



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# Corporate Performance Measurement

Report against the Corporate Plan 2008-2011  
January - June 2009

October 2009

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# Part 1

## Foreword

Every three years, the HSE publishes a Corporate Plan. It guides our strategic planning and decision making for the following three years.

The current plan covers the years 2008 to 2011. It sets out what we are seeking to achieve by 2011. It outlines our overall strategic direction and specifically the six strategic objectives that we are focused on to deliver improved services and better value.

These cover:

- **Health and Wellbeing**
- **Sustainable Services**
- **Quality and Safety**
- **Trust and Confidence**
- **Operational Excellence**
- **Unlocking our potential**

This report reviews the progress we are making towards achieving these objectives.

This is the first time we have reported against the Corporate Plan 2008 – 2011 and it is anticipated that this type of detailed analysis will be repeated every six months.

The analysis examines measures which are spread across our objectives. These measures are representative. If we are doing well in these measures it can be assumed we are progressing towards achieving our objectives. If we are falling behind on some measures the opposite applies.

The analysis shows that, so far 23 of the measures reported against target, are performing at 70% or greater. For seven measures we are below this threshold. As this is the first analysis of a three year programme which will run to 2011, the results represent a snapshot in time along a continuous journey rather than an end point.

The areas where the report highlights good performance include the level and speed of reduction in MRSA levels, childhood vaccination reaching 95% and the establishment of child and adolescent mental health teams.

Areas that need focused attention include breastfeeding, caesarean section rates, disability assessment rates against standards set in regulation and emergency department experience for people admitted.

Future reports will track trends and progress. They will also take account of programmes which operate across longer timeframes; such as the development of primary care teams.

Over time this analysis will enable us to create an ongoing picture of how we are performing during the life of the current Corporate Plan. This will act as an important reference point as we design and implement more detailed annual national and regional service plans. It will enable us to identify where adjustments need to be made to ensure we remain on track. This may involve redirecting resources, adjusting our targets based on resources available and indeed changing the way we provide services. This will be particularly helpful as the integrated service programme is embedded in the four regions.

Our performance monitoring and measurement systems have been enhanced significantly in recent years. They are now central to our transformation programme and frontline and support services from long term planning to local decision making.

We now have unprecedented levels of visibility of how resources are being employed and the results being achieved. The response of managers and clinicians to this level of accountability has been very positive. In addition to highlighting weakness it also brings to the fore success and greater transparency in the use of resources. This report adds further to our capability in this area and I thank you for your co-operation and for providing the information that has made it possible.



**Professor Brendan Drumm**  
 Chief Executive Officer  
 Health Service Executive (HSE)

# Introduction

## Levels of planning and performance measurement

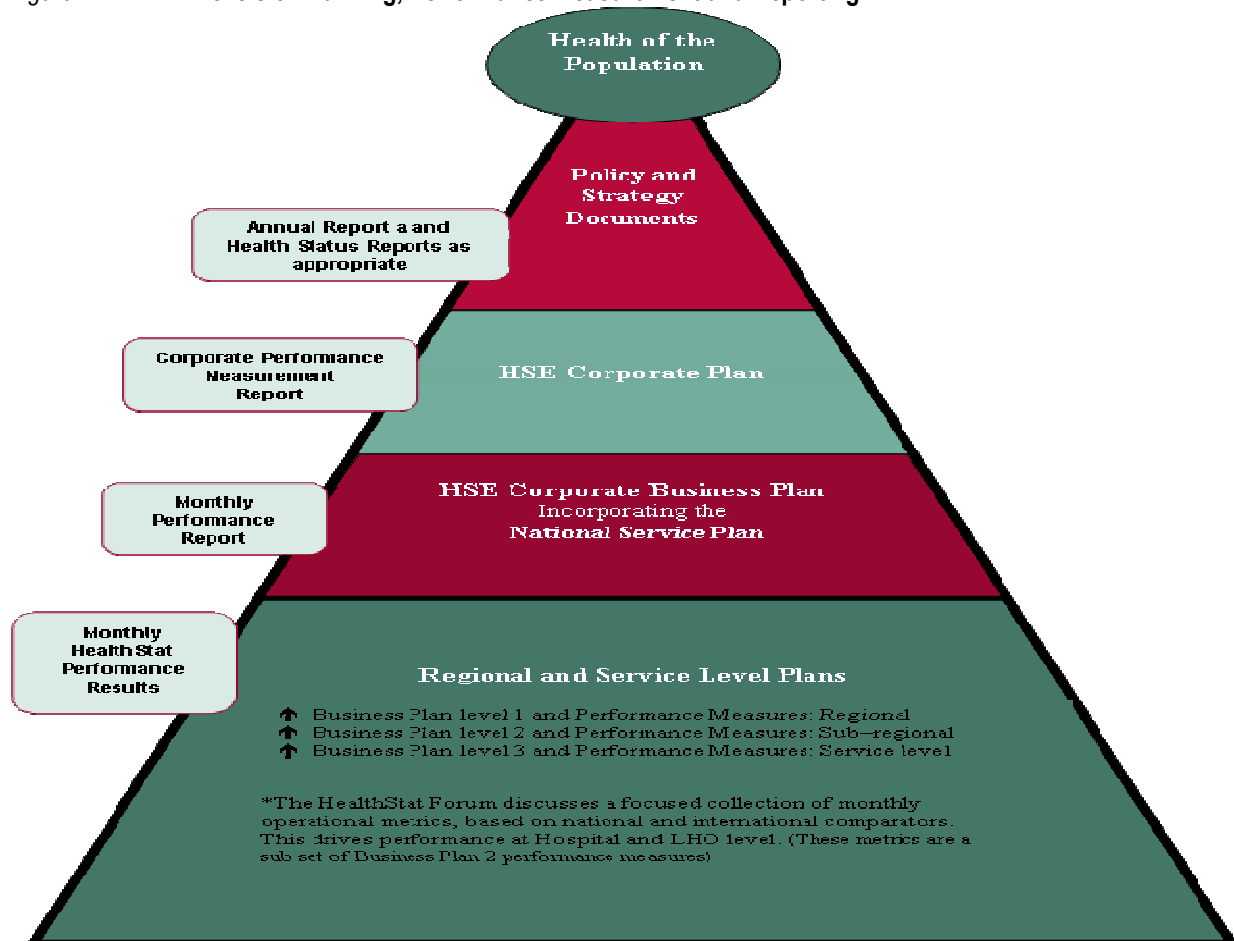
Planning takes place at several levels and takes into account internal and external guidance provided through, for example, the DoHC Statement of Strategy, National Policy Documents, economic forecasts and clinical and quality priorities.

There are different tiers of planning and performance measurement in 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 Performance 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, Performance Measurement and Reporting



A key requirement of this planning and information process is that it is supported by a strong “spine” composed of common definitions, accurate metadata, and robust formats and rules for data delivery and use and this is being currently developed between the HSE and the DoHC.

A Joint Department of Health and Children (DoHC) and HSE Performance Information Group (JPIG) has been working together to develop a performance measurement and management framework with common datasets of information. Access to and analysis of common datasets by both the DoHC and the HSE is seen as critical to service evaluation and to the identification and delivery of service improvements.

### 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 Measurement Report (CPM) 2009, a set of Key Performance Indicators (KPIs) were agreed with the Department of Health and Children. Not all KPIs are included in this first report due to their ongoing development. Defining and collecting the appropriate performance indicators is a continuous, evolving process that will develop over the period of the corporate plan.

This first report is the start of that process and gives a snapshot in time as of the end of June 2009. This will be the baseline on which to measure our progress over the three year period. Where previous years' information is available, this has also been included to aid trend analysis.

### Corporate Objectives and Metrics

The HSE Corporate Plan and the 6 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
- Infectious diseases
  - Salmonella
  - Cryptosporidiosis
  - Tuberculosis
  - Chlamydia
- Suicide Rate
- Deliberate self harm

#### 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
- Child and adolescent mental health
- Children in residential care
- Care planning for children in care
- Average length of acute stay
- Inpatient / day case ratios

### 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
- Symptomatic breast cancer service
- MRSA
- Food Safety inspections
- Emergency planning
- Complaints

### 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
- Aftercare support services for young people
- Disability assessments
- Emergency Dept: Experience of all attendees
- Emergency Dept: Experience of people admitted
- Public / private hospital activity

### 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)
- Human Resources
  - HR strategy
  - Employee engagement
  - Workforce planning
- Whole Time Equivalents (WTE's)
- Absenteeism
- Information Communication Technology (ICT)
- Parliamentary Questions (PQ's)
- Freedom of Information (FOI)

### Relative Performance

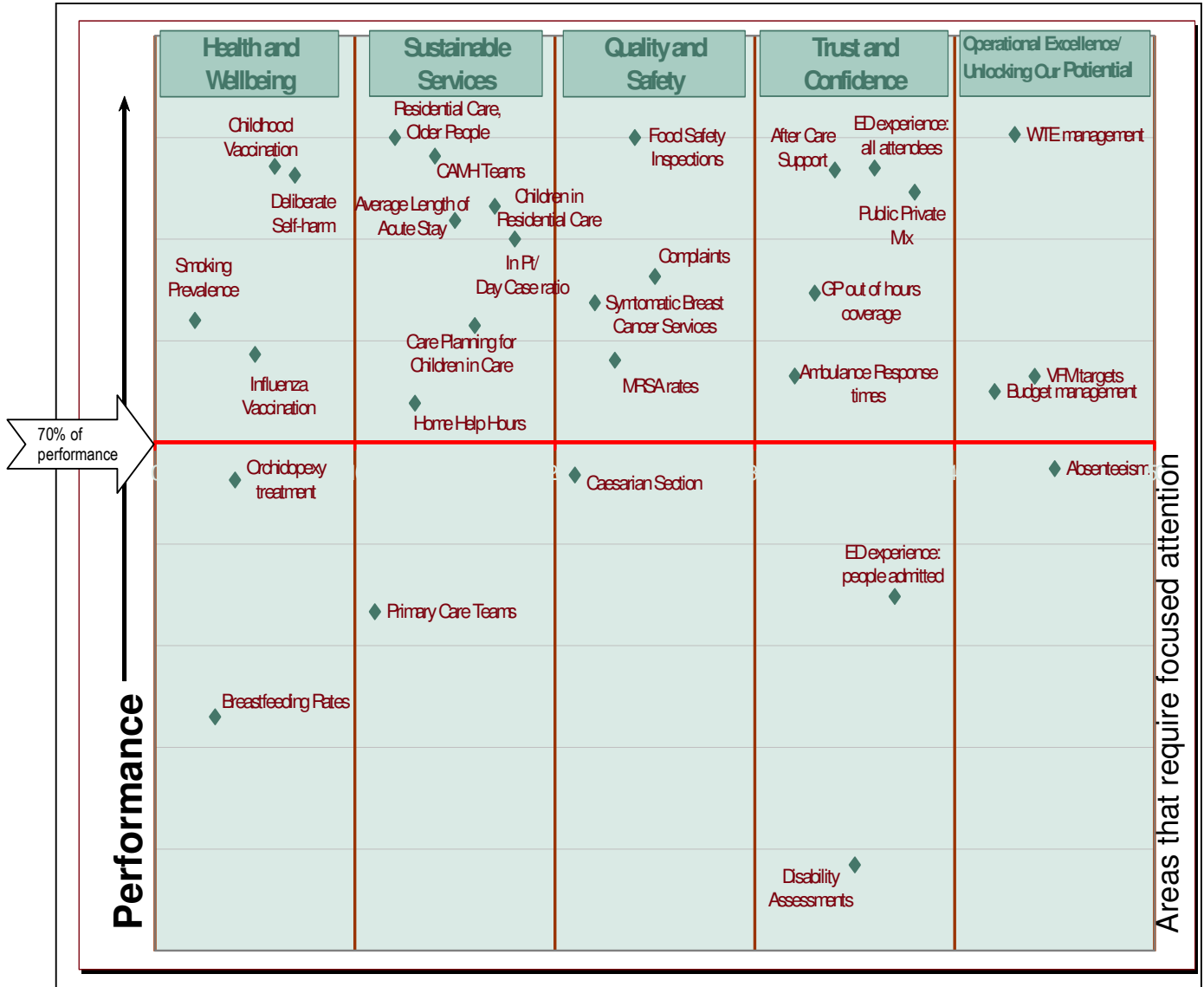
Assessment of progress against a Corporate Plan / Corporate Objectives informs future planning and priorities. To make this assessment, it is useful to take stock of where our performance lies against national or international benchmarks.

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 measures in the Corporate Plan which ask how are we performing against the position we desire to be in within 3 years. This CPM Report provides an opportunity to check progress against our desired medium and long term performance and reflect progress against HSE objectives and priorities as set out annually in the NSP. The targets against which performance is measured are outlined in the fact sheets for each metric in Part 2 of this report.

It is important to note that measures contained within the Corporate Plan are, in a number of cases, annualised within the National Service Plan and targets may be realised before the lifetime of the Corporate Plan is concluded. Others refer to longer term objectives which incorporate the period covered by the Corporate Plan and beyond.

# Performance Dashboard

Using selected key performance indicators, the dashboard below provides an indication of performance under the broad areas of the corporate objectives. The dashboard plots performance and allows us to see the areas that are performing well, above the red line and those which need focused attention below the red line.



The dashboard shows relative performance along the y (vertical) axis from 20%-100% performance. The red line is at 70% performance against target. The performance points are spread across the x (horizontal) axis in sequence.

### Conclusion

This Corporate Performance Measurement report provides an opportunity to check progress against our desired longer term objectives and priorities as set out in the Corporate Plan and implemented annually through the NSP. Used as one part of the continuous performance monitoring and measurement system, the CPM can provide us with valuable information to guide annual priorities. It involves a wide overview of the health system from Health and Wellbeing across to Operational Systems. It is intended that, building on this first report, performance trends can be mapped, which will inform future strategic and annual planning.

# Part 2

# Health and Wellbeing

## Smoking Prevalence

**Metric Used**

The prevalence of cigarette smoking

**Rationale**

Tobacco use is the leading cause of preventable death in Ireland. Each year, more than 6,000 people die prematurely from diseases caused by tobacco smoke. [www.otc.ie]

**Data Source**

Office of Tobacco Control  
www.otc.ie

**Period Covered By Data**

March 2004 – March 2008

**Target Information**

<20% of the population smoking

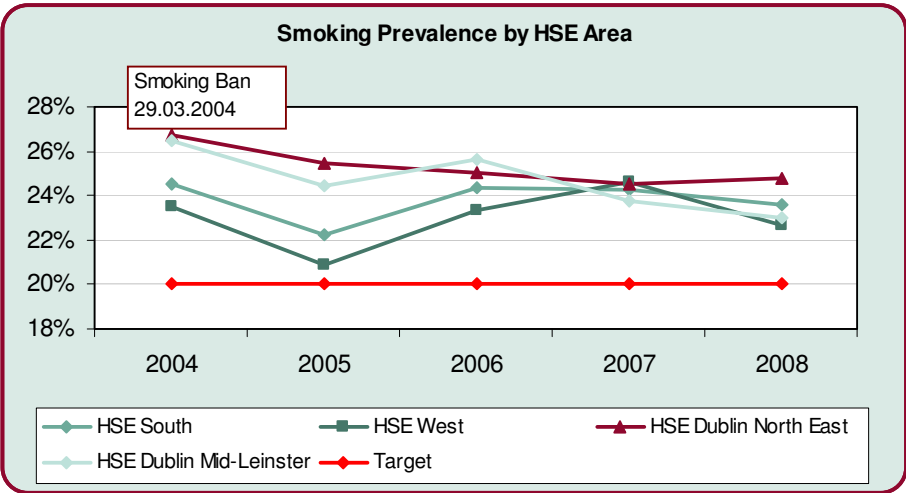
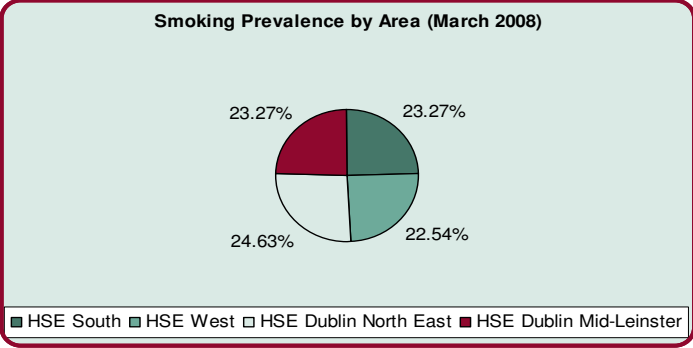
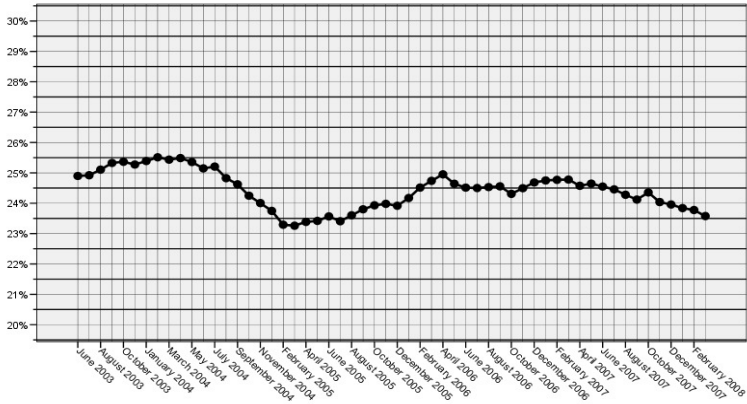
**Commentary**

A national average prevalence rate of 23.6% highlights the fact that there is still a worrying trend in relation to the recruitment of young smokers. The tobacco industry still continues to attract young smokers at a rate of around 50 per day in Ireland.

The HSE deliver smoking cessation services at area level and are involved in advising on policy.

**Cigarette Smoking Prevalence**

12 month moving average trend ending March 2008



## Breastfeeding Rates

### Metric Used

The % of babies seen at the 3 month PHN assessment who were partially or exclusively breastfed

### Rationale

The WHO, UNICEF, the Department of Health and Children and the HSE recommend exclusive breastfeeding for the first six months of life followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond in order to maximise the evidence-based health advantages of breastfeeding. Breastfeeding promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhoea or pneumonia, and helps for a quicker recovery during illness. [“Exclusive Breastfeeding”, WHO: *Child and Adolescent Health and Development: Breastfeeding*, [www.WHO.int](http://www.WHO.int)]

### Data Source

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

### Period Covered By Data

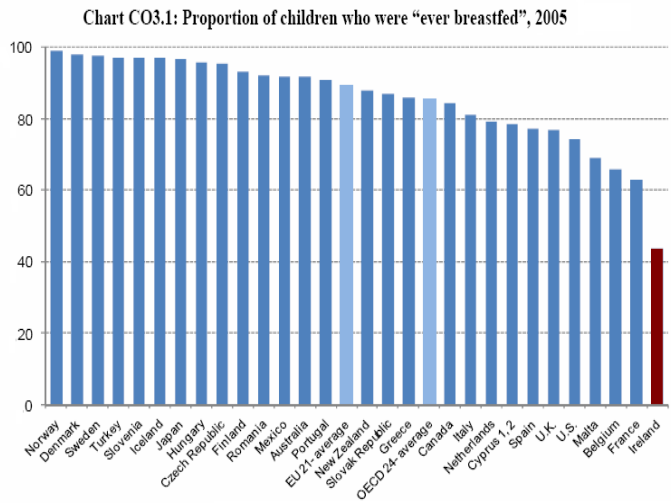
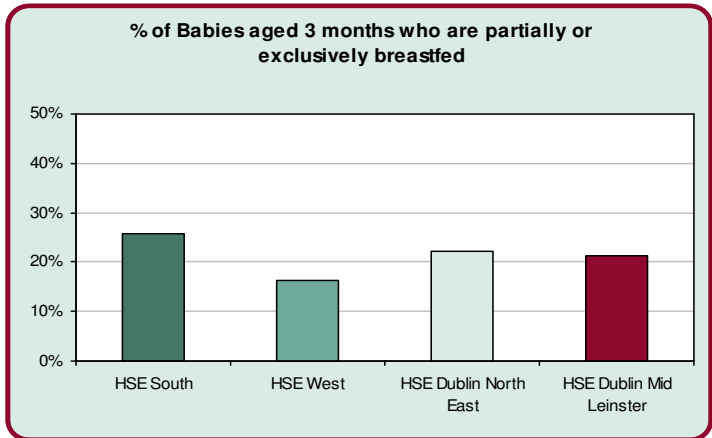
Q2 2009

### Target Information

2% increase in breastfeeding rates year-on-year in each LHO area (Strategy target) from baseline of 2001. Based on this the 2009 target is 30% breastfeeding at 3 months. International OECD average is 50% breastfeeding at 3 months and this is used to judge performance in this report.

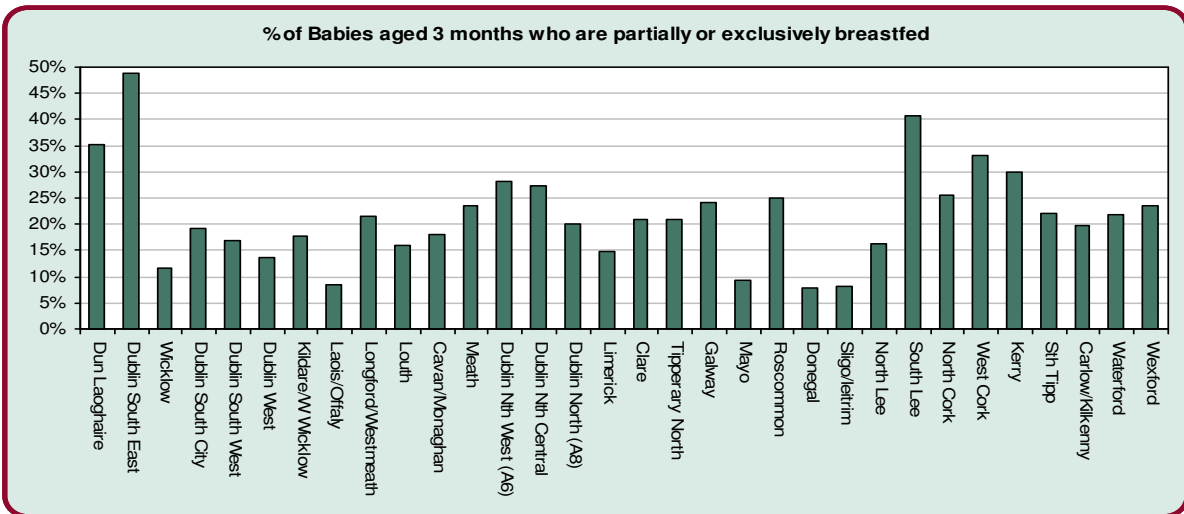
### Commentary

Nationally, 34.5% of babies are partially or exclusively breastfed at 3 months. 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 breastfeeding initiation and continuation. A recent (Aug 2009) OECD report places Ireland at the bottom for rates of breastfeeding in an analysis of 29 countries. A continued focus on Breastfeeding is required through our maternity units and Public Health Nursing service.



Source: National surveys

<http://www.oecd.org/dataoecd/30/56/43136964.pdf>



## Orchidopexy Treatment

**Metric Used**

The number of boys 0 - 4 years (inclusive) undergoing orchidopexy as a percentage of all boys aged 0 - 14 years (inclusive) undergoing orchidopexy.

**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**

HIPE

**Period Covered By Data**

2007 – 2008  
Data reported annually in arrears

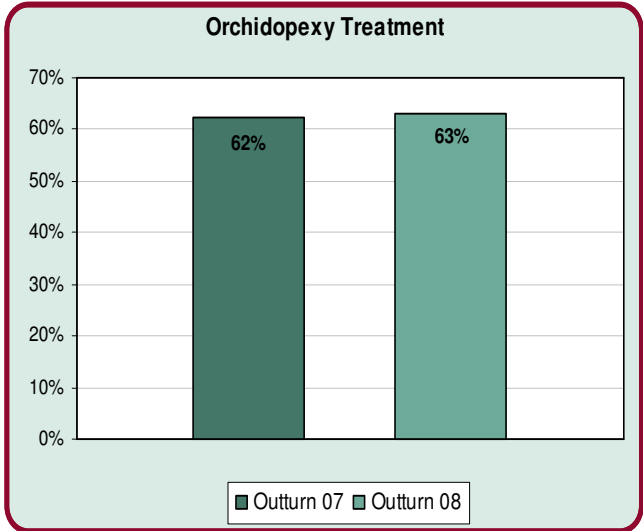
**Target Information**

International Targets  
75% surgery <24 mths  
95% surgery < 60 mths

**Commentary**

Reported performance is not reaching the levels which international evidence suggests is required to provide an effective response to this problem.

An analysis is required to ascertain the level of screening, reporting, referral and treatment to clearly see where processes and responses can be improved.



## Vaccines

### Influenza Vaccination

**Metric Used**

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**

2003 – 2008

**Target Information**

75% of the elderly population vaccinated annually by 2010; World Health Organisation (WHO).

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

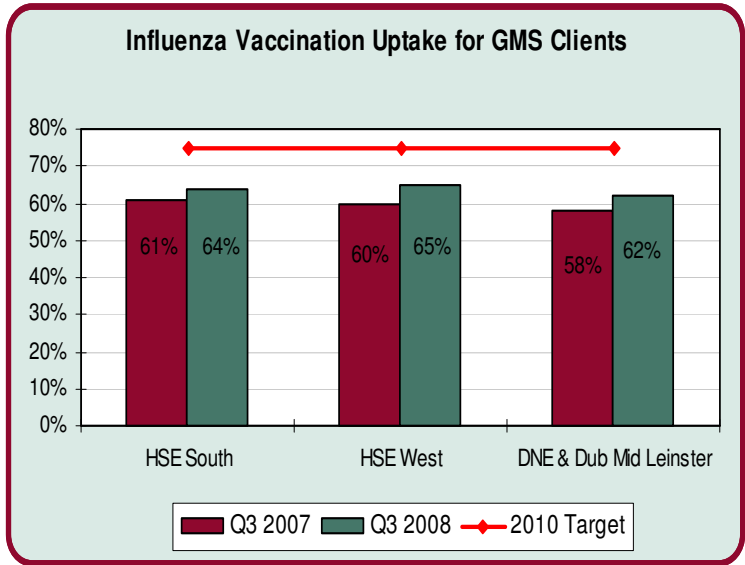
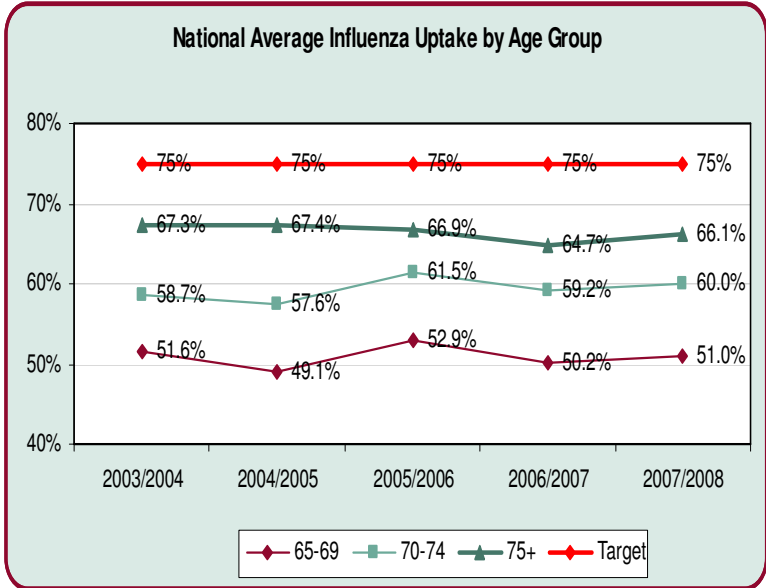
**Commentary**

Nationally, the uptake of the influenza vaccine in those aged 65 years and over was 63% in 2005/06 but fell to 61% during 2006/07. In the 2007/08 period this increased again to 64%.

The uptake for vaccination is highest in the over 75 year group. As this is the group most at risk, this is appropriate.

A national telephone survey of risk groups and the uptake of influenza and pneumococcal vaccine in Ireland (conducted in 2006), estimated a 68.6% uptake of influenza vaccine among those aged 65 years or older, which reached the then 2006 WHO target. Most people surveyed who availed of the vaccine did so based on the advice of their GP. The main reason for not getting vaccinated was because people felt they had little chance of actually getting influenza. Other studies have also reported that the cost of vaccination, a lack of awareness of the risks of influenza disease, a distrust of vaccinations, a belief that vaccines do not work and health professionals not recommending vaccination strongly enough are possible reasons for inadequate vaccination uptake.

Health professionals should encourage and facilitate access to vaccination for their at-risk patients, including everyone aged 65 or older.



## Childhood Vaccination

### Metric Used

The number and percentage of children 24 months of age who have received 3 doses of vaccine against D3, P3, T3, Hib3, Polio3, MenC3 and HepB (see explanation box below)

### 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 World Health Organisation 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

National Immunisation Office (NIO)  
www.immunisation.ie

### Period Covered By Data

Q4 2008

### Target Information

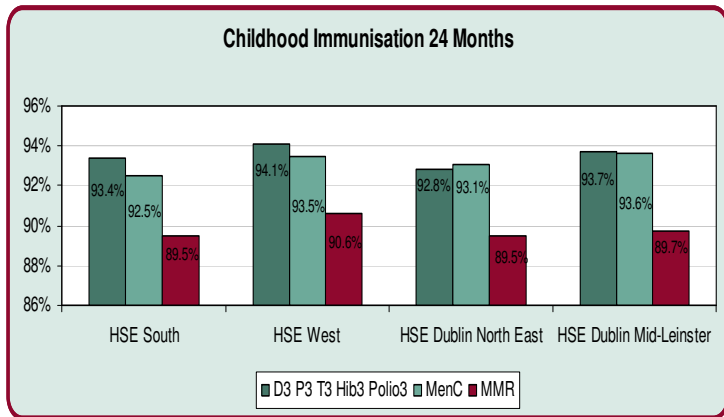
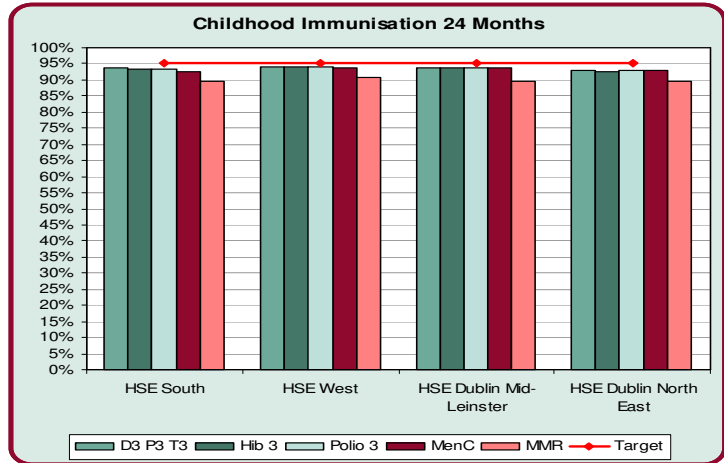
>95% of children vaccinated at 24 months WHO

### Commentary

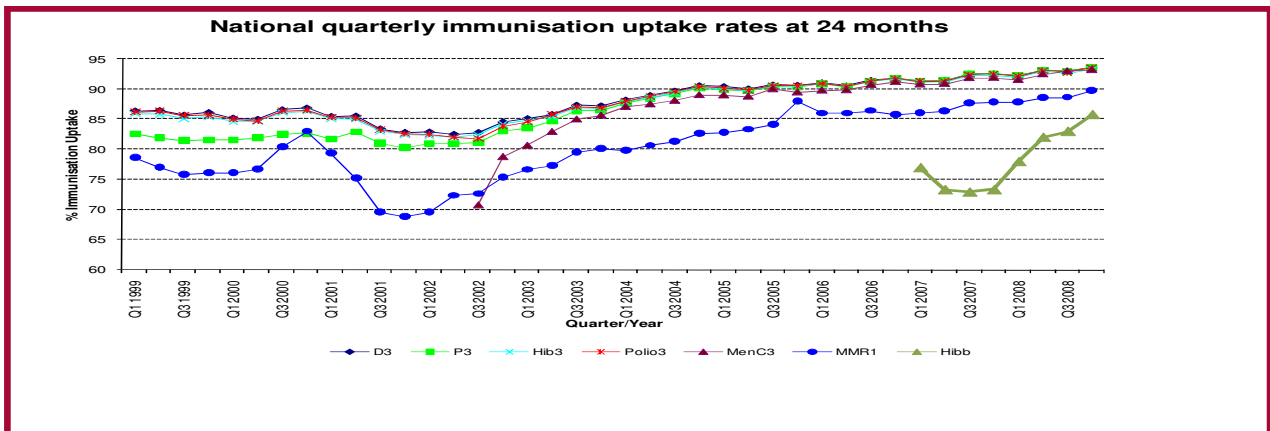
National immunisation uptake rates for children at 24 months of age in Q4 2008 reached **94%** for third dose of diphtheria, tetanus, pertussis (DTP), **93%** for third dose of Haemophilus influenza b (Hib) and polio and **90%** for first dose of measles, mumps, rubella (MMR) vaccines. These uptake rates have improved significantly since 2005 when the equivalent rates for DTP and MMR were 90% and 83%.

Twelve local health office areas reached or exceeded the 95% target for DTP, two areas reached 95% for MMR and one area, Roscommon reached 95% for all childhood vaccines.

These uptake rates have been achieved through a partnership approach between the HSE and those general practitioners involved in programme delivery.



- D3 = Third dose diphtheria vaccine
- P3 = Third dose pertussis (whooping cough) vaccine
- Polio 3 = Third dose polio vaccine
- Hib 3 = Third dose Hib vaccine
- MenC = Third dose of meningococcal C vaccine
- Hib b = Fourth dose Hib vaccine
- MMR 1 = First dose MMR (measles, mumps, rubella) vaccine



## Infectious Diseases

### Salmonella

**Metric Used**

The number of clinical notifications of Salmonellosis in Ireland

**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**

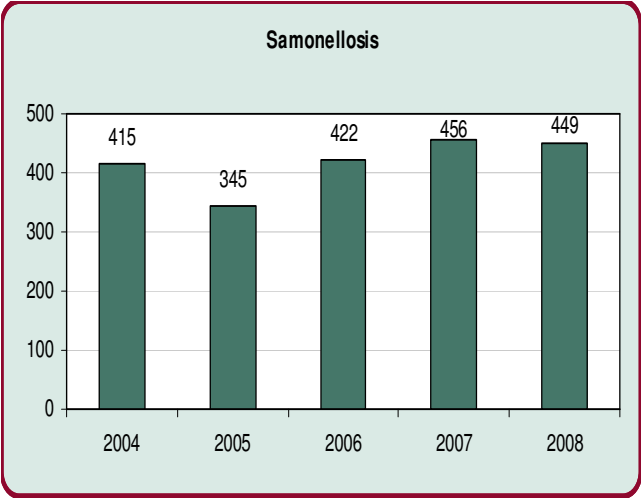
2004 - 2008

**Target Information**

No target available.

**Commentary**

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**

The number of Cryptosporidiosis notifications in Ireland

**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 – 2008

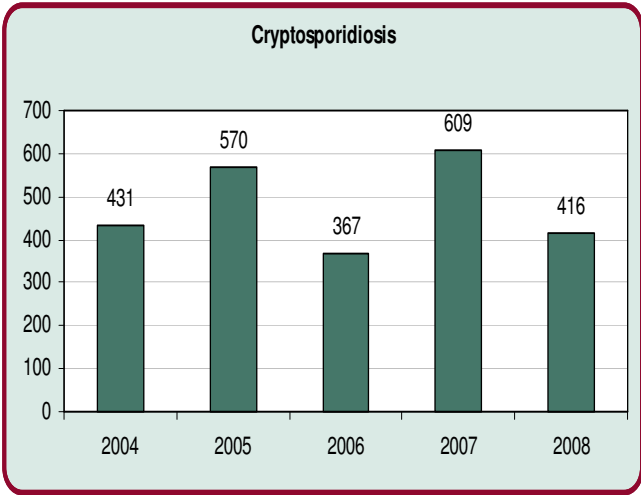
**Target Information**

No target available.

**Commentary**

In 2007 there were 609 cases notified to the HPSC, (up 66% on 2006). The main reason for the 2007 increase was the very high number of notifications in HSE West due to a large outbreak 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.

The EPA has adopted a risk based and outcome driven approach to the enforcement of the Drinking Water Regulations focusing on issues that present the greatest risk to health such as contamination with *E. coli* and *Cryptosporidium*. The EPA is notified by local authorities of each failure to meet the microbiological and chemical standards or where there is a risk to health.



## Tuberculosis

**Metric Used**

The number of Tuberculosis notifications in Ireland

**Rationale**

According to the World Health Organization (WHO), nearly 2 billion people (one third of the world's population) have been exposed to the tuberculosis pathogen. TB is much less common in developed countries, such as Ireland. Early diagnosis is essential to stop the infection spreading from person to person.

**Data Source**

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

**Period Covered By Data**

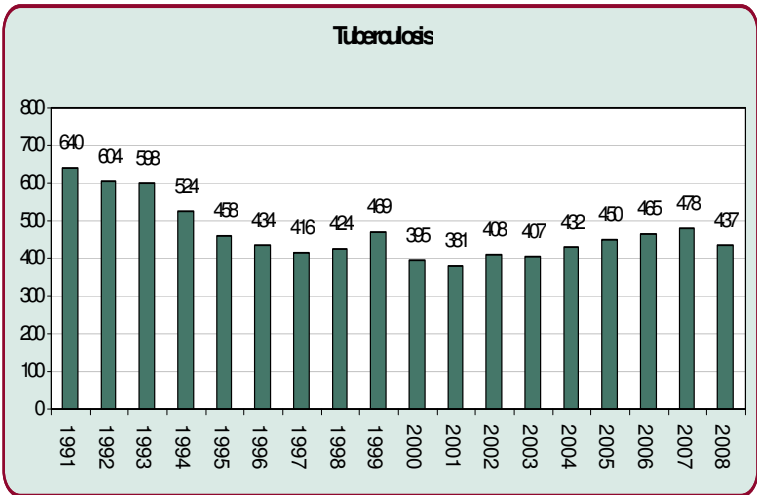
1991 - 2008

**Target Information**

0 cases by 2050

**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.



## Chlamydia

**Metric Used**

The number of notifications of Chlamydia in Ireland

**Rationale**

Chlamydia infections of the genital tract are the most common bacterial sexually transmitted diseases in the developed world. In Ireland there has been a three-fold increase in the number of new cases per year since 1993. However, Chlamydia infection may be even more common than those figures suggest — in some cases, people who carry the infection may be unaware of it for some time; in other cases, confirmed cases of chlamydial infection may not be reported even though chlamydial infection is a notifiable disease.

Chlamydia control programmes in other countries have been successful in reducing the number of new cases, and there may be a need now for a similar screening programme in Ireland.

**Data Source**

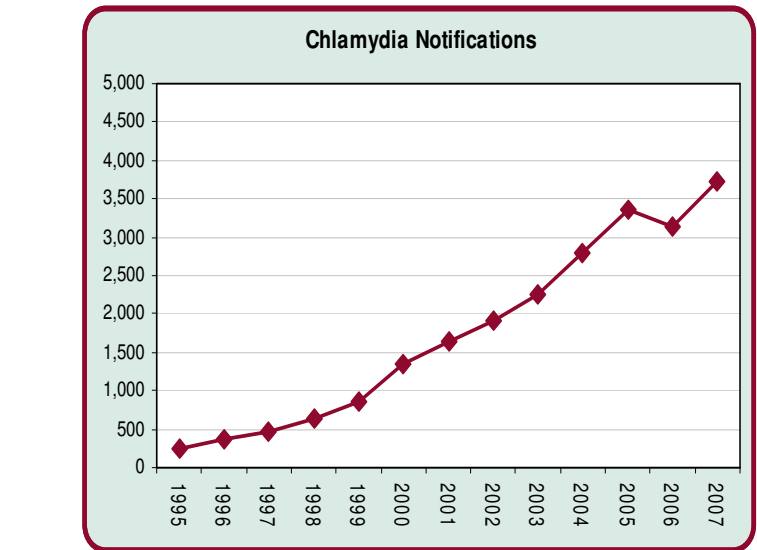
Health Protection Surveillance Centre (HPSC)  
www.hpsc.ie

**Period Covered By Data**

1995 - 2007

**Target Information**

No target available.



**Commentary**

Since 1995 the number of notified cases of chlamydia has increased steadily each year. Notifications increased from 245 to 3,353 (1995 – 2005). However, in 2006 the rate fell by 6%. Males accounted for 46% of cases and 53% female (1% unknown). Those aged 0-19 years accounted for 14% of cases, 70% were 20-29, 13% were 30-39, 3% were aged 40 years or older. Strong evidence is now available that chlamydia screening and treatment not only reduces the prevalence of lower genital tract infection, but also decreases the incidence of costly complications in affected people. Untreated, chlamydia can cause severe, reproductive and other health problems, which include both short and long-term consequences.

## Suicide Rates

**Metric Used**

The 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 Ireland (NSRF)  
[www.nsrif.ie](http://www.nsrif.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 – 2006  
 Data relating to 2007 / 2008 is currently being validated by the NSRF. Therefore the final year of accurate data relates to 2006.

**Target Information**

No national target has been set as it has been decided to prioritise the accuracy of suicide mortality in Ireland in the first instance.

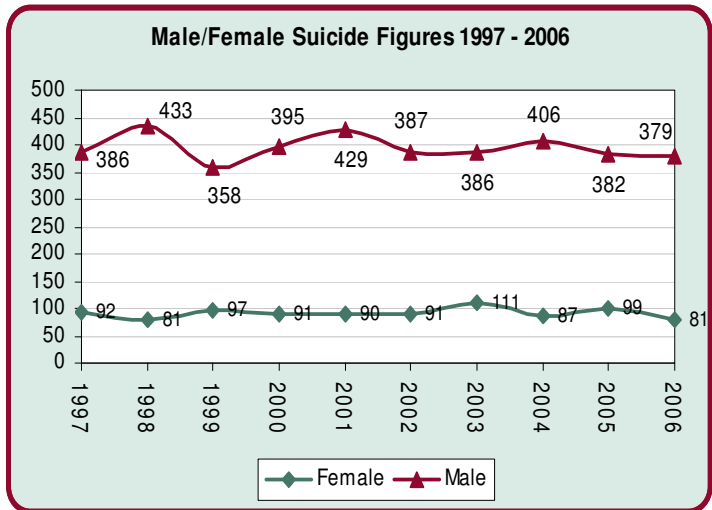
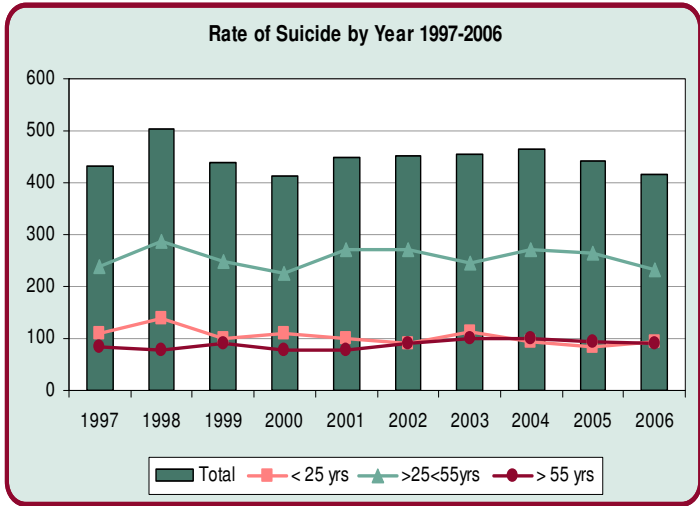
**Commentary**

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 fifth 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 more than 90% 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, honour).

In response to the current economic situation, the HSE has recently (July 2009) 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').



### Deliberate Self Harm

**Metric Used**

The rate of re-presentation of cases of 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.nsrif.ie](http://www.nsrif.ie)

**Period Covered By Data**

2005 - 2008

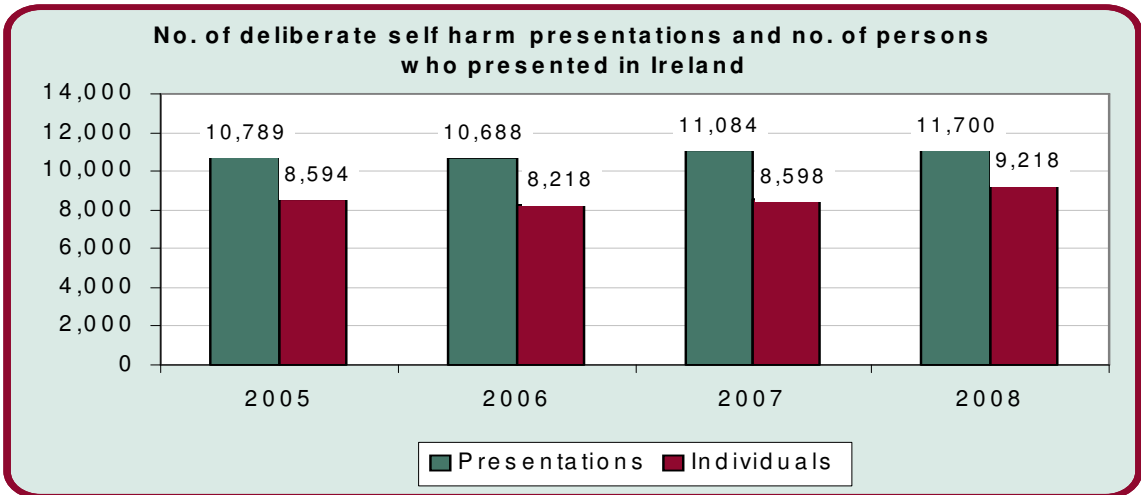
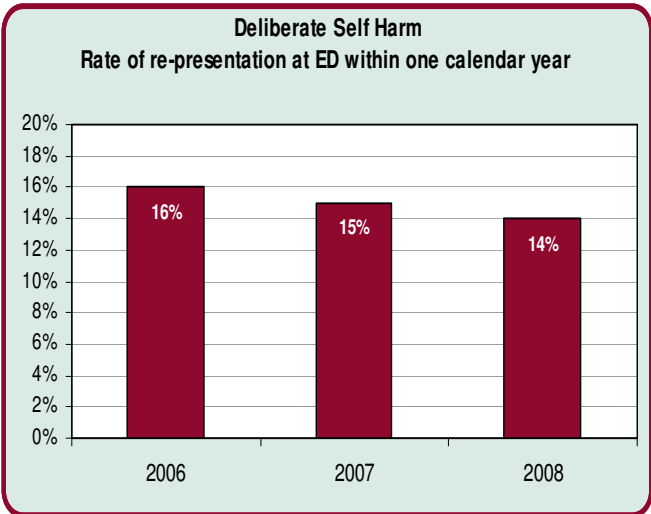
**Target Information**

Incremental reduction, 10% from 2007 figures.  
Target for 2009 is < 13.5%

**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.



# Sustainable Services

## Primary Care Teams

### Metric Used

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.

The development of PCTs is a key priority for PCCC 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.

### Data Source

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

### Period Covered By Data

Latest position June 2009 Performance Report

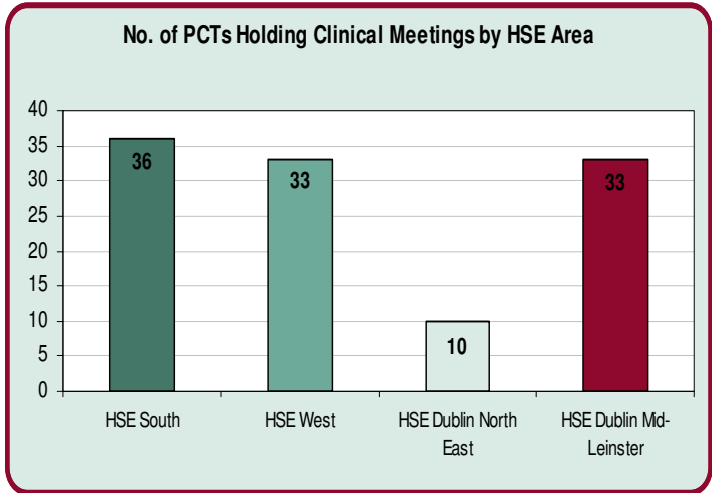
### Target Information

210 teams (Phase 1) holding clinical team meetings by end 2009

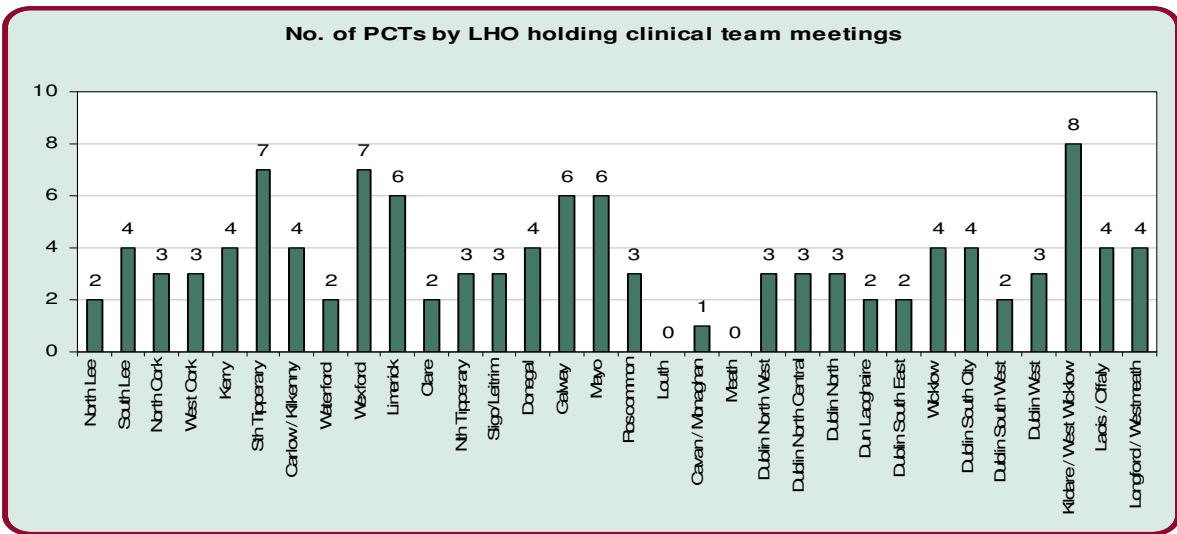
### Commentary

At present there are 112 PCT's operating across the country. This involves a total of 438 GP staff and 754 HSE staff.

It is anticipated that in excess of 210 (NSP target) teams will be in operation by the end of 2009. This is due to a faster rate of progression of PCTs in a number of areas. While DNE have a lower number of PCTs operational at the time of reporting, an additional 15 PCTs are scheduled to be operational by the end of 2009 and a further 18 in 2010. This will bring the total number of PCTs operational in the DNE Area to 43 by the end of 2010.



HSE South	HSE West	HSE Dublin North East	HSE Dublin Mid-Leinster
1,081,968	1,012,413	928,619	1,216,848
(Population Census 2006)			



## Residential Care, Older People

### Metric Used

The number and % 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 their policy and in their investment in community and home care services. This metric is a proxy to measure the levels of older people in residential care where the aim is that no more than 10% of those over 75 years and no more than 4% of those over 65 years should be in residential care.

### Data Source

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

### Period Covered By Data

Q4 2008

### Target Information

Less than 10% of the population aged over 75 years living in long term Residential Care.

By 2013, no more than 4% of the population aged 65 years and over living in long term Residential Care (*medium planning target of the Long Term Care Interdepartmental Working Group*).

### Commentary

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

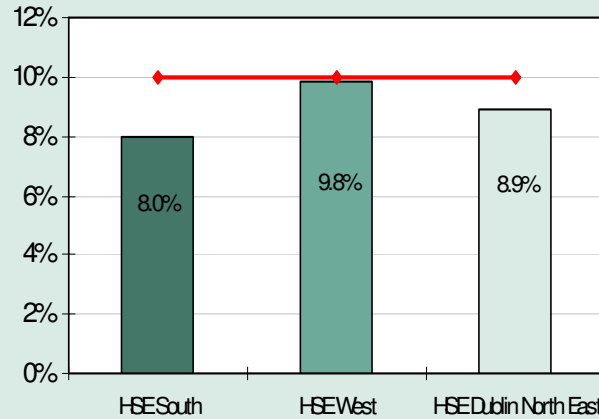
Overall, people are living longer and healthier lives. Providing the support which enables older persons with care needs to stay at home for as long as possible can help greatly to improve their situation and it is what the majority of older people want.

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.

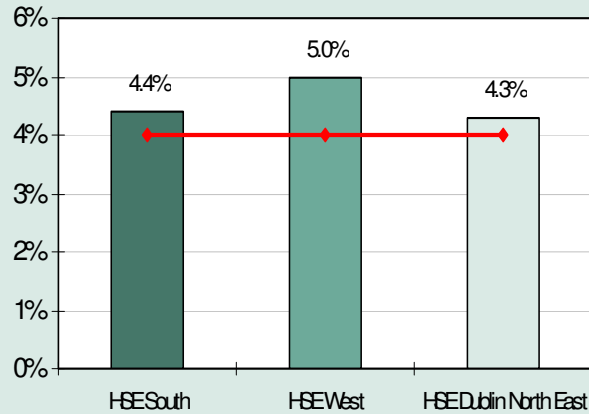
In addition, the implementation of 'A Fair Deal' will have an impact on the proportion of older people in residential care in the future.

% of population 75+ in Residential Care



\* Data relating to DML is incomplete therefore it has not been included in this report.

% of population aged 65 years + in Residential Care



\* Data relating to DML is incomplete therefore it has not been included in this report.

## Home Help Hours

### Metric Used

The number of people receiving home help hours per 10,000 population.

### 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

PCCC Older Persons Minimum Dataset

### Period Covered By Data

Latest position as of June 2009

### Target Information

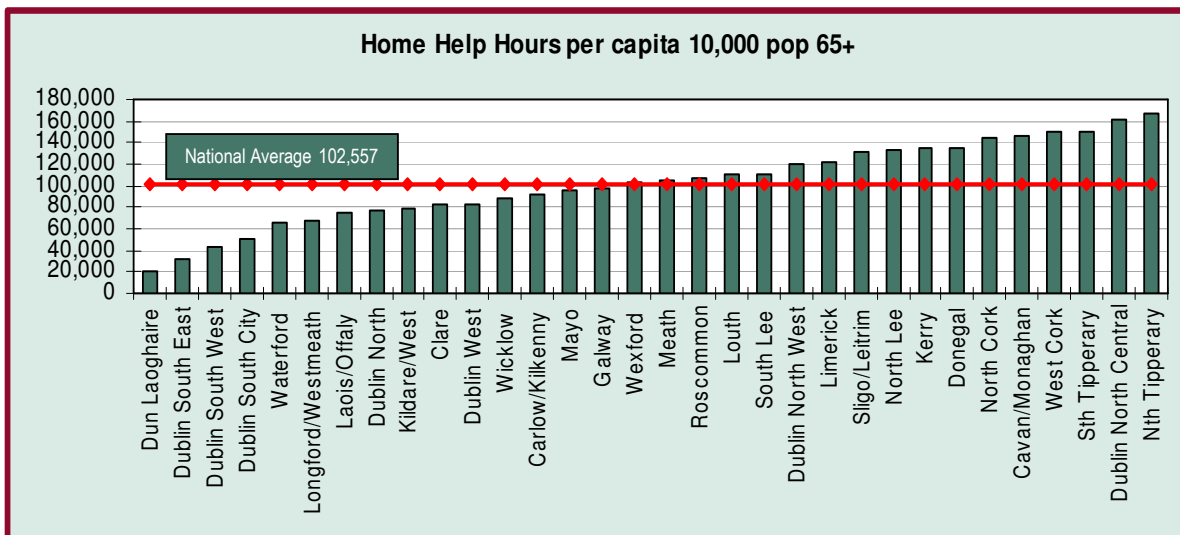
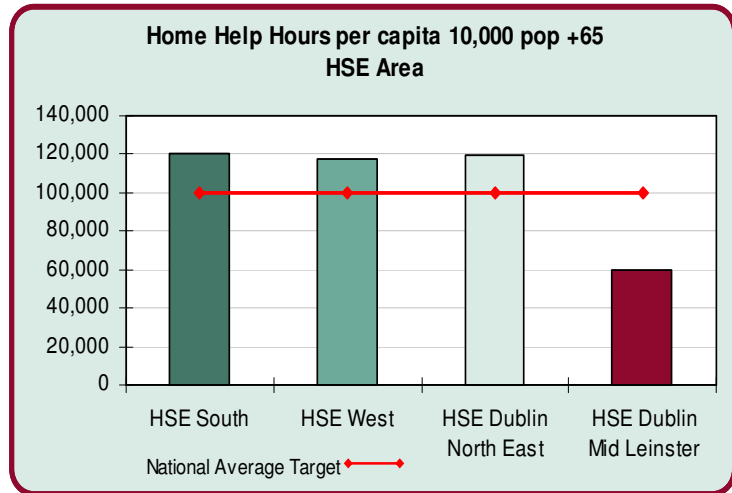
Peer comparison; aim to have equity of access within available resources. Target for 2009 80th percentile of peer performance.

### 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**

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).

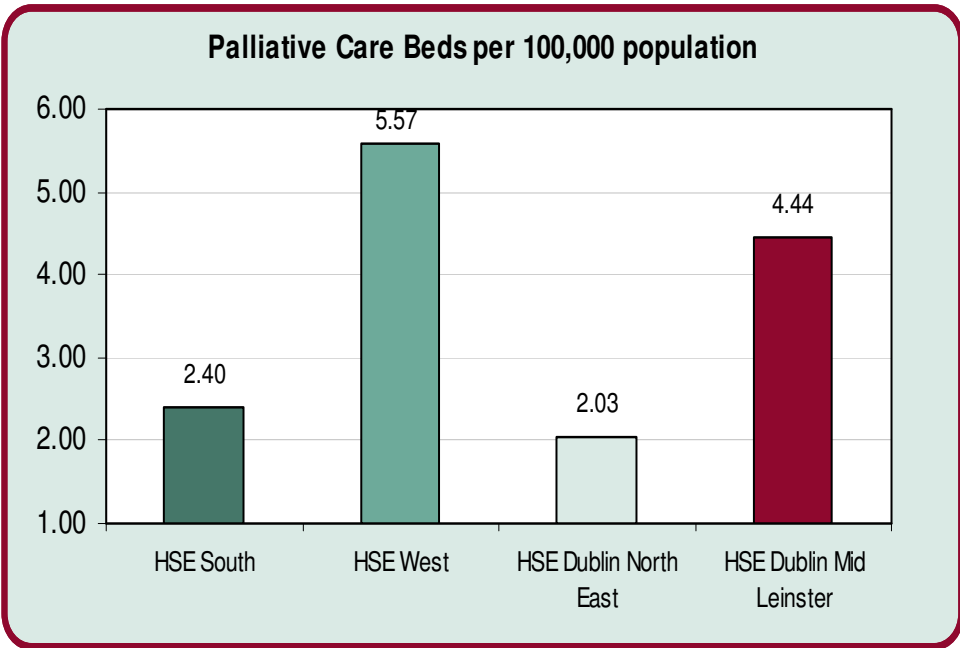
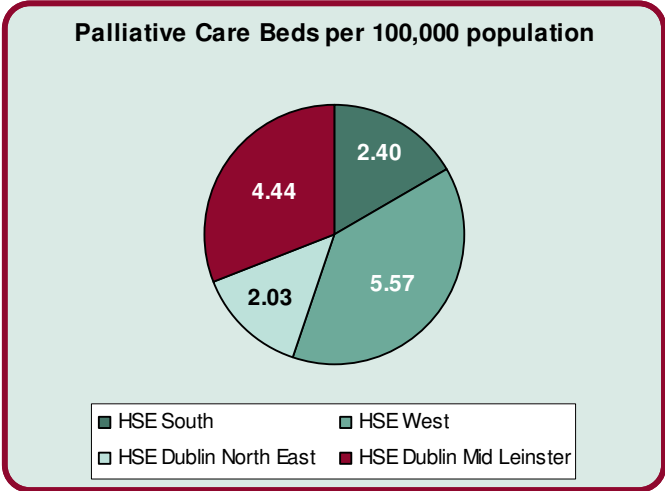
**Target Information**

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

**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 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.



## Child and Adolescent Mental Health Teams

**Metric Used**

The number of Child & Adolescent Mental Health Teams

**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). The programme recommends the creation of community mental health teams with a range of disciplines available to the service user to meet their individual needs.

**Data Source**

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

**Period Covered By Data**

2008 – June 2009

**Target Information**

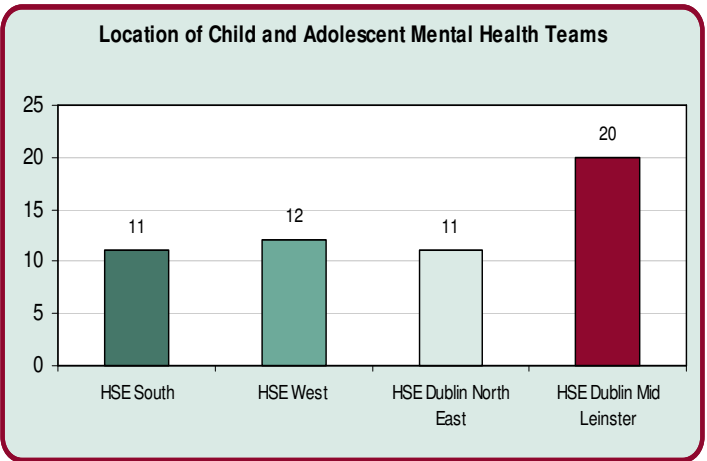
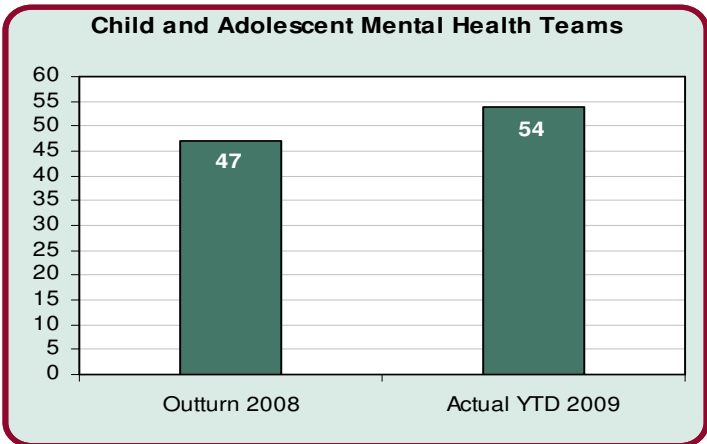
HSE National Service Plan target 2009: 55 teams. This is an incremental target towards the target of 99 specified in the Vision for Change

'Vision for Change' recommendation: 99 Teams, including 84 Community based teams, 14 Day hospital teams and 14 Hospital Liaison teams.

**Commentary**

Child and Adolescent Mental Health Services are provided in a variety of settings around the country with a total of 54 CAMHS teams serving the various components as of June 2009. These services include Community-based Child & Adolescent Teams (49), Day Hospital services (2), Liaison Services and Inpatient Services (3).

The number of CAMHS teams operating nationally has increased from 47 teams at the end of December 2008 to 50 teams by end January 2009 and a further 4 teams as of June 2009. It is planned that a further 35 Allied Health Professional posts will be positioned in 2009 to develop an additional six teams by the end of 2009. This will increase the teams to 64 which represents a 36% increase since 2008.



HSE South	HSE West	HSE DNE	HSE DML
268,236	250,106	225,749	290,493

Population <18 years of age (Census 2006)

### Children in Residential Care

**Metric Used**

The number and % of children in Residential Care as a % of all children in care

**Rationale**

Monitoring of the placement of children aged 12 and under 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 Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

**Period Covered By Data**

Position as of June 2009

**Target Information**

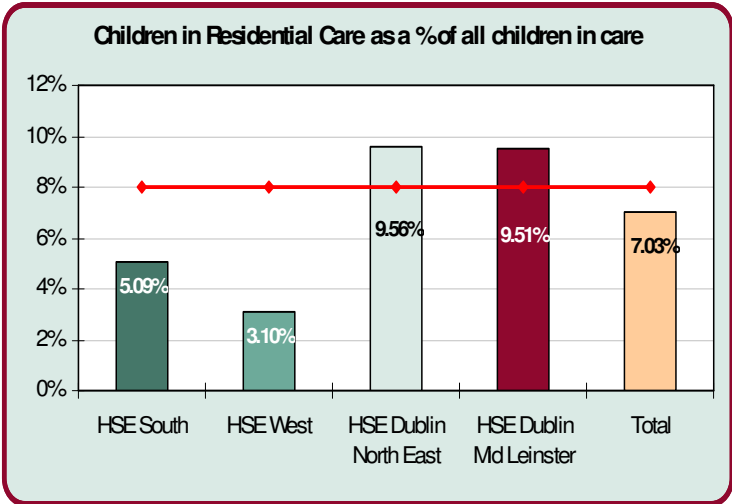
NSP 2009 target < 8%: international target < 5%.  
Target used for CPM in 2009 6.5%

**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**

The number and % of children in care during the reporting period who had a care plan in place.

**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**

Childcare Minimum Dataset

**Period Covered By Data**

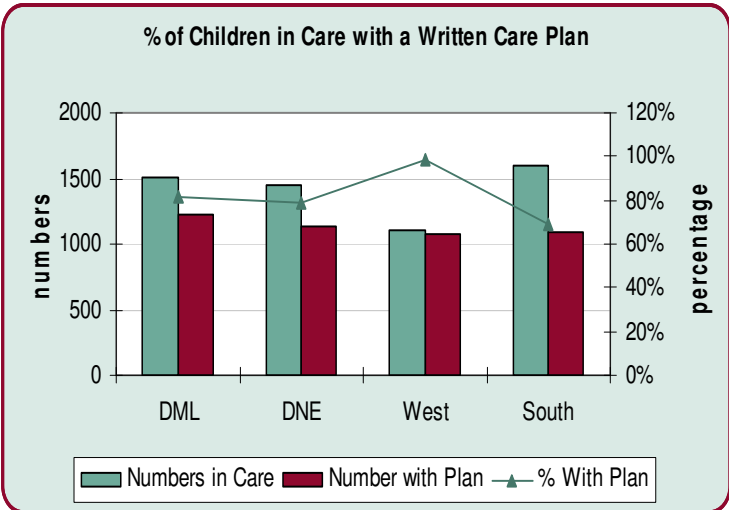
Position as of June 2009

**Target Information**

NSP target 82%. Target used in CPM is 100%.  
Ryan Report - all children in care to have a written care plan. Target to achieve 100% by 2011.

**Commentary**

At the end of Q2 2009 80% 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 70.9% in Q2 2009, an increase of 78%. Similarly, DNE has improved performance from 60% in Q4 2008 to 78.9% in Q2 2009, a 31% increase.



PCCC 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 2011.
- Impact of social work recruitment.
- Impact of implementation of standardised care plan and guidance documentation.

## Average Length of Stay

**Metric Used**

The overall 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 Management Unit, National Hospital Office, HSE

**Period Covered By Data**

June 2008 v June 2009

**Target Information**

5.9 days (NSP 2009)

**Commentary**

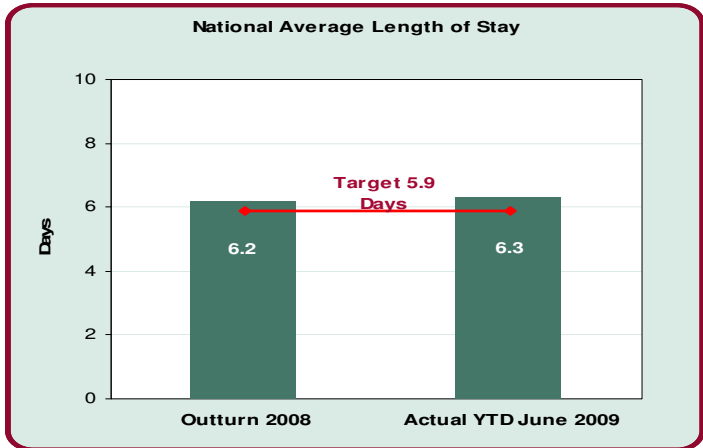
This is a crude overview of the current ALOS position in Irish hospitals. A more comprehensive analysis would factor in complexity and age profile of hospitals' patients.

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.

Delayed discharges have increased by 23% from June 2008 to June 2009. This has had a significant impact on efforts to reduce ALOS. When excluding bed days lost to delayed discharges from calculations the ALOS reduces to 5.8 for 2009.



## Inpatient / Day Case Ratios

**Metric Used**

Day case discharges as a proportion of in patient and day case 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 Management Unit, National Hospital Office, HSE

**Period Covered By Data**

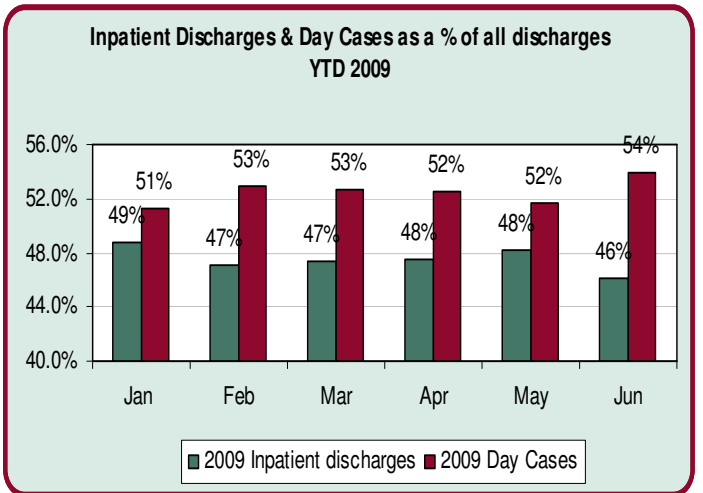
Jan – Jun 2008

Jan – Jun 2009

**Target Information**

55% is the NSP 2009 target. International target for basket of Day Cases is 70%. Target used in CPM is 60%.

The volume of Inpatients and Day Cases combined has increased compared to 2008 (1.9%). This increase has been solely in day cases with an actual reduction in the number of inpatient discharges in 2009 to date. The ratio of day cases has increased from 51.2% (Jan – Jun 2008) to 52.5% (Jan – Jun 2009).



# Quality & Safety

## Caesarean Section

### Metric Used

The proportion 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 Management Unit, National Hospital Office, HSE  
www.cso.ie

### Period Covered By Data

1950 – 2006: Births in Ireland (CSO)  
Jan – June 2009: Births / Caesarean Sections

### Target Information

The World Health Organisation (WHO) recommends that the rate of Caesarean Sections should account for not less than 5% nor more than 15% of all births.

A target of <20% has been set in the NSP 2009 and this is used for the purposes of the CPM.

### 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).

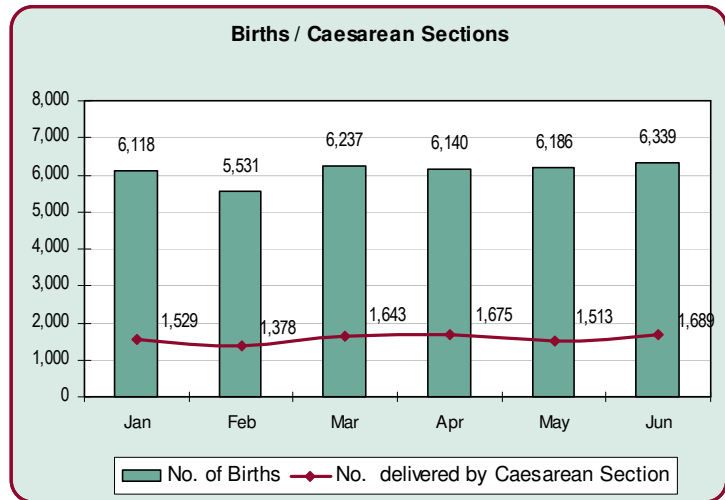
The National Perinatal Reporting System (NPRS) gathers information on approximately 65,000 birth records every year from 22 hospitals and 20 independent midwives.

The rate of delivery by caesarean section has been steadily increasing since 1993 (13%), 1999 (20.5%), 2002 (22%), 2006 (25.5%). Currently (June 2009) the average rate of babies delivered by Caesarean section in Ireland stands at 26.6%; or over 10% higher than the rate recommended by the WHO.

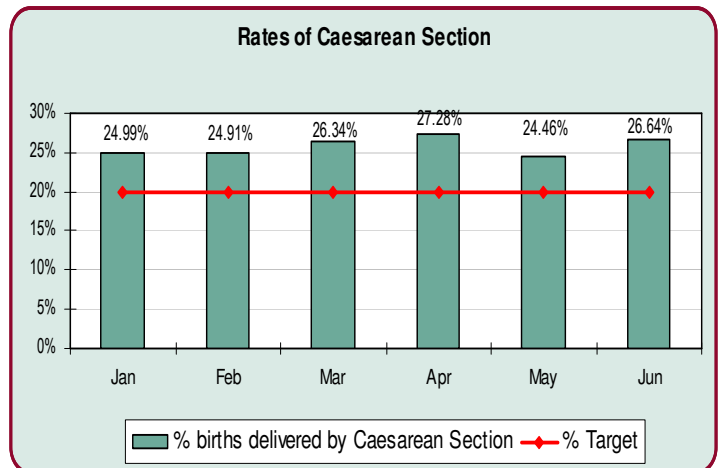
An examination of caesarean section rates across Europe highlights an increase in the number of caesarean sections in all European countries; however the rates in Ireland are amongst the highest in Europe [WHO data].

Given the significant health affects caesarean sections can have on mothers and their babies and the higher associated cost implications it is important to investigate the factors which are driving the increased rate here in Ireland.

Births / Caesarean Sections



Rates of Caesarean Section



### Symptomatic Breast Cancer Services

**Metric Used**

The number and % of cases compliant with HIQA standard of 2 weeks for urgent referrals.

The number and % of women seen who were waiting longer than 12 weeks for access to symptomatic service.

**Rationale**

The National Cancer Control Programme (NCCP) set out to achieve 90% of all breast cancers treated within the 8 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, will be fully in place by end 2009 (target compliance in all 8 centres).

**Data Source**

Collection by data managers at 8 cancer centres (6 of which are 2008 new NCCP appointments).

**Period Covered By Data**

January v June 2009

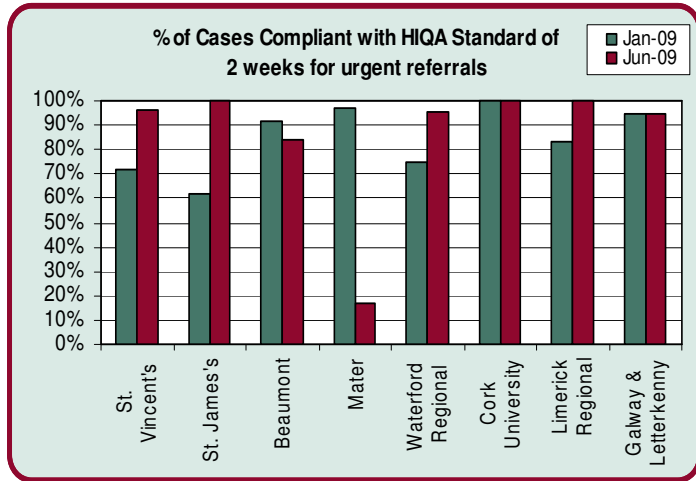
**Target Information**

100% for both metrics

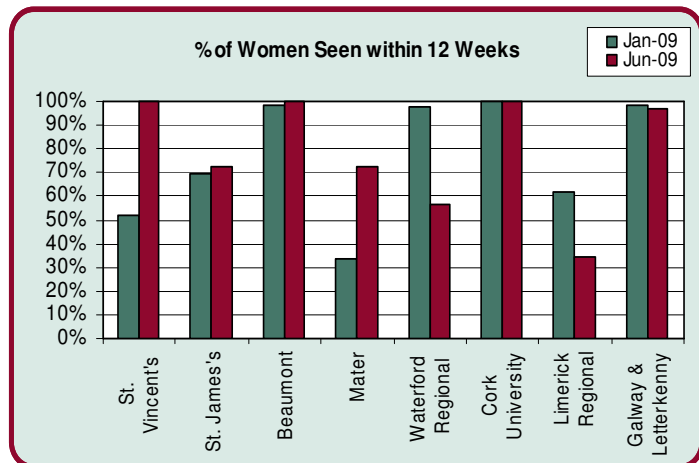
**Commentary**

Investment in the 8 cancer centres and amalgamation of services has provided the opportunity to improve access to breast services for urgent symptomatic breast disease. The priority during 2009 is the urgent target of 2 weeks, and provision of an improved service for non symptomatic patients referred (target 12 weeks), with the aim of full 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 09 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**

The rate of MRSA blood stream infections.

**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**

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

**Period Covered By Data**

2002-2009 (to end Q1): 4-quarterly moving average

**Target Information**

To reduce MRSA infections by 30% from 2007 rates. 2007 was 37.5%, a 30% reduction would give a target of 26.25% for the CPM.  
 Ref: HSE Infection Control Plan 2007: 'Say No to Infection'

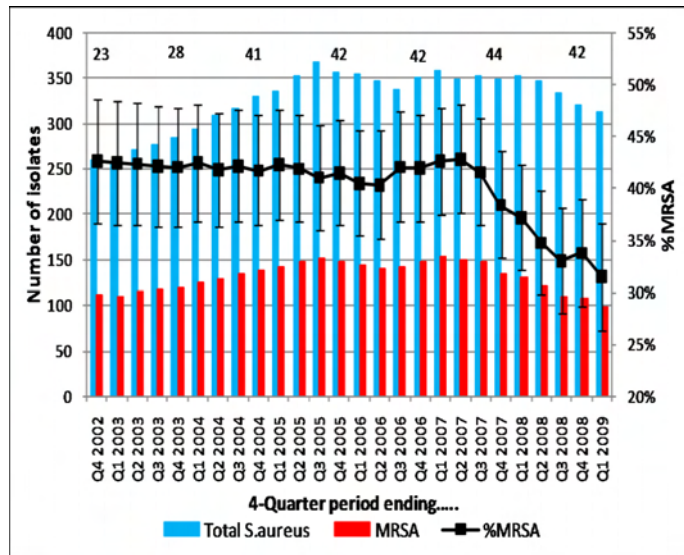
**Commentary**

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 laboratory detection and improved implementation of isolation precautions in hospitals).

There has been a reduction in hospital antibiotic use, between 2007 and 2008, with an associated reduction in direct drug costs of 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.

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.



## Food Safety Inspections

### Metric Used

Number of Food Safety Inspections carried out by Environmental Health Officers (EHO's) in Ireland

### Rationale

Environmental Health food inspections monitor the safety and cleanliness of our food supplies. EHO's sample a wide range of foodstuffs to ensure compliance with the legal requirements relating to food additives, compositional standards and labelling.

### Data Source

HSE Environmental Health Department

### Period Covered By Data

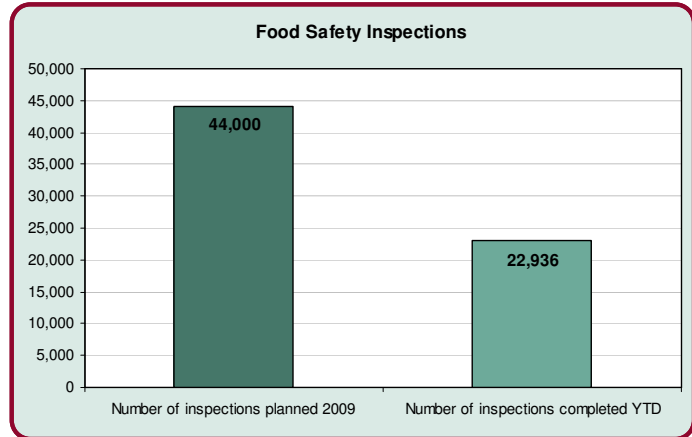
Jan – June 2009

### Target Information

Annual target as per Population Health National Service Plan for food safety: 44,000 (half year target 22,000)

### Commentary

2009 is the start of the first full year of Environmental Health as a national service and national data is available for the first time in relation to the Environmental Health activities above (excluding food safety). Food safety inspections are on target for 2009. The review of the food safety service contract with the Food Safety Authority of Ireland (FSAI) identified that previous targets were not realistic. A review of food safety targets is underway. In the interim the agreed target with the FSAI is an annual target of 44,000 food safety inspections.



## Emergency Planning

### Metric Used

Appropriate Emergency Planning contingencies are in place in the HSE.

### Rationale

The National Crisis Management Team (NCMT) have ensured that appropriate arrangements had been put in place to manage containment of the Pandemic H1N1 2009. As of June 2009, the HSE along with many other countries, has moved from containment to mitigation of the flu pandemic.

### Data Source

HSE – National Crisis Management Team (NCMT) within the HSE

### Period Covered By Data

Position as of June 2009

### Target Information

Not applicable

### Commentary

#### Summary of the NCMT Preparedness Actions

1. The identification of priority services that need to continue through a Pandemic and identification of staff throughout the organisation that can be redeployed to other duties such as Mass Vaccination centres and Flu Clinics is underway.
2. Updated action plans for each Hospital, Local Health Office, Public Health Department and the Ambulance Service are being actioned locally.
3. The stages of responses which will be delivered as case numbers and severity increase are being finalised:
  - a. Stage 1 The current Public Health lead response
  - b. Stage 2 GP lead response, Antivirals in Community Pharmacies and Hospitalisation increasing
  - c. Stage 3 Special measures such as Flu Clinics and Telephone Hotline put in place to protect GPs and Hospitals
4. Work is continuing on Mass Vaccination arrangements to specify the logistical and staffing requirement of delivery of approximately 200,000 doses of vaccine each week from the Autumn onwards. This may have implications for our National Service Plan.
5. National stockpile of essential items to manage a Pandemic is nearing completion and work is underway on the distribution and dispensing arrangements required.
6. Work on the minimum dataset is at an advanced stage which will ensure that systems are in place to provide management with the essential information needed to manage the crisis daily.
7. Communications Strategy is in place which will ensure that the communications elements for both external and internal communications for the possible stages of a Pandemic are in place or drafted. These include TV, radio and print adds, web content, press briefings and information lines.
8. HR policies specific to the massive redeployment requirements of a pandemic have been finalised as have policy regarding absenteeism and overtime.
9. ICT are continuing to ensure that support is in place for the management of the dataset, flu clinics, vaccination clinics and the telephone hotline.
10. A financial approval process is in place in relation to costs being incurred in preparing our response for Pandemic Flu.

## Complaints

**Metric Used**

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**

Latest position as of June 2009

**Target Information**

It is the aim of the service to deal with complaints within 30 working days

**Commentary**

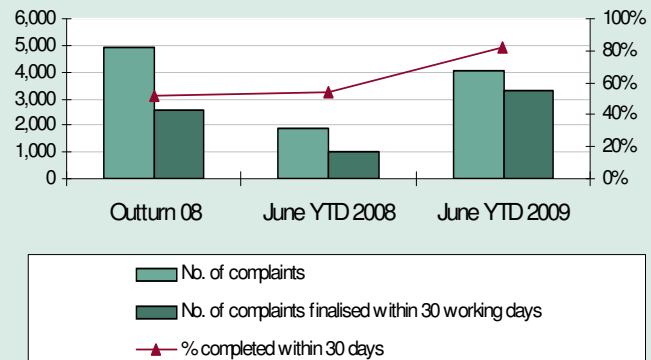
The reason for the increase in the number of complaints received in 2008 v 2009 is due to improvements in the reporting of 'Complaints Resolved Informally'.

This number has also increased in 2009 due to the inclusion of 3 sets of figures in the activity data (i.e. 'Complaints Resolved Informally', 'Complaints Withdrawn' and 'Complaints dealt with within 30 working days at Stage 2'). Previously, only the number recorded in the 'Complaints Dealt with within 30 working days' column was used. This current method of calculation provides a more accurate figure under the heading 'Number of Complaints Finalised within 30 Working Days'.

It should be noted that there are a number of reasons for complaints to be recorded under 'Complaints received pending at end of last month':

- Complaints received up to the last day of any month are counted as part of the complaints received in that month but would not usually be finalised before the first day of the next month.
- 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.

**No and % of Complaints dealt with within 30 days**

# Trust and Confidence (Access)

## Ambulance Response Times

**Metric Used**

Proportion of ambulance 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**

Outturn 2008 and 2009 YTD

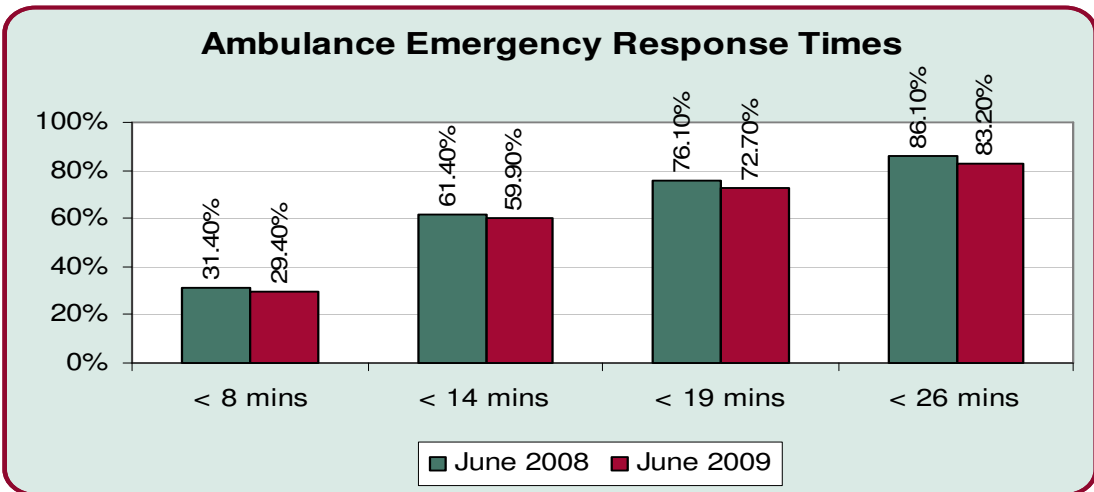
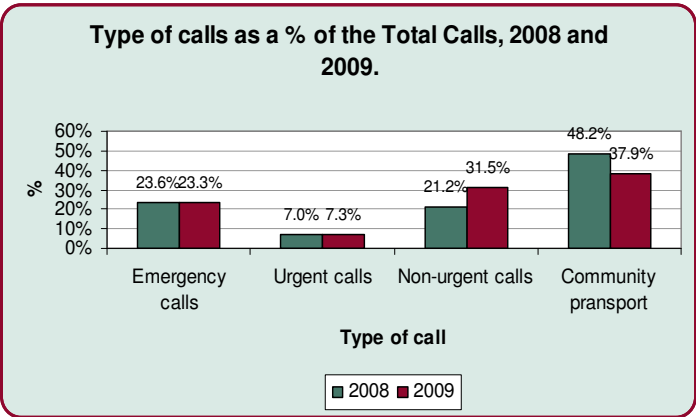
**Target Information**

NSP 2009 Targets:  
 <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. This is the target used in the CPM.

**Commentary**

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 YTD 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.



### GP Out of Hours Service

**Metric Used**

The % of the population who have access to structured 24 hour (co-op) urgent GP out of hours services

**Rationale**

During 2008 approximately 920,000 contacts were made to GP Out of Hours services. 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, since 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**

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

**Note:** Data relates to GP Co-ops with 24 hour coverage.

**Period Covered By Data**

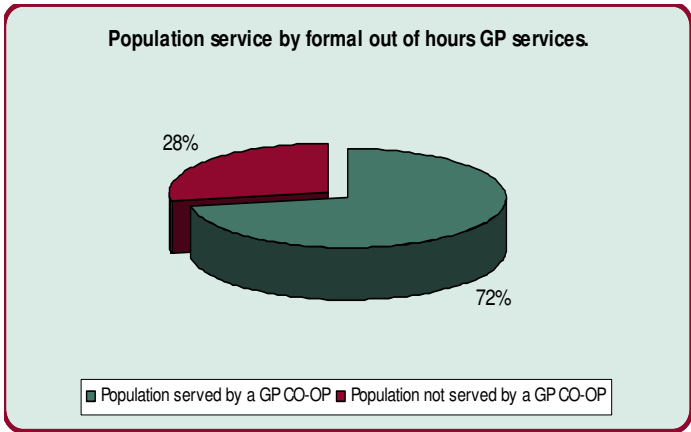
Position as of June 2009

**Target Information**

85% of the population with formal out of hours coverage is used as the target for the CPM. This is an incremental aim towards 100% coverage for the population.

**Commentary**

Approximately 3.063 million people in Ireland now have access to structured 24 hour (co-op) urgent GP out of Hours services (approximately 72% of the total population, CSO Census data 2006). There is, however, 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).



### Aftercare Support Services for Young People

**Metric Used**

Number and % of LHOs operating a formal leaving and aftercare support service for young people leaving care.

**Rationale**

Section 45 of the Child Care Act 1991 sets out general powers that the HSE have to support young people when leaving care. Whilst the statutory legislation does not place any specific duties upon the HSE, they are required, considering their ongoing responsibilities towards young people who were formerly in their care, to act in the manner of a 'good parent'. Internationally, many interpretations of good practice in relation to aftercare support specify a continuing obligation up until the age of 21.

**Data Source**

Performance Monitoring Unit, Primary Community and Continuing Care (PCCC), HSE

**Period Covered By Data**

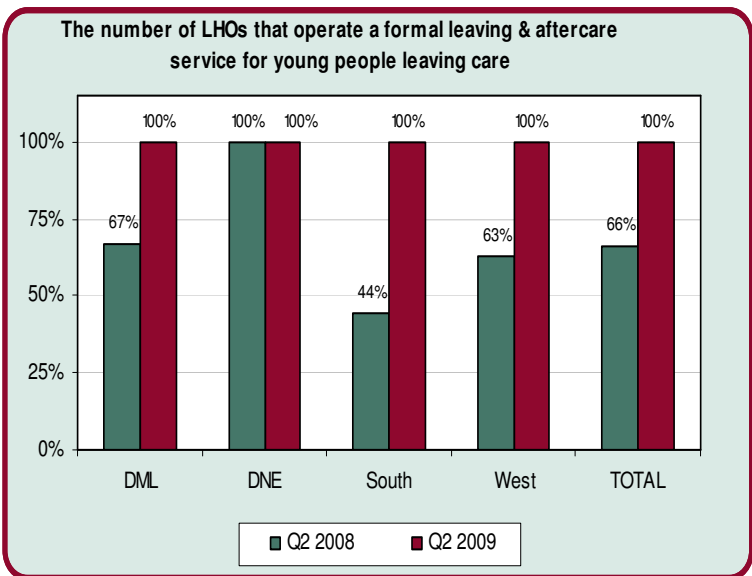
Position as of June 2009 Performance Report

**Target Information**

32 LHO's (100% coverage)

**Commentary**

All 32 LHO Areas now have an aftercare support service for young people in place.



## Disability Assessments

### Metric Used

The number of assessments completed within the timelines as provided for in the regulations

### Rationale

The Disability Act 2005 provides for the assessment of need of people with disabilities and the consequent drawing up of service statements. The assessment of need is carried out or arranged by assessment officers who are independent officers of the HSE. After the assessment, a service statement is drawn up by a liaison officer who is also an independent HSE official. At present only children under the age of five are entitled to an assessment. It is intended that other age groups will be gradually be included so that everyone with a disability will be covered by 2011.

### Data Source

Assessment Officer's System (AOS) database - Disabilities Information Unit

### Period Covered By Data

Q4 2008

### Target Information

100% completed within specified timelines as laid down in regulation.

### Commentary

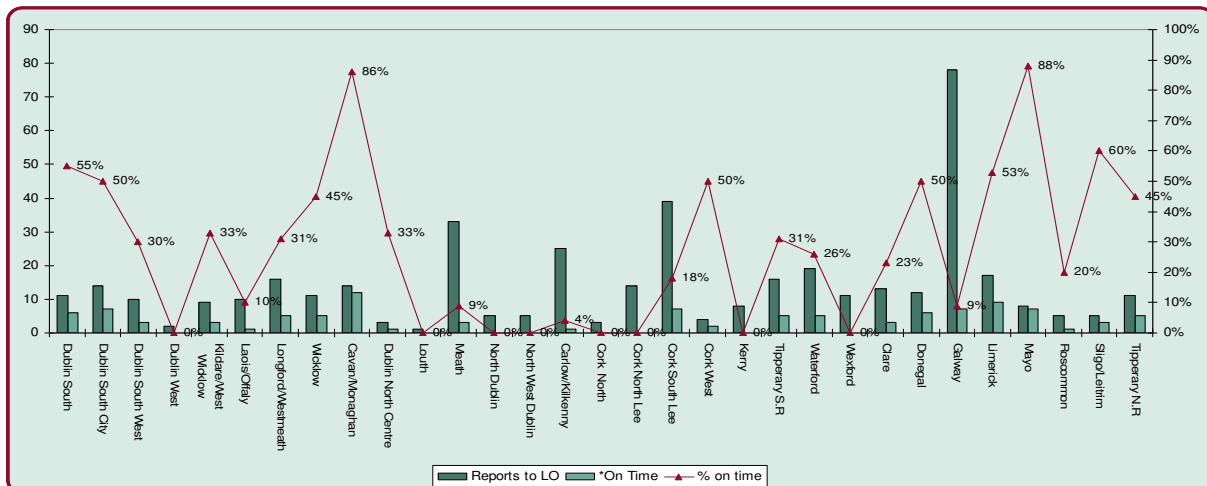
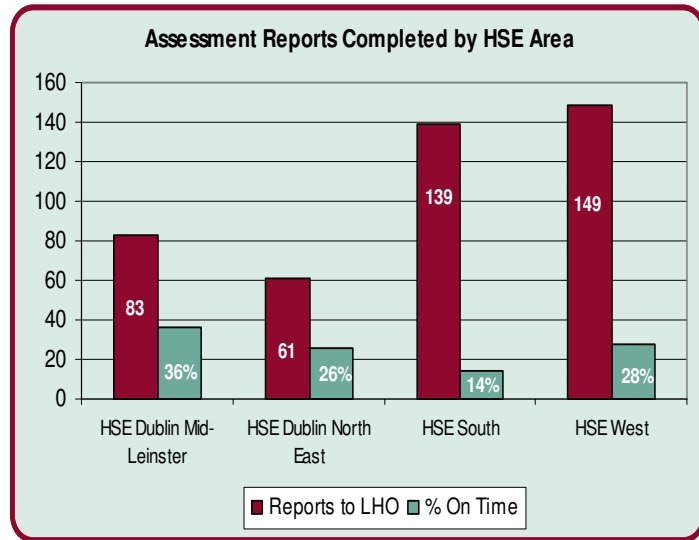
432 Assessment Reports were completed and given to the Liaison Officers during the 4<sup>th</sup> quarter of 2008 of which 107 (25%) were completed within the statutory timeframes.

Across LHOs there is variation in the number of assessments both commenced and completed on time ranging from 0% in 8 LHOs to 88% in Mayo. However, it must be borne in mind that the number of applications is quite low so percentages may appear truncated as a result. For example, in Dublin North Central, 3 applications were completed of which 1 was completed on time.

A number of Local health 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
- 140 posts allocated from the 2008 development funding to provide additional capacity to provide assessments. Recruitment for these posts was delayed and did not commence until July / Aug 2008. Year to date, 131 of these posts have been filled with 9 remaining.
- New guidelines for Assessors and Assessment Officers designed to make the process more efficient were put in place in May 2009.

A particular focus is now being taken by the PCCC management team on seven LHOs with the longest time taken to complete assessments. Each LHO is being asked to identify the specific reasons for delays in their areas and for action plans with identified responsibilities to address these issues. Improvements should be evident by fourth quarter figures. Once improvement has been achieved in these areas, attention can be focused on the next poorest performers.



### Emergency Department: Experience of All Attendees

**Metric Used**

Average time from registration to discharge from Emergency Department (ED) for all attendees.

**Data Source**

Performance Management Unit, National Hospital Office, HSE

**Period covered by Data**

Position as of May and June 2009

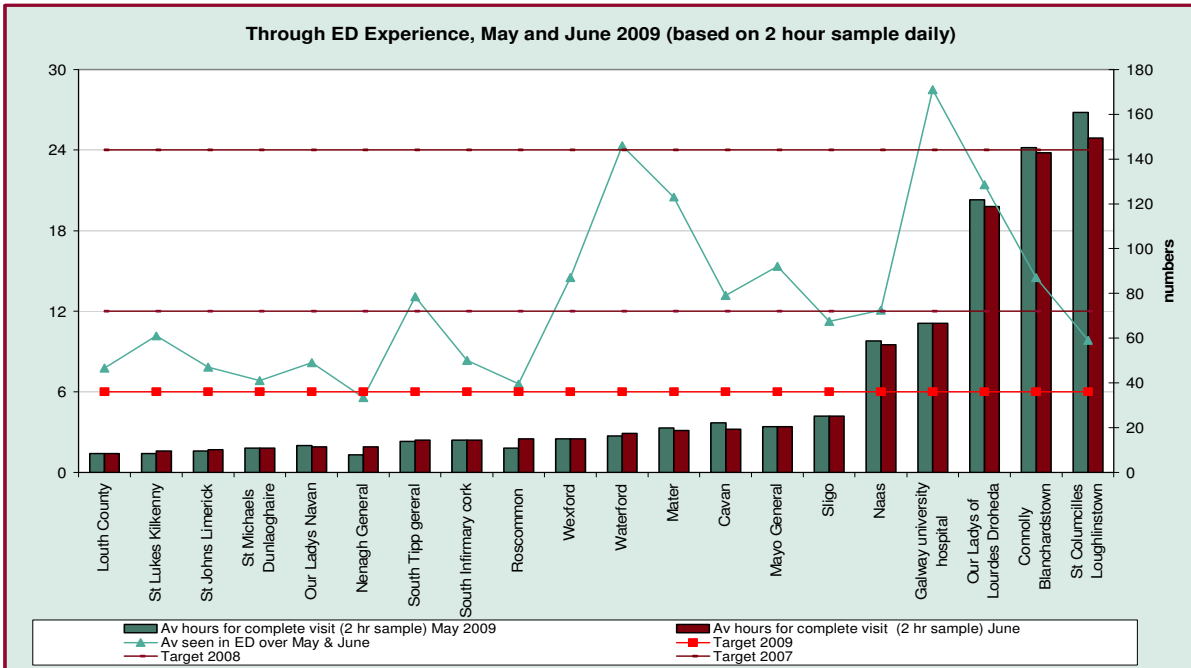
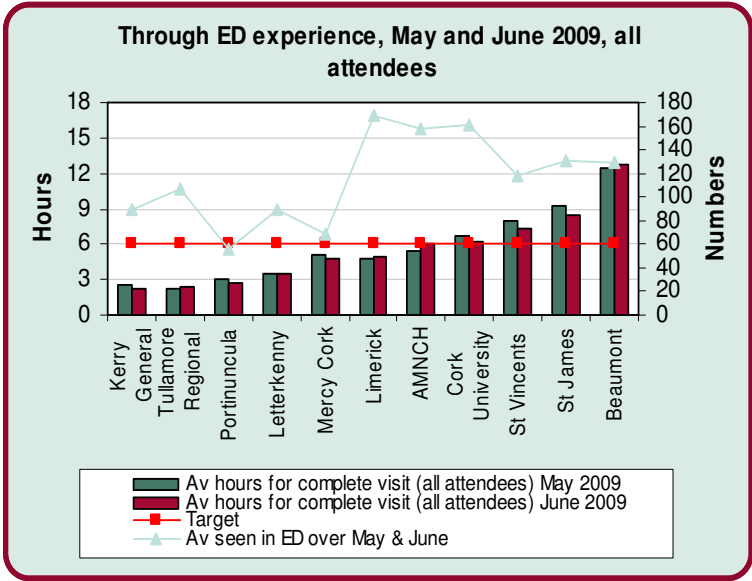
**Target Information**

6 hours the average time from registration to discharge from ED

**Commentary**

Data is now available from 31 EDs on the complete ED experience\*, from registration to admission/discharge, covering May and June 2009. This provides a baseline against which progress towards the target of 6 hours can be tracked.

The June data shows 22 out of 31 EDs (71%) meeting the target for all attendees at ED. There are some notable performances - average number of daily attendances in Limerick, AMNCH and Waterford are over 150 people, yet their patient experience is managed within 6 hours.



\*Two methods are currently used to examine the through ED Patient Experience:  
 Method 1: all attendees are tracked over 24 hours (Chart 1)  
 Method 2: a sample of attendees is taken over a two hour period between 11am and 1pm and their experience is tracked over the day (Chart 2).

## Emergency Department: Experience of People Admitted

### Metric Used

Average time from registration to discharge from Emergency Department (ED) for people who are admitted.

### Data Source

Performance Management Unit, National Hospital Office, HSE

### Period covered by Data

Position as of May and June 2009

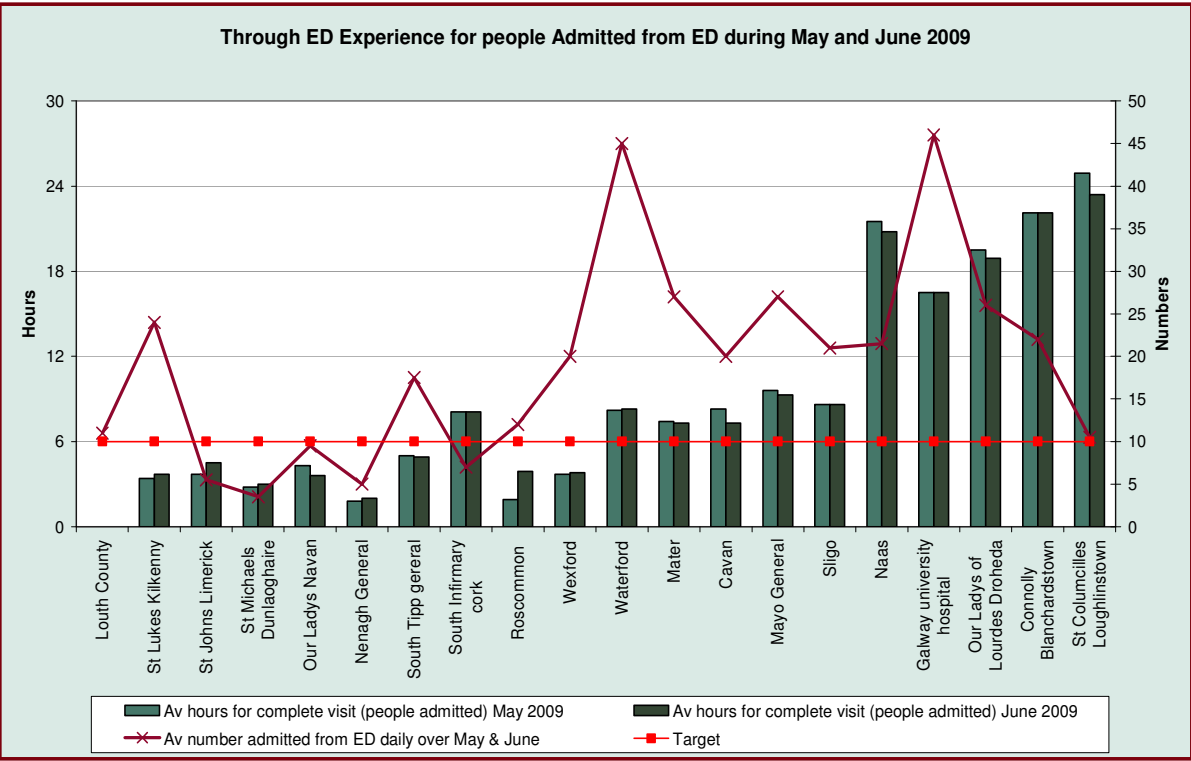
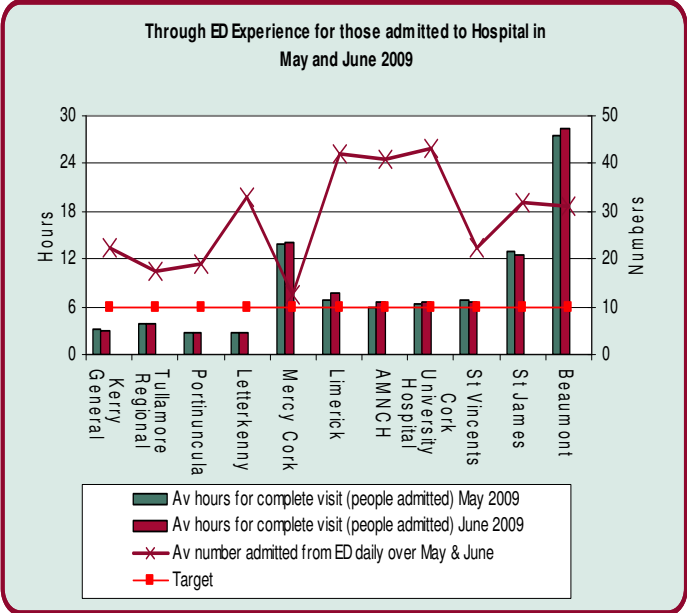
### Target Information

6 hours - average time from registration to discharge from ED

### Commentary

The through ED Experience for the group who are admitted is longer on average. 13 out of 31 EDs (42%) meet the six hour target currently set for this group. Delayed discharges are significant in two of the hospitals who have long waiting times for patients being admitted; however the cause and effect of this needs further examination as the data shows variable effect across the hospitals.

This information will be refined and expanded during 2009 and will provide a baseline and trend for analysis of successful practice and causes of delays.



Public / Private Hospital Activity

**Metric Used**

Public as a % of all patients  
 Elective 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**

Performance Management Unit, National Hospital Office, HSE

**Period Covered By Data**

Jan – Jun 2009

**Target Information**

80% public as a % of all patients (NSP 2009)

**Commentary**

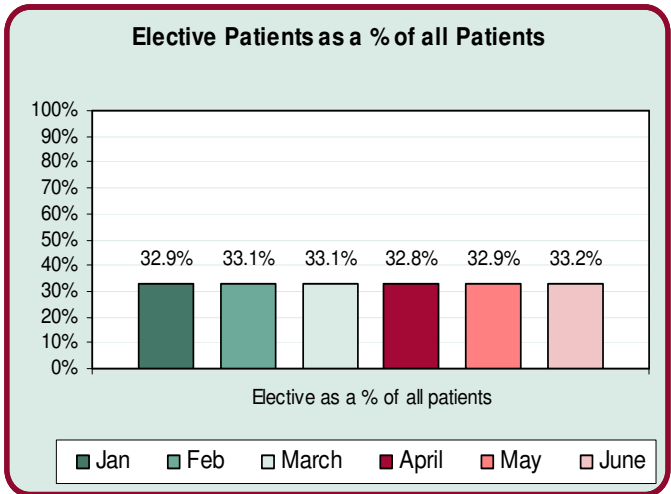
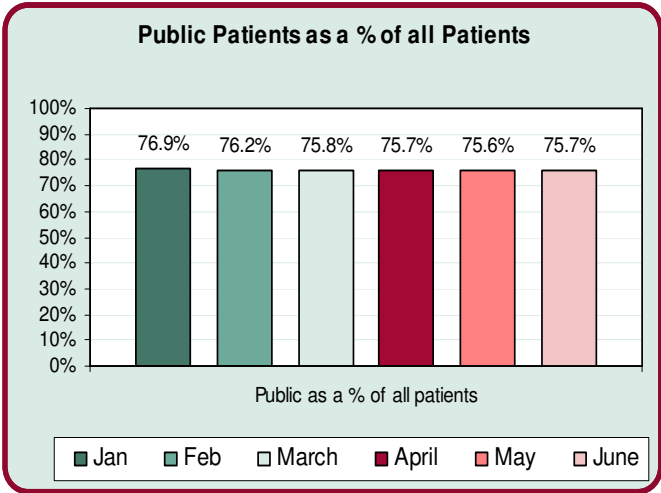
While the percentage of public inpatients treated in the period January – June 2009 is below the NSP target of 80%, the figure compared to the same period last year has improved from 74.8% public (2008) to 75.7% public (June 2009).

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

Emergency admissions to hospitals has increased from 66.3% (June 2008) to 66.8% (June 2009).

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.



# Operational Excellence and Unlocking Our Potential

## Budget Management

### Metric Used

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

Position as of June 2009

### Target Information

No variation from overall budget within a fiscal year.

### Commentary

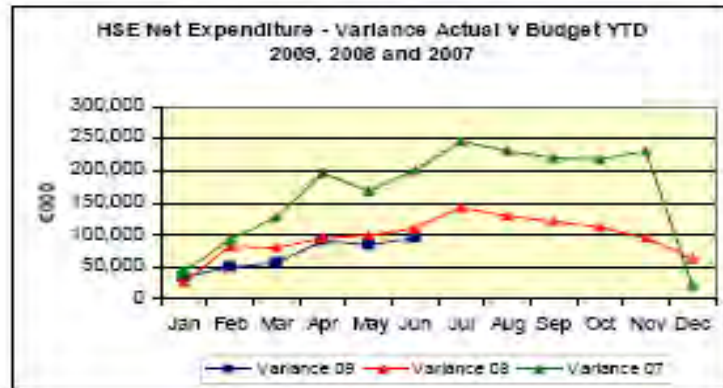
The financial results for June show total expenditure of **€6.802 billion** against a year to date budget of **€6.706 billion** – a deficit of **€95.9 million**.

- The deficit for the half year to the end of June 2009 is €95.9m, including €5m for the Health Repayments Scheme. It is anticipated that the HSE will obtain a technical adjustment at year end which will bring the Health Repayments scheme budget up to €80m as reflected in the vote.
- The deficit at the end of June is made up of the following components:

Statutory Hospitals	€32m
Pensions	€40m
Voluntary hospitals	€10m
Schemes	€9m
Repayments Scheme	€5m
<b>Total</b>	<b>€96m</b>

- Local Health Offices are exhibiting a small surplus to the end of June.
- Significant actions are required in two hospital networks, West/NW and Mid West, to bring expenditure in line with budget. Other hospital networks are working within their overall 2009 business plans.
- The significant cost of pensions is an issues which will have to be addressed in the overall global financial situation.

€95.9 million represents less than 1% of the budget on a full year basis. Budget process has improved and there is clarity around the issues which have to be managed to break even by year end.



### 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**

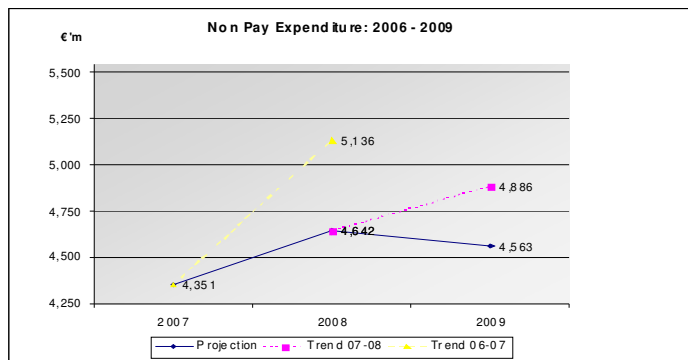
Current position as of June 2009

**Target Information**

The VFM requirement for 2009 is the delivery of €115m efficiencies and maintenance of the €280m delivered in 2008. All contributing to the €300m required overall between 2007 and 2010.

Target used in CPM is the % achievement of planned VFM.

VFM	Required Reduction €m	June YTD €m
<b>Non Pay</b>		
Travel and Subsistence	6,200	2,709
Legal	2,000	0,000
Advertising	1,000	0,500
Nurse Training and Education	5,000	2,500
Nat. Drugs Formulary	8,000	0,640
Maintenance	3,500	1,750
<b>Service Adjustments/Reconfigs</b>		
Patient Transport	3,670	1,600
Blood Usage	11,800	5,900
Laboratory	2,000	0,250
Reconfig PCCC Admin Processes	6,385	1,749
Reconfig Child Care	10,000	3,587
Disability Providers	10,000	4,968
<b>Pay</b>		
PCCC Mental Health	12,662	3,971
NHO Non Mgt Admin Pay	8,570	0,000
3% Reduction in Mgt Admin	24,213	2,200
<b>Total</b>	<b>115.00</b>	<b>32.324</b>

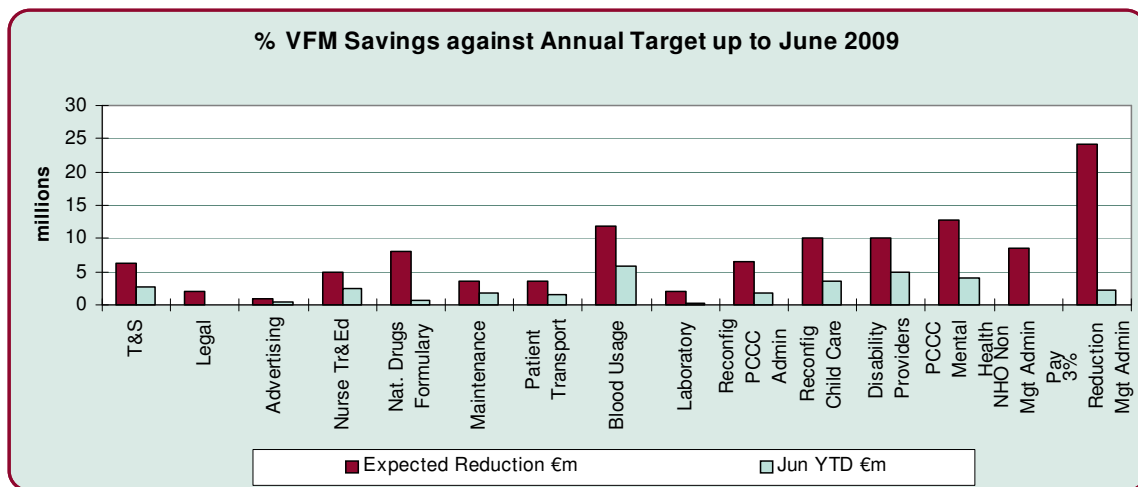


**Commentary**

A VFM programme was agreed and is reported monthly as part of the routine PR process, where actual YTD savings and projected full years savings are presented with commentary on trends and / or issues arising. In terms of the profile for delivery of efficiencies, it would not be expected that June YTD would demonstrate half of the annual target given that some measures, although actioned, may not impact in demonstrable financial figures until the last quarter. Also, the required €115 million is projected to be achieved through higher than expected returns in some planned VFM areas such as Travel and Subsistence (T&S) and through compensating efficiencies in areas which were not reported as part of the original VFM measures such as non-clinical non-pay. These efficiencies are projected to total over €200m. Across Pay and Non Pay there is financial evidence of the delivery of reconfiguration measures and / or locally taken compensating actions to address cost pressures.

The graph below represents the continuation of the reduction in the rate of non-pay cost growth, excluding schemes which resulted in net cost avoidance of €484m in 2008 and a projected net €249m in 2009. Significantly, the downward projection curve in 2009 indicates the extent of the cost reductions being delivered in addition to the cost avoidance.

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.



## Human Resources

### Metric Used

Development of a Human Resources Strategy.

### Commentary

The Mission and Vision have been developed and will be communicated as part of the Transformation Programme. The strategic direction of Human Resources has been set within the HR function. Key roles have been identified, clarified and are in the process of being filled.

### Metric Used

The roll out of Performance Management throughout the organisation.

### Commentary

Performance Planning Review (PPR) is now in place for Senior Managers, providing a cascade process for goals agreed by Senior Management Team.

### Metric Used

Employee engagement survey conducted.

### Commentary

A comprehensive employee engagement plan (including survey) is currently in the process of being finalised (June 2009). Representatives from HR, Communications and the Health Services National Partnership Forum (HSNPF) are involved in the drafting processes.

It is proposed that the plan will be brought to the Senior Management Team and then to the HSNPF in early September. The survey will take into account the recent wellbeing survey conducted for HSE employees.

### Metric Used

Integrated Workforce Planning Strategy developed.

### Commentary

Workforce planning strategy has been completed and will be published early in Q3.

### Metric Used

Employee engagement survey conducted.

### Commentary

A comprehensive employee engagement plan (including survey) is currently in the process of being finalised (June 2009). Representatives from HR, Communications and the Health Services National Partnership Forum (HSNPF) are involved in the drafting process. It is proposed that the plan will be brought to the Senior Management Team and then to the HSNPF in early September.

### Whole Time Equivalents (WTE)

**Metric Used**

Numbers of Whole Time Equivalents (WTEs) against 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**

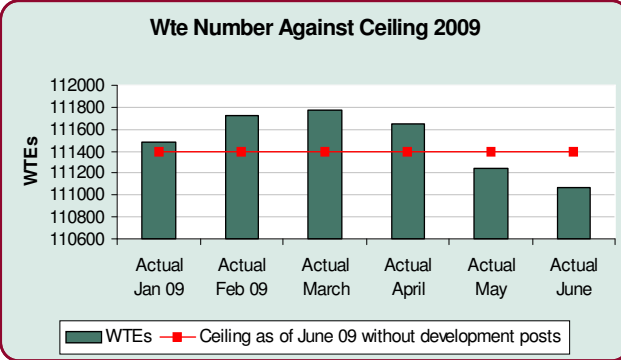
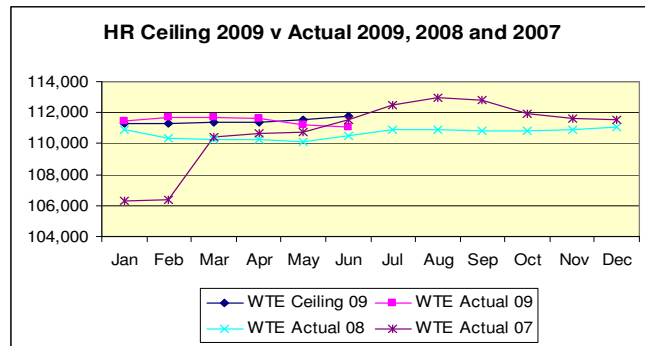
Position as of June 2009

**Target Information**

Manage delivery of services within WTE complement 0% deviation from WTE ceiling.

**Commentary**

The HSE is within the notified approved employment ceiling of 111,800 WTEs by some 739 WTEs as of the end of June. As this figure of 111,800 includes adjustments pertaining to 2009 developments yet to be put in place and some further 2008 developments in process, a more appropriate ceiling to measure ceiling compliance against outturn at the end of June is 111,392 WTEs and is thus 331 WTEs or 0.30% within that ceiling.



### Absenteeism

**Metric Used**

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

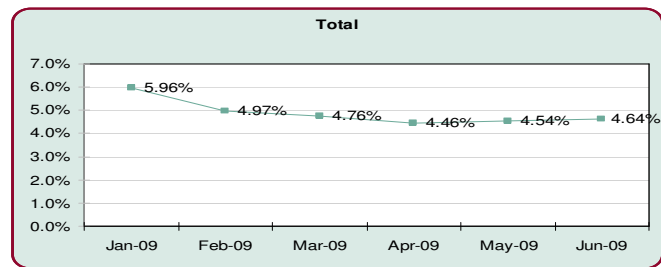
**Period Covered By Data**

Jan – June 2009

**Target Information**

< 3.5% absenteeism

**Commentary**



	Total	HSE	Voluntary Hsp	PCCC Voluntary Agencies
Jan-09	5.96%	6.55%	4.80%	5.20%
Feb-09	4.97%	5.49%	4.03%	4.33%
Mar-09	4.76%	5.14%	3.98%	4.22%
Apr-09	4.46%	4.77%	3.51%	4.50%
May-09	4.54%	4.83%	3.69%	4.40%
Jun-09	4.64%	5.03%	3.68%	4.23%

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.

## Information Communication Technology (ICT)

### Metric Used

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

Corporate ICT, HSE

### Period Covered By Data

Status at the end of June 2009

### Target Information

Not relevant

### Commentary

In order to support the HSE vision there are a number implications for ICT. The key information focus must be the patient; information must follow the patient through the health system. Health Professionals must have access to all the pertinent information at the point of consultation, diagnosis, treatment or care. They must be able to send and receive information, requests for service, bookings etc in respect of their patients from third parties.

ICT will be based on information and technology standards and ensure the security of data and systems.

The HSE ICT strategy has not yet been launched. The strategy is currently being reviewed by the National Director of ICT.

In the interim, ICT continue to progress projects and initiatives in support of the Transformation Programme. Specifically, during 2009 the HSE received sanction to progress 112 ICT projects, with a further 44 projects currently under consideration. 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.

In reference to the HSE 2008-2011 Corporate Plan, ICT are already pursuing several major strategic initiatives that have national applicability such as NIMIS, iSOFT Patient Administration Systems, Healthlink, Health Atlas, ICT deployment to Primary Care Team sites, National Maternal & Newborn Systems, Electronic Blood Tracking Systems, new Internet and Intranet services, etc.

ICT are supporting regional and local initiatives via the implementation of a large number of smaller projects including some funded by the Innovation Fund.

ICT are enhancing the ICT Infrastructure by increasing the size of the footprint covered by the HSE single data network ('National Health Network'), by upgrading and consolidating our data centres, by deploying security solutions such as laptop encryption and by pursuing new initiatives such as Directory Services that 'logically' join up our systems and users nationally.

### Parliamentary Questions (PQ's)

**Metric Used**

Number and percentage of Parliamentary Questions 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 Office, HSE

**Period Covered By Data**

1 Jan – 31 July 2008  
1 Jan – 31 July 2009

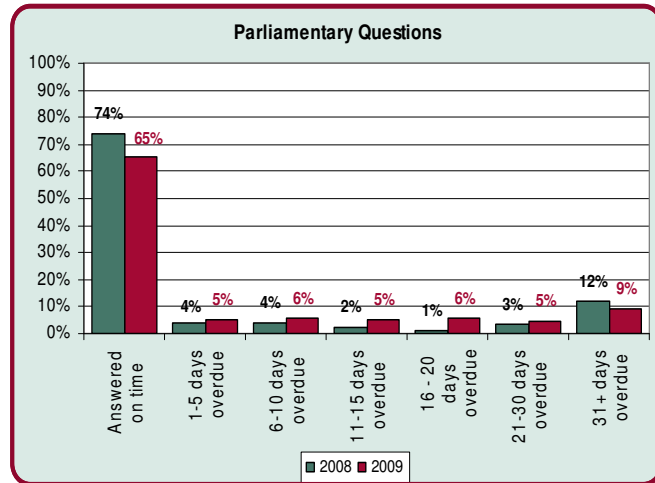
**Target Information**

75% response rate within 15 working days

**Commentary**

Total no of PQs handled Jan to July 2008 was 2,516. Total number of PQs handled Jan to July 2009 was 1,981. The HSE Service Plan 2009 set a target of 75% response rate for parliamentary questions within a 15 working day timeframe. To date this year, despite the recruitment restrictions and the consequent pressures on the organisation, we have achieved a 67% performance rate on target. It is intended to achieve our target of 75% by year end.

Other work carried out by PAD includes handling all relevant Oireachtas Committees, representations and informal queries from Oireachtas members



### Freedom of Information (FOI)

**Metric Used**

No and % of FOI requests which are processed within required timeframe

**Rationale**

The Freedom of Information Act came into effect on 21 April 1998. This Act gives citizens the right to access records held by Government Departments.

**Data Source**

Consumer Affairs, HSE

**Period Covered By Data**

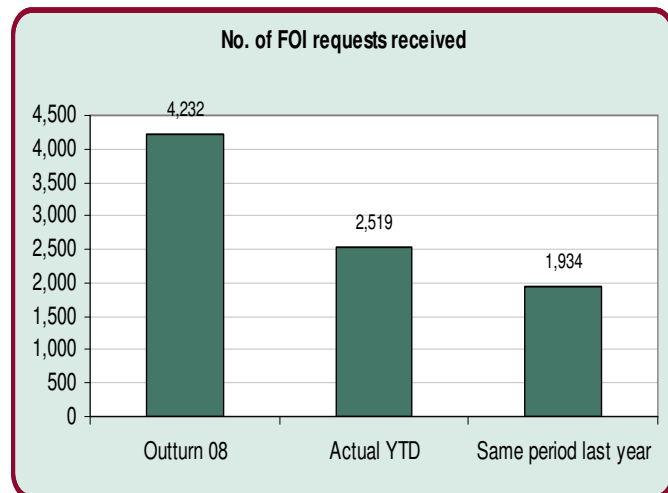
2008 – 2009

**Target Information**

A decision on an FOI application must normally be made within 4 weeks.

**Commentary**

There has been a significant increase in the volume of FOI requests (up by 30% compared to 2008). However, the HSE strives to meet the 4 week deadline set out in the FOI Act. The HSE acknowledges that access to information, as a matter of right, is essential for a healthy and democratic society.



## Abbreviations

<b>ALOS</b>	Average Length of Stay
<b>AOS</b>	Assessment Officers System
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CPM</b>	Corporate Performance Measurement
<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>DTP</b>	Diphtheria, Tetanus, Pertussis
<b>ED</b>	Emergency Department
<b>EHO</b>	Environmental Health Officers
<b>EPA</b>	Environmental Protection Agency
<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>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>OEDC</b>	Organisation for Economic Cooperation and Development
<b>PAD</b>	Parliamentary Affairs Division
<b>PCCC</b>	Primary, Community and Continuing Care
<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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