duration of approximately 6 weeks before subsiding. Pertussis occurs endemically with periodic outbreaks. Worldwide, over 45 million cases occur annually, with more than 250,000 deaths.

Epidemiological data on pertussis in Ireland has been gathered annually since 1948. There has been a steady decline in mortality which commenced before the introduction of the vaccine, but the rate of decline accelerated following its introduction. Prior to the introduction of vaccination most cases occurred in young children. Now the highest incidence, morbidity and rare mortality are in infants. Internationally, an increase rate among adolescents and adults has been reported (although this has not been evident from notification data in Ireland). This change in the epidemiology of pertussis is due to the waning immunity that occurs after both disease and vaccination, and to a reduction in natural boosting. 30% of adults with a cough lasting longer than 2 weeks may have pertussis. Pertussis is no longer available as a single vaccine. A full course of vaccine confers protection in over 80% of recipients. Immunity wanes with age and is low or absent 10-12 years after primary immunisation. High vaccine uptake rates, including booster doses, are therefore very important in order to reduce the incidence of pertussis. Current guidelines advise 3 doses in infancy at 2, 4 and 6 months (6 in 1 vaccine), plus 2 booster doses at 4-5 years (4 in 1) and at 11-14 years.

Pertussis Notifications &amp; Crude Incidence Rate per 100,000 population



## Tetanus

## Metric Used

Tetanus: Number of notifications and Crude Incidence Rate per 100,000 population.

## Rationale

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

## Data Source

Health Protection Surveillance Centre (HPSC)  
www.hpsc.ie

## Period Covered by Data

2000 – 2009 (2009 data provisional)

## Target Information

No target specified at this time

## National Overview

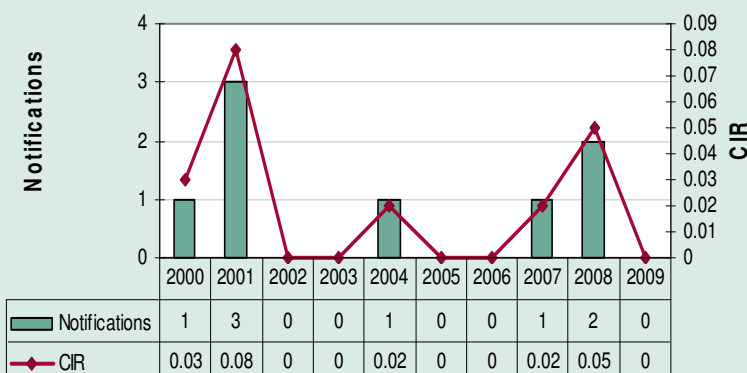
0 notifications (2009)

## Commentary

Tetanus (also known as 'lockjaw') is a medical condition characterised by a prolonged contraction of skeletal muscle fibres. Infection generally occurs through contamination of a cut or a deep puncture wound. As the infection progresses, muscle spasms develop in the jaw and elsewhere in the body. Tetanus is now rare in Ireland due to routine immunisation programmes. However, the bacterium that causes the disease is still present in the soil, which cannot be eradicated from our environment. The only way to protect against tetanus is by immunisation. The tetanus vaccine is given as part of the routine childhood immunisation programme (referred to as the "6-in-1" vaccine). Vaccination is given at 2, 4 and 6 months of age. Booster vaccine doses are given at 4-5 years of age and again between 11-14 years of age.

Individuals who have wound injuries are medically assessed to determine what treatment is needed to prevent tetanus. The treatment recommended by the doctor will depend on history of tetanus vaccination, type of wound and whether it is considered to be a 'tetanus prone wound' (such as wounds contaminated with dirt, faeces, soil and saliva).

Tetanus Notifications &amp; Crude Incidence Rate per 100,000 population



## Haemophilus influenzae

**Metric Used**

*Haemophilus influenzae* (type B): Number of notifications and Crude Incidence Rate per 100,000 population.

**Rationale**

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

**Data Source**

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

**Period Covered by Data**

2000 – 2009 (2009 data provisional)

**Target Information**

No target specified at this time

**National Overview**

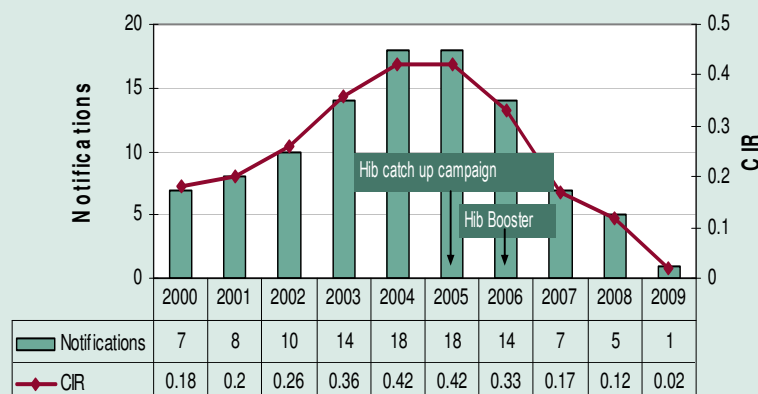
1 notification / 0.02 CIR per 100,000 population (2009)

**Commentary**

*Haemophilus influenzae* type b, or Hib, is an illness that can cause a potentially fatal brain infection in young children. Until recently, Hib disease was an important cause of serious, often deadly, infections in children under age 5. However, with the development and widespread use of vaccines against Hib, very few cases are now diagnosed.

The Hib conjugate vaccine was introduced in Ireland in 1992. A marked decline in incidence followed. Increase in vaccine failures seen in 2004/2005 was attributed to waning immunity. A Hib booster catch-up campaign in 2005 was offered to all children 12 months to < 4 years of age. A routine Hib booster was introduced in September 2006 for all children aged 12 months. Both these campaigns had a considerable impact in reducing incidence of Hib disease in recent years. Current guidelines advise 3 doses of Hib vaccine in infancy and one booster dose at 13 months (2,4 and 6 months, 6 in 1 vaccine), 13 months (Hib vaccine).

**Haemophilus influenzae (type B) Notification & Crude Incidence rate per 100,000 population**



## Hepatitis B

**Metric Used**

Hepatitis B (acute and chronic): Number of notifications and Crude Incidence Rate per 100,000 population.

**Rationale**

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

**Data Source**

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

**Period Covered by Data**

2000 – 2009 (2009 data provisional)

**Target Information**

No target specified at this time

**National Overview**

838 notifications / 19.76 CIR per 100,000 population (2009)

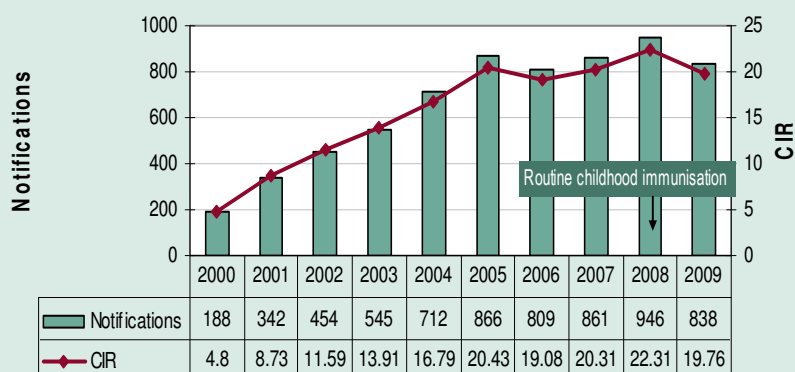
**Commentary**

Hepatitis B is a vaccine preventable disease which is transmitted through contact with the blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. It is a viral infection that attacks the liver and can cause both acute and chronic disease. About 2 billion people worldwide have been infected with the virus and about 350 million live with chronic infection. An estimated 600,000 persons die each year due to the acute or chronic consequences of hepatitis B [www.WHO.int]. About 25% of adults who become chronically infected during childhood later die from liver cancer or cirrhosis (scarring of the liver) caused by the chronic infection. The hepatitis B virus is 50-100 times more infectious than HIV. Hepatitis B virus is an important occupational hazard for health workers. Hepatitis B is preventable with a safe and effective vaccine.

Prior to 2007, immunisation was recommended only for at risk population groups (individuals at occupational risk, close contact with infected persons, etc). In 2008 routine childhood immunisation was introduced. Current guidelines advise 3 doses in infancy at 2, 4 and 6 months (6 in 1 vaccine).

The prevalence of hepatitis B infection in Ireland is relatively low. However, infection is more prevalent in certain high-risk populations such as injecting drug users, prisoners and immigrants from high endemicity countries.

**Hepatitis B (acute and chronic) Notifications & Crude Incidence Rate per 100,000 population**



## Neisseria meningitidis serogroup C (MenC)

### Metric Used

Neisseria meningitidis serogroup C (MenC): Number of notifications and Crude Incidence Rate per 100,000 population.

### Rationale

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

### Data Source

Health Protection Surveillance Centre (HPSC)  
www.hpsc.ie

### Period Covered by Data

2000 – 2009 (2009 data provisional)

### Target Information

No target specified at this time

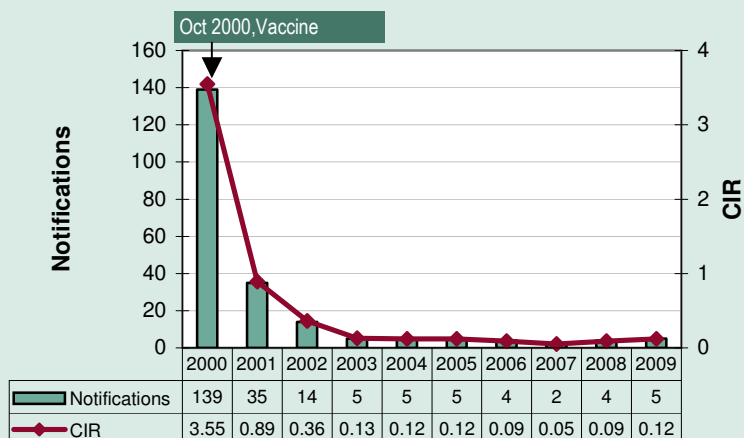
### National Overview

5 notifications / 0.12 CIR per 100,000 population (2009)

### Commentary

Invasive meningococcal disease is the most common form of bacterial meningitis in Ireland, causing up to 90% of the cases in 2000. This disease may present as meningitis, septicaemia (blood poisoning) or both. It is an infection caused by the organism *Neisseria meningitidis*. Infants and young children are most susceptible and *N. meningitidis* infections are an important cause of infection in developed and developing countries. Prior to the introduction of the meningococcal C conjugate (MenC) vaccine in Ireland (Oct 2000), serogroup C accounted for 30-35% of cases of IMD and group B for approximately 70%. The MenC vaccine has by been offered to everyone under 23 years of age and has also been included as part of the primary immunisation schedule for infants. This vaccine has been extremely successful in reducing serogroup C disease in Ireland, with the number of cases being reduced by 96% in 2009 when compared with 2000.

### Neisseria meningitidis serogroup C notifications & Crude incidence rate per 100,000 population



## Measles

### Metric Used

Measles: Number of notifications and Crude Incidence Rate per 100,000 population.

### Rationale

Surveillance of vaccine preventable diseases is critical in order to monitor the effectiveness of vaccination programmes.

### Data Source

Health Protection Surveillance Centre (HPSC)  
www.hpsc.ie

### Period Covered by Data

1990 – 2009 (2009 data provisional)

### Target Information

No target specified at this time

### National Overview

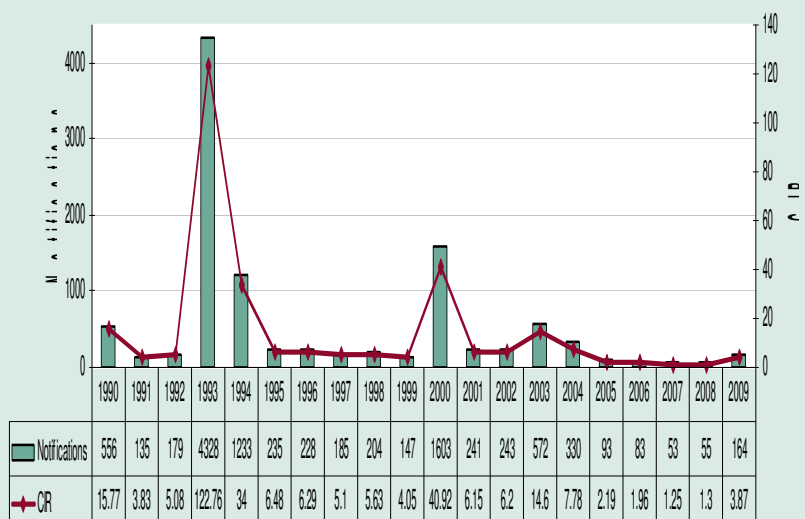
164 notifications / 3.87 CIR per 100,000 population (2009)

### Commentary

The incidence of measles has declined dramatically since the introduction of the measles vaccine in 1985. The MMR vaccine was incorporated into the programme in October 1988. In July 1992 a second MMR for both boys and girls aged 10-14 years was introduced replacing the previous selective rubella vaccination programme for prepubertal girls.

The number of reported cases fell from a peak of almost 10,000 cases in 1985 to 135 cases in 1991. However outbreaks continued to occur with 4328 cases in 1993 and 1603 cases in 2000 where the outbreak was predominantly centred in North County Dublin. More recently a national outbreak commenced at the end of 2009 and continues in 2010.

### Measles Notifications & Crude Incidence Rate per 100,000 population



## Infectious Diseases

## Salmonella

**Metric Used**

Salmonella: Number of notifications and Crude Incidence Rate per 100,000 population.

**Rationale**

Surveillance of human Salmonella infections plays a critical role in understanding and controlling food borne illness due to Salmonella.

**Data Source**

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

**Period Covered by Data**

1990 – 2009 (2009 data provisional)

**Target Information**

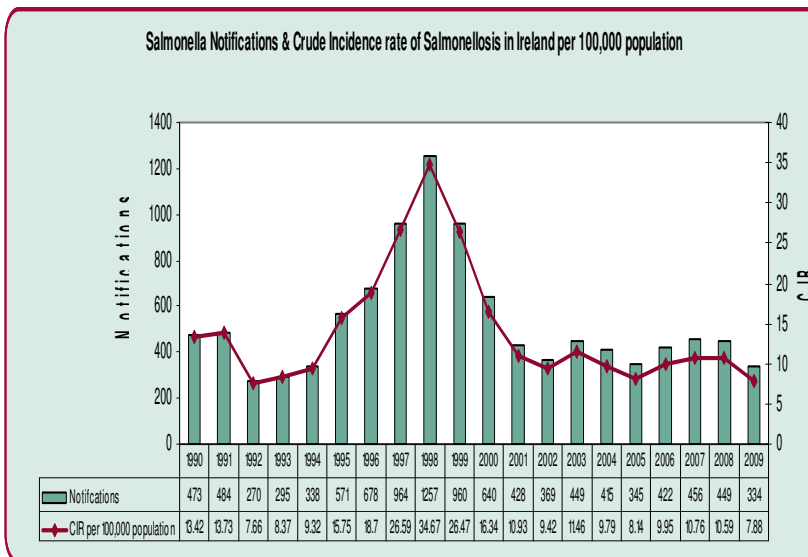
No target specified at this time

**National Overview**

334 notifications / 7.88 CIR per 100,000 population (2009)

**Commentary**

For the past nine years, the incidence of salmonellosis in Ireland has remained reasonably steady with around 350-450 cases reported per annum. This is a decrease from the number of cases that were reported in the late 1990s, when the number of cases peaked at 1257 cases in 1998. Salmonellosis continues to be an extremely significant cause of gastroenteritis in Ireland. Enhanced surveillance of salmonellosis facilitates more timely intervention and control of spread not only nationally but at a European level.



## Cryptosporidiosis

**Metric Used**

Cryptosporidiosis: Number of notifications and Crude Incidence Rate per 100,000 population.

**Rationale**

Human cryptosporidiosis became a notifiable disease on 1 Jan 2004. Prior to this, cryptosporidiosis was notifiable in Ireland only in young children under the category 'Gastroenteritis in children under 2'. Two aspects of Cryptosporidium make it of particular public health significance. While it causes severe watery non-bloody diarrhoea in immuno-competent individuals, it can cause chronic persistent gastroenteritis in the immuno-compromised. The second important feature of Cryptosporidium from a public health perspective is its relative resistance to chlorination, which results in the potential for outbreaks associated with swimming pools and with drinking water supplies that rely primarily on chlorination for treatment.

**Data Source**

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

The Provision and Quality of Drinking Water in Ireland - A Report for the Years 2007 – 2008  
[www.epa.ie](http://www.epa.ie)

**Period Covered by Data**

2004 – 2009 (2009 data provisional)

**Target Information**

No target specified at this time

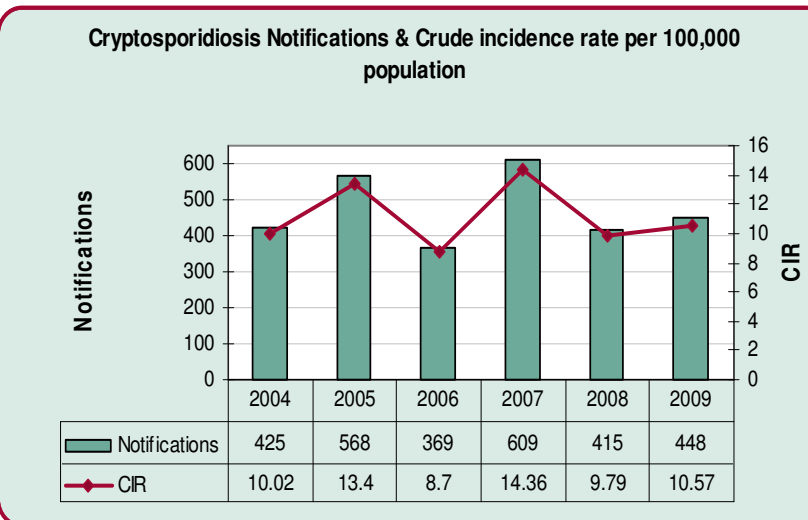
**National Overview**

448 notifications / 10.57 CIR per 100,000 population (2009)

**Commentary**

Over the last six years the highest number of cryptosporidiosis notifications was in 2007, when 609 cases were notified to the HPSC, (up 66% on 2006). The main reason for the 2007 increase in notifications was due to a large outbreak in HSE West linked to public water supplies which accounted for almost 50% of all cases reported. Contingency planning to deal with outbreaks continues to be a priority to deal with avoidable consequences of potential infection.

There are regular consultations between the HSE and the Local Authorities / EPA in respect of specific supplies. The HSE has established a National Drinking Water group to facilitate a consistent response to these matters. In addition, the HSE is in dialogue with the EPA and the Department of the Environment on prioritising remedial work and heightening surveillance of at risk supplies. Risk assessment in respect of cryptosporidium in drinking water is an important element in these deliberations.



## Tuberculosis

### Metric Used

Tuberculosis: Number of notifications and Crude Incidence Rate per 100,000 population.

### Rationale

In 2009, the WHO estimated that over 2 billion people (one third of the world's population) were infected with TB bacilli, the microbes that cause TB. The vast majority of TB deaths are in the developing world and more than half of all deaths occur in Asia. TB is much less common in developed countries, such as Ireland. Early diagnosis and treatment are essential to stop the infection spreading from person to person.

### Data Source

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

### Period Covered by Data

1991 – 2008 (2008 data is provisional)

### Target Information

The WHO Stop TB programme aims to eliminate TB as a global public health problem by 2050. This means to reduce the rate of TB to < 1 case per million population per annum. This equates to 5 cases per annum in Ireland.

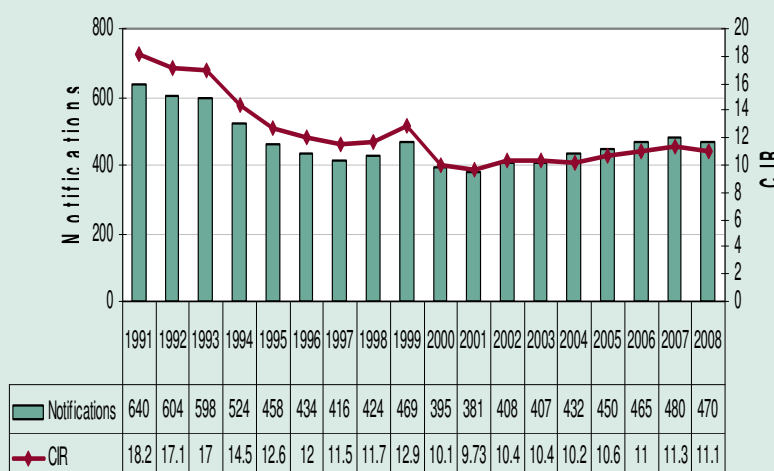
### National Overview

470 notifications / 11.1 CIR per 100,000 population (2008).

### Commentary

In recent years, the quality of the data, and in particular data on treatment outcome, has greatly improved. The importance of good surveillance data cannot be underestimated as it will help guide where resources should be directed in order to ensure effective control of TB in Ireland and to reach the global elimination target by 2050.

Tuberculosis Notifications & Crude incidence rate per 100,000 population



## Chlamydia

### Metric Used

Chlamydia: Number of notifications and Crude Incidence Rate per 100,000 population.

### Rationale

Genital Chlamydia infection is the most common bacterial sexually transmitted disease in the developed world. If an infection is undiagnosed and therefore untreated, significant ill health can result. Although the infection is easily treated, few patients present with symptomatic disease. Symptoms of infection may be absent in up to 80% of women / 40% of men.

### Data Source

Health Protection Surveillance Centre (HPSC)  
[www.hpsc.ie](http://www.hpsc.ie)

### Period Covered by Data

1995 – 2008 (2009 not available)

### Target Information

No target specified at this time

### National Overview

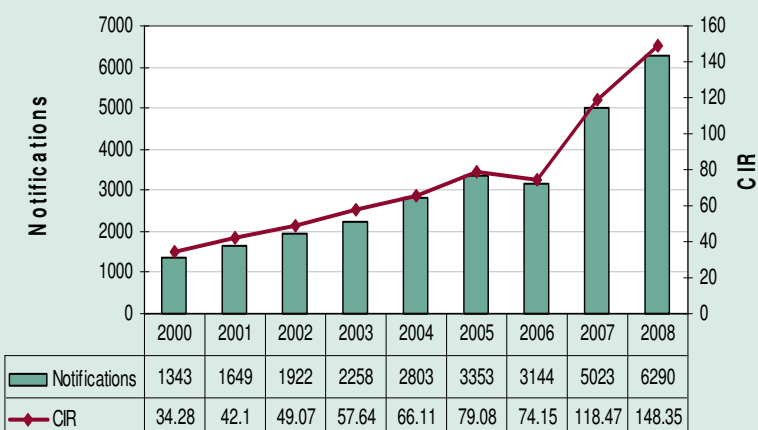
6290 notifications (2008) / 148.35 CIR per 100,000 population (2008)

### Commentary

In Ireland there has been a twenty-five fold increase in the number of cases notified since 1995. In 2008, Chlamydia accounted for 56% of all sexually transmitted infections (STI) and 70% of all STIs in adolescents aged 0-19 years. Incidence is highest among young men and women aged 20-29 years. These trends reflect a significant change in attitude and sexual behaviour in recent years.

The true prevalence of genital Chlamydia in Ireland is unknown. Survey data from other European countries suggest a population prevalence of 1.4 - 3% among people aged 18 - 44 years. Data from England's National Chlamydia Screening Programme indicates that 10% of sexually active young men and women up to the age of 25 test positive for infection. In this country, this equates to approximately 63,000 men and women aged 15-24 years.

Chlamydia Notifications & Crude incidence rate per 100,000 population



## Suicide Rates

### Metric Used

Suicide: Number and rate of suicide nationally.

### Rationale

Collecting data on rates of suicide provides a solid evidence base for policy development and intervention in the prevention of suicide and the management of patients presenting with deliberate self harm.

### Data Source

National Suicide Research Foundation (NSRF)  
[www.nsrff.ie](http://www.nsrff.ie)

National Strategy for Action on Suicide Prevention, 2005 – 2014

National Office for Suicide Prevention (NOSP)  
[www.nosp.ie](http://www.nosp.ie)

### Period Covered by Data

1997 – 2008 (data for 2008 is provisional).

### Target Information

A national target of a 10% reduction in suicide numbers between 2005 and 2006 (agreed in 2006).

10% reduction in suicide by 2010 (Corporate Plan 2008 – 2011)

### National Overview

424 people committed suicide (2008, figures are provisional)  
a reduction of 7.8% on 2007 figures.

### Commentary

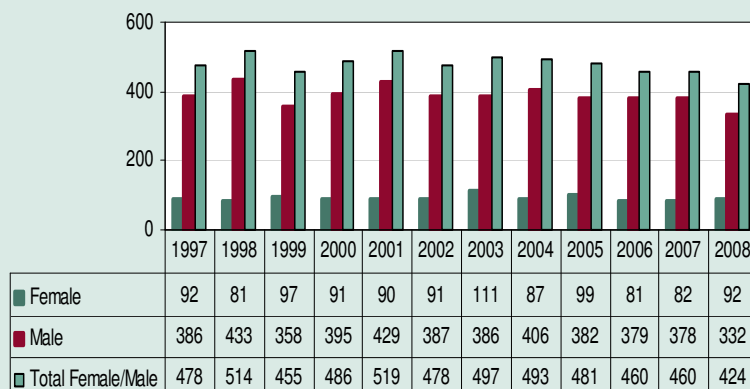
Suicide is now among the three leading causes of death among those aged 15-44 years (both sexes). These figures do not include suicide attempts (up to 20 times more frequent than completed suicide). Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries [WHO].

Currently, youth suicide rates in Ireland are fourth highest in the European Union (World Health Organisation, 2005). Older People, especially older men, may also be vulnerable and suicide is affecting increasing numbers of Irish people across the lifespan.

Mental disorders (particularly depression and substance abuse) are associated with a high percentage of all cases of suicide; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations (e.g. loss of a loved one, employment, financial crisis).

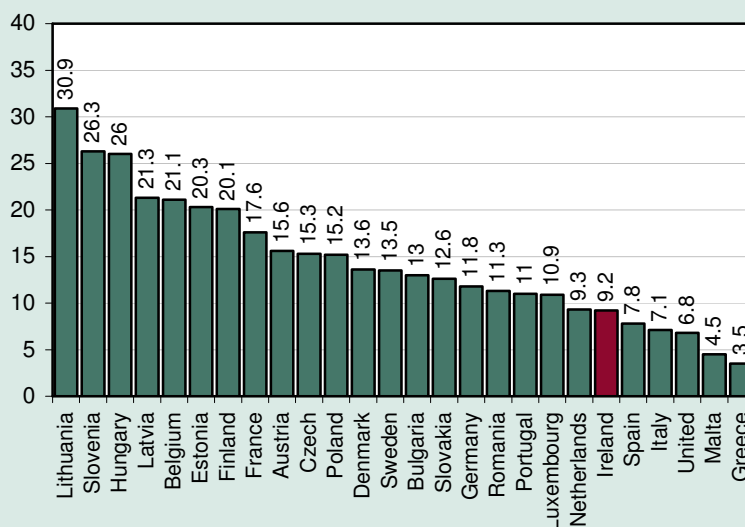
In response to the current economic situation, the HSE has launched a national programme in an effort to offset the potential impact of the recession on suicide rates ('Looking after your mental health in tough economic times'). Leaflet available from Citizens Information or Money Advice and Budgeting Service or [www.healthpromotion.ie](http://www.healthpromotion.ie).

### Male/Female Suicide Figures 1997 - 2008



\*Data returns for 2008 are provisional

### EU Total Population Suicide Rates per 100,000 2006



## Deliberate Self Harm

### Metric Used

Deliberate self-harm: The rate of re-presentation of people with Deliberate Self Harm at Emergency Departments, within one calendar year.

### Rationale

A history of one or more acts of deliberate self-harm is the strongest predictor of repeated suicidal behaviour, both fatal and non-fatal. Therefore, the assessment of future suicide risk and adequate treatment referral are crucial in preventing further suicidal behaviour. The National Registry of Deliberate Self Harm reports that among deliberate self-harm patients presenting to accident and emergency departments, there is considerable diversity with regard to assessment procedures and treatment referral.

### Data Source

National Registry of Deliberate Self Harm at the National Suicide Research Foundation Ireland  
[www.nsrfl.ie](http://www.nsrfl.ie)

### Period Covered by Data

2006 - 2008

### Target Information

13.3%, 2009, this reflects 5% annual reduction in repeated self harm by 2010 as reflected in the Corporate Plan 2008 – 2011

12% Medium Term Target

### National Overview

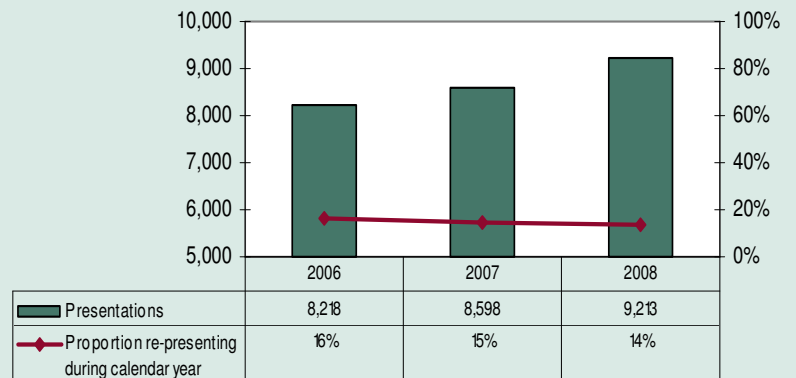
14% rate of re-presentation of cases of Deliberate Self Harm at Hospital Emergency Departments (Dec 2008).

### Commentary

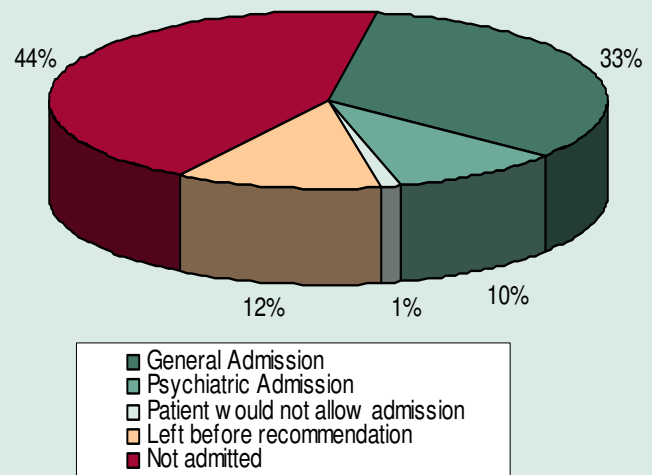
The National Parasuicide Registry reported 11,700 cases of deliberate self-harm presenting at the emergency departments of our hospitals in 2008. More than one in five (21%) of all deliberate self harm presentations were due to repeat acts. Within this, 14% of patients made at least one repeat visit. This was down from 15% in 2007.

Care choices at point of presentation and planned follow up may result in a reduction in the representation rates. Trends over time can highlight hospital, community and primary care service provision and examples of cross service delivery around the country which may provide exemplars to drive improvement in performance in this area.

No. of deliberate self harm presentations and rate of re-presentations at ED within one calendar year



Recommended next Care for deliberate self harm patients in 2008



# Trust and Confidence (Access)

## Ambulance Response Times

### Metric Used

Ambulance response times: Proportion of urgent calls responded to within predefined time bands.

### Rationale

Response times are an indicator of the efficiency in the provision of pre-hospital emergency care services.

### Data Source

Ambulance Services, HSE

### Period Covered by Data

Position as of Dec 2008 / Dec 2009

### Target Information

NSP 2009:

< 8 mins (32%)

<14 mins (62%)

<19 mins (76%)

<26 mins (86%)

Long term target to match international norms of 95% of emergency call responded to within 19 minutes.

### National Overview

< 8 mins 29.5%

< 14 mins 59%

< 19 mins 72.3%

< 26 mins 83.1%

### Commentary

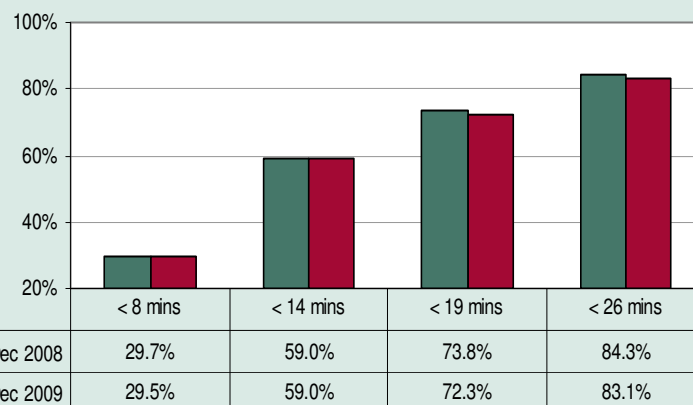
11 Ambulance Command and Control Centres co-ordinate pre-hospital emergency care services for 97 ambulance stations.

The strategic plan for the ambulance service outlines the direction in which resources available can be used to provide the most appropriate services. From the data available it can be seen that the proportion of community transport has reduced in 2009 and emergency calls and urgent calls are slightly up.

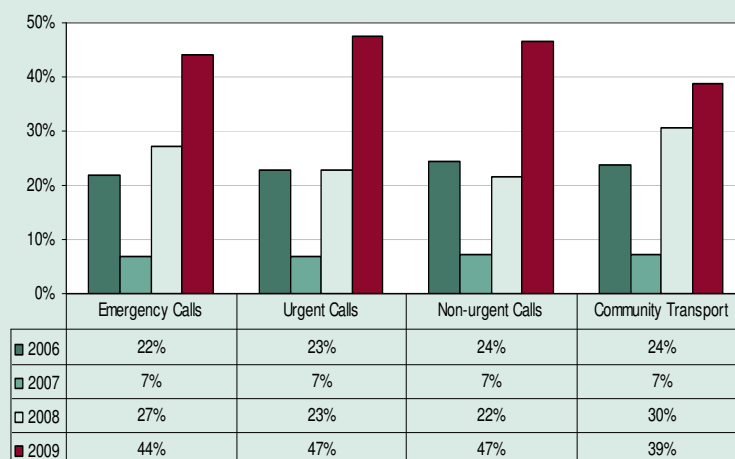
Work will continue to deploy skilled ambulance services where they add most value and to look at alternative solutions for community and non-urgent transport.

Response rates will continue to be monitored and a performance improvement plan is being developed.

### Ambulance Emergency Response Times



### %breakdown of Ambulance Calls



## GP Out of Hours Service

### Metric Used

GP Out of Hours: the % of the population who have access to structured urgent GP Out of Hours Service.

### Rationale

In parts of Ireland, GPs have come together to form co-operatives providing a medical service outside normal working hours. The co-operative may be based in a health centre, public hospital or in another location (often provided by the HSE). Participating GPs provide this service on a rota basis in the evenings, at weekends and on bank and public holidays.

Not only do GP out-of-hours services provide essential medical cover after normal office hours, they also act as a vital means of managing demand on the rest of the health service as in the absence of accessible GP out-of-hours services, patients may seek care by attending the Emergency Department of their local acute hospital, or by using the ambulance/ emergency services.

### Data Source

Business Intelligence Unit (BIU), Non Acute, HSE

### Period Covered by Data

Position as of Dec 2009

### Target Information

80% 2009 (incremental target towards 85%)

85% Medium Term Target

### National Overview

Approximately 3.063 million people in Ireland now have access to an Out of Hours GP Service (approximately 72% of the total population, CSO Census data, (2006).

During 2009, 931,330 contacts were made to GP Out of Hours services.

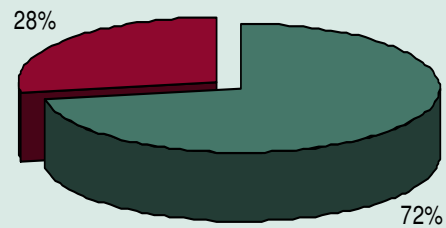
### Commentary

There is considerable variation between regions, and between the size and structure of the individual co-operatives. SOUTHDOC serves the largest population nationally accounting for 13.7% of the total population covered by these services (population covered is 580,000) followed by DDOC (534,233) and CAREDOC (525,000). The smallest population served by a GP Co-operative is NOWDOC (169,000) and KDOC (170,000).

There remain a number of LHO's that have no cover (e.g. parts of Galway and Limerick).

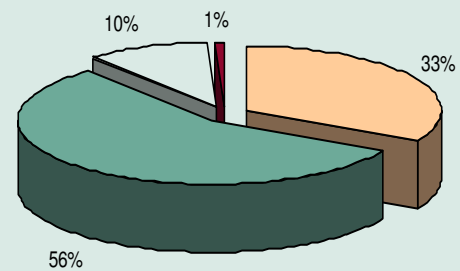
A detailed examination of the type of contact made with the Out of Hours service indicates that the majority (56%) resulted in attendance at a Treatment Centre. Attendance at a Treatment Centre would usually follow telephone triage so is a good indication of hospital avoidance via the Emergency Department.

### Population serviced by formal out of hours GP service



■ Population served by a GP CO-OP ■ Population not served by a GP CO-OP

### Analysis of Contact with GP Out of Hours Services



■ Triage Only ■ Treatment Centre ■ Home Visit ■ Other

## Child and Adolescent Mental Health

### Metric Used

CAMHS: % of new referrals seen within 3 months.

### Rationale

Delivery of a modern mental health services in the community is a cornerstone of a 'Vision for Change' (report of the expert group on Mental Health Policy, 2006).

All 50 CAMH Community Teams screen referrals received. Those deemed to be urgent are seen as a priority. Those deemed to be routine are placed on a waiting list to be seen. It is the ultimate objective of the HSE that 100% of children would be seen within 3 months of referral.

### Data Source

Business Intelligence Unit (BIU) (Non Acute), HSE

### Period Covered by Data

2008 – Dec 2009

### Target Information

#### Waiting Times to be seen and Overall Waiting List:

Target to reduce waiting times in 2010 using 2009 data as base position (NSP 2009).

- ❑ Overall reduction in Waiting list for Community CAMHS by >5% with a focus on waiting lists >12 months (2010).
- ❑ 70% new cases seen within 3 months of receipt of referral (2010), increasing to 100% over a period of 3 – 5 years.

#### CAMH Teams:

55 Teams (NSP 2009)

99 Teams ('A Vision for Change' Mental Health Policy, 2006)

### National Overview

2,608 children and adolescents waiting to be seen (Dec 2009)

- ❑ 907 (34.8%) waiting <3 months
- ❑ 516 (19.8%) waiting 3-6 months
- ❑ 623 (23.9%) waiting 6-12 months
- ❑ 562 (21.5%) waiting >12 months

67.5% of new cases seen were offered a first appointment within 3 months of receipt of referral (July to December 2009).

50 Teams (Dec 2009)

### Commentary

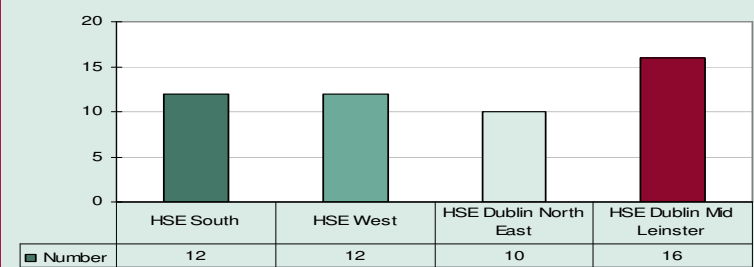
During 2009, there was a reduction of more than 16% in the number of children waiting to be seen by CAMH Teams in the community.

As size of waiting lists is not evenly distributed across the service, an overall target of >5% reduction in the number on the waiting list was agreed, with a focus on reducing the number of children waiting greater than 12 months to be seen.

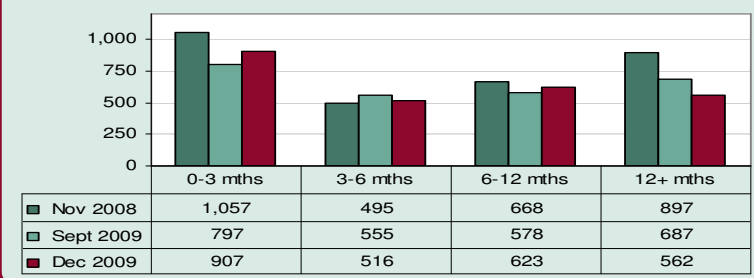
From July to December 2009, the average performance across the 50 CAMH Teams was 67.5% of new cases were offered a first appointment within 3 months of receipt of referral. Of the 50 CAMH Teams, 26 Teams (52%) were above this figure.

Some CAMH service in the South has been affected on by a lack of continuous Consultant Psychiatrist cover over the past number of years. Two additional psychiatrists have now been appointed to the HSE South and vacant posts have been filled in a permanent capacity. The numbers waiting greater than 12 months in HSE South have decreased by 20% from September to Dec 2009.

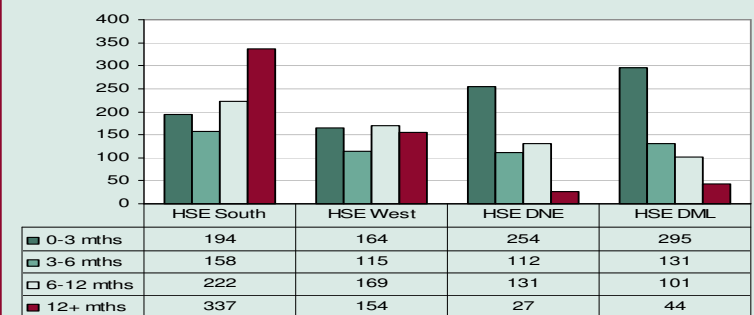
Child and Adolescent Community Mental Health Teams



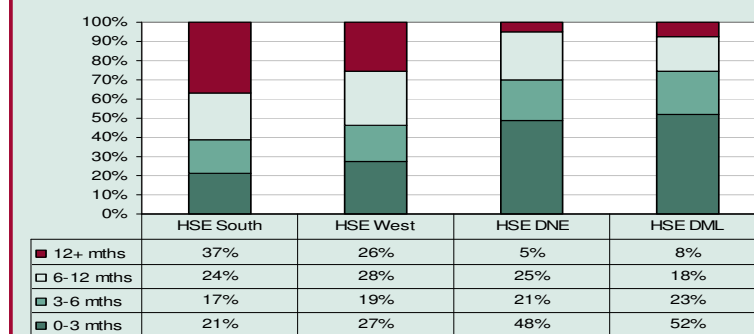
Number of children waiting to be seen by time (months)



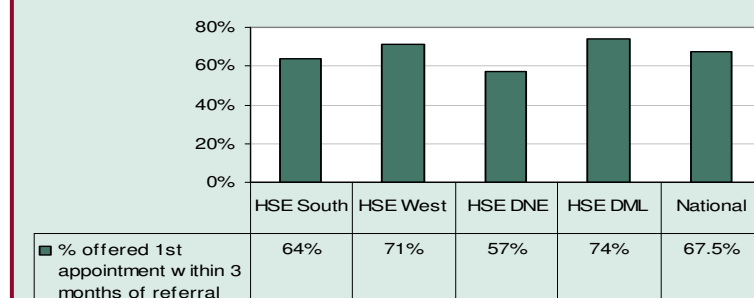
Breakdown of Waiting List (December 2009) by HSE Area



% Breakdown of Waiting List (December 2009) by HSE Area



% of children seen within 3 months of referral by region



## Disability Assessments

### Metric Used

Intellectual Disability Under 5 Assessments: No. of completed assessments that were within the timelines as provided for in the Regulations.

### Rationale

Part 2 of the Disability Act 2005 commenced on 1 June 2007 in respect to children aged under 5 years. The Act provides for the identification and delivery of individual health, education and personal social services for people with disabilities who meet the relevant eligibility criteria set out in the Act.

In particular the Act provides people with disabilities with an entitlement to:

- An independent assessment of health and education needs. This is carried out by an independent Assessment Officer.
- A statement of services (Service Statement). This is drawn up by a Liaison Officer (also known as a Case Manager).
- Pursue a complaint through an independent redress mechanism if there is a failure to provide these entitlements.

It is envisaged that the extension of the Act to children aged 5 - 18 and to adults will be implemented on a gradual basis.

### Data Source

Assessment Officer's System (AOS) Database (Quarterly Reports)  
Disabilities Information Unit

### Period Covered by Data

Q1, Q2, Q3 2009

### Target Information

100% NSP 2009  
100% Medium term target

### National Overview

24% (347 out of 1,436) of completed assessments were within the statutory timeframes.

### Commentary

Across LHOs there is wide variation in the number of assessments which are overdue for completion. While the data shows that this is in single figures in 14 of the 32 LHO Areas, it is in excess of 40 in 8 areas and in excess of 100 in one area.

A number of LHO Offices are experiencing difficulties in complying with the statutory timeframes due to:

- Difficulties accessing particular assessments, especially in the Dublin Area.
- Level of coordination of Early Intervention Services within a LHO.
- In Budget 2009, an additional €7.2 million was allocated in respect of Disability Services for children with special needs. 90 additional multi disciplinary posts including speech and language therapists, occupational therapists, physiotherapist and psychologists are being recruited to develop and enhance assessment and intervention services to children of school going age with disabilities. These 2009 posts are in addition to the 140 posts allocated from the 2008 development funding to provide for the development of additional services for people with disabilities. 136 of these posts have been filled with 4 remaining vacancies that are in the process of being filled. The remaining posts will be filled in conjunction with the filling of the 2009 posts.

The position with regard to the 90 WTEs as at the 31 December 2009 is as follows:

- Number of posts filled to date 45.85 WTE.
- 8.65 WTE start dates agreed.
- 19.80 WTE accepted and processing clearances.
- 15.70 WTE recruitment process in progress.

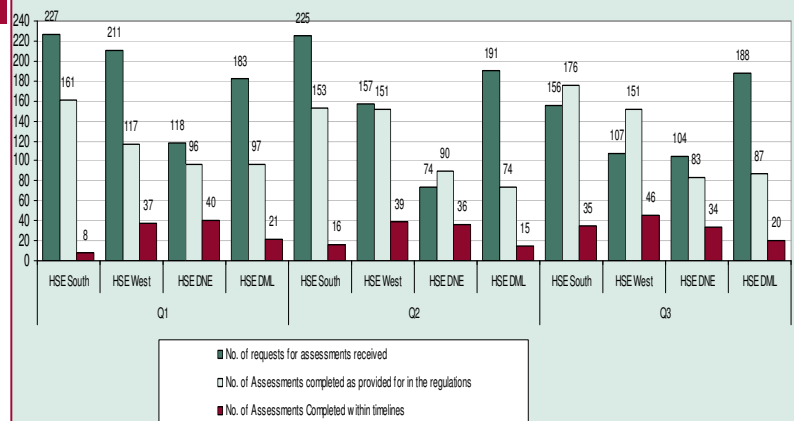
A number of national panels went live in late December and offers are being made to successful candidates. Other posts will need to be re advertised and this is currently underway.

New guidelines for Assessors and Assessment Officers designed to make the process more efficient were put in place in May 2009. The purpose of the revised guidance issued to assessors involved in assessments arranged under the Disability Act was to help achieve greater consistency across the system nationally with respect to:

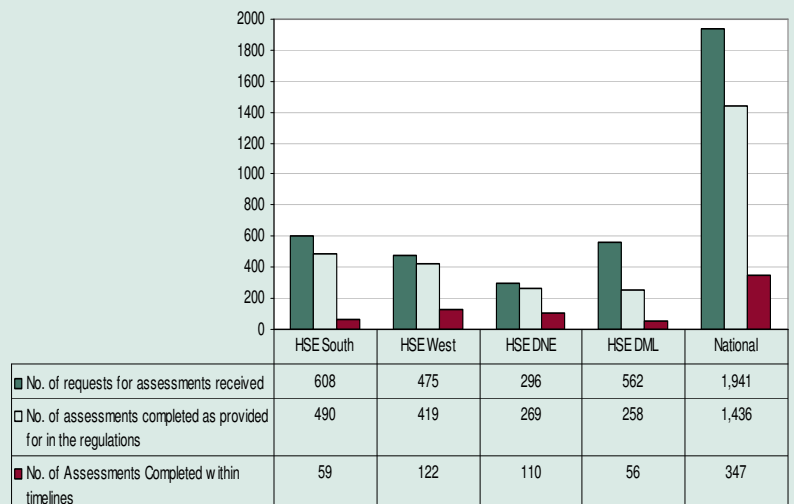
- The interpretation of the terms used in the definition of disability contained in the Act
- The level and depth of assessment required at first referral stage

A particular focus is now being taken by the Management Team on those LHO Areas with the largest number of assessments overdue for completion. This data is highlighted in both the HealthStat reports and at Performance Review Meetings and actions to address the issues involved are identified.

Under 5 Assessments by HSE Area



Under 5 Assessments (overview of 2009)



## Emergency Department Patient level Experience

### Metric Used

Emergency Department Experience: % of people seen in ED based on numbers seen in the 2x2 hour sample daily.

### Rationale

The time interval between onset of symptoms and treatment and/or admission to hospital can impact of the effectiveness of treatment therefore it is important to have an overview of the patient time in ED. The time taken between registration and admission or discharge in ED also influences satisfaction with the service received.

Knowledge of the time experience of people attending ED can be used to plan improvement where necessary. Differences between hospitals also allow examples of good processes and practice to emerge which can be shared across management areas.

### Data Source

ED returns from 14 hospitals (representing 34% of annual ED attendances) collated by the Business Intelligence Unit (BIU) (Acute), HSE

### Period Covered by Data

July – Dec 2009

### Target Information

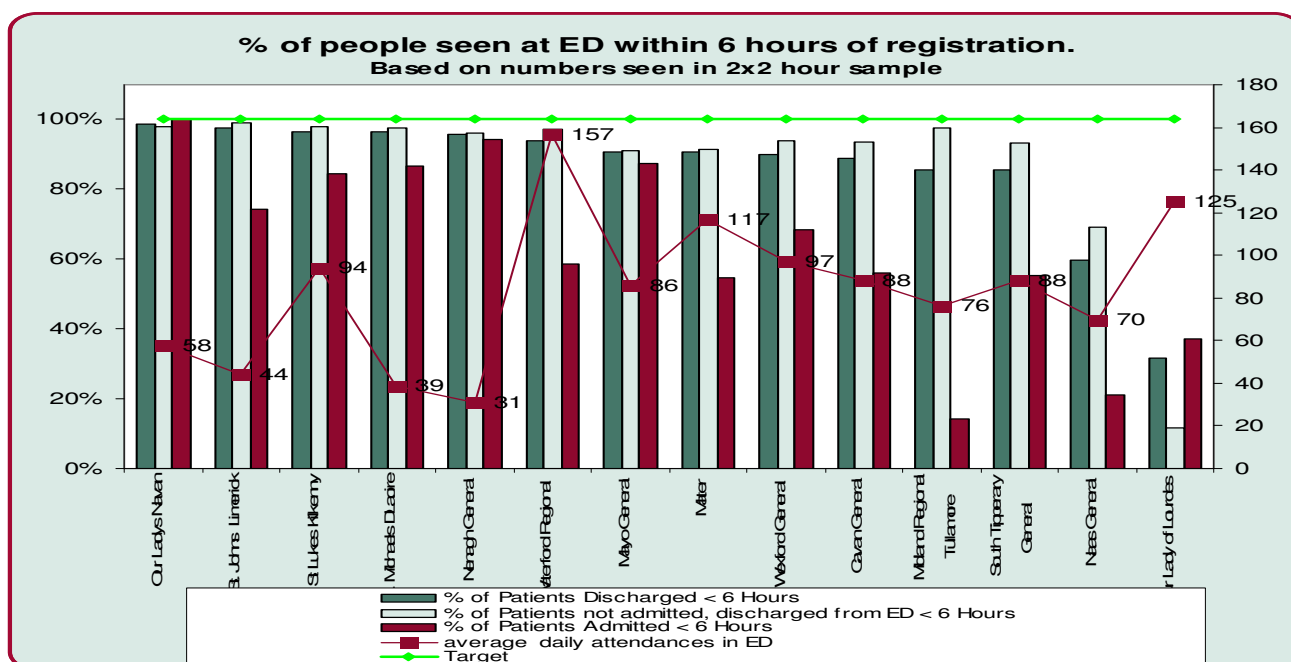
100% of people admitted or discharged within 6 hours of registration NSP 2009 and Medium Term Target

### National Overview

In this sample, drawn from returns from July to Dec 2009, 88% of all attendees were seen within the target of 6 hours. 54% of those admitted were admitted within 6 hours, and 94% of those who were discharged directly from the ED and did not require admission.

### Commentary

The Regional Directors of Operations have the measure timely ED experience as a key performance measure for 2010 and all hospitals have been asked to review their ED processes and practices. An exercise is under way to validate the data used for this measure and it is planned to have a more complete picture by the end of 2010.



## Public / Private Hospital Activity

**Metric Used**

In-patient activity: Public as a % of all patients.

**Rationale**

It is public policy that 80% of all patients treated in public Hospitals would be public patients. This provides equitable access across public hospitals.

**Data Source**

Business Intelligence Unit (Acute), HSE

**Period Covered by Data**

Jan – Dec 2009

**Target Information**

80% public as a % of all patients NSP 2009

**National Overview**

75.5% public patients as a % of all patients

**Commentary**

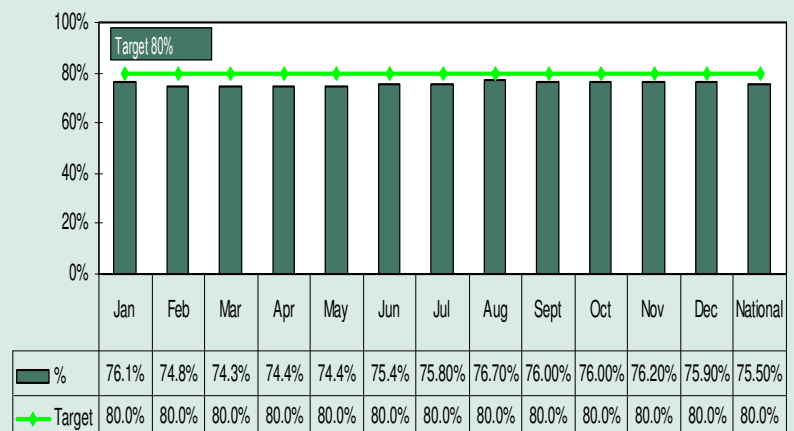
While the percentage of public inpatients treated in the period 2009 is below the NSP target of 80%, the figure compared to last year has improved from 74.1% public (2008) to 75.5% public (2009).

The HSE is working towards the 80% public figure, however the volume of emergency work does limit the ability to reach this target.

It is worth noting that hospitals do not have control over the numbers of patients presenting as an emergency nor can they control their decision on public / private patient status should they be admitted.

The percentage of elective patients has decreased in 2009 compared to the same period last year and this further limits the control on the percentage of public patients.

Public as a % of all patients



# Sustainable Services

## Primary Care Teams

### Metric Used

Primary Care Teams: The number of Primary Care Teams (PCT's) holding clinical team meetings.

### Rationale

PCT's are an inter-disciplinary team-based approach to primary care provision. The introduction of a team-based approach to primary care has advantages for users and providers.

### Data Source

Business Intelligence Unit (BIU), HSE

### Period Covered by Data

Position as of Jan / Dec 2009

### Target Information

210 Teams NSP 2009  
400- 600 Teams by 2011 (Primary Care Strategy)

### National Overview

219 PCT's nationally (Dec 2009)

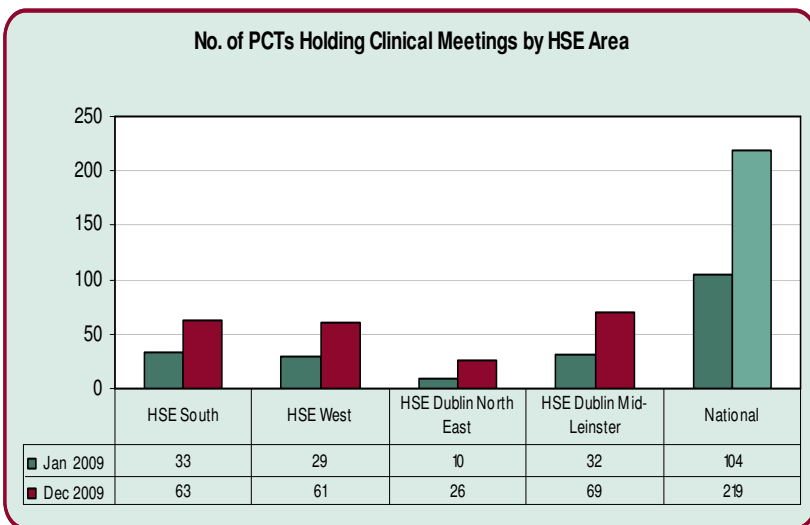
### Commentary

The development of PCTs is a key priority for the HSE where the aim is to facilitate access into, through and out of the system and to ensure that quality care is provided in a way that maximises convenience for clients/patients.

The holding of clinical team meetings by PCTs is crucial to the development and implementation of care plans for specific patients; particularly those with chronic illness and those presenting with multiple conditions.

At present there are 219 PCT's operating across the country (9 above target). The development of PCT's in Louth is aligned with the overall reconfiguration of health services in the area and will be progressed in that context.

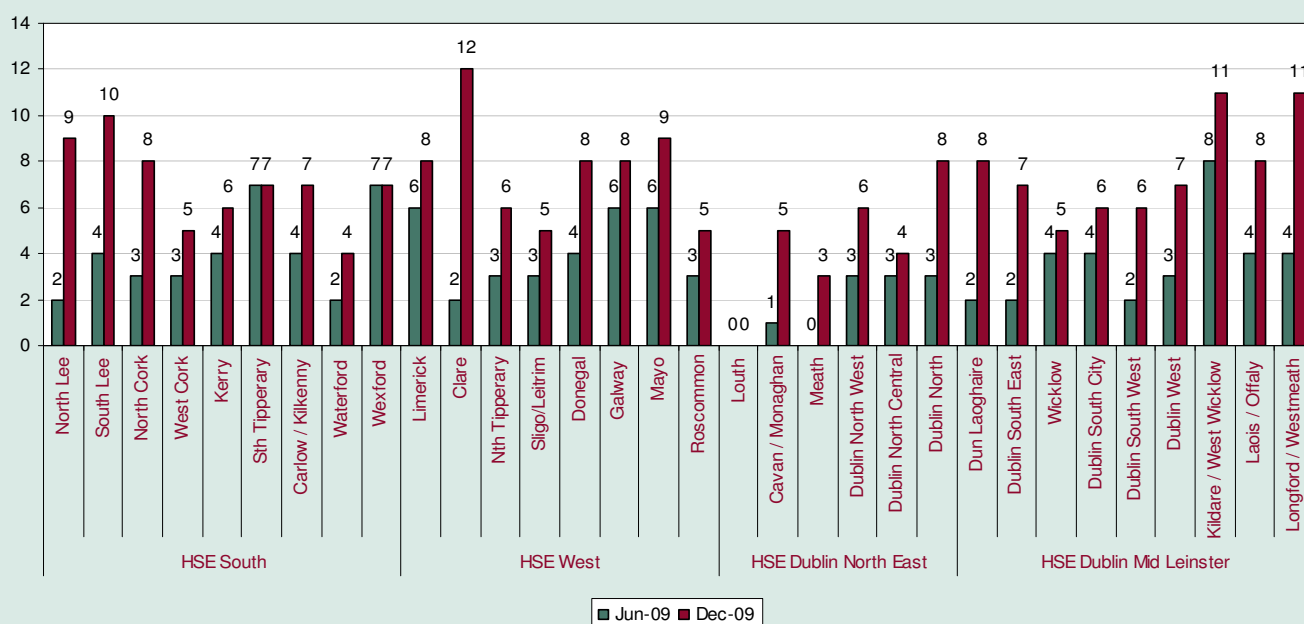
No. of PCTs Holding Clinical Meetings by HSE Area



Population Census 2006

HSE South	1,081,968
HSE West	1,012,413
HSE Dublin North East	928,619
HSE Dublin Mid Leinster	1,216,848

No. of PCTs by LHO holding clinical team meetings



## Residential Care, Older People

**Metric Used**

Residential care for Older People: the % of the population aged 65 years and over and aged 75 years and over in residential care continuing care settings as a % of the total population aged 65 and over and aged 75 and over.

**Note:** Data relates to Older People resident in HSE publicly funded Continuing Care Units and Older People resident in Private Nursing Homes who are in receipt of a HSE subvention.

**Rationale**

The older population have stated that their preference is to remain in their own homes for as long as they can manage to do so. The HSE has reflected this in policy and through investment in community and home care services.

This metric measures the levels of older people in residential care where the aim is that no more than 10% of those aged >75 years and no more than 4% of those aged >65 years should be in residential care.

**Data Source**

Business Intelligence Unit (BIU), Non Acute, HSE

**Period Covered by Data**

Q4 2008 (Data for DML unavailable)

**Target Information**

<10% of the population aged >75 years living in long term Residential Care.

< 4.5% of Older Persons aged >65 years living in long term Residential Care 2009

< 4% Corporate Plan 2008 - 2011

By 2016, no more than 4% of the population aged >65 years living in long term Residential Care (*medium planning target of the Long Term Care Interdepartmental Working Group*).

**National Overview**

8.9% of population aged >75 years in residential care

4.6% of population aged >65 years in residential care

**Commentary**

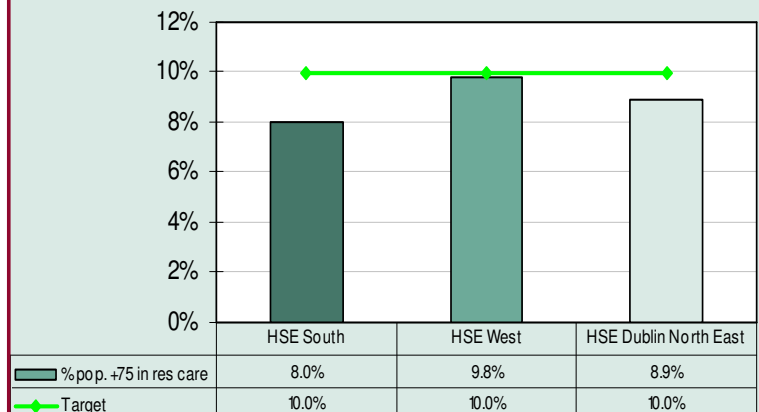
Nationally, the target of no more than 10% of older people aged > 75 years living in residential care is being achieved; while the target of no more than 4% aged >65 is slightly behind target at 4.6%.

Overall, people are living longer and healthier lives. Providing the support which enables older persons with care needs to stay at home for as long as possible can help greatly to improve their situation and it is what the majority of older people want.

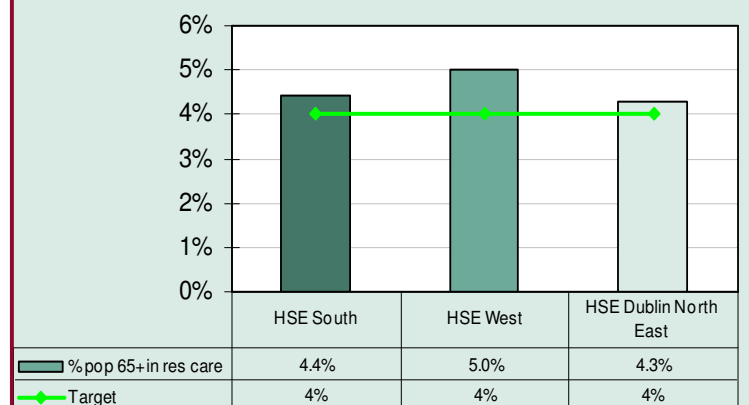
Our ageing population now includes a growing number of the very old (e.g. the 85+ age group has increased by 27% between 2003 and 2008). This presents challenges in terms of service delivery relative to the diminishing number of carers, changes in family structures and increasing loneliness as a result of social isolation.

By 2030, the average life expectancy at birth will be 81.5 years for men and 86 years for women. The challenge is to improve the mix and availability of services that enable a larger number of older persons to stay in their homes in proximity to neighbours and friends.

In addition, the implementation of 'A Fair Deal' will have an impact on the proportion of older people in residential care in the future.

**% of population 75+ in Residential Care**

\*Data for DML unavailable

**% of population aged 65 years + in Residential Care**

## Home Help Hours

### Metric Used

Home Help Hours: Home Help Hours per capita 10,000 population (aged >65 years).

### Rationale

Home Help provision is designed to maintain clients in their own home for as long as possible. Providing the support which enables an older person with care needs to stay at home can help greatly to improve their situation.

In addition, home help provision supports the acute hospital system through hospital avoidance and in facilitating timely discharge.

Equitable access to such provision across the 75 year plus age group also contributes to reducing the overall proportion of older persons who require full time residential care by supporting people to live at home for as long as possible. This is recognised best practice internationally.

### Data Source

Business Intelligence Unit (BIU), Non Acute, HSE

### Period Covered by Data

Position as of June 2009

### Target Information

Peer comparison; aim to have equity of access within available resources.

### National Overview

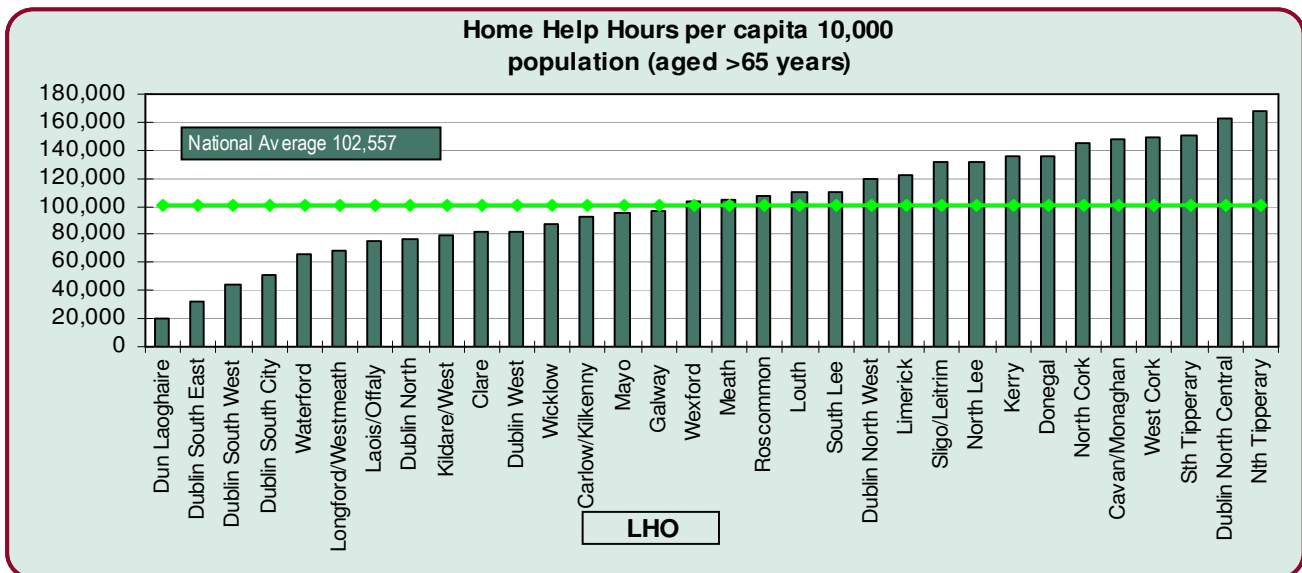
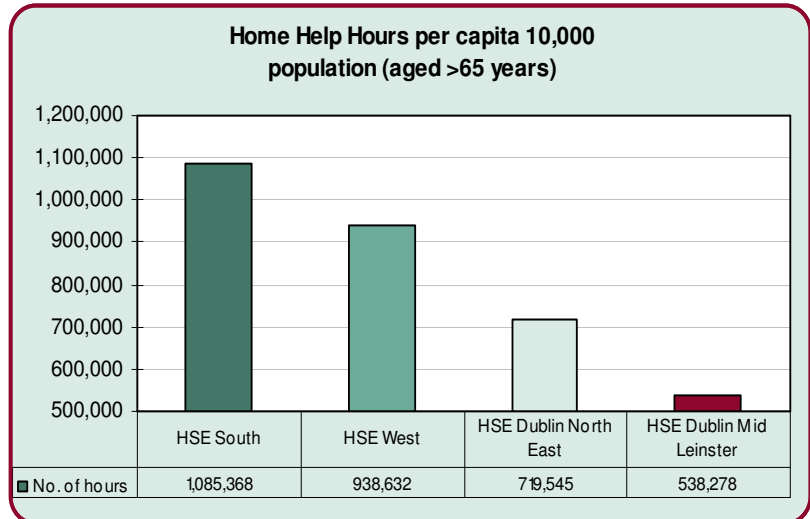
102,557 average provision of Home Help Hours per capita 10,000 population aged >65 years per LHO Area.

### Commentary

There is wide variation in the number of home help hours provided across LHOs (ranges from 19,820 in Dun Laoghaire to 167,459 in North Tipperary). There are a number of possible reasons for this variation; including differences in the old age dependency ratio (those aged 65 years and over as a percentage of those aged 15-64), variation in levels of affluence / deprivation, and variations in the levels of community versus acute hospital supports available historically.

North Tipperary, for example has an old age dependency ratio of 14.3% compared to 10.2% in Dublin South West and 10.6% in Dublin East. While Dun Laoghaire has a dependency ratio of 13.5%, this LHO is located in a more affluent area. Provision of home care packages have also strategically targeted those LHOs experiencing most difficulties in relation to Emergency Department attendance and delayed discharges (namely DML and DNE). Therefore, the provision of home help should be seen in the context of the broader provision of community supports for older people.

A review of home help hours is underway to standardise Home Help agreements. This will assist in implementing a standardised approach for home help hour allocation.



## Palliative Care Beds

**Metric Used**  
 Palliative Care: The number of specialist palliative care beds per 100,000 population.

**Rationale**  
 Palliative care is aimed at providing compassionate and holistic care (physical, spiritual, social and emotional support) to terminally ill individuals, their families and significant others when the focus is on comfort rather than on cure, or prolongation of life.

**Data Source**  
 Palliative Care Baseline Study (2006) and based on the output of the HSE Audit (2007) by each Administrative Area. 2007 Audit prepared by Prospectus Consultants.

**Note:** Data does not include beds in acute services.

**Period Covered by Data**  
 Data is covering the period from the baseline study in 2006 to present (2009).

**Target Information**  
 Monitoring is ongoing during 2009 with a view to target setting for 2010.

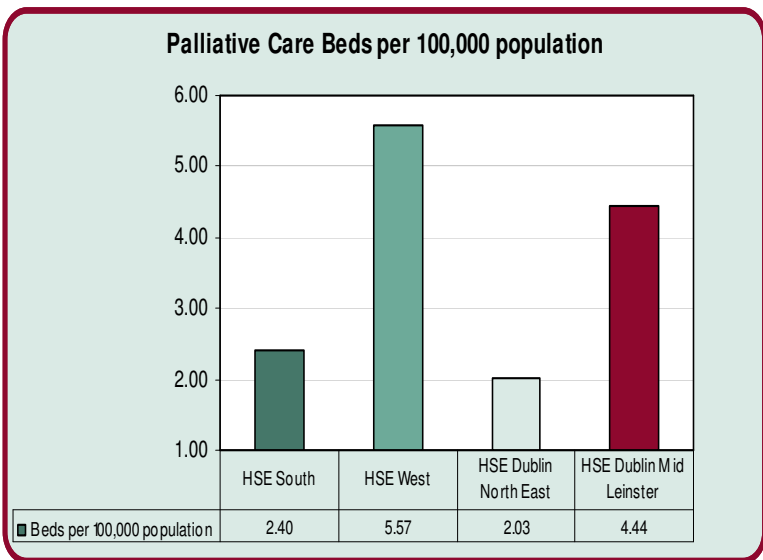
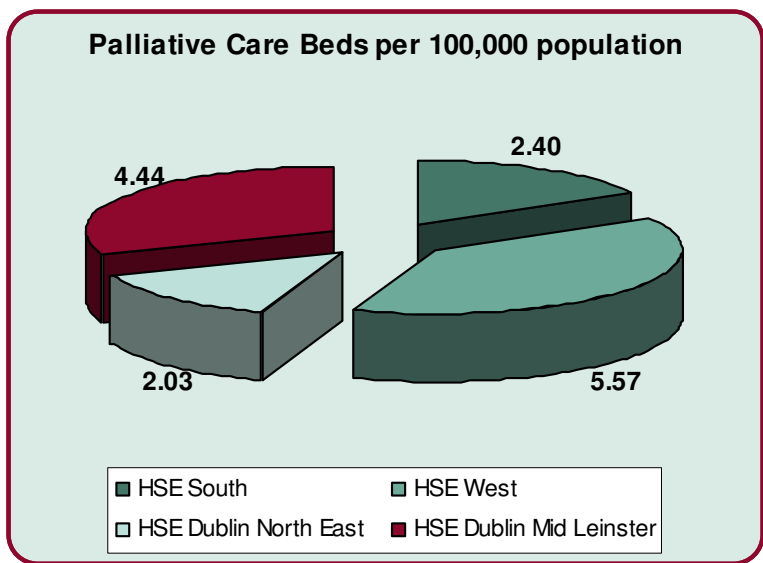
**National Overview**  
 3.7 beds per 100,000 population nationally

**Commentary**  
 There is wide regional and intra-regional variation in the availability of specialist inpatient beds. This variation is noted in the National Developmental Framework for Palliative Care Services and the priority deficits for immediate action are documented.

The national priorities reflect the gaps that currently exist in particular areas and services and the prioritisation reflects the largest gaps. A total of 41 national priorities have been agreed for inclusion in the 2009-2013 Development Framework, six of which relate to specialist inpatient units.

Specialist inpatient unit deficits in Laois/ Offaly, Longford / Westmeath, Kildare / West Wicklow, St. Francis Hospice, Raheny, Donegal, Limerick and Our Lady's Hospice & Blackrock are included in this plan with 203 specialist inpatient beds identified for development at a revenue cost of €6.956m.

It is acknowledged that work is required to refine a robust minimum dataset for existing levels of services nationally.



## Children in Residential Care

**Metric Used**

Children in residential care: No and % of children in Residential Care as a % of all children in care

**Rationale**

Monitoring of the placement of children is critical in order to ensure appropriate placement and appropriate use of resources. Where possible and appropriate, the HSE strives to place children in need of care with foster parents.

**Data Source**

Performance Report (Nov 2009)  
Business Intelligence Unit (BIU), HSE

**Period Covered by Data**

Position as at November 2009

**Target Information**

8% NSP 2009  
5% Medium Term Target

**National Overview**

388 (6.8%) children in Residential Care (Nov 2009).

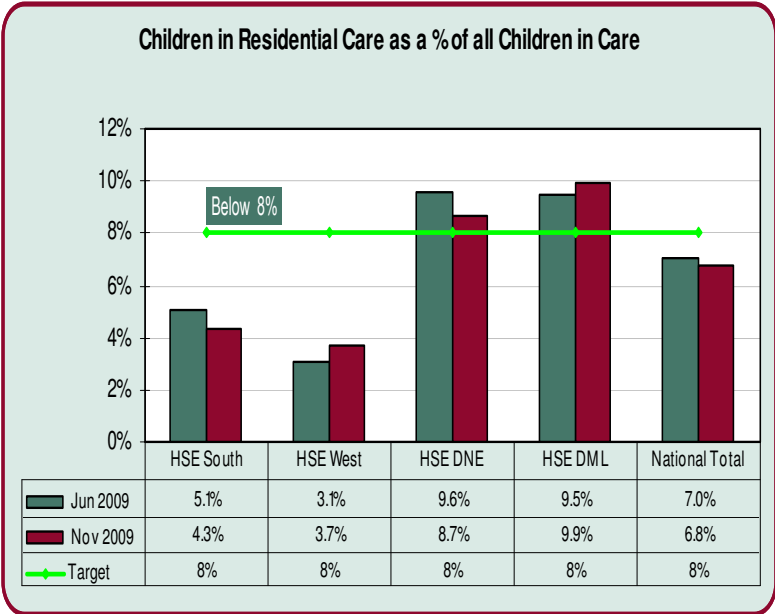
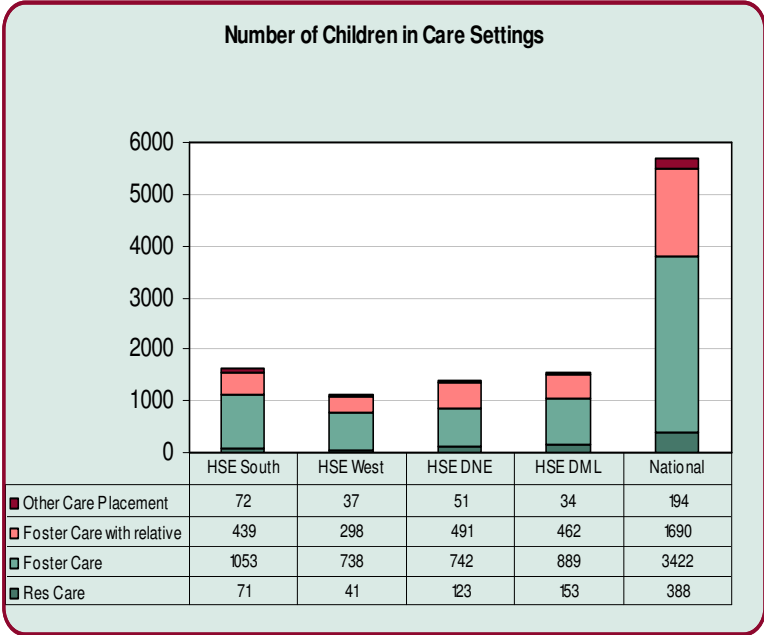
**Commentary**

In June 2009 there were 5,646 children in care across the various care placement types (an increase of 380 children or 7.2% on June 2008). Of this total, 397 children were in residential care (7% of the national total).

Variation in the number of the children in residential care should be seen in the context of the overall increase in the number of children in care. The numbers in residential care has remained largely static since 2008 while numbers in foster care have grown.

The urban character of DML and DNE accounts for some of this variation, not least due to the number of areas where there is a higher social deprivation index.

Comparing this year with 2008, there has been an increase (8%) in the number of children in foster care. A number of high profile fostering campaigns took place during 2008 which has favourably contributed to this increase. The aim of the HSE is to ensure, in so far as possible, that children are placed in a safe home environment.



## Care Planning for Children

### Metric Used

Children care planning: No. and % of children in care who currently have a written care plan as defined by Child Care Regulations

### Rationale

Care planning is seen as a vital element of the quality provision of services to children in care. A care plan should set out the framework for the case management of the child in care highlighting the goals to be achieved and the desired outcomes for the best interest of the child.

The objective of this measure is to ensure compliance with the Child Care regulations 1995 and to ensure a coordinated approach to supporting the development of children in care.

### Data Source

Performance Report (PR) Nov 2009  
Business Intelligence Unit (Non Acute), HSE

### Period Covered by Data

Position as of Q3 2009.

### Target Information

82% NSP 2009  
100% medium term target

Ryan Report - all children in care to have a written care plan.

### National Overview

4779 of 5,639 Children in Care (84.7%) had a written care plan (Q3 2009).

### Commentary

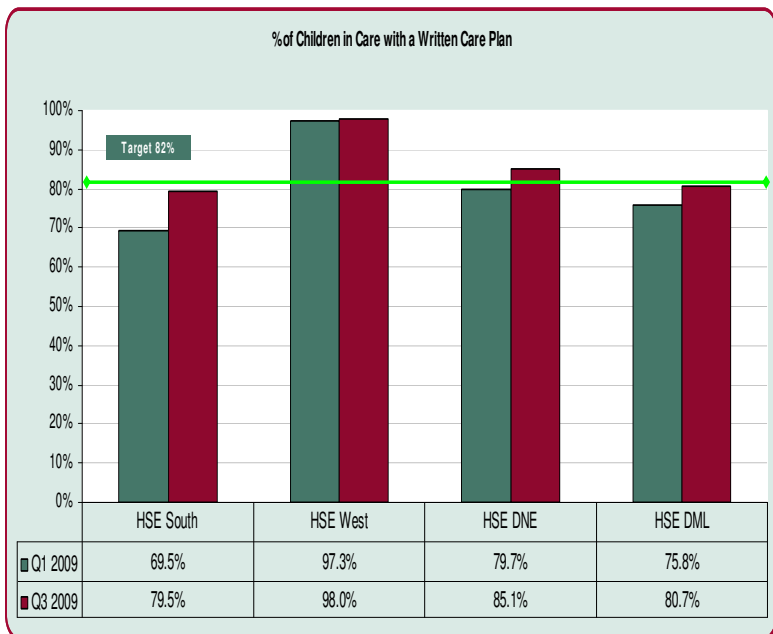
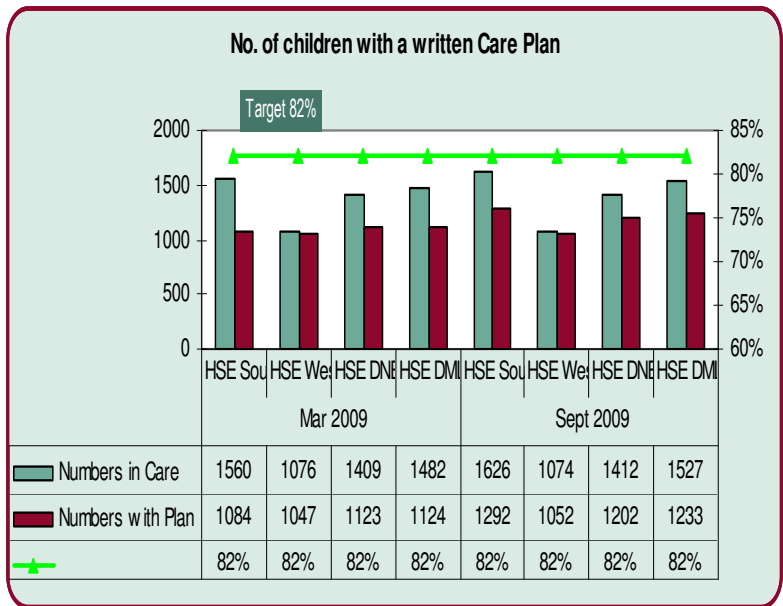
At the end of Q1 2009 79.2% of children in HSE care had a written care plan compared to a HSE target of 82%. While the graph shows considerable divergence across HSE Areas, this variation has narrowed significantly since Q4 2008 (64%).

DML in particular has shown significant improvement increasing from 39.8% in Q4 2008 to 80.7% in Q3 2009.

Similarly, DNE has improved performance from 60% in Q4 2008 to 85.1% in Q3 2009.

The HSE has committed to improve on performance in 2010 to achieve 90% at national level based on:

- Ryan Report implementation plan to ensure all children in care have a written care plan (work to achieve 100% by the end of 2010).
- Impact of social work recruitment.
- Impact of implementation of standardised care plan and
- Guidance documentation.



## Average Length of Stay

**Metric Used**  
In-patient activity: ALOS for all inpatient discharges and deaths

**Rationale**  
It is recognised that it is possible to provide a safe, quality service and at the same time meet targets around average length of stay as set up by peer and international review. This maximises the efficiencies in the system and supports better access to services.

**Data Source**  
Performance (PR) Dec 2009  
Business Intelligence Unit (Acute), HSE

**Period Covered by Data**  
2008 – Dec 2009

**Target Information**  
5.9 days NSP 2009  
5.6 Medium Term Target

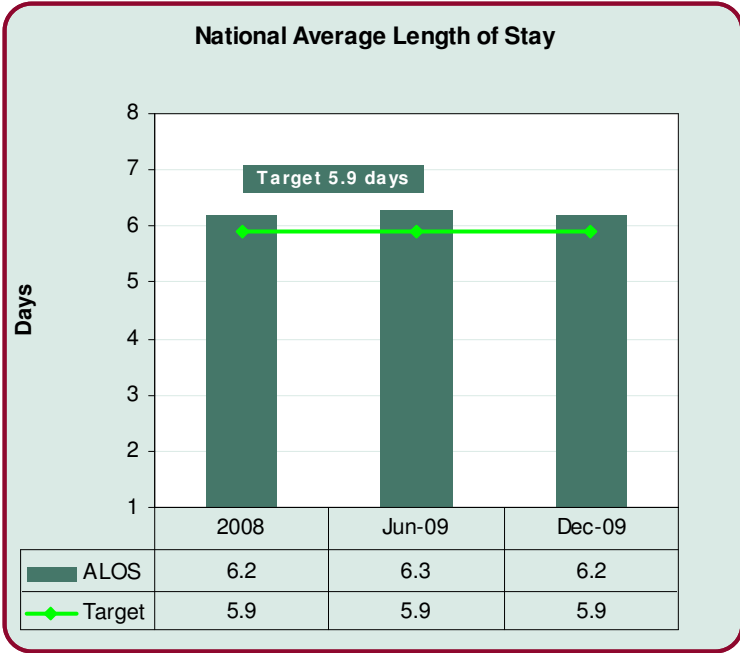
**National Overview**  
6.2 days (Dec 2009)

**Commentary**  
This is a crude overview of the current ALOS position in Irish hospitals. The data is not casemix adjusted but is adjusted for delayed discharges. A more comprehensive analysis would factor in complexity and age profile of hospitals' patients.

A customised, target ALOS has been set for each hospital. Variances against the target are then calculated through the HIPE system. The HSE is actively engaged in a comprehensive programme to reduce lengths of stay in hospital through:

- Greater emphasis on discharge planning
- Appropriate admission days (bringing patients into hospital on the day of their surgery)

In recent Service Plans, the NHO has strived to carry out relatively minor procedures on a day case basis as opposed to admitting the patient. By moving these patients to daycase there would be a slight upward shift in the ALOS as the more complex in patient procedures require longer stays.



## Inpatient / Day Case Ratios

**Metric Used**

Inpatient/Day Case Ratio: Day cases as a % of all acute discharges.

**Rationale**

Managing treatment on a day case basis, where appropriate, can provide a more customer friendly and cost effective service. It can also reduce the risk of hospital acquired infection and improve the quality of the service provided. NSP 2009 targeted a shift from inpatient discharges to day cases for elective inpatients with a short average length of stay.

**Data Source**

Performance Report (Dec 2009)  
Business Intelligence Unit (Acute), BIU

**Period Covered by Data**

Jan – Dec 2009

**Target Information**

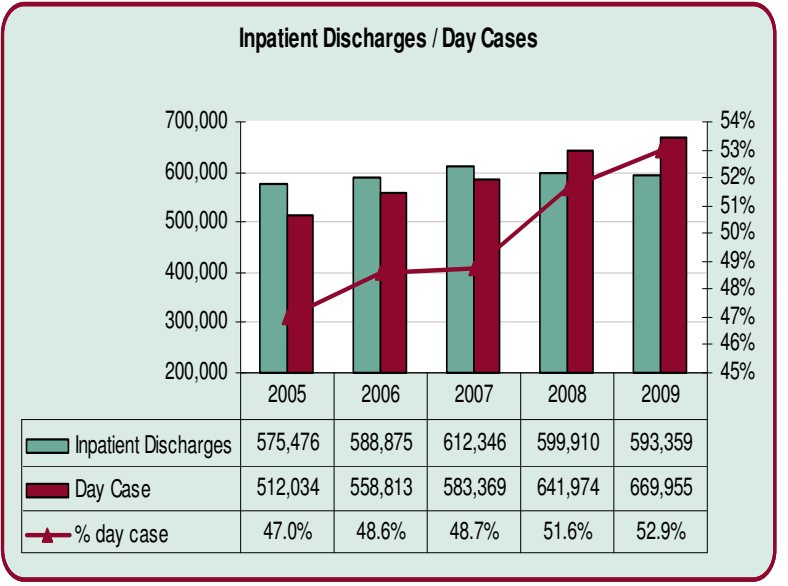
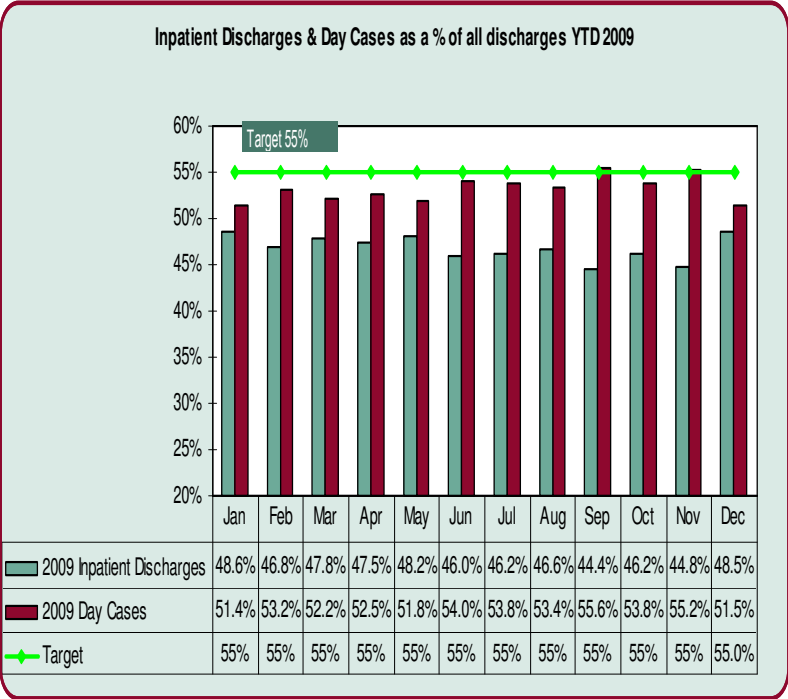
55% NSP 2009 all activity  
75% Medium Term Target for a specified basket of procedures

**National Overview**

53.8% average day case % July – Dec 2009  
52.9% average day case % Jan – Dec 2009

**Commentary**

The volume of Inpatients and Day Cases combined has increased compared to 2008 (1.7%). This increase has been solely in day cases with an actual reduction in the number of inpatient discharges in 2009. The ratio of day cases has increased from 51.6% in 2008 to 52.9% in 2009.



## Appropriate Use of Beds

### Metric Used

Appropriate use of acute beds: % of inappropriate placements in an acute bed on day of care and % of inappropriate admissions into an acute bed relative to AEP (Appropriate Evaluation Protocol)

### Rationale

It is HSE policy to treat patients in the most appropriate setting in which they can receive safe quality care. Information on appropriateness of admission, and placement in an acute bed at a point in time, supports a planned approach providing alternative access to treatment which would meet patients needs within an acute admission or allow them to be discharged earlier.

### Data Source

Acute Hospital Bed review 2007 (based on a sample of 3,035 patients 36% sample rate in 37 hospitals).

### Period Covered by Data

November 2006 – February 2007

### Target Information

Day of Care: 30% NSP 2009  
Day of Admission: 10% NSP 2009

### National Overview

Day of Care: 39% of those surveyed were outside the AEP for day of care and could potentially have been cared for in an alternative environment.

Day of Admission: 13% of patients were found to be outside the AEP and could potentially have been treated outside an acute setting.

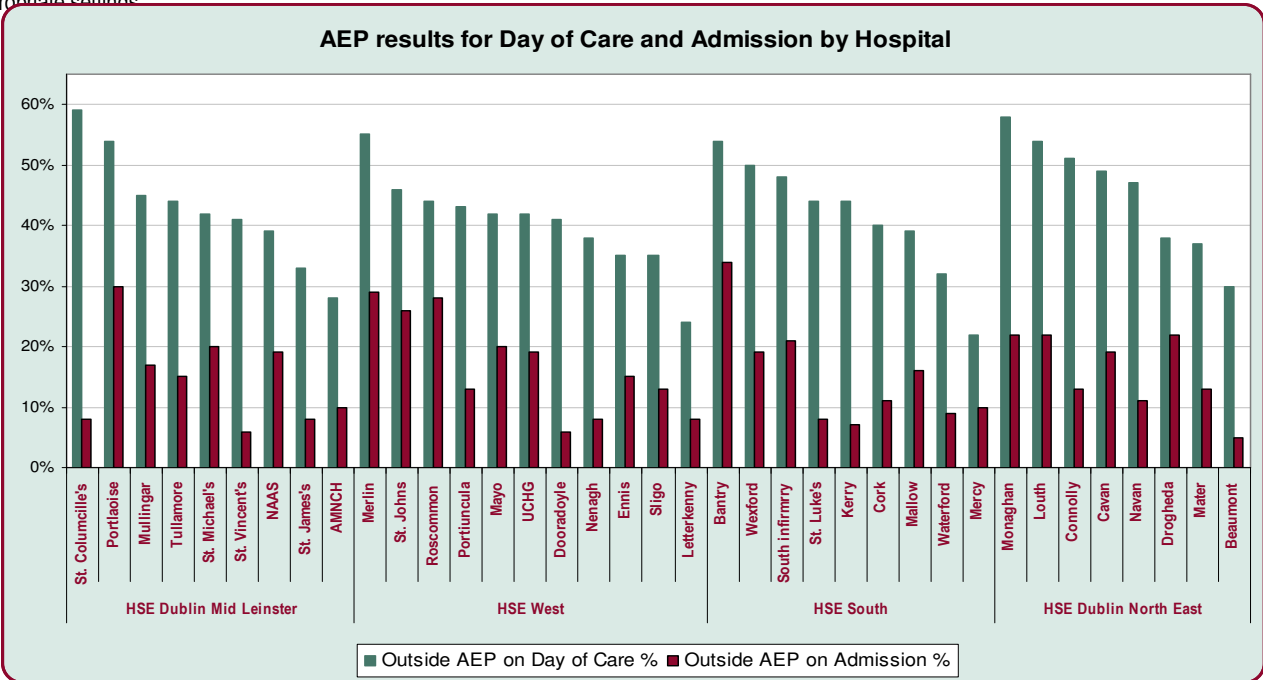
### Commentary

There were variations across regions and across hospitals within regions. 31% of those admitted for elective surgery were admitted earlier than was necessary or the elective surgery could have taken place in a non-acute setting.

The factors found to influence both appropriateness of admission and appropriate placement in an acute bed at a point in time included:

- access to assessment/diagnostics;
- access to community based services including therapy,
- specialist nursing and
- home care support.

Planned activity in the 2010 service plan aims to decrease the level of inpatient admission and increase the level of day case and treatment in other appropriate settings.



# Quality & Safety

## Caesarean Section

### Metric Used

Caesarean sections: The number and % of births delivered by Caesarean Section.

### Rationale

International studies have shown that caesarean sections pose increased risks for mother and baby with the consensus highlighting the preference for spontaneous vaginal birth.

### Data Source

Performance Report (Dec 2009)  
Business Intelligence Unit (Acute), HSE

### Period Covered by Data

Jan – Dec 2009

### Target Information

20% NSP 2009  
15% World Health Organisation (WHO) / HSE Medium Term Target

### National Overview

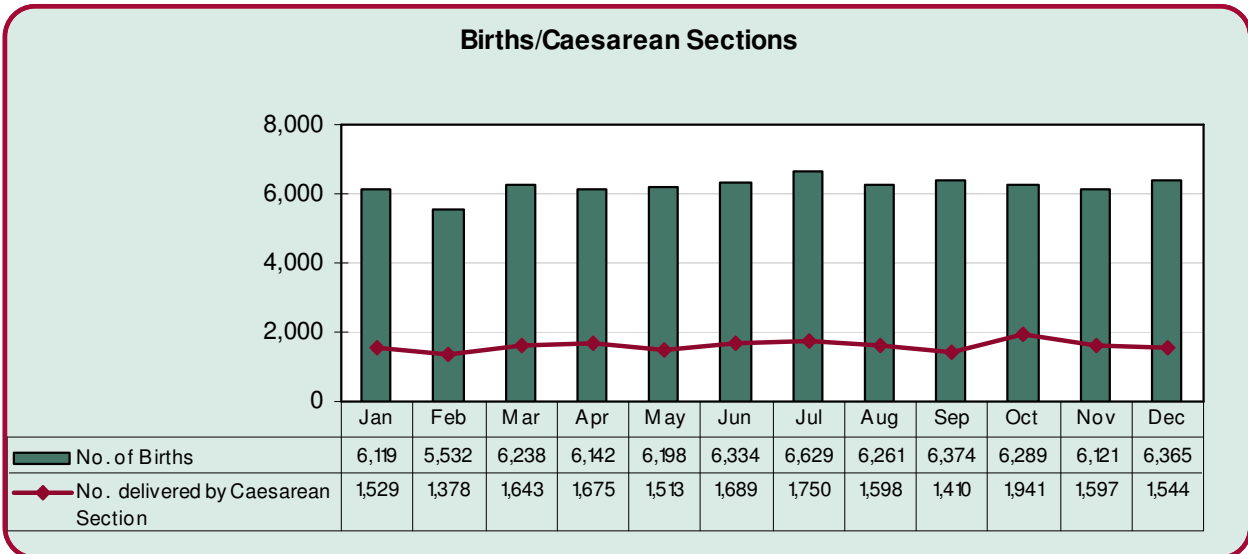
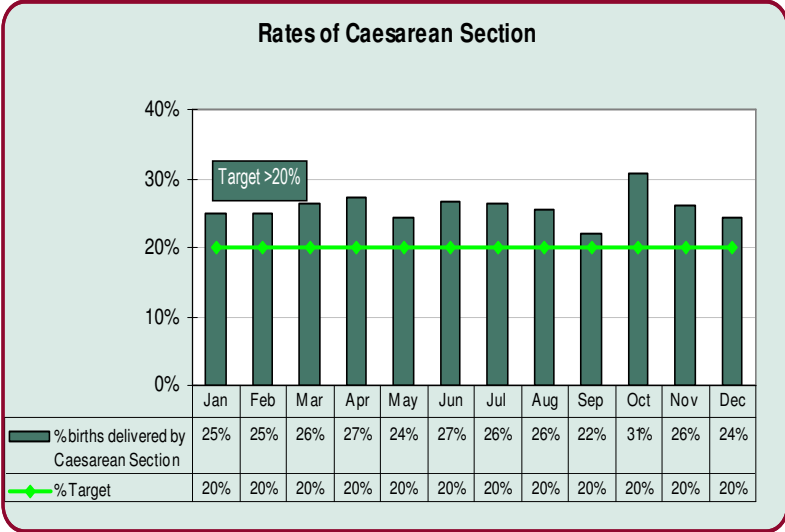
25.8% of births delivered by Caesarian Section, average July - Dec

### Commentary

The number of births registered in 2008 was the highest since the end of the 19th century (CSO). In addition, Ireland has the highest birth rate of any EU country (ESRI). The National Perinatal Reporting System (NPRS) gathers information on approximately 65,000 birth records every year from 22 hospitals and 20 independent midwives. The rate of delivery by caesarean section has been steadily increasing since 1993 (13%), 1999 (20.5%), 2002 (22%), 2006 (25.5%). Currently (Dec 2009) the average rate of babies delivered by Caesarean section in Ireland stands at 24.3%.

An examination of caesarean section rates across Europe highlights an increase in the number of caesarean sections in all European countries. The rates of caesarean sections in Ireland are currently around the average for OECD countries however; the rates of rise in caesarean sections are amongst the highest in Europe.

An analysis of caesarean sections in Ireland has been the subject of discussion between the office of the Chief Medical Officer (CMO) and the Institute of Obstetricians and Gynaecologists and will be the focus of ongoing monitoring, review and action.



## Cancer Survival Rates

### Metric Used

Cancer survival: 5 year survival for major cancer types: age standardised for Colorectal, Lung, Breast, Prostate.

### Rationale

Cancer survival rates reflect the underlying effectiveness of screening, diagnosis and effective treatment. The five year rates allow us to compare performance against appropriate comparators.

### Data Source

National Cancer Registry Ireland  
www.NCRI.ie

### Period Covered by Data

1994 - 2004 diagnoses follow up to end of 2005.

### Target Information

European average performance as listed in Patterns of care and survival of cancer patients in Ireland 1994- 2004

- Colorectal (56.2%)
- Lung (10.9%)
- Female Breast (79%)
- Prostate (77.5%)

### National Overview

- Colorectal 53.2%
- Lung 10.6%
- Female Breast 76.9%
- Prostate 82.9%

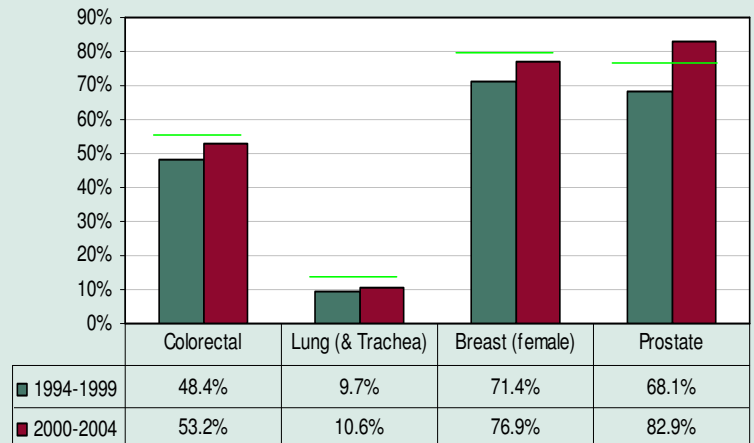
### Commentary

Significant improvements were seen in the five-year relative survival of patients with colorectal, lung, prostate and female breast cancer in this time period.

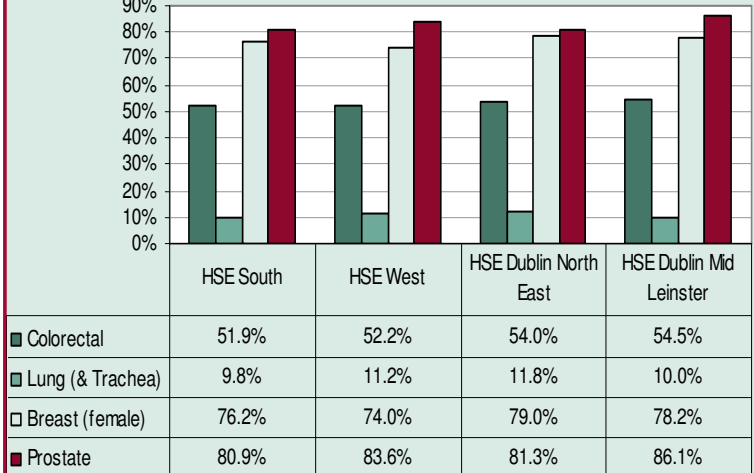
The NCCP has endeavoured to address the issue of survival rates through the prioritisation of specialist consultant delivered high volume surgery for a number of cancers combined with standards for access to diagnostics, surgery and treatment.

2010 will see the development of Rapid Access Diagnostic Clinics in established specialist centres (Lung and Prostate).

Five year survival rate by diagnosis cohort



Age standardised 5 year relative cancer survival 2000-2004 by HSE region



## Symptomatic Breast Cancer Services

### Metric Used

Symptomatic Breast Cancer Services:  
 % of cases compliant with HIQA standard of 2 weeks for urgent Referrals.  
 % of women seen within 12 weeks of referral.

### Rationale

The National Cancer Control Programme (NCCP) set out to achieve 90% of all breast cancers treated within the eight designated cancer centres, with Letterkenny as a special arrangement linked to Galway.

The aim for referred breast patients to the symptomatic service is to comply with the HIQA sanctioned standards:

- Urgent – seen with 2 weeks
- Soon – seen within 6 weeks
- Non symptomatic – seen within 12 weeks.
- HIQA requirement – 95% compliance.

New and transferred resources, together with capital investment allocated by NCCP to an equitable level was 100% fully transferred by year end 2009.

### Data Source

Performance Report (Dec 2009)  
 National Cancer Control Programme (NCCP).

### Period Covered by Data

June v Dec 2009

### Target Information

95% NSP 2009  
 95% Corporate Plan

### National Overview

98% Cases complaint with HIQA Standard of 2 weeks for Urgent Referrals (Dec PR)

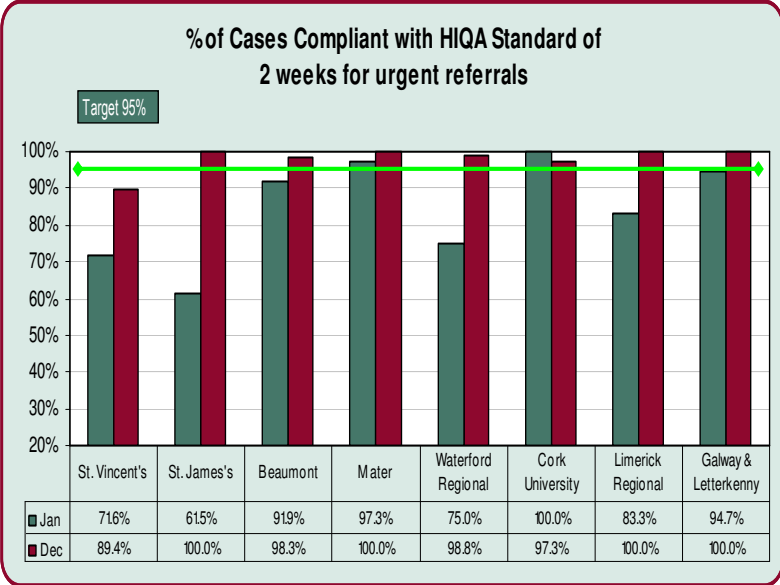
95% Women seen within 12 weeks (Dec PR)

### Commentary

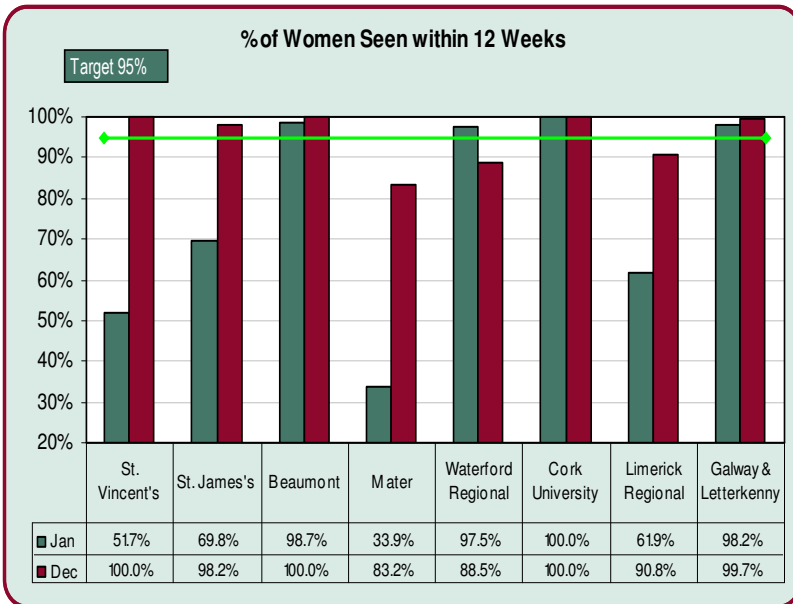
During 2009 symptomatic breast diagnosis and surgery transferred into 8 cancer centres. Investment in these centres and amalgamation of services has provided the opportunity to improve access to breast services for urgent symptomatic breast disease.

The priority during 2009 was the urgent target of 2 weeks and provision of an improved service for non symptomatic patients referred (target 12 weeks), with the aim of 95% compliance for both standards by year end.

A number of consultant appointments are still in the process of being filled.



**Note:** Mater Hospital anomaly for June 2009 in graph – This unit was essentially closed for a period of 8 weeks due to a capital development which has doubled the imaging capacity. Urgent patients were referred to other centres during this period. Extra clinics were established to address any waiting list for non urgent patients.



## MRSA (Methicillin Resistant Staphylococcus Aureus)

**Metric Used**  
 MRSA: MRSA blood stream infections as a % of all *Staphylococcus aureus* (*S. Aureus*) infection in hospital.

**Rationale**  
 The HSE is committed to ensuring that infection control is an integral part of clinical and corporate governance within every healthcare institution in Ireland

**Data Source**  
 Health Protection Surveillance Centre (HPSC)  
[www.HPSC.ie](http://www.HPSC.ie)

"Say no to Infection": healthcare-associated infection and antimicrobial resistance: a national strategy (2007)

**Period Covered by Data**  
 1999 – Q3 2009

**Target Information**  
 To reduce MRSA infections by 30% from 2007 rates. In 2007 the rate was 37.5%. A reduction of 30% would give a target of 26.25% for the Corporate Plan report.

20% (Medium Term Target, European Health Index)

**National Overview**  
 28% MRSA blood stream infections as a % of all *Staphylococcus aureus* (*S. Aureus*) infection in hospital (Q3 2009)

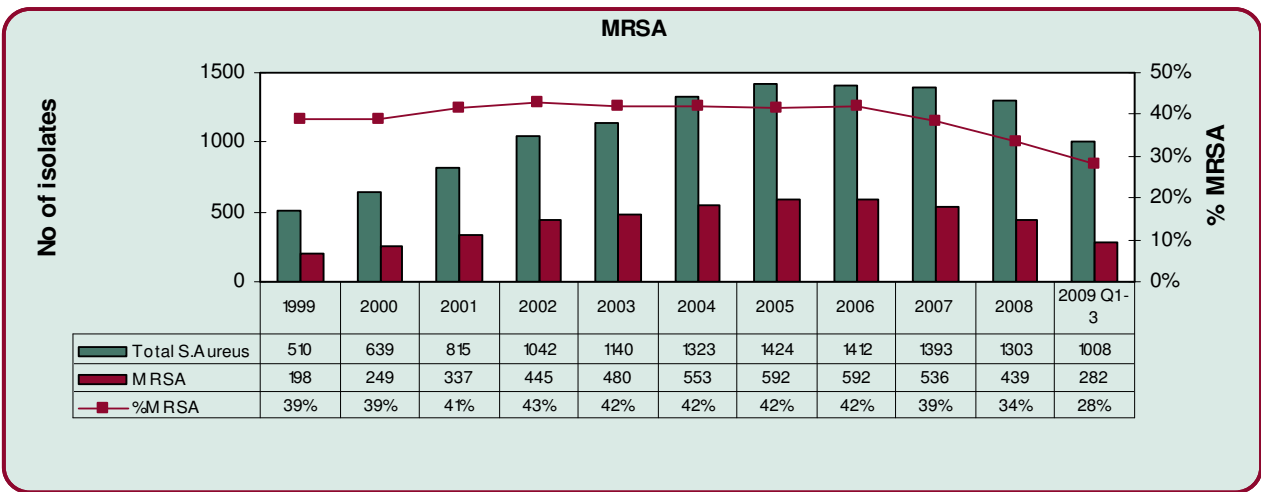
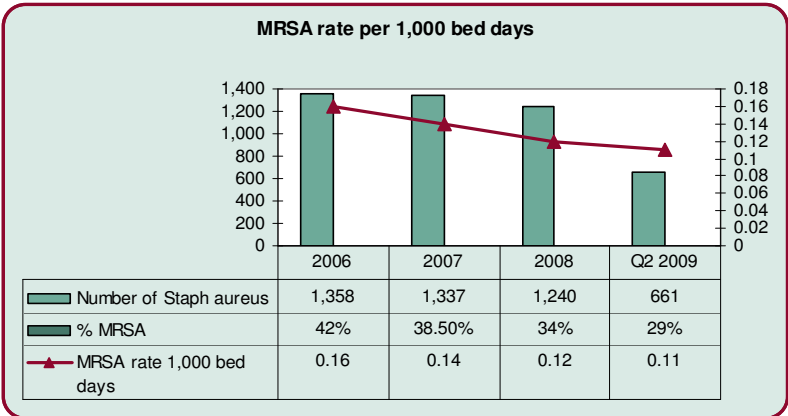
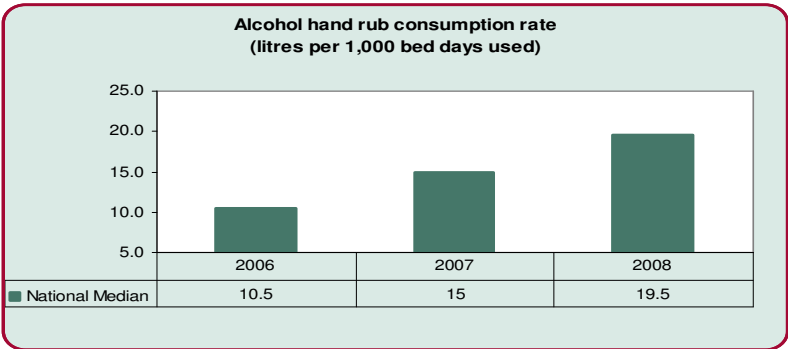
**Commentary**

There has been a significant decrease in the rate of MRSA bloodstream infection. Initial analysis suggests this is at least partially due to interventions directed specifically at MRSA (such as improvements in hand hygiene, laboratory detection and improved implementation of isolation precautions in hospitals).

There has been a reduction in hospital antibiotic use (2007 – 2008), with an associated reduction in direct drug costs (at least €1 million), which has been facilitated by the appointment of additional medical microbiologists and antibiotic pharmacists. The reduction in antibiotic use has probably contributed to the reduction in MRSA, and also to the recent reduction in reported cases of *Clostridium difficile* infections.

Bloodstream infections caused by other antimicrobial resistant bacteria, such as *E. coli* and enterococci ("VRE"), continue to increase. Ireland now has one of the highest levels of VRE in Europe. Implementation of the HSE's Health Care Acquired Infections (HCAI) strategy, and the Strategy for the Control of Antimicrobial Resistance in Ireland (SARI), are essential to counteract this threat to patient safety. In order to evaluate the impact of hand hygiene practices on HCAI rates it is important to monitor hand hygiene compliance by health care workers to determine if this intervention is effective in reducing infection rates. Measurement of consumption of alcohol hand rub represents one method recommended by both the WHO and the Centres for Disease Control and Prevention to monitor hand hygiene compliance. While a number of caveats exist that need to be taken into account when interpreting this data, a correlation between consumption of alcohol hand rub in an institution and the frequency of hand hygiene has been demonstrated.

The level of penicillin resistance among strains of *Streptococcus pneumoniae* ("pneumococcus") has increased alarmingly, and is mainly related to the high level of antibiotic use outside of hospitals in Ireland. Implementation of the hospital and GP prudent antibiotic education programme, and public education on prudent antibiotic use, are required to address this threat.



## Complaints

**Metric Used**  
Complaints: The number and % of complaints dealt with within 30 working days.

**Rationale**  
Providing a prompt response to complaints received leads to earlier satisfaction and quality improvement measures. It emphasises that complaints are taken seriously and promotes better user confidence. Lessons learned from complaints can be fed back into the system.

**Data Source**  
Consumer Affairs, HSE

**Period Covered by Data**  
2008 - 2009

**Target Information**  
95% dealt with within 30 working days.

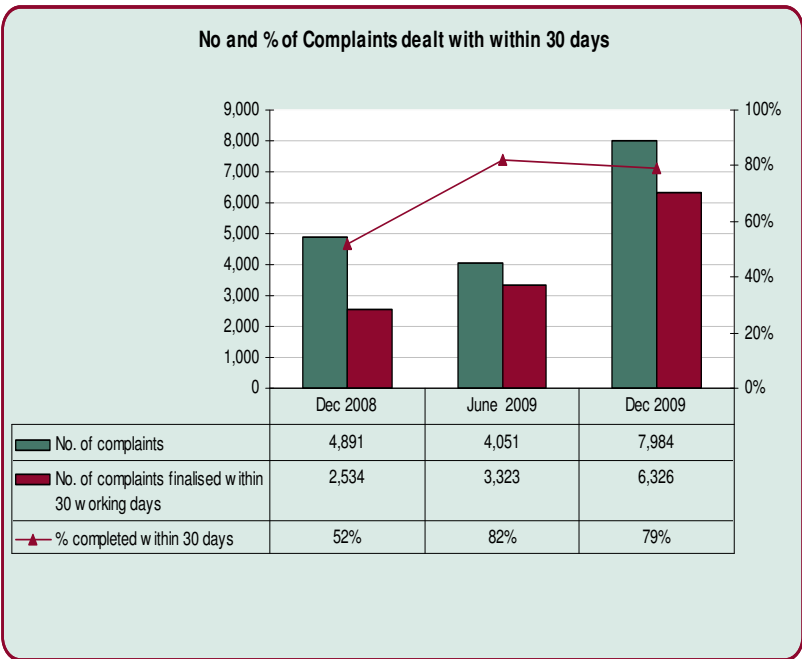
**National Overview**  
79.2% of complaints were dealt with within 30 working days

**Commentary**  
The reason for the increase in the number of complaints received in 2008 v 2009 is due to improvements in the reporting of 'Complaints Resolved Informally'.

Complex cases may remain open over a more than one reporting period due to their very nature. Some cases may remain open pending communication from the complainant – whether they wish to proceed, if they wish to take up the offer of a meeting.

Some complaints may remain open if meetings are organised with a number of people and scheduling the meeting(s) within the 30 day timeframe is not possible.

Patterns and types of complaints are kept under review and analysis and lessons learned are fed back to the services



## Parliamentary Questions (PQ's)

**Metric Used**

Parliamentary Questions (PQs): no. and % responded to within required timeframe.

**Rationale**

The role of HSE Central Parliamentary Affairs Division (PAD) is to manage the interface between the HSE, Department of Health and Children and the Oireachtas by organising, developing and monitoring the efficient conduct of all parliamentary affairs as they relate to the HSE.

**Data Source**

Parliamentary Affairs Division (PAD), HSE

**Period Covered by Data**

2008 - 2009

**Target Information**

75% response rate within 15 working days.

**National Overview**

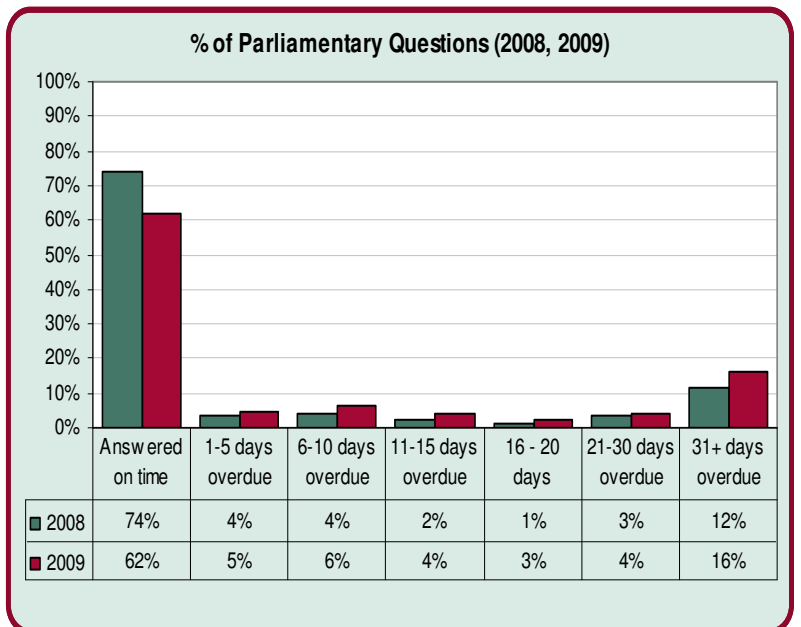
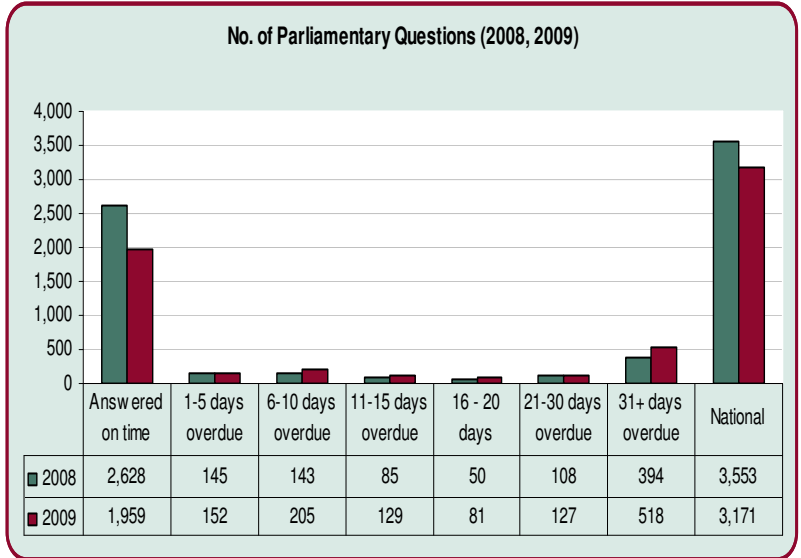
62% PQs answered within 15 working days (Dec 2009)  
3,171 Total number of PQs handled (Jan - Dec 2009).

**Commentary**

The HSE Service Plan 2009 set a target of 75% response rate for parliamentary questions within a 15 working day timeframe.

The Parliamentary Affairs Division are continuing to plan more Efficient and effective ways of doing business.

A national ICT system is being developed which will add to the efficiency in managing and replying to PQs. It is hoped that the system will be in place (subject to full testing, a pilot scheme and staff training) during the first half of 2010.



### Satisfaction Rates

**Metric Used**

Consumer Satisfaction: The rating of quality of care by HSE Area for GP, Community, Inpatient and Outpatient services.

**Rationale**

Consumer satisfaction information provides the views and attitudes of the general public and feedback from those who have experience of health services. This information help the HSE to plan services which are more consumer friendly.

**Data Source**

Insight 07; Health and Social Services in Ireland - a survey of consumer satisfaction

**Period Covered by Data**

November 2006 – March 2007

**Target Information**

95% of people would consider their experience good, very good or excellent

**National Overview**

86.3% rate the quality of care as good, very good or excellent.

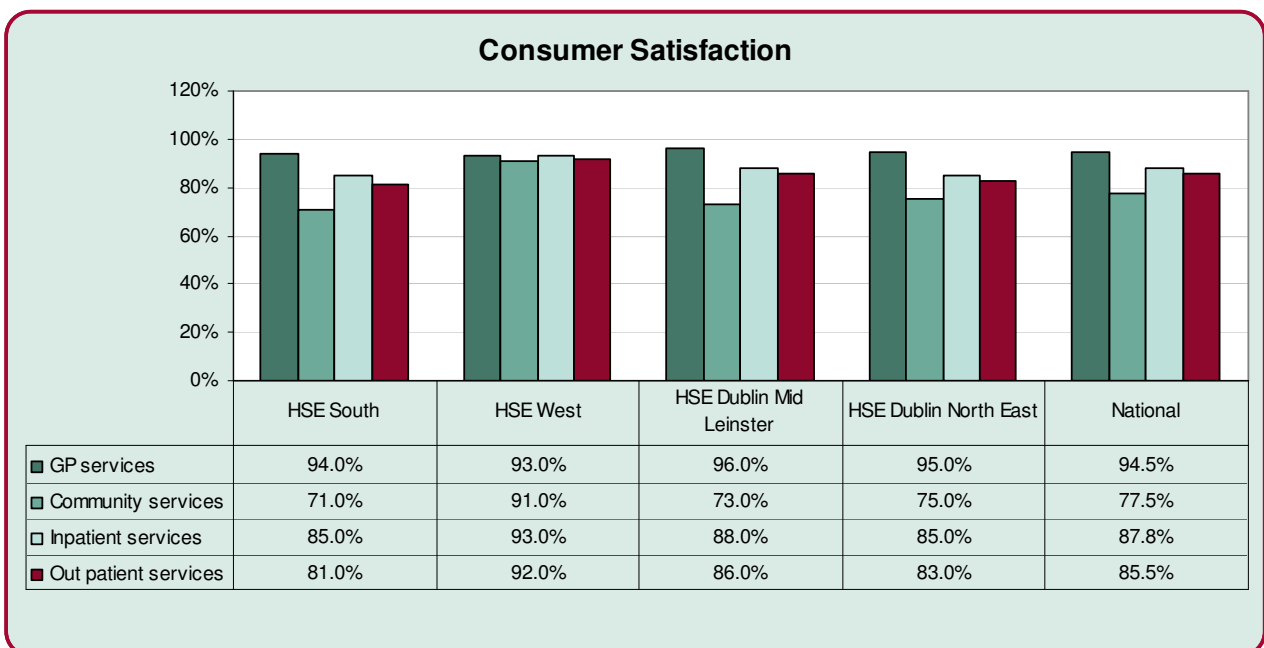
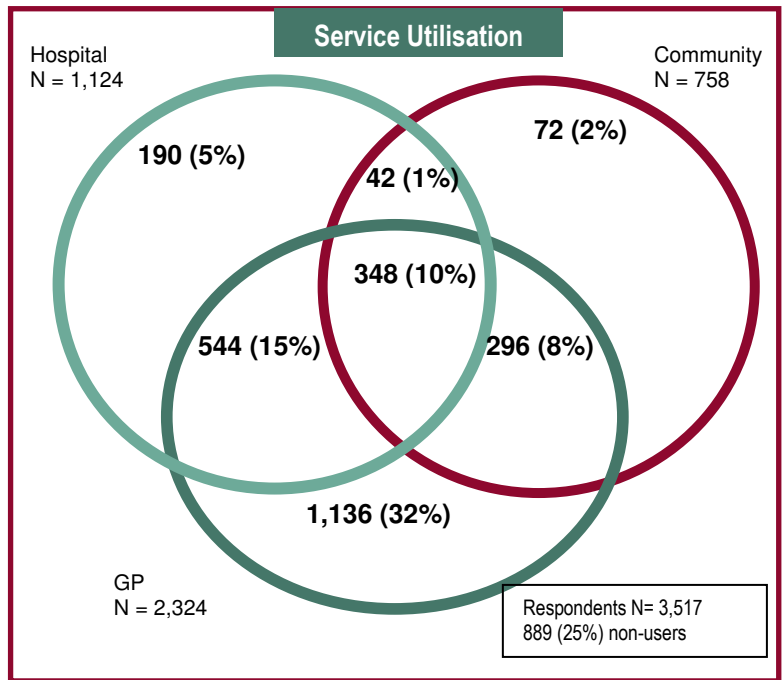
**Commentary**

Insight 07 generally demonstrated that there was a strong satisfaction among those who had experience of using health services and a high level of trust in health professionals. There were some variations in rated satisfaction within settings. The GP setting rated most positively. Within the acute settings those whose experience was in the ED were less satisfied that for other outpatients.

The areas of consumer experience which were followed up in this survey include; access to reliable services, effective treatment by a trusted professional, involvement in decisions, information provided, physical environment, involvement of family, continuity of care.

These dimensions of care align with the Corporate Objectives and findings from consumer surveys assist in meeting these objectives in a way that also meets consumer needs.

There is a requirement to gather further views from consumers in a systematic way. The service plan 2010 commits to building on the approach to systematically capturing views of patients/service users on their experience of services.



# Operational Excellence and Unlocking Our Potential

## Budget Management

### Metric Used

Budget Management: Budget against planned position

### Rationale

The HSE is legally required to remain within the voted budget.

### Data Source

Finance Unit, HSE

### Period Covered by Data

Jan – Dec 2009

### Target Information

No variation from overall budget within a fiscal year.

### National Overview

Within Vote

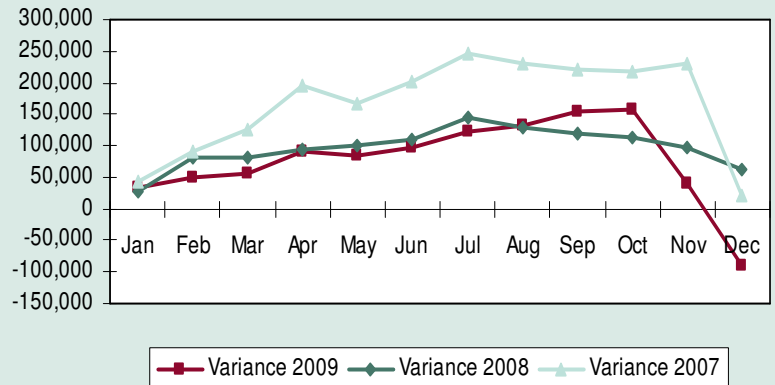
### Commentary

The financial results for December show total expenditure of €13.621 billion against an annual budget of €13.712 billion – a surplus of €90.46 million.

The key messages from 2009 are as follows:-

- Breakeven achieved on the vote
- Surplus result in Income & Expenditure terms versus budget. The surplus of 90m arises primarily due to monies provided for swine flu and Fair Deal which remained unspent at year end. This money has been provided for 2010.
- Significant funding removed from service budgets to fund pensions and schemes
- Major growth in medical cards, however effect of the Financial Emergency Measures Bill has meant that not all the budget applied to schemes was required and a year end surplus has arisen. The cash payment of arrears on the 'Hickey' case means there is not a surplus on the vote.
- Considerable achievement of cost control in all areas of the organisation – the only area with a material budget overrun for 2009 was the West hospitals.
- Final budgetary overrun on pensions was €64m however this was offset somewhat by savings by corporate functions.
- Population Health surplus arising from timing of vaccine purchases for the Pandemic.
- Some funds remained unallocated at year end – for example Fair Deal.

HSE Net Expenditure - Variance Actual v Budget YTD 2009, 2008 and 2007



## Value for Money (VFM)

**Metric Used**

Value for Money (VFM)

**Rationale**

Sustainable delivery of services and sustainable health funding for these services are dependant on the focused use of resources with minimisation of waste or inefficiencies. A focused VFM programme assists the organisation to deliver on these and to ensure that resources are best used in delivering services.

**Data Source**

VFM Unit within Finance, HSE

**Period Covered by Data**

Jan – Dec 2009

**Target Information**

The VFM requirement for 2009 is the delivery of €115m of efficiencies.

**National Overview**

Savings of €115.1m achieved in 2009 (Dec 2009).

**Commentary**

A VFM programme was agreed and is reported monthly as part of the routine PR process. Actual YTD savings and projected full years savings are presented with commentary on trends and / or issues arising. Detailed VFM financial reporting confirms the €115m was delivered including compensating efficiencies achieved beyond the required adjustments in areas such as Drugs & Medicines, Patient Transport, Maintenance, Advertising as well as other non-pay headings (e.g. Catering, Office and Computers). The broader requirement to deliver the Service Plan 2009 within the available resources required efficiencies beyond the identified VFM Programme towards breakeven. In addition to VFM of €280m in 2008 and €115m in 2009, there has been a further €100m of additional breakeven efficiencies including reduced Medical & Surgical costs, reduced administrative costs and variable pay costs such as overtime, on call etc.

Clearly there is financial evidence of significant efficiencies being achieved by services and managers in the last two years in not just the delivery of actual cost reductions through the VFM and other budget management and service reconfiguration initiatives, but also through the management of non-pay cost growth and the resulting cost avoidance.

On the basis of comparison of the non-pay costs 2007-2009 and applying the rate of cost growth 2006 / 2007 to 2008 and 2007 / 2008 to 2009, there was a net non-pay cost avoidance in the HSE of €484m in 2008 and a further €300m in 2009. For example, if X-Ray cost growth had not been managed, the projected opening cost for 2010 would be nearly €6.7m (11% higher). Equally, Office Expenses, Rent & Rates would be €20m (10%) higher and Catering would be €13m (13%) higher.

Also, on the basis of a comparison of the total pay bill (excluding superannuation), full year pay costs in 2009 were maintained at prior year levels, with the average monthly cost reducing below 2008 levels in the second half of the year. There is considerable performance in management of variable pay such as a 13% reduction in Overtime costs and a 5% reduction in On Call costs.

It should be noted that this level of cost reduction and management of cost growth resulting in cost avoidance in non-pay areas over 2007, 2008 and 2009 mean that there is significantly reduced scope for further cost efficiencies in 2010. It will be extremely challenging for the system to maintain the previous year's cost reductions, and manage the rate of cost growth while delivering services within the resulting base as well as the further VFM adjustments in 2010 of €106m.

	€m
<b>Non Pay</b>	
T&S	8.1
Legal	2.3
Advertising	2.6
Education and Training	4.7
Drugs and Medicines	8.0
Maintenance	5.2
Patient Transport	5.0
Blood and Blood products	9.8
Laboratory	6.4
Reconfiguration Admin Processes	6.4
Reconfiguration Child Care	6.2
Disability Services Efficiencies	9.5
Catering	5.7
Office Expenses Rents and Rates	10.0
Computers	1.0
Heat, Power and Light	2.5
<b>Pay</b>	
Reconfiguration of Mental Health Staff Costs	7.1
Reconfiguration of Hospital Staff Costs	8.6
Reconfiguration of Management/Admin Staff Costs	6.1
<b>Total</b>	<b>€115.1</b>

## Inpatient Spend Per Day

### Metric Used

In-patient activity: Hospital In-patient Casemix adjusted cost per case.

### Rationale

The national Casemix Project was established in 1991 arising from the recommendation of the Commission on Health Funding that each hospital should be funded for the provision of an agreed level of service to public patients, based on the activity level implied by its role and catchment area, and the Casemix based cost of meeting this – techniques such as DRG (Diagnosis Related Group) should be used to determine the level of funding. Financial allocations using Casemix are now utilised in 39 hospitals.

Accountability is one of the cornerstones of HSE policy. The Casemix system highlights variances in performance, both between hospitals and within hospitals themselves. This assists management to establish which issues need to be addressed.

### Data Source

Casemix / HIPE, HSE

### Period Covered by Data

2008 data utilised for 2009 budget runs and incorporated into the 2010 financial allocations to hospitals

### Target Information

The Mean for the hospital group.

### National Overview

Group 1 mean €5,469  
 Group 2 mean €4,917  
 Maternities: mean €4,791  
 Paediatrics: mean €6,500

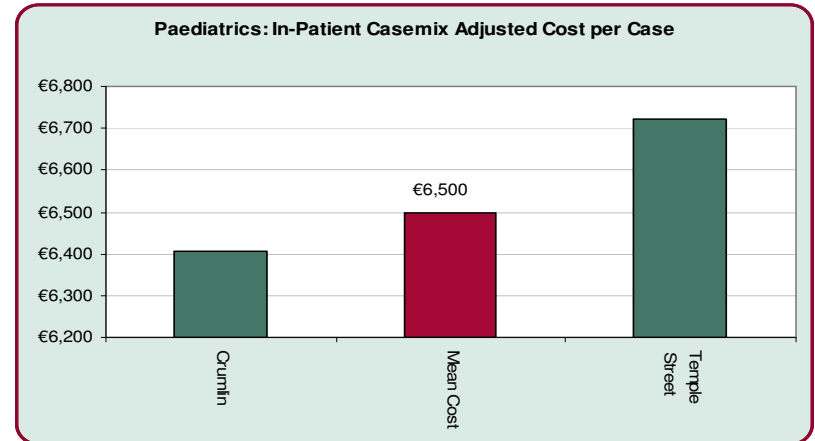
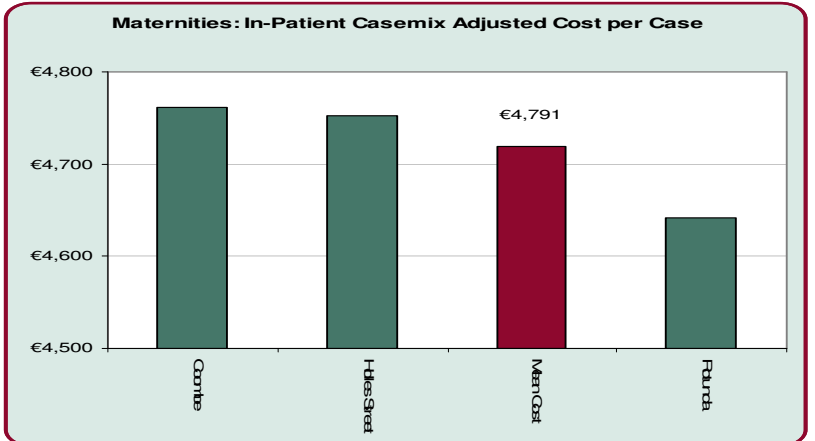
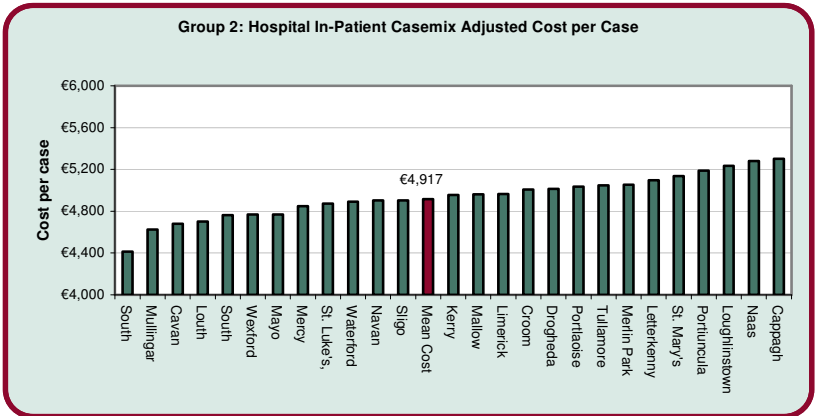
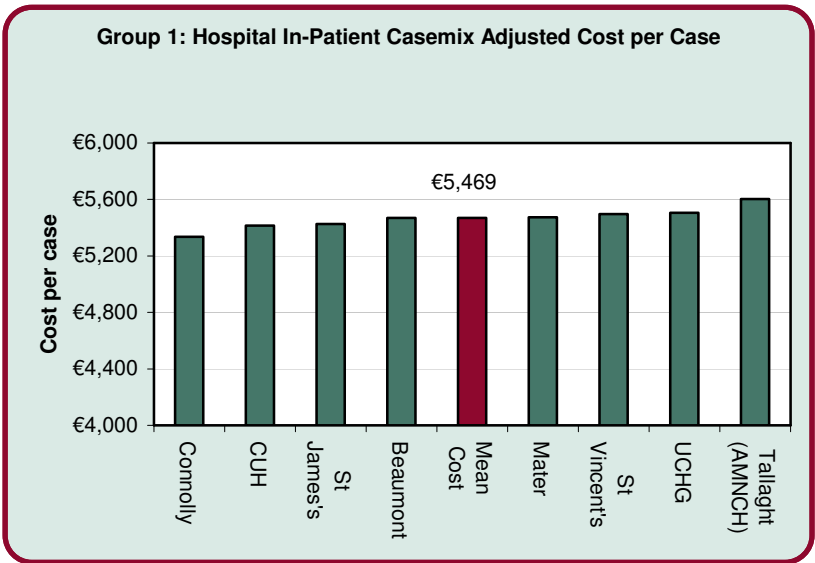
### Commentary

Hospitals are classified into 4 groups for casemix purposes. Within a hospital group, average costs per case, adjusted for the casemix complexity of the patient workload, can be compared.

Variation in casemix-adjusted cost per case provides a Measure of the relative efficiency of hospitals.

Budget-neutral casemix-based financial allocations have the effect of transferring funding from less efficient hospitals to the more efficient.

The graphs show the range of costs per case across hospitals. This variation can be due to a number of factors, but a major contributor to reduced efficiency is high lengths of hospital stay.



## Whole Time Equivalents (WTE)

### Metric Used

Whole Time Equivalents (WTEs): numbers against approved ceiling.

### Rationale

Effective and efficient delivery of health services require proactive management of all resources. One measure is deviation from the agreed ceiling of WTEs. Close tracking can support forward planning to ensure we have the right resources in the right place.

Current efficiency measures also require a rebalancing of posts from Management Administration to front line. Future measures will reflect the rebalancing position of this.

### Data Source

National Employment Management Unit (NEMU), HSE Human Resources Directorate

### Period Covered by Data

Jan – Dec 2009

### Target Information

Manage delivery of services within WTE complement

### National Overview

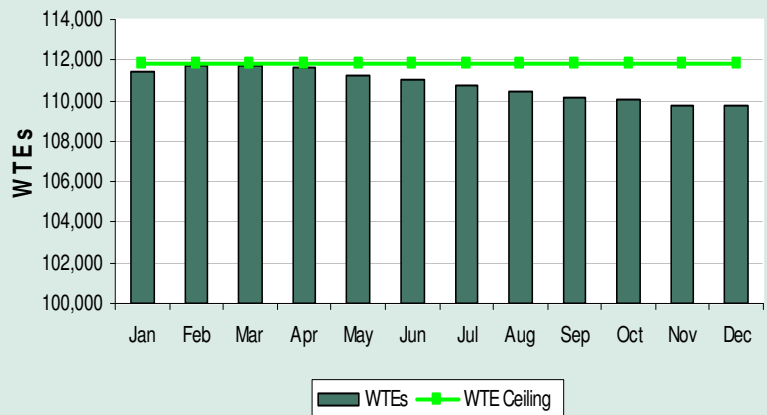
109,753 WTE (Dec 2009)

### Commentary

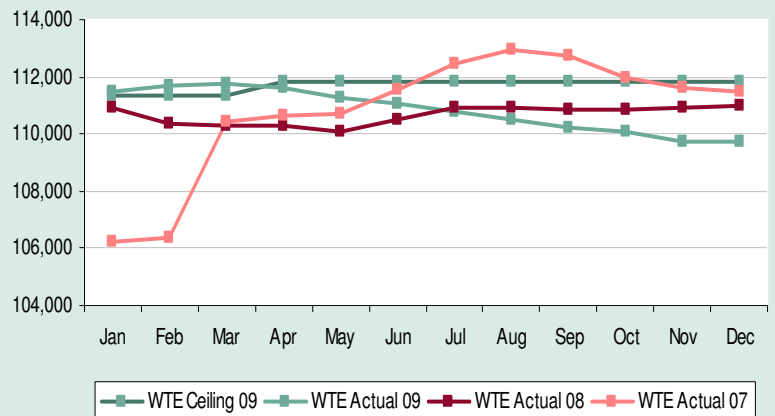
Overall in 2009 the HSE WTEs were 2,047 under the ceiling. Reducing employment levels were driven by both cost containment and moratorium measures which were put in place across the health service throughout 2009.

Within this reduction there were a number of posts recruited in grades which had a derogation from the general moratorium on recruitment. There were also some additional sanctions provided by the Department of Health and Children and Department of Finance in respect of non-derogated posts which were also filled during the year.

WTE Number Against Ceiling 2009



HR Ceiling 2009 v Actual 2009,2008 and 2007



## Absenteeism

### Metric Used

Absenteeism: Rates of absenteeism within the HSE.

### Rationale

The HSE is actively engaged in effective procedures that record and measure absenteeism. This will allow the organisation to analyse absence levels and engage in absence-preventing activities and strategies on a proactive basis.

### Data Source

National Employment Monitoring Unit (NEMU), HSE Human Resources Directorate

### Period Covered by Data

Jan – Nov 09

### Target Information

< 4% 2009 (incremental target towards < 3.5%)  
< 3.5% medium term target

### National Overview

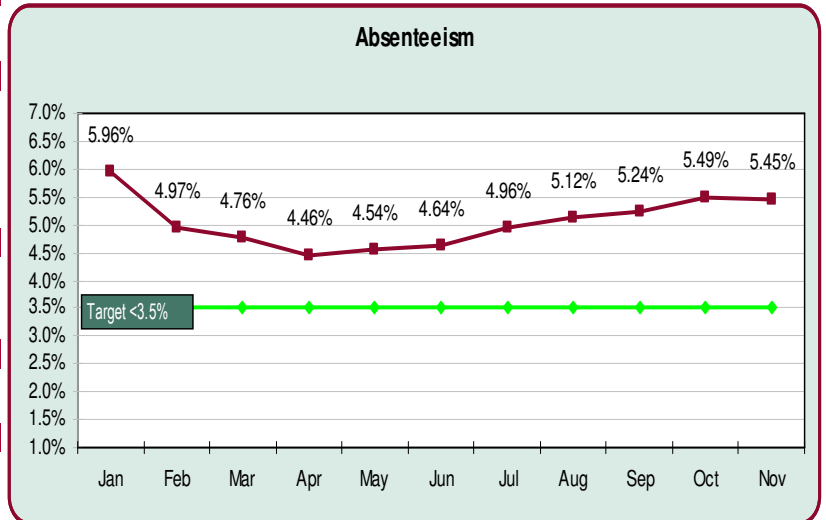
5.45% - rate of absenteeism (Nov 2009)

### Commentary

Coverage of absenteeism rates by LHO / Hospital and Voluntary Agency is now close to 100%, although in the case of a number of LHOs, the figures submitted may not fully be reflective of all their staff. Work continues to address such deficits.

Lost time is any time lost through absences due to certified and uncertified sick leave and unexplained absences. Absenteeism is reported for those currently on payroll but does not include absences due to maternity leave, carer's leave or other statutory approved leave. This measures lost time against available time and is expressed as a percentage.

One of the approaches being pursued in relation to the management of absenteeism is the application of tiered financial adjustments in agencies showing a pattern of consistent variance from HSE specified targets.



	Total	Target	HSE	Voluntary Hospital	PCCC Voluntary Agencies
Jan	5.96%	3.5%	6.55%	4.80%	5.20%
Feb	4.97%	3.5%	5.49%	4.03%	4.33%
Mar	4.76%	3.5%	5.14%	3.98%	4.22%
Apr	4.46%	3.5%	4.77%	3.51%	4.50%
May	4.54%	3.5%	4.83%	3.69%	4.40%
June	4.64%	3.5%	5.03%	3.68%	4.23%
July	4.96%	3.5%	5.38%	3.96%	4.49%
Aug	5.12%	3.5%	5.61%	3.94%	4.56%
Sep	5.24%	3.5%	5.69%	4.20%	4.66%
Oct	5.49%	3.5%	5.88%	4.60%	4.97%
Nov	5.45%	3.5%	5.98%	4.12%	4.89%

## Information Communication Technology (ICT)

### Metric Used

ICT: Progress on implementation of an ICT strategy

### Rationale

ICT is fundamental to ensure a high performing best practice health system. It needs to be embedded in the delivery of patient diagnosis, treatment and care. ICT is a prime driver of significant and continuous improvements in efficiency effectiveness and the quality of patient services.

ICT is the critical and differentiating enabler of organisational transformation and development.

The ICT strategy will provide a road map on how ICT services will be delivered. The key ICT strategy objectives are to support and enable the provision of quality by ensuring that ICT will be patient/client centric, supporting clinical practice, providing information where and when required in a relevant and meaningful way.

### Data Source

ICT, HSE

### Period Covered by Data

Position as of Dec 2009

### Target Information

Implementation of the ICT Strategy

### National Overview

The HSE ICT strategy has not yet been launched. The strategy is currently being updated by the National Director of ICT for consideration by the Board of the HSE in May 2010.

### Commentary

In the meantime, ICT continue to progress projects and initiatives in support of the Transformation Programme. In total 125 projects were undertaken in 2009, 60 of which completed in 2009 and 65 are continuing in 2010. Some of the projects were sanctioned late in 2009 and as a result will not incur significant expenditure until 2010. As part of the ICT Project Approval Process, all projects must be approved by the relevant business unit and validated against the ICT Strategy prior to implementation.

## Procurement

### Metrics Used

- Implementation of Procurement Operating Model
- Sourcing savings
- % Contract coverage
- Stock managed at Point of Use

### Rationale

Following the publication of the "Strategy for the Implementation of e-Procurement in the Irish Public Sector" (April 2002), the HSE published its own procurement strategy (2003). The Department of Finance established the National Public Procurement Policy Unit (NPPPU) as a result of a Government decision (April 2005). The role of the NPPPU is to develop public sector procurement, policy and practice through a process of procurement reform.

The current reform of the health service structures provides an opportunity to fully develop the procurement capability of the HSE at various levels to create a cohesive and strategic procurement focus.

The HSE is now implementing a new operating model for procurement in line with strategy. The new model is structured around a separation of sourcing, tendering and contracting activity from inventory, logistics and materials management combined with a separation of strategic and transactional activity. The model will deliver a service in line with the National Public Procurement Policy Framework.

### Data Source

Procurement Directorate

### Period Covered by Data

Status at the end of Dec 2009

### Target Information

- Implement model over five years (2007 – 2011)
- Sourcing savings are projected at €132.7m over 5 years (2007-2011) with an exit run rate of €61.9m per annum net of additional costs of €3.3m.
- 100% contract coverage
- 3,500 Point of Use locations

### National Overview

- Sourcing savings: Savings of €34 million have been achieved to date (2007 – 2009) or (26% of the 5 year target of €132.7m).
- % Contract coverage: 40% Contract Coverage (Dec 2009)
- Stock managed at Point of Use: 122 locations (Dec 2009)

### Commentary

The Business Case supporting the new procurement model has been impacted by the changed environment. However an interim implementation approach has been developed. Achievement of targets to date is the result of fast tracking specific initiatives. The effort applied to agreeing commercial arrangements with key HSE suppliers had a significant positive impact during 2009.

Achievement of targets in future years will require full implementation of the Procurement Operating Model including;

- full implementation of a portfolio and category management approach to sourcing
- implementation of the recommendations of the Logistics & Inventory Management Review which was completed in 2009
- deployment of a single national finance & procurement system

Pending full implementation of the above it will be necessary, in 2010, to assess previous targets against realistic timelines for the achievement of those targets.

# Abbreviations

<b>AEP</b>	Appropriate Evaluation Protocol
<b>ALOS</b>	Average Length of Stay
<b>AOS</b>	Assessment Officers System
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CPr</b>	Corporate Plan Report
<b>CSO</b>	Central Statistics Office
<b>DML</b>	Dublin Mid Leinster
<b>DNE</b>	Dublin North East
<b>DoHC</b>	Department of Health and Children
<b>DRG</b>	Diagnosis Related Group
<b>DTP</b>	Diphtheria, Tetanus, Pertussis
<b>ECHP</b>	European Community Household Panel
<b>ED</b>	Emergency Department
<b>EPA</b>	Environmental Protection Agency
<b>ESPAD</b>	European School Survey Project on Alcohol and other Drugs
<b>ESRI</b>	Economic and Social Research Institute
<b>EU</b>	European Union
<b>FOI</b>	Freedom of Information
<b>FSAI</b>	Food Safety Authority of Ireland
<b>GMS</b>	General Medical Services
<b>GP</b>	General Practitioner
<b>HBSC</b>	Health Behaviour in School Aged Children
<b>HRBS</b>	Human Resources Business Solution
<b>Hib</b>	Haemophilus influenza b
<b>HIPE</b>	Hospital In-Patient Enquiry
<b>HIQA</b>	Health Information and Quality Authority
<b>HPSC</b>	Health Protection Surveillance Centre
<b>HR</b>	Human Resources
<b>HSE</b>	Health Service Executive
<b>HSNPF</b>	Health Services National Partnership Forum
<b>ICT</b>	Information Communication Technology
<b>LHO</b>	Local Health Office
<b>MMR</b>	Measles, Mumps, Rubella
<b>MRSA</b>	Methicillin Resistant Staphylococcus Aureus
<b>NCCP</b>	National Cancer Control Programme
<b>NCMT</b>	National Crisis Management Team
<b>NEMU</b>	National Employment Monitoring Unit
<b>NIO</b>	National Immunisation Office
<b>NPRS</b>	National Perinatal Reporting System
<b>NSP</b>	National Service Plan
<b>OECD</b>	Organisation for Economic Cooperation and Development
<b>PAD</b>	Parliamentary Affairs Division
<b>PCRS</b>	Primary Care Reimbursement Service
<b>PCTs</b>	Primary Care Teams
<b>PHN</b>	Public Health Nurse
<b>PI</b>	Performance Indicators
<b>PPR</b>	Performance Planning Review
<b>PQ</b>	Parliamentary Question
<b>PR</b>	Performance Reports
<b>SARI</b>	Strategy for Control of Antimicrobial Resistance in Ireland
<b>TB</b>	Tuberculosis
<b>UNICEF</b>	United Nations International Children's Emergency Fund
<b>VFM</b>	Value for Money
<b>WHO</b>	World Health Organisation
<b>YTD</b>	Year to Date

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