Corporate Plan report

Report against the HSE Corporate Plan 2008 - 2011

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Health Service Executive

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Performance Dashboard

Strategic Objective	Key Performance Measures	Page Number	Target 2010	Results in each Year 2008	2009	2010	Trend since 2008	% variance target v result
Health and Wellbeing	Smoking prevalence	4	20.0%	27.2%	24.6%	23.2%	↑	-16.0%
	Breastfeeding rates, exclusive at 3 months	5	32%		21.5%	22.7%	↑	-29.1%
	Orchidopexy: no completed < 60 months expressed as a %	6	95%	61%	60%		→	-100.0%
	Influenza vaccine % uptake > 65 years (GMS)	7	75%	61.7%	70.1%	53.8%	↓	-28.3%
	Childhood vaccination: % uptake (24 months) for Diphteria (D3), Tetanus (T3), Pertussis (P3)	8	95%	94.0%	94.0%	93.9%	→	-1.2%
	Pertussis: CIR per 100,000 population	9	Aim to decrease notifications year on year. No targets set.	2.45	1.84	2.52	↓	
	Tetanus: CIR per 100,000 population	10		0.05	0.00	0.00	→	
	Haemophilius Influenzae (type b): CIR per 100,000 population	11		0.12	0.02	0.07	↑	
	Hepatitis B (acute and chronic): CIR per 100,000 population	12		21.80	19.20	15.80	↑	
	N. meningitides serogroup C: CIR per 100,000 population	13		0.09	0.12	0.09	→	
	Measles: CIR per 100,000 population	14		1.30	3.80	10.30	↓	
	Salmonella: CIR per 100,000 population	15		10.60	7.90	8.40	↑	
	Cryptosporidiosis: CIR per 100,000 population	15		9.79	10.50	6.93	↑	
	Tuberculosis: CIR per 100,000 population	16		11.00	11.10		→	
	Chlamydia: CIR per 100,000 population	16		148.35	133.90		↑	
	Suicide: Number of persons who committed suicide	17	10% reduction	506	527		↓	-38.3%
	Deliberate Self Harm at ED: rate of re-presentation within one calendar year	18	13.3%	13.9%	14.3%		→	100.0%
Trust and Confidence	Ambulance response times: % within 19 minutes	19	76%	73.8%	72.3%	71.3%	↓	-6.2%
	GP out of hours service: % of pop who have access to urgent GP out of hours	20	80.0%		72%	72%	→	-10.0%
	CAMHS Teams: % new referrals seen within 3 months of referral	21	70%		67.5%	68.3%	→	-2.4%
	Disability: % under 5 assessments completed within timelines in regulations	22	100%	25.0%	23.8%	20.7%	↓	-79.3%
	Emergency Department: Wait times from registration to admission / discharge *(change in data collection makes trending impossible)*	23	100%		88.0%	62.7%		
	Public private hospital activity: based on all acute activity	24	80%	75.0%	75.5%	77.1%	↑	-3.6%
Sustainable Services	Primary care teams: number holding clinical team meetings	25	394	104	219	348	↑	-11.7%
	Elder Abuse: % referrals to receive first response from Case Worker within 4 weeks	26	100%			98.0%		
	Palliative care: number of specialist palliative care beds per 100,000 population	27			3.7			
	Children in residential care: as a % of all children in care	28	7.0%	7.0%	6.9%	7.4%	→	-5.7%
	Care planning for children: % of children in care with a written care plan	29	100%	59.9%	84.7%	90.1%	↑	-9.9%
	ALOS: Average length of stay for all inpatients, discharges and deaths	30	5.6	6.2	6.2	6.1	→	-8.9%
	Day Case Surgeries: % day case surgeries as a % of day case plus Inpatients (for specified basket of procedures)	31	75%		65.0%	70.0%	↑	-6.7%
Quality and Safety	Caesarean section: rate as a % of all births	32	No target	22.5%	24.3%	26.1%	↓	
	Colposcopy: Urgent waiting times within 2 weeks	33	100%			100.0%		
	*5 year survival Colorectal Cancer	34	56.2%	47.1%	51.0%	56.2%	↑	0.0%
	*5 year survival Lung (& Trachea) Cancer	34	10.9%	9.2%	10.9%	12.6%	↑	15.6%
	*5 year survival Breast (Female) Cancer	34	79.0%	70.3%	75.1%	80.7%	↑	2.2%
	*5 year survival Prostate Cancer	34	77.5%	63.9%	79.2%	89.1%	↑	15.0%
	Symptomatic Breast Cancer services: % seen within 2 weeks	35	95%		87.7%	95.1%	↑	0.1%
	MRSA: % *Staphylococcus aureus* bloodstream infections in hospital	36	27.0%	33.7%	27.1%	24.3%	↑	10.0%
	Complaints: % dealt with within 30 working days	37	85%	72.0%	79.2%	76.9%	↑	-9.5%
	Parliamentary Questions: % responded to within 15 working days	38	75%	73.8%	61.8%	52.5%	↓	-30.0%
Operational Excellence	Budget: Variance of budget against planned position	39	0%	0.5%	-0.7%	-0.8%	→	1.0%
	Value for money (VfM): % achievement of set target	40	100%	94.3%	100.0%	100%	↑	0.0%
	Whole Time Equivalents (WTEs): % against ceiling	42	0.0%	-1.0%	-0.17%	-0.13%	↑	1.3%
	Absenteeism: % on payroll absent because of sick leave	43	3.5%	5.76%	5.05%	4.70%	↑	-34.3%

Notes:

Grey cells indicate that data was unavailable or that trending was not possible.
*Cancer Survival Rates relate to set time bands *(see page 34 for further detail).*

% Variance target v result performance:

Performance within 5% of target = Green
Performance between 5 - 10% of target = Amber
Performance greater than 10% from target = Red

Overview of Key messages

Achievement of performance over the past three years:

- The most significant population health trend over the past three years has been in relation to improved cancer survival rates. The trend is upwards and we are equalling or better than the European average.
- Colposcopy waiting times have been reduced to the target times of <2 weeks for urgent referrals.
- We have reached and surpassed the target set for reducing MRSA in our hospitals over the past three years and continue to see improvement.
- Behind the delivery of the same level of services in the past three years was the imperative to reduce staff numbers and drive savings. The staff numbers have reduced by 3,053 since 2008 and we are 1,400 ahead of the target set for reductions under the moratorium at the end of 2010. As well as the pay savings derived from the reduction in WTEs €688m has been achieved in non-pay areas.
- Many services increased over this period for example: 19.5% more medical cards, 37.3% more GP visit cards and the ancillary services that go with these; an increase of 8.7% in out patient attendances; 15.7% more Day Case discharges. Over this period, above and beyond normal planned work, 1.1 million pandemic vaccines were also delivered.

Upward performance trends reported, although target set was not fully reached:

- The percentage of all discharges which are public has risen from 74% in 2008 to 77% in 2010 against a target of 80%.
- The percentage of day case surgeries, for a specific basket of procedures, has risen from 65% to 70% against a target of 75%.
- At the end of 2010, 348 PCTs are reported to be in place, against a target of 394. 244 of these teams became operational in the past 3 years.
- The response rate for Elder Abuse referrals by Senior Case Workers was 98% in 2010, against a target of 100%.
- The percentage of young people seen by Community Child and Adolescent Mental Health (CAMH) teams, within three months of their referral was 68.3%, against a target of 70%.
- Care planning for children in care rose from 60% in 2008 to 90.1% in 2010 against a target of 100%.

Areas of performance which are identified for focused attention

- The achievement of timely disability assessments for children aged less than 5 years continue to perform at a very low level. This is the focus of a performance management initiative in 2011.
- The number of people spending more than 6 hours in our ED departments is at an unacceptable level. We see in the average performance across the 20 hospitals reporting patient experience time in 2010 that it is those hospitals with the greatest average daily attendances that are finding it hardest to reach the level of performance required. A management response to manage demand in ED is now in place, this has a series of alerts which in turn trigger a response to help to manage the service need: scheduling of elective procedures to free up beds, rostering of clinicians to ensure that the appropriate level of skill and decision making is available; manage discharge.
- Absenteeism has been steadily improving but the effect of every % improvement is such that efforts to reduce from the current 4.7% to closer to the 3.5% target will provide much needed additional resources across all services. In the future there it may be useful to look at more sensitive measures of absenteeism across different grades of staff. There is evidence that the type of shift and the category of job held influences absenteeism and requires different responses.

Population Health: Areas of Key Focus

- Breastfeeding rates are increasing but there is a percentage variance of more than 25% from the HSE target of 32% of mothers exclusively breastfeeding at 3 months, which in itself is modest in comparison to European norms.
- Although childhood immunisation has been performing well, there are some concerns over Hib_b which is showing a rate of 85.4% and $MenC_3$ which is showing a rate of 86.1% during Q3 and Q4 2010.
- In vaccine preventable disorders measles stands out as being the disease which showed a big increase in reported numbers over the period 2009 – 2010.
- Smoking prevalence, a key indicator of long term health, is going the right direction but stubbornly staying above 23% against a target of <20%.
- The proxy for childhood screening, orchidopexy shows a worsening performance down to 60% against a target, based on best clinical outcome, of 95%.
- Suicide rate and numbers have risen over the past 3 years.

Alphabetical Index to Performance Indicators

Health and Wellbeing

Smoking Prevalence

Metric Used
Cigarette smoking; national prevalence by gender and by age.

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

Accurately measuring prevalence monitors the effectiveness of cessation strategies (e.g. taxation, pack warnings, public information campaigns).

Data Source
Office of Tobacco Control
www.otc.ie

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

Period Covered by Data
2004 – 2010

Target Information
<20% of the Irish population smoking

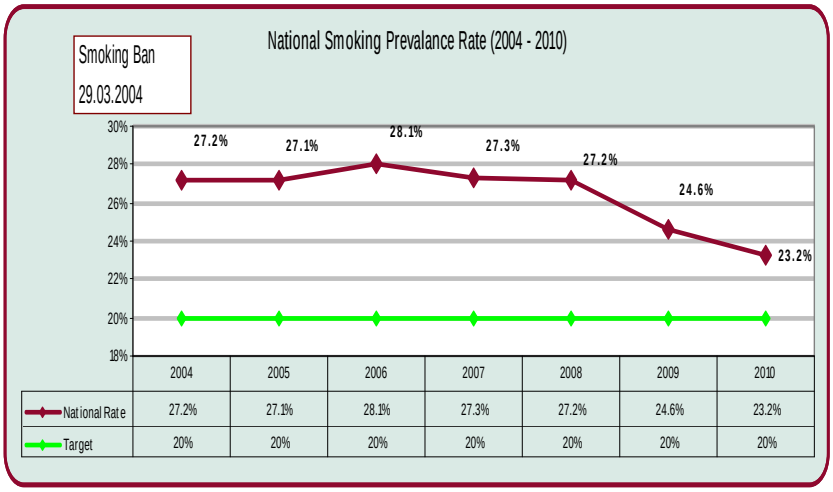
Performance Overview
An average of 23.2% of the Irish population were smoking in Dec 2010

Commentary
Tobacco is the major preventable cause of death and chronic disability in Ireland today. Tobacco related cardiovascular and respiratory diseases and cancer cause approximately 5,200 deaths per year in Ireland [www.tri.ie].

Smoking prevalence in Ireland has been decreasing since the 1980's. The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation.

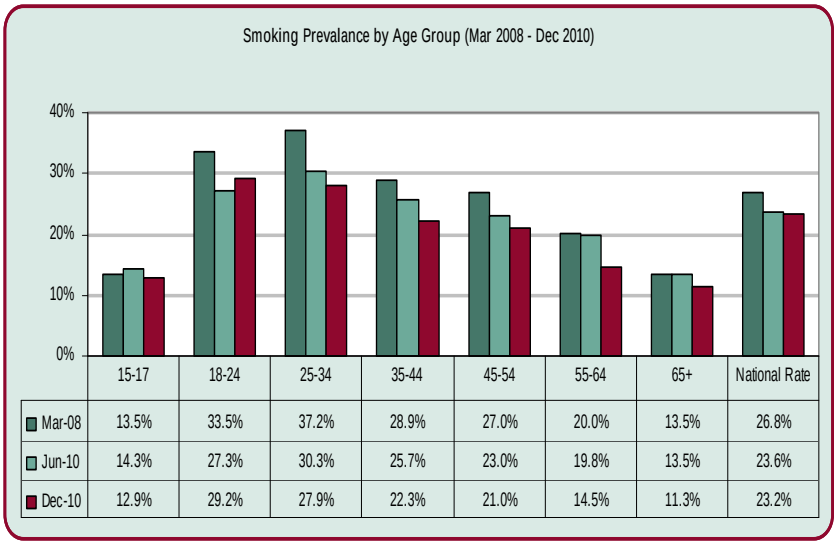
As our overall smoking rates are still relatively high, the HSE has developed a comprehensive tobacco control framework, based on the WHO MPOWER model to tackle our tobacco problem.

An implementation group has been established to roll out the framework actions over the next 5 years. Particular attention will be paid to making all our campus sites smoke free, enforcing existing legislation, helping smokers quit using our direct smoking cessation service, the Quitline and our web based tools. In addition, work will continue in developing sustainable social marketing campaigns which will encourage smokers to quit, and nonsmokers not to start.

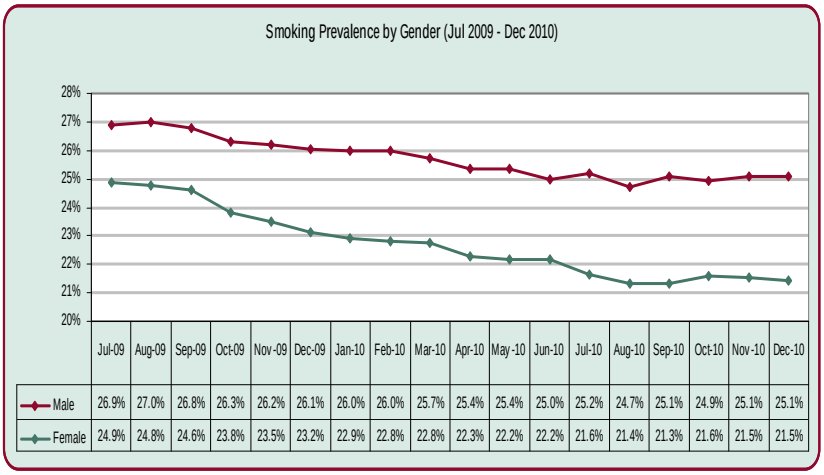


	2004	2005	2006	2007	2008	2009	2010
National Rate	27.2%	27.1%	28.1%	27.3%	27.2%	24.6%	23.2%
Target	20%	20%	20%	20%	20%	20%	20%

Note: Collection methodology changed in May 2008 (sample population includes both landline and mobile phone respondents). This methodology change resulted in an increase in prevalence (of about 3%) from May 2008. Therefore, pre-May 2008 data has been re-calibrated to allow for trend analysis, with the caveat that calibration may not restore strict comparability.



	15-17	18-24	25-34	35-44	45-54	55-64	65+	National Rate
Mar-08	13.5%	33.5%	37.2%	28.9%	27.0%	20.0%	13.5%	26.8%
Jun-10	14.3%	27.3%	30.3%	25.7%	23.0%	19.8%	13.5%	23.6%
Dec-10	12.9%	29.2%	27.9%	22.3%	21.0%	14.5%	11.3%	23.2%



	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
Male	26.9%	27.0%	26.8%	26.3%	26.2%	26.1%	26.0%	26.0%	25.7%	25.4%	25.4%	25.0%	25.2%	24.7%	25.1%	24.9%	25.1%	25.1%
Female	24.9%	24.8%	24.6%	23.8%	23.5%	23.2%	22.9%	22.8%	22.8%	22.3%	22.2%	22.2%	21.6%	21.4%	21.3%	21.6%	21.5%	21.5%

Breastfeeding Rates

Metric Used
The % of babies (aged 3 months) who are exclusively breastfed.

Rationale
Quality data on the prevalence and duration of breastfeeding is critical in order to assess Ireland's achievement of the WHO target of exclusive breastfeeding for the first six months.

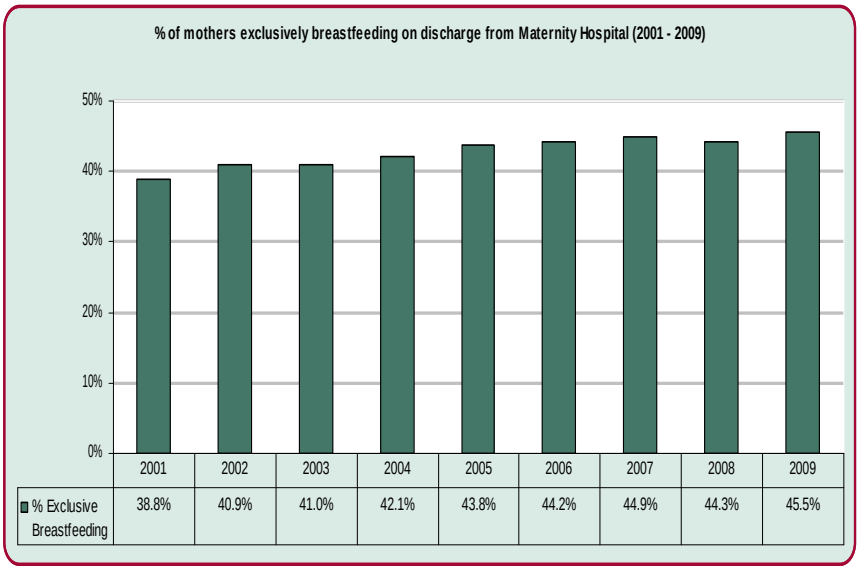
Data Source
Perinatal Statistics Report (Economic and Social Research Institute, ESRI) www.ESRI.ie

Childcare Database, Business Intelligence Unit (BIU), HSE

Period Covered by Data
2010

Target Information
32% of babies aged 3 months should be exclusively breastfed.

Performance Overview
22.7% of babies (aged 3 months) were exclusively breastfed on average in 2010.

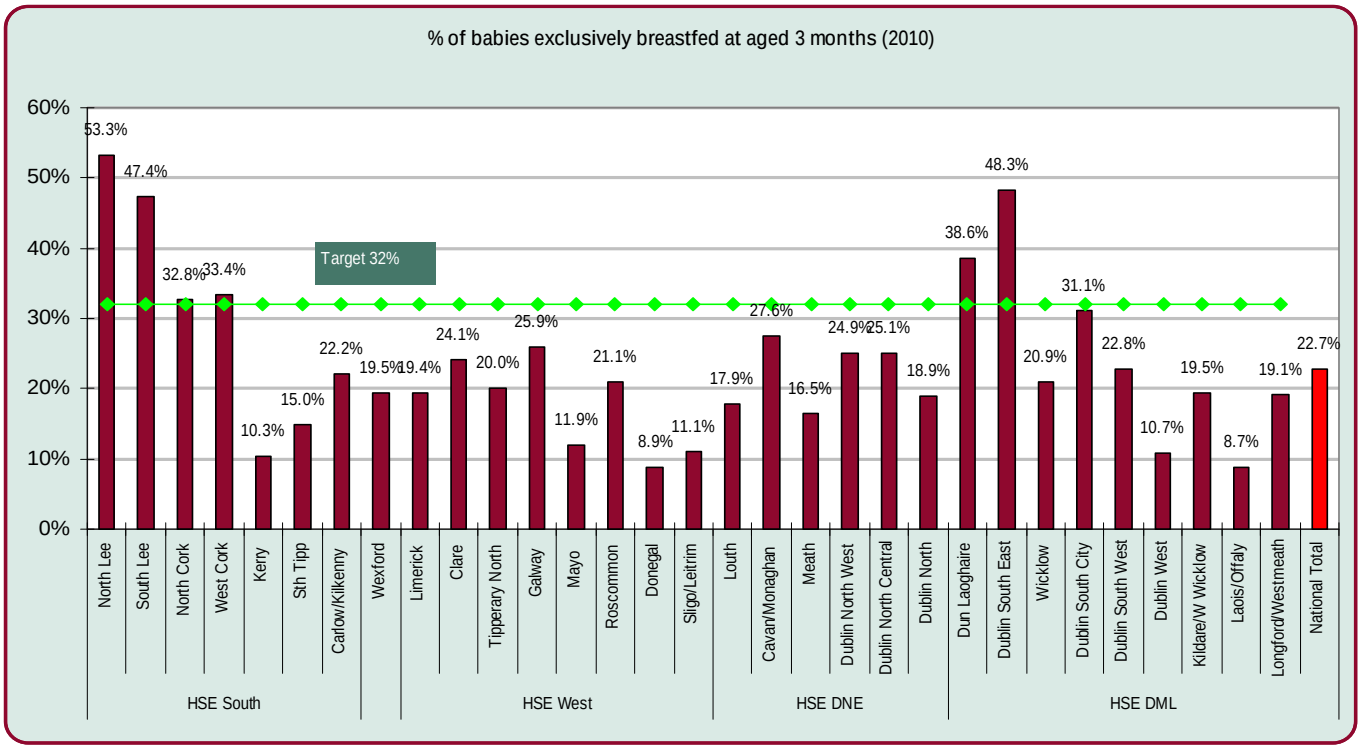


Above chart relates to % of mothers breastfeeding on discharge from Maternity Hospital. Data collated by the NPRS (National Perinatal Reporting System). NPRS collects data on approx. 65,000 birth records each year from 22 hospitals and 20 independent midwives.

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

An OECD Report (Aug 2009) places Ireland at the bottom for rates of breastfeeding in an analysis of 29 countries. The HSE is addressing this by spearheading the implementation of *'Breastfeeding in Ireland: A Five Year Strategic Action Plan'* (DOH&C Oct 2005). The following areas of focused work have been completed or are currently underway:

- Infant Feeding Policy for Maternity Hospitals developed
- Review of breastfeeding support services provided by PHN's complete
- Research undertaken to identify the support needs and barriers to breastfeeding for families least likely to breastfeed
- Database of Irish infant feeding research developed
- Pilot of Baby Friendly Hospitals in the community underway
- National Breastfeeding Week held annually



Orchidopexy Treatment

Metric Used

The Number of boys 0 - 4 years (<60 months) undergoing orchidopexy treatment as a percentage of all boys aged 0 – 14 years (inclusive) undergoing orchidopexy treatment.

Rationale

Cryptorchidism is the absence of one or both testes from the scrotum. About 3% of full-term and 30% of premature infant boys are born with at least one undescended testis, making cryptorchidism the most common birth defect of the male genitalia. However, about 80% of cryptorchid testes descend by the first year of life (the majority within three months), making the true incidence of cryptorchidism around 1% overall. The goal of a screening program is to detect all patients with undescended testes at an appropriate age and to refer them for orchidopexy (surgery to fasten an undescended testes into the scrotum). Early surgery (at less than 2 years of age) reduces the risk of torsion, infertility and malignant transformation in later life. Delayed surgery may be due to delayed diagnosis which may reflect poor access to care or poor assessment at the point of care. It may also be due to long waiting lists for surgery following referral. Therefore late orchidopexy is a good indicator of the quality of care. It is possible but unlikely that late diagnosis is due to the testes ascending after an initial screen.

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

Data Source

Hospital In-Patient Enquiry (HIPE)
HSE Health Atlas

Period Covered by Data

2006 - 2009

Target Information

95% of all undescended testes should be surgically repaired by 5 years of age.

Performance Overview

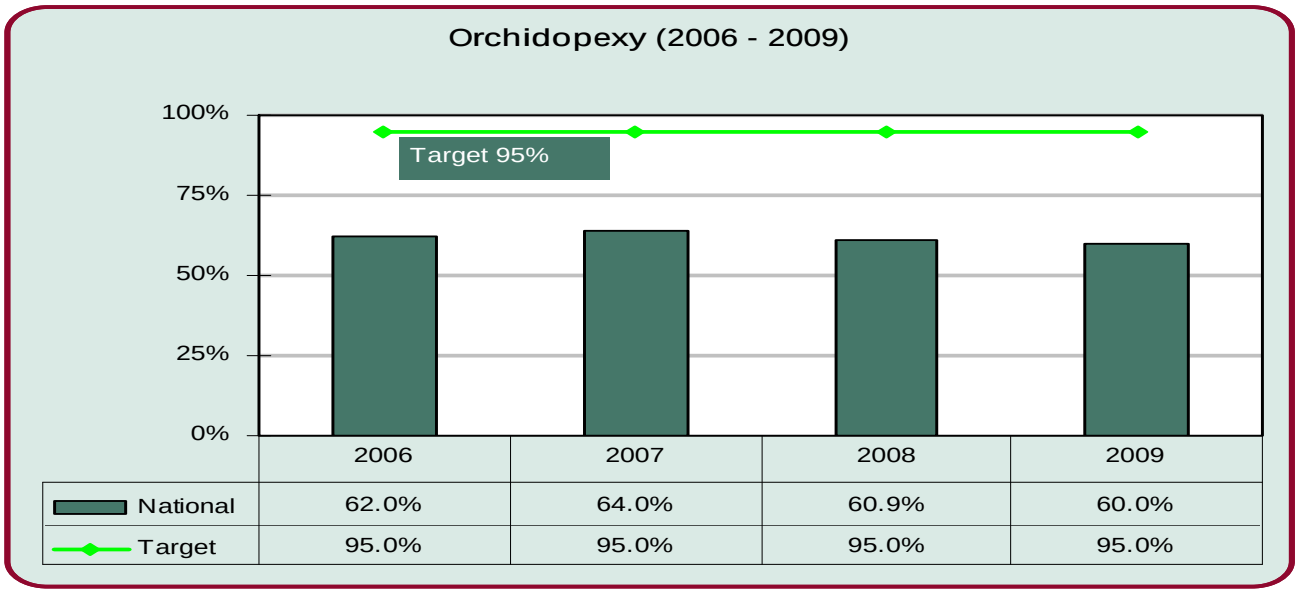
60% of boys identified with undescended testes have had surgical intervention by 5 years of age.

Commentary

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

The delay in surgery indicates either a failure in screening or a delay in accessing services. Delay in orchidopexy can have serious implications in later life. Cases should be reviewed to establish what system failure is resulting in an unacceptably high proportion of late orchidopexy. Improvements to the system of screening, diagnosis and treatment are to be made. In the UK the implementation of locally agreed guidelines, provision of written information to GPs and parents, and the use of a computerised recall system achieved the target within 3 years.

There is a need for continued emphasis in this area in order to ascertain the level of screening, reporting, referral and treatment to clearly see where processes and responses can be improved. The protocols and practice around orchidopexy will be examined in conjunction with public health service providers to increase the level of screening, reporting, referral and timely treatment.



	2006	2007	2008	2009
National	62.0%	64.0%	60.9%	60.0%
Target	95.0%	95.0%	95.0%	95.0%

Vaccines

Influenza Vaccination

Metric Used

Influenza: the % uptake of seasonal influenza vaccine among the GMS population aged 65 years and older.

Rationale

In Ireland, annual seasonal influenza vaccination is recommended for all persons aged 65 years of age and older. Influenza vaccination is thought to reduce influenza related morbidity by 50-60% 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

Period Covered by Data

Influenza Seasons 2003 / 2004 – 2009 / 2010

Target Information

75% of all older persons should receive an annual flu vaccination:
Note: WHO target of 75% relates to all older people aged 65 years and older. Data presented here relates to GMS Clients (Medical Card / GP Visit Card).

Performance Overview

53.8% of GMS Clients availed of the national seasonal influenza vaccine uptake rate (2009 / 2010)

Commentary

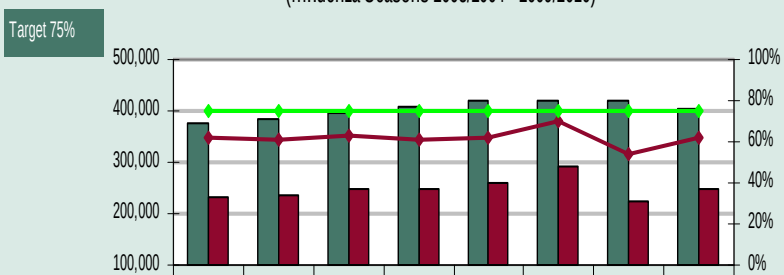
In Ireland, the average seasonal influenza vaccination uptake rate for the 2009 / 2010 influenza season among Medical Card holders and GP Visit card holders aged 65 years of age and older was 53.8%. This is a marked decrease on the reported uptake rate of 70.1% for the 2008 / 2009 influenza season.
This is the lowest uptake rate reported since influenza vaccine uptake surveillance was initiated during the 2003 / 2004 influenza season.

During the 2009 / 2010 season, variation in vaccination coverage was observed between HSE areas (ranging from 51.6% - 56.4%).

The uptake for vaccination was highest in the group aged 75 years and older (57.4%).

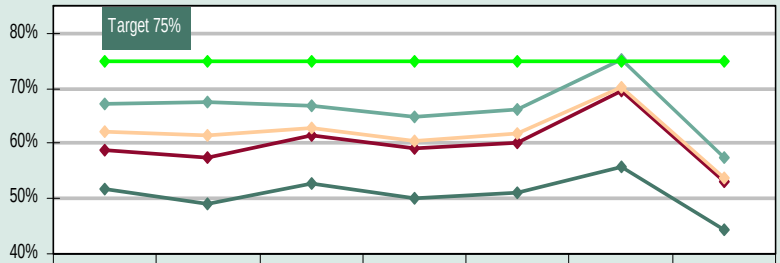
The reason for the decrease in uptake during the 2009 / 2010 influenza season is not yet clear. It is likely that the intense media coverage surrounding the 2009 / 2010 influenza pandemic and the vaccination campaign against pandemic influenza affected seasonal influenza uptake rates for the 2009 / 2010 influenza season. It is possible that people were more likely to receive the pandemic influenza vaccine rather than the seasonal influenza vaccine and particularly so as the pandemic influenza strain was the principal circulating influenza strain.

Influenza Vaccination Uptake for GMS Clients
(Influenza Seasons 2003/2004 - 2009/2010)



	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	Mean
No. Medical Card Holders	374,739	385,162	395,458	407,196	419,767	419,327	419,010	402,951
No. Vaccinated	232,410	236,425	249,013	246,695	259,100	293,890	225,358	248,984
% Uptake	62.0%	61.4%	63.0%	60.6%	61.7%	70.1%	53.8%	61.8%
Target	75%	75%	75%	75%	75%	75%	75%	75%

National Average Influenza Uptake by Age Group
(Influenza Seasons 2003/2004 - 2009/2010)



	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010
65-69	51.6%	49.1%	52.9%	50.2%	51.0%	55.8%	44.5%
70-74	58.7%	57.6%	61.5%	59.2%	60.0%	69.7%	53.2%
75+	67.3%	67.4%	66.9%	64.7%	66.1%	75.1%	57.4%
65+	62.0%	61.4%	63.0%	60.6%	61.7%	70.1%	53.8%
Target	75%	75%	75%	75%	75%	75%	75%

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

Childhood Vaccination

Metric Used

The % children at 24 months of age who have received three doses of vaccines against diphtheria (D_3), pertussis (P_3), tetanus (T_3), *Haemophilus influenzae* type b (Hib_3), polio ($Polio_3$), meningococcal group C ($MenC_3$), hepatitis B ($HepB_3$) and pneumococcal conjugate vaccine (PCV_3), one booster of vaccine against *Haemophilus influenzae* type b given after 12 months of age (Hib_b) and one dose of vaccine against measles, mumps and rubella (MMR_1).

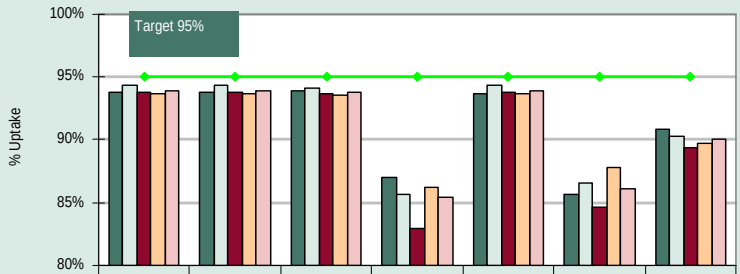
Rationale

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

Data Source

Health Protection Surveillance Centre (HPSC) *www.hpsc.ie*
National Immunisation Office (NIO) *www.immunisation.ie*

Immunisation Uptake Rates in Children 24 Months of Age in 2010



	D3 T3	P3	Hib3	Hibb	Polio3	MenC3	MMR1
HSE South	93.7%	93.7%	93.9%	87.1%	93.7%	85.6%	90.9%
HSE West	94.4%	94.4%	94.2%	85.7%	94.4%	86.6%	90.2%
HSE DML	93.7%	93.7%	93.6%	83.0%	93.7%	84.6%	89.4%
HSE DNE	93.7%	93.7%	93.5%	86.2%	93.7%	87.7%	89.7%
National Rate	93.9%	93.9%	93.8%	85.4%	93.9%	86.1%	90.1%
Target	95%	95%	95%	95%	95%	95%	95%

Period Covered by Data

Uptake rates of D_3, P_3, T_3, Hib_3, $Polio_3$, MMR_1, $MenC_3$ and Hib_b, for children 24 months of age in 2010 (children born between 01/01/2008 and 31/12/2008) and uptake rates of $HepB_3$ and PCV_3 for children 24 months of age during Quarters 3 and 4 2010 (children born between 01/07/2008 and 31/12/2008).

Target Information

95% uptake of childhood immunisations

Performance Overview

National uptake rates, in 2010, were 94% for D_3, P_3, T_3, Hib_3 and $Polio_3$, 90.1% for MMR_1, 86.1% for $MenC_3$ and 85% for Hib_b. National uptake rates (combined Q3 and Q4 2010 data only) were 94% for $HepB_3$ and 88% for PCV_3.

Commentary

The 2010 D_3, P_3, T_3, Hib_3 and $Polio_3$ uptake rates (94%) are very encouraging and are very close to the target uptake rate of 95%. However, during Q3 and Q4 2010, there was a dramatic decline in $MenC_3$, a decline in Hib_b and a relatively low uptake of PCV_3, as reported on the childhood immunisations systems.

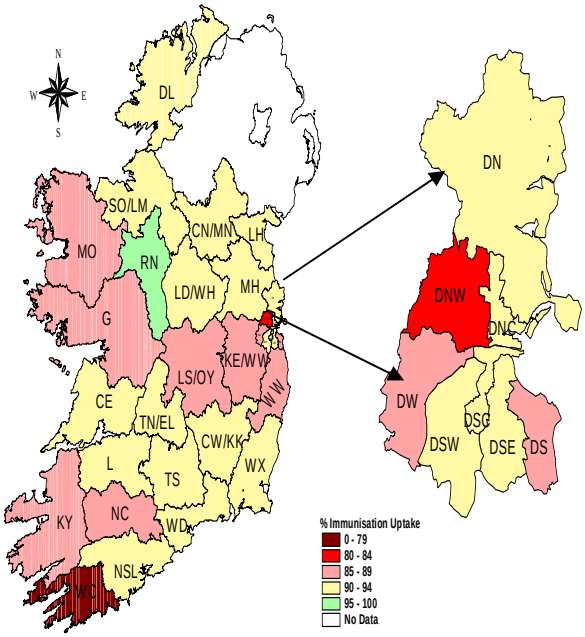
Since 1 September 2008 the new primary childhood immunisation schedule has been implemented for children born on or after 1 July 2008. Under the new schedule children now receive hepatitis B vaccine (as part of a 6 in 1 which contains diphtheria, tetanus, pertussis, polio, Hib and hepatitis B vaccines) and pneumococcal conjugate vaccine (PCV). In addition, there is a change in timing of the Hib booster and meningococcal group C (MenC) vaccines. These changes to the schedule mean that three injections (6 in 1, PCV and MenC vaccines) are now recommended at six months of age and two GP visits are required after 12 months. The first dose of MMR and the third dose of PCV should be given at 12 months of age, while the third dose of MenC vaccine and a Hib booster vaccine should be given at 13 months of age.

The decline in MenC and Hibb and low uptake of PCV may be related to the introduction of the new schedule with children not attending for the 5th visit at 13 months or to parents choosing to have some but not all of the vaccines recommended at the 12 and 13 month visits. There is also a suggestion that some children are not receiving three vaccines at their 6 month visit but are deferring one until their child is older.

In response Health Protection and NIO have undertaken a number of initiatives:

- Communication sent to all GPs and practice nurses outlining recent uptake statistics and a checklist of how to improve the rates.
- Consultation with the Irish College of General Practice, practice development coordinators and the Irish Practice Nurses Association.
- Letter sent to all parents before their child reaches 12 months of age reminding them to attend both the 4th + 5th visits highlights that their child is not yet fully protected against most forms of meningitis.
- Focus groups with parents of young children have been held to obtain views on immunisation and the schedule. The outcome of these discussions has been fed into the revision of the immunisation booklet given to all parents. The new booklet and posters will focus on the importance on completing the required five GP visits and will be launched for Ireland's participation in the WHO's European Immunisation week (23-30 April 2011).
- HPSC in collaboration with the HSE and NIO have initiated a review of a sample of children reported as vaccination defaulters for the third dose of MenC and the Hib booster dose. The objectives of this review are to assess the accuracy of the data, to correct vaccination records (where inaccurate) and to encourage parents of defaulters to bring their children for vaccination.

MMR Immunisation Uptake Rates (%) by LHO in Children 24 months of age in 2010



Vaccine Preventable Diseases

Pertussis

Metric Used

Pertussis: Number of notifications and crude incidence rate (CIR) per 100,000 population.

Rationale

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

Data Source

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

Period Covered by Data

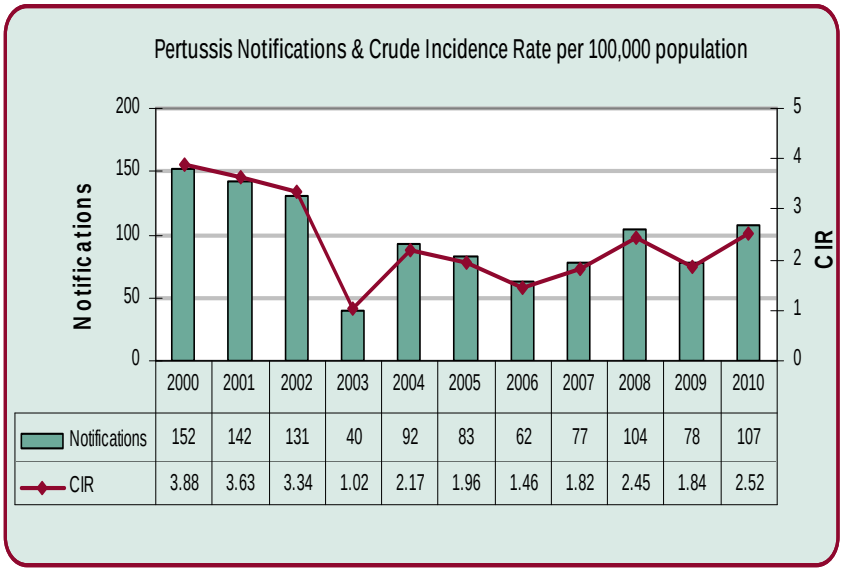
2000 – 2010 (2010 data provisional)

Target Information

No target specified at this time

Performance Overview

107 notifications of Pertussis / 2.52 CIR per 100,000 population (2010)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Notifications	152	142	131	40	92	83	62	77	104	78	107
CIR	3.88	3.63	3.34	1.02	2.17	1.96	1.46	1.82	2.45	1.84	2.52

Commentary

Pertussis, also known as whooping cough, is a highly contagious disease caused by the bacterium *Bordetella pertussis*. In Ireland, prior to the introduction of vaccination most cases occurred in young children. Now the highest incidence is in infants.

Internationally, an increased rate among adolescents and adults has been reported. This change in the epidemiology of pertussis is due to the waning immunity that occurs after both disease and vaccination, and to a reduction in natural boosting.

Current childhood immunisation guidelines recommend pertussis vaccination at 2, 4 and 6 months and a booster dose at 4-5 years and at 11-14 years. A full course of vaccine confers protection in over 80% of recipients. Immunity wanes with age and is low or absent 10-12 years after primary immunisation. High vaccine uptake rates, including booster doses, are therefore very important in order to reduce the incidence of pertussis.

There was a community outbreak of pertussis (n=67 cases) in the HSE North West in 2010.[1] This outbreak affected the general population but spread mostly among children under six months of age, between one and four years old and among the 10-14 year-olds. [1]

Epidemiological investigations suggest that waning immunity and the absence of a booster dose during the second year of life could have contributed to the outbreak.[1]

References: 1. Barret AS, Ryan A, Breslin A, Cullen L, Murray A, Grogan J, Bourke S, Cotter S. Pertussis outbreak in northwest Ireland, January – June 2010. Euro Surveill. 2010;15(35):p=19654. Available online: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19654

Vaccine Preventable Diseases

Tetanus

Metric Used

Tetanus: Number of notifications and crude incidence rate (CIR) per 100,000 population.

Rationale

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

Data Source

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

Period Covered by Data

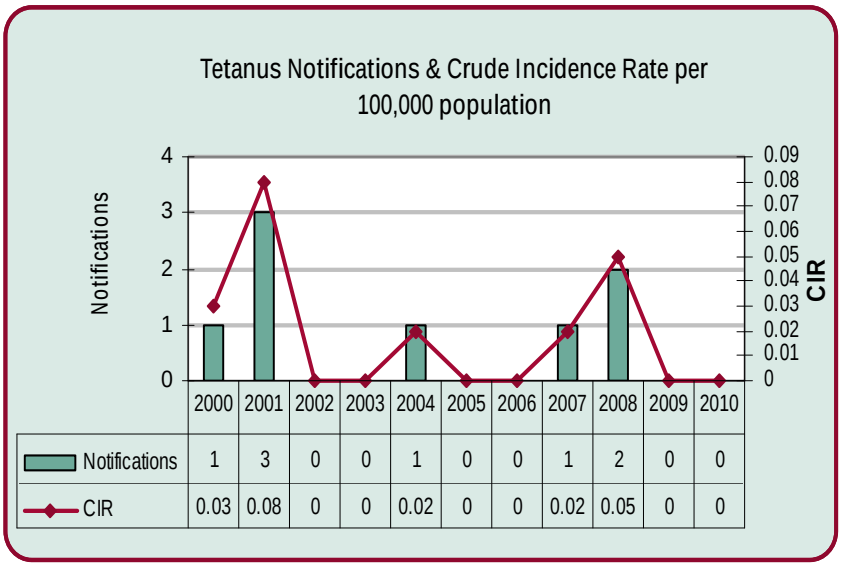
2000 – 2010 (2010 data provisional)

Target Information

No target specified at this time

Performance Overview

0 notifications of Tetanus (2010)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Notifications	1	3	0	0	1	0	0	1	2	0	0
CIR	0.03	0.08	0	0	0.02	0	0	0.02	0.05	0	0

Commentary

Tetanus (also known as 'lockjaw') is an acute neurological disease, caused by the neurotoxin produced by *Clostridium tetani*. It is characterised by muscular rigidity with superimposed contractions. Tetanus spores are present in the soil and in the gut and faeces of some animals.

Infection can occur through contamination of a puncture wound, burn or trivial wound and through injecting drug use. Tetanus is now rare in Ireland due to routine immunisation programmes. Zero cases of tetanus were notified in Ireland in both 2009 and 2010.

The tetanus vaccine is recommended as part of the routine childhood immunisation programme. Vaccination is recommended at 2, 4 and 6 months of age. A booster dose is recommended at 4-5 years of age and at 11-14 years of age.

Injecting drug users (IDUs) are considered to be at risk of tetanus. IDUs who have not received five doses of tetanus-containing vaccine or are unsure about their vaccination status, should receive additional tetanus-low dose diphtheria (Td) vaccination.

Vaccine Preventable Diseases

Haemophilius influenzae

Metric Used

Haemophilius influenzae (type B): Number of notifications and Crude incidence rate (CIR) per 100,000 population.

Rationale

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

Data Source

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

Period Covered by Data

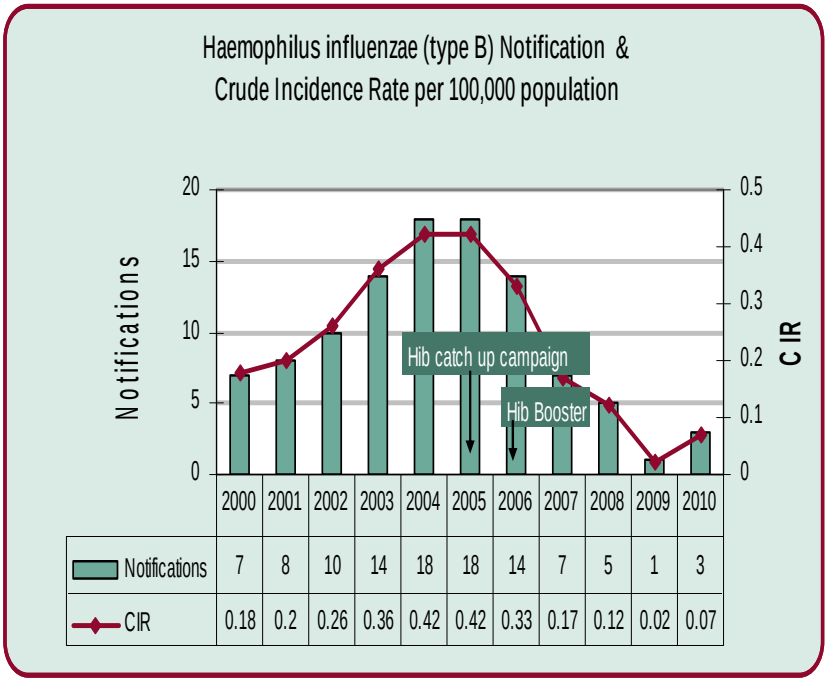
2000 – 2010 (2010 data provisional)

Target Information

No target specified at this time

Performance Overview

3 notifications of *Haemophilius influenzae* / 0.07 CIR per 100,000 population (2010)



Commentary

Until recently, *Haemophilius influenzae* type b, or Hib disease was an important cause of serious, often deadly, infections in children under age 5. However, with the development and widespread use of vaccines against Hib, very few cases now occur.

The Hib conjugate vaccine was introduced in Ireland in 1992. A marked decline in incidence followed. Increase in vaccine failures seen in 2004/2005 was attributed to waning immunity. A Hib booster catch-up campaign in 2005 was offered to all children 12 months to < 4 years of age.

A routine Hib booster was introduced in September 2006 for all children aged 12 months. Both these campaigns had a considerable impact in reducing incidence of Hib disease in recent years.

Current guidelines advise 3 doses of HiB vaccine in infancy (2, 4 and 6 months, 6 in 1 vaccine) and one booster dose at 13 months (Hib vaccine).

Maintaining high Hib vaccine uptake rates, including the Hib booster dose are therefore very important to ensure invasive Hib disease remains at very low incidence in Ireland.

Vaccine Preventable Diseases

Hepatitis B

Metric Used

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

Rationale

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

Data Source

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

Period Covered by Data

2000 – 2010 (2010 data provisional)

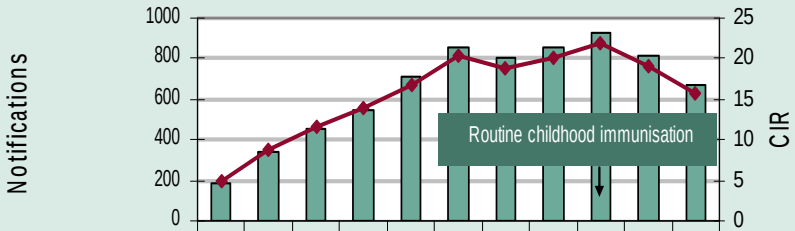
Target Information

Improvement in enhanced surveillance, especially risk factor data for targeted intervention strategies.

Performance Overview

670 notifications of Hepatitis B / 15.8 CIR per 100,000 population (2010)

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



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Notifications	188	342	454	545	712	860	802	857	925	812	670
CNR	4.8	8.73	11.59	13.91	16.79	20.3	18.9	20.2	21.8	19.2	15.8

Commentary

Hepatitis B is a vaccine preventable disease which is transmitted through contact with the blood or body fluids of an infected person. The main routes of transmission are through sexual contact, or vertical transmission from mother to baby, or through injecting drug use. Over 90% of people infected as adults clear the virus within a year of infection, but there is a high probability of developing chronic infection if hepatitis B is acquired in infancy (90%) or early childhood (25-30%).

A proportion of people with chronic infection develop progressive fibrosis which can lead to cirrhosis, liver failure and carcinoma. Prior to 2008, immunisation was recommended only for at risk population groups (individuals at occupational risk, close contact with infected persons, etc). In 2008 routine childhood immunisation was introduced. Current guidelines advise 3 doses in infancy at 2, 4 and 6 months (6 in 1 vaccine).

The prevalence of hepatitis B infection in Ireland is relatively low (less than 1%), and provisional data from 2010 shows a 20% decrease in new notifications compared to 2009. One possible reason for this decrease could be reduced immigration rates to Ireland. Most cases of chronic hepatitis B are probably acquired outside Ireland.

Infection is more prevalent in certain high-risk populations such as injecting drug users, prisoners and immigrants from high endemicity countries and people with multiple sexual partners. In 2010, risk factor data were available for 65% of acute cases (n=33). Of these, 65% (n=27) were likely to have been sexually acquired.

The number of acute cases acquired sexually, both heterosexually and through MSM contact, is of concern and indicates a target area for prevention activities.

The completeness of the enhanced surveillance data needs to be improved. In 2010, only 65% of acute and 46% of chronic hepatitis B cases had risk factor data assigned. This compares with 89% of acute and 56% of chronic hepatitis B cases in 2008. Continued quality surveillance data is essential in order to identify high risk populations, support health planning and monitor the effectiveness of control and preventative measures over time.

Vaccine Preventable Diseases

Neisseria meningitidis serogroup C (MenC)

Metric Used

Neisseria meningitidis serogroup C: Number of notifications and crude incidence rate per 100,000 population.

Rationale

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

Data Source

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

Period Covered by Data

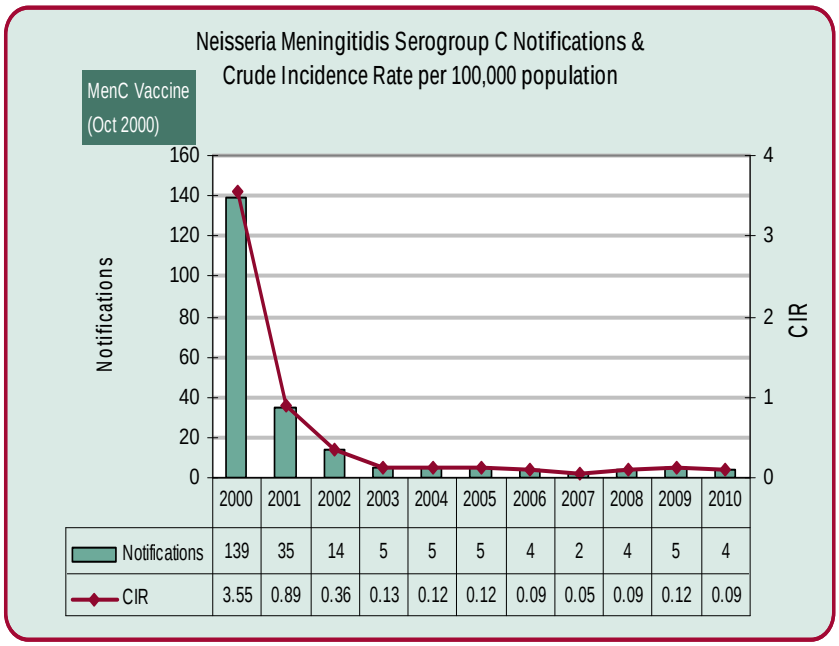
2000 – 2010 (2010 data provisional)

Target Information

No target specified at this time

Performance Overview

4 notifications of *Neisseria meningitidis* serogroup C / 0.09 CIR per 100,000 population (2010)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Notifications	139	35	14	5	5	5	4	2	4	5	4
CIR	3.55	0.89	0.36	0.13	0.12	0.12	0.09	0.05	0.09	0.12	0.09

Commentary

Invasive meningococcal disease is the most common form of bacterial meningitis in Ireland. This disease may present as meningitis, septicaemia (blood poisoning) or both. It is an infection caused by the organism *Neisseria meningitidis*. Infants and young children are most susceptible.

Prior to the introduction of the meningococcal C conjugate (MenC) vaccine in Ireland (Oct 2000), serogroup C accounted for 30-35% of cases of IMD and group B for approximately 70%.

The MenC vaccine has by been offered to everyone under 23 years of age and has also been included as part of the primary immunisation schedule for infants. This vaccine has been extremely successful in reducing serogroup C disease in Ireland, with the number of cases being reduced by 97% in 2010 when compared with 2000.

Maintaining high MenC vaccine uptake rates are therefore very important to ensure *N. meningitidis* serogroup C disease remains at very low incidence in Ireland.

Vaccine Preventable Diseases

Measles

Metric Used
Measles: Number of notifications and crude incidence rate (CIR) per 100,000 population.

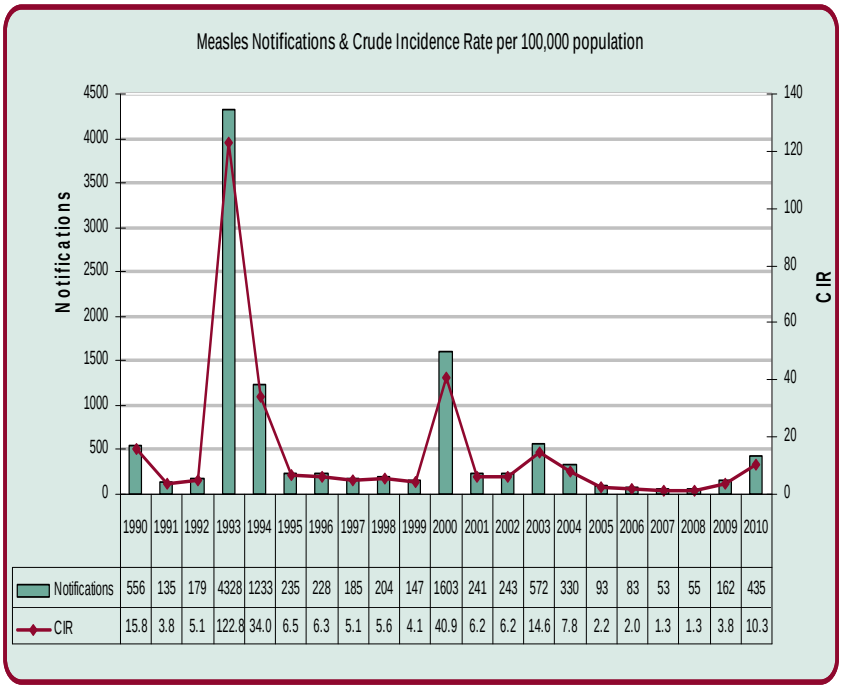
Rationale
Surveillance of vaccine preventable diseases is critical in Order to monitor the effectiveness of vaccination programmes.

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

Period Covered by Data
1990 – 2010 (2010 data are provisional)

Target Information
WHO target: Elimination of measles in WHO European Region by 2015.

Performance Overview
435 notifications of Measles / 10.3 CIR per 100,000 population (2010)



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Notifications	556	135	179	4328	1233	235	228	185	204	147	1603	241	243	572	330	93	83	53	55	162	435
CIR	15.8	3.8	5.1	122.8	34.0	6.5	6.3	5.1	5.6	4.1	40.9	6.2	6.2	14.6	7.8	2.2	2.0	1.3	1.3	3.8	10.3

Commentary

In Ireland, despite the dramatic reduction in measles cases following the introduction of a measles vaccine in 1985 and MMR in 1988, measles continues to be a problem with recurrent outbreaks. The number of measles notifications fell from a peak of almost 10,000 cases in 1985 to 135 in 1991. However outbreaks continued to occur with 4,328 cases in 1993 and 1,603 cases in 2000.

The latest measles outbreak occurred from August 2009 to early May 2010. Of the 468 notifications 65% were unvaccinated. Minority groups were disproportionately affected with 15% of cases in Irish Travellers (0.5% of population are Irish Travellers) while 1.5% were Roma (~0.1% of population are Roma). Five cases were recorded as Eastern European. There were anecdotal reports (unquantified) of some child cases not vaccinated due to parental objection to vaccines. (Ethnicity, place of birth /nationality are not routinely collected as part of notification data. Ethnicity can be difficult to establish and report on. Figures presented based on available data.)

Since the national collation of cohort based immunisation uptake data commenced in Ireland in Quarter 1 1999, uptake of the first dose of MMR at 24 months has never reached the WHO target of 95%. Although the uptake of the first dose of MMR remains below the target of 95% it has increased significantly from the low of 69% in Quarter 4 2001.

While the uptake of MMR remains below the target of 95% required to prevent the spread of measles outbreaks will continue to occur.
There is no systematic collection of data on the second dose of MMR vaccine in most areas of the country and it is not possible to link MMR dose one and MMR dose two on children in most areas. Therefore, Ireland cannot determine the uptake of two doses of MMR. Two doses are needed to prevent outbreaks occurring. In 2010, the 53 member states of the WHO European Region adopted a resolution to renew their commitment to the elimination of measles and rubella and the prevention of congenital rubella syndrome by 2015.

In 2007, Ireland completed the National Measles Elimination Strategy (available at http://www.hpsc.ie/hpsc/A-Z/VaccinePreventable/Measles/Publications/).

Key to the strategy is achieving at least 95% MMR uptake of two doses of MMR among children after the first birthday and again as 4-5 years of age.

Infectious Diseases

Salmonella

Metric Used
Salmonella: Number of notifications and crude incidence rate (CIR) per 100,000 population.

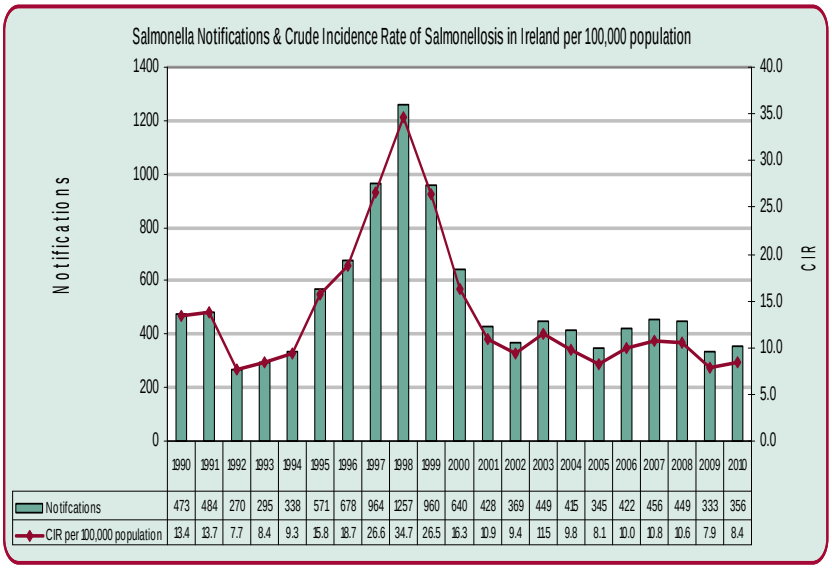
Rationale
Surveillance of human Salmonella outbreaks plays a critical role in understanding and controlling food borne illness due to *Salmonella*.

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

Period Covered by Data
1990 – 2010 (2010 data are provisional)

Target Information
No target specified at this time

Performance Overview
356 notifications of Salmonella / 8.4 CIR per 100,000 population (2010)



Commentary
For the past ten years, the incidence of salmonellosis in Ireland has remained reasonably steady (around 350-450 cases reported per annum). This is a decrease from the number of cases that were reported in the late 1990s, when the number of cases peaked at 1,257 (1998). Salmonellosis continues to be an extremely significant cause of gastroenteritis in Ireland. The fall in the numbers of cases and the decrease in the size of outbreaks reflect the strength of response in ensuring the safety of food and control of outbreaks when they develop. Enhanced surveillance of salmonellosis facilitates more timely intervention and control of spread not only nationally but at a European level.

Cryptosporidiosis

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

Rationale
Human cryptosporidiosis became a notifiable disease in 2004. Prior to this, cryptosporidiosis was notifiable in Ireland only in young children as '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 feature of *Cryptosporidium* 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.

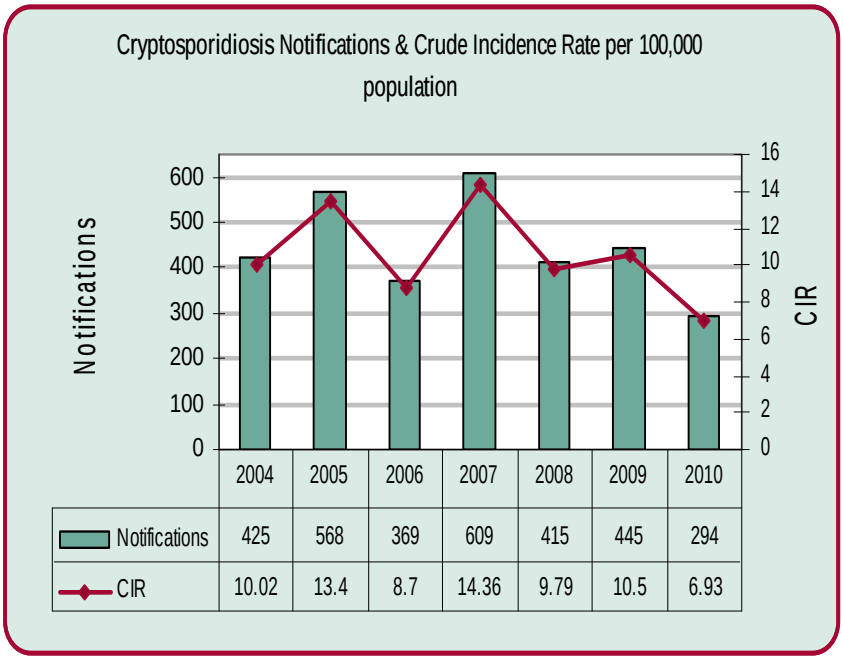
Data Source
Health Protection Surveillance Centre (HPSC) *www.hpsc.ie*

'The Provision and Quality of Drinking Water in Ireland - A Report for the Years 2008 – 2009' www.epa.ie

Period Covered by Data
2004 – 2010 (2010 data provisional)

Target Information
No target specified at this time

Performance Overview
294 notifications / 6.93 CIR per 100,000 population (2010)



Commentary
The highest number of cryptosporidiosis notifications was in 2007, when 609 cases were notified to the HPSC (up 66% on 2006). The main reason for the 2007 increase was a large outbreak in HSE West linked to public water supplies which accounted for almost 50% of all cases reported. Contingency planning to deal with outbreaks continues to be a priority to deal with avoidable consequences of potential infection.
There are regular consultations between the HSE, Local Authorities / EPA in respect of specific supplies. The HSE has established a National Drinking Water group to facilitate a consistent response to these matters. In addition, the HSE is in dialogue with the EPA and the Department of the Environment on prioritising remedial work and heightening surveillance of at risk supplies. Risk assessment of *Cryptosporidium* in drinking water is an important element in these deliberations.

Tuberculosis

Metric Used

Tuberculosis: number of notifications and crude incidence rate (CIR) per 100,000 population.

Rationale

In 2009, the WHO estimated that there were 14 million cases of TB, resulting in 1.7 million deaths. The vast majority of TB cases (85%) occurred in South-East Asia, African and Western Pacific regions. TB is much less common in developed countries, such as Ireland. Early diagnosis and treatment are essential to stop the infection spreading from person to person.

Data Source

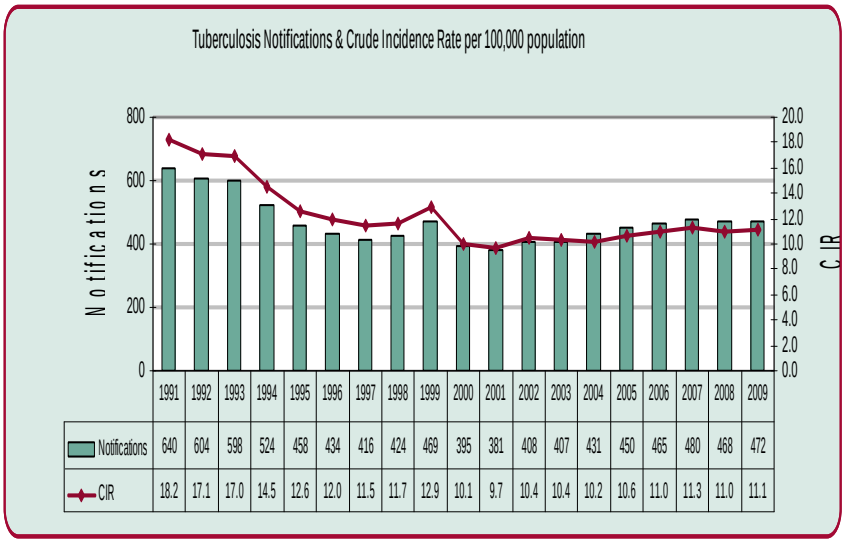
Health Protection Surveillance Centre (HPSC) *www.hpsc.ie*

Period Covered by Data

1991 – 2009 (2009 data are provisional)

Target Information

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



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Notifications	640	604	598	524	458	434	416	424	469	395	381	408	407	431	450	465	480	468	472
CIR	18.2	17.1	17.0	14.5	12.6	12.0	11.5	11.7	12.9	10.1	9.7	10.4	10.4	10.2	10.6	11.0	11.3	11.0	11.1

Performance Overview

472 notifications of Tuberculosis / 11.1 CIR per 100,000 population (2009).

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. Guidelines on the Prevention and Control of Tuberculosis in Ireland were by HPSC published in April 2010. These guidelines are an update on the Report of the Working Party on Tuberculosis, originally published by the Department of Health in 1996.

Chlamydia

Metric Used

Chlamydia: number of notifications and crude incidence rate per 100,000 population.

Rationale

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

Data Source

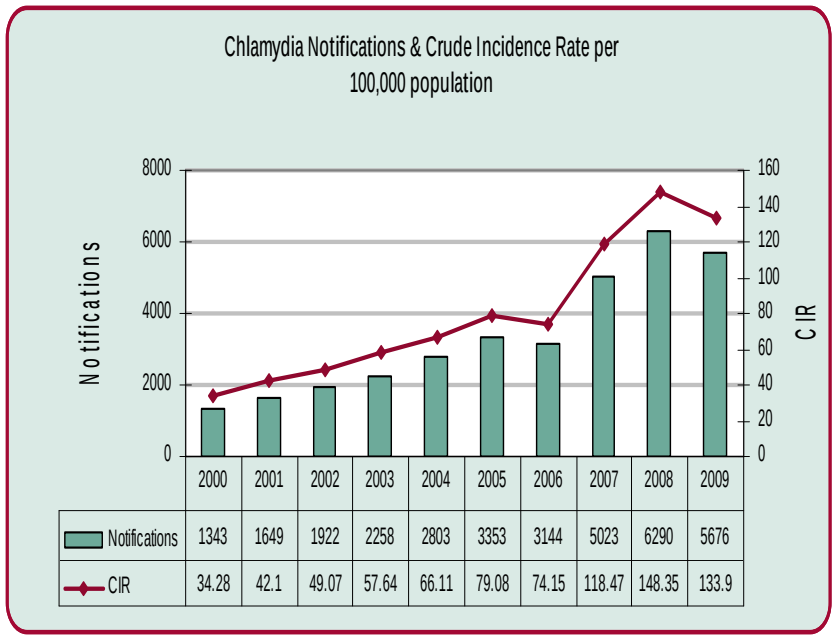
Health Protection Surveillance Centre (HPSC) *www.hpsc.ie*

Period Covered by Data

1995 – 2009 (2009 data are provisional, 2010 not available)

Target Information

No target specified at this time



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Notifications	1343	1649	1922	2258	2803	3353	3144	5023	6290	5676
CIR	34.28	42.1	49.07	57.64	66.11	79.08	74.15	118.47	148.35	133.9

Performance Overview

5676 notifications of Chlamydia (2009) / 133.87 CIR per 100,000 population (2009)

Commentary

In 2009, chlamydia accounted for 58% of all sexually transmitted infections (STI) and 66% of all STIs in adolescents aged less than 20 years. Incidence is highest among young men and women aged 20-29 years. These trends reflect an increase in notification and may also reflect a change in attitude and sexual behaviour in recent years.

Suicide Rates

Metric Used
Number and rate of suicide nationally.

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

Data Source
National Suicide Research Foundation (NSRF) *www.nsrf.ie*
National Strategy for Action on Suicide Prevention (2005 – 2014)
National Office for Suicide Prevention (NOSP) *www.nosp.ie*
World Health Organisation (EU Suicide Data) *www.who.int*

Period Covered by Data
1997 – 2009 (2009 data provisional)

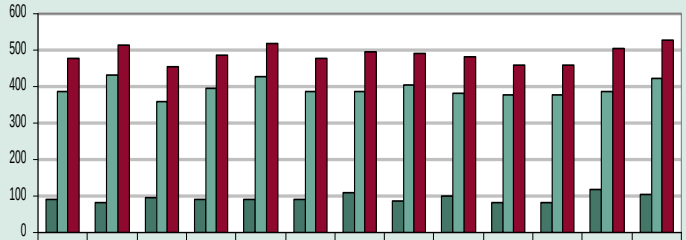
Target Information
A national target of a 10% reduction, year on year, was proposed in 2006.

Performance Overview
The latest available information is for 2009 (provisional data) when 527 people took their own life. This equates to a rate of 11.8 people per 100,000 population.

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].

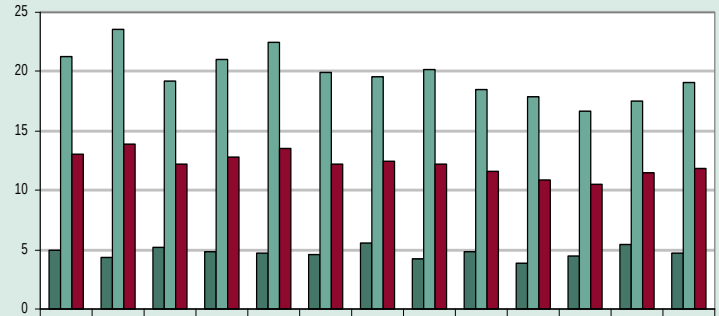
527 people took their own life in Ireland in 2009. This is an increase of 14.5% on the 2007 figure (460).

Female / Male Suicide Figures (1997 - 2009)



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Female	92	81	97	91	90	91	111	87	99	81	82	120	105
Male	386	433	358	395	429	387	386	406	382	379	378	386	422
Total Female / Male	478	514	455	486	519	478	497	493	481	460	460	506	527

Crude Rate of Suicide per 100,000 population (1990 - 2009)



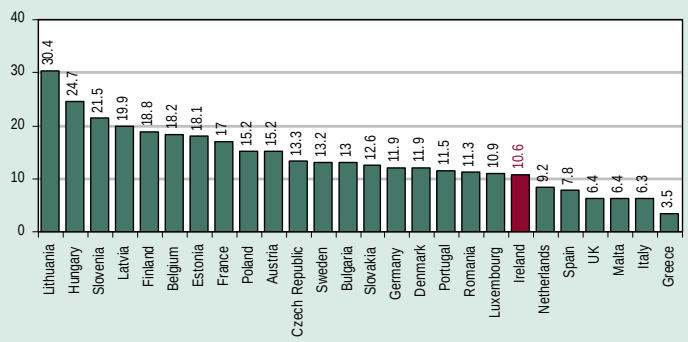
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Female	5.0	4.3	5.1	4.8	4.7	4.6	5.5	4.3	4.8	3.8	4.4	5.4	4.7
Male	21.2	23.5	19.3	21.0	22.4	19.9	19.5	20.2	18.5	17.9	16.7	17.5	19.0
All	13.1	13.9	12.2	12.8	13.5	12.2	12.5	12.2	11.6	10.9	10.6	11.4	11.8

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

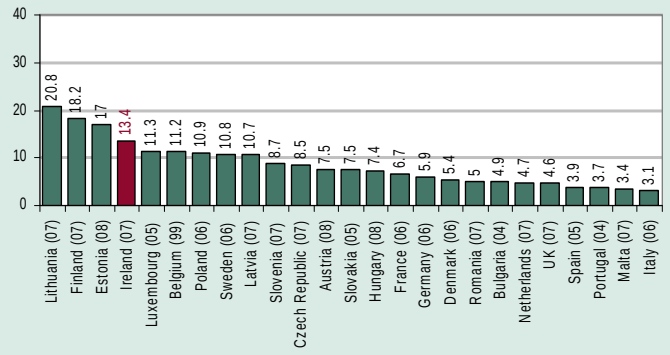
Mental disorders (particularly depression and substance abuse) are associated with a high percentage of all cases of suicide; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations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

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

Total Suicide Rate per 100,000 population in the EU (1999 - 2008)
(Published by WHO 2008)



Youth Suicide Rate (15 - 24 yr olds) per 100,000 population in the EU



Deliberate Self Harm

Metric Used

The rate of re-presentation of people with deliberate self harm at Emergency Departments, within one calendar year.

Rationale

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

Data Source

National Registry of Deliberate Self Harm at the National Suicide Research Foundation Ireland
www.nsrf.ie

Period Covered by Data

2002- 2009

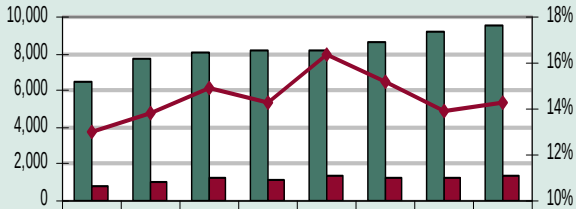
Target Information

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

Performance Overview

The latest information from 2009 reports a 14.3% rate of re-presentation of cases of Deliberate Self Harm at Hospital Emergency Departments (2009).

Repetition of Deliberate Self Harm (2002 - 2009)



	2002	2003	2004	2005	2006	2007	2008	2009
Number persons treated	6,476	7,738	8,055	8,160	8,218	8,598	9,218	9,493
Number persons repeated	843	1,065	1,201	1,164	1,346	1,303	1,278	1,356
% who repeated during calendar year	13.0%	13.8%	14.9%	14.3%	16.4%	15.2%	13.9%	14.3%

Commentary

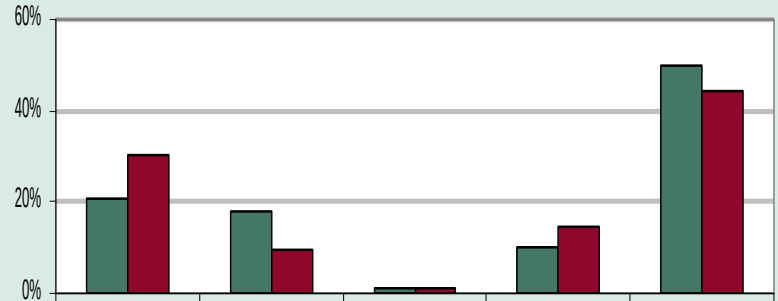
In 2009, the National Registry of Deliberate Self Harm in Ireland recorded 11,966 presentations to hospital due to deliberate self harm nationally. This involved 9,493 individuals. Taking the total population into account, the age-standardised rate of individuals presenting to hospital following deliberate self harm in 2009 was 209 per 100,000, a significant 5% increase on the rate of 200 per 100,000 in 2008 and the third successive increase in the national rate of hospital-treated deliberate self harm.

Consistent with previous years, deliberate self harm was over represented in the younger age groups. Almost half of all presentations (45%) were by people under 30 years of age and 87% were by people aged less than 50 years. As in previous years, the peak rate for women was in the 15-19 years age group (approximately 635 per 100,000), whereas the peak rate among men was in 20-24 year-olds) (526 per 100,000).

Both the number of people presenting with deliberate self harm and the proportions re-presenting have increased. One fifth of all deliberate self harm presentations were due to repeat acts. Continued efforts need to be made to prioritise national implementation of evidence-based treatments shown to reduce risk of repetition, such as cognitive behavioural, dialectical behavioural and problem-solving interventions.

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.

Recommended Next Care (2008 / 2009)



	General Admission	Psychiatric Admission	Patient would not allow admission	Left before recommendation	Not admitted
2008	21.0%	18.0%	1.2%	9.9%	49.9%
2009	30.5%	9.8%	1.0%	14.4%	44.3%

Trust and Confidence (Access)

Ambulance Response Times

Metric Used
The proportion of urgent calls to the ambulance service which are responded to within predefined time bands.

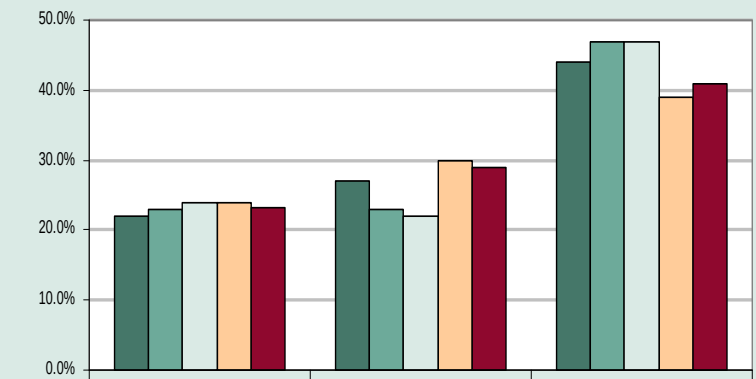
Rationale
Response times are an indicator of the efficiency in the provision of pre-hospital emergency care services.

Data Source
Ambulance Services, HSE

Period Covered by Data
Dec 2008 – Dec 2010

Target Information
Proportion of urgent calls responded to within the following predefined time bands:
< 8 mins (32%)
<14 mins (63%)
<19 mins (76%)
<26 mins (86%)

Performance Overview
During 2010, the proportion of urgent calls responded to within the following predefined time bands:
< 8 mins (26.4%)
< 14 mins (56.0%)
< 19 mins (71.3%
< 26 mins (82.1%)



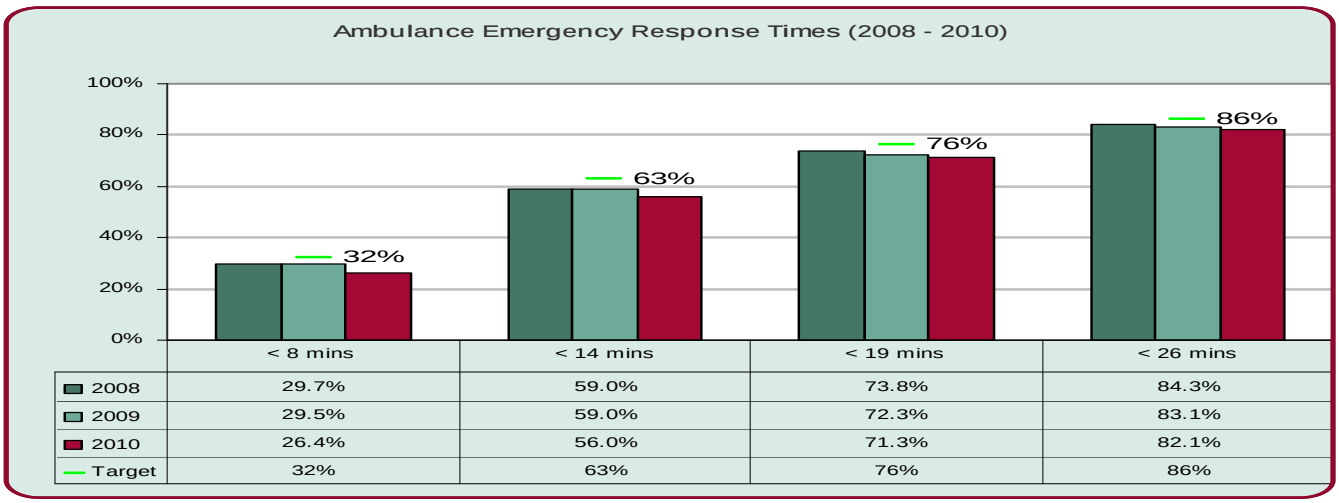
	Emergency Calls	Non-urgent Calls	Community Transport
Dec 2006	22.0%	27.0%	44.0%
Dec 2007	23.0%	23.0%	47.0%
Dec 2008	24.0%	22.0%	47.0%
Dec 2009	24.0%	30.0%	39.0%
Dec 2010	23.3%	29.0%	41.0%

Commentary
10 Ambulance Command and Control Centres co-ordinate pre-hospital emergency care services for 94 Ambulance Stations.

The Strategic Plan for the National Ambulance Service outlines the direction in which resources available can be used for the most appropriate services. From the data available it can be seen that the proportion of community transport has decreased in 2010 due to greater control on hired transport; however emergency and urgent calls are in line with previous years. There has been an increase in demand for non urgent or inter hospital transport placing significant demand on emergency ambulance provision and consequently response times performance. Work will continue to deploy Paramedics and Advanced Paramedics where they add most value and to look at alternative solutions for community / non-urgent (inter hospital) transport.

HIQA have published a set of performance indicators for both emergency response times and quality standards including hospital turnaround times and the numbers of Advanced Paramedics dispatched to life threatening emergencies. These are more specific than previous standards and focus clearly on ensuring the right resource is dispatched to and arrives at the patient in pre defined time bands which are dependant on the patient's acuity. These new standards will be onerous to achieve and will require significant re-alignment of existing services and clear investment in services to support inter hospital transfers so as to free up emergency ambulance provision to focus on emergency 999 calls.

As part of a programme for change, the National Ambulance Service has embarked on a Control Centre Reconfiguration Project to transition from 11 Control Centres to 1 Primary Centre and 1 Secondary Centre with a view to eliminating all forms of operational boundaries which inhibit the nearest resource being dispatched to the nearest emergency. Additionally, a performance Improvement Action Plan is in development and will focus on addressing many micro issues that have the potential to inhibit an improvement trajectory in response time's performance.



	< 8 mins	< 14 mins	< 19 mins	< 26 mins
2008	29.7%	59.0%	73.8%	84.3%
2009	29.5%	59.0%	72.3%	83.1%
2010	26.4%	56.0%	71.3%	82.1%
Target	32%	63%	76%	86%

GP Out of Hours Service

Metric Used
The % of the population who have access to structured urgent GP Out of Hours Service.

Rationale
In parts of Ireland, GPs have come together to form co-operatives providing a medical service outside normal working hours. The co-operative may be based in a health centre, public hospital or in another location (often provided by the HSE).

Participating GPs provide this service on a rota basis in the evenings, at weekends and on bank and public holidays.

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

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

Period Covered by Data
2009

Target Information
80% of the population should have access to a formal out of hour GP service by 2010

Performance Overview
Over 3 million people in Ireland now have access to an Out of Hours GP Service (approximately 72% of the total population, CSO Census data (2006).

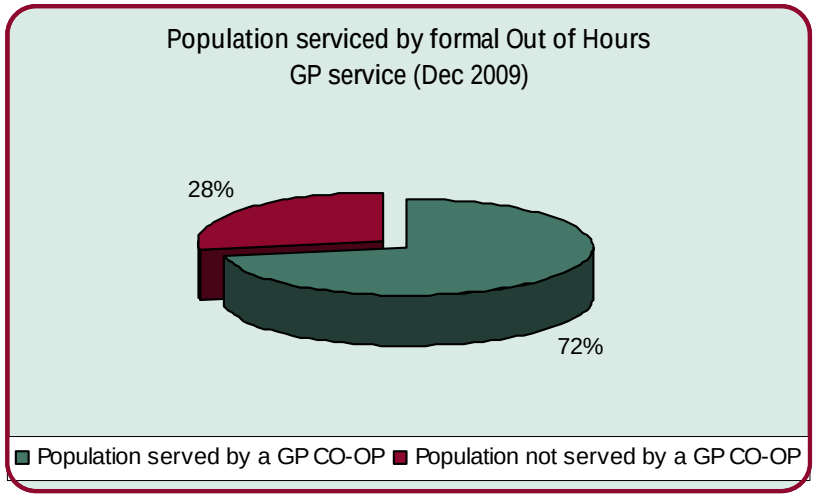
899,189 contacts were made with the GP OOH Service (Jan-Dec 2010).

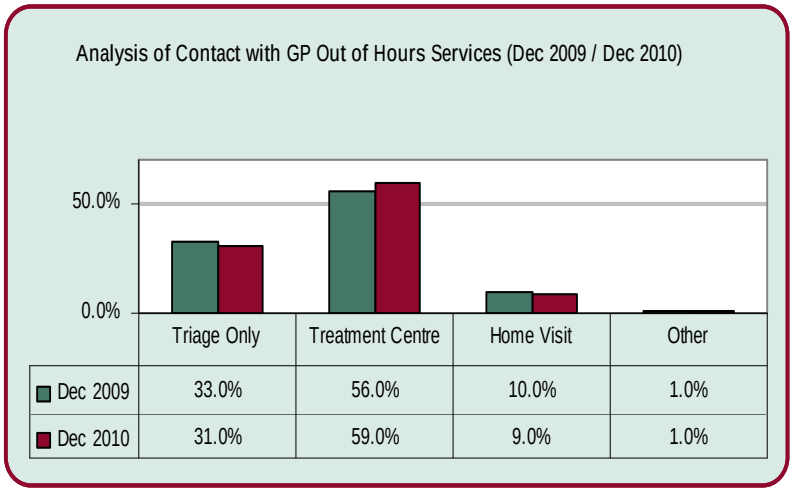
Commentary
There is considerable variation between regions, and between the size and structure of the individual co-operatives.

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

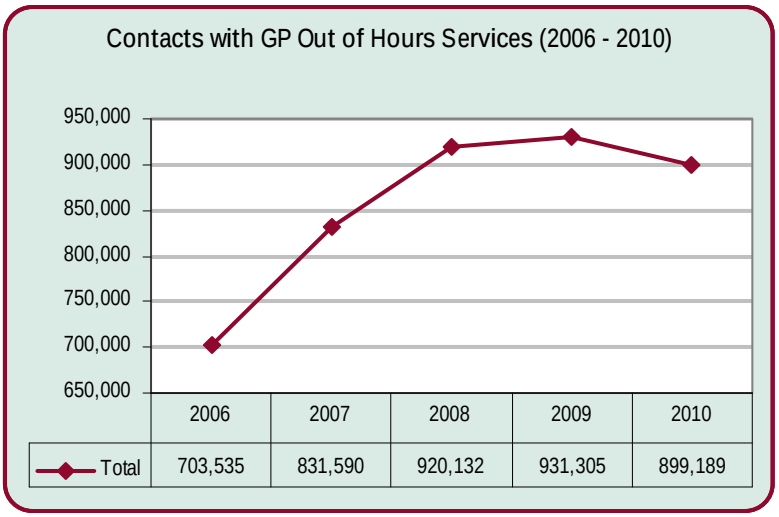
There remain a number of LHO's that have no cover (e.g. parts of Galway, Limerick and Sligo).

As of December 2010, 899,189 contacts were made with the GP Out of Hours Service (-3.4% decrease on same period 2009). A detailed examination of the type of contact made with the Out of Hours service indicates that the majority (59%) resulted in attendance at a Treatment Centre.





	Triage Only	Treatment Centre	Home Visit	Other
Dec 2009	33.0%	56.0%	10.0%	1.0%
Dec 2010	31.0%	59.0%	9.0%	1.0%



	2006	2007	2008	2009	2010
Total	703,535	831,590	920,132	931,305	899,189

Child and Adolescent Mental Health

Metric Used
The percentage of new referrals seen by Community CAMHS teams who were within 3 months of referral.

Rationale
Timely access to assessment and treatment improves the outcome for young people experiencing mental health issues.

It is the ultimate objective of the HSE that 100% of children would be seen within 3 months of referral.

Data Source
CAMHs data base.
Business Intelligence Unit (BIU) (Non Acute), HSE

Period Covered by Data
Nov 2009 – Dec 2010

Target Information
Waiting Times to be seen and Overall Waiting List:

- 70% new cases seen within 3 months of receipt of referral (2010), increasing to 100% over a period of 3 – 5 years.

Performance Overview
68.3% of new referrals seen were within 3 months of referral between January and December 2010.

Commentary

Waiting time:
From Jan – Dec 2009, the average performance across the 50 Community CAMHS Teams was that 68.3% of new cases seen were within 3 months of receipt of referral. Of the 50 Community CAMHS Teams, 17 Teams (34%) were operating above this figure. This is based on actual waiting time for those seen.

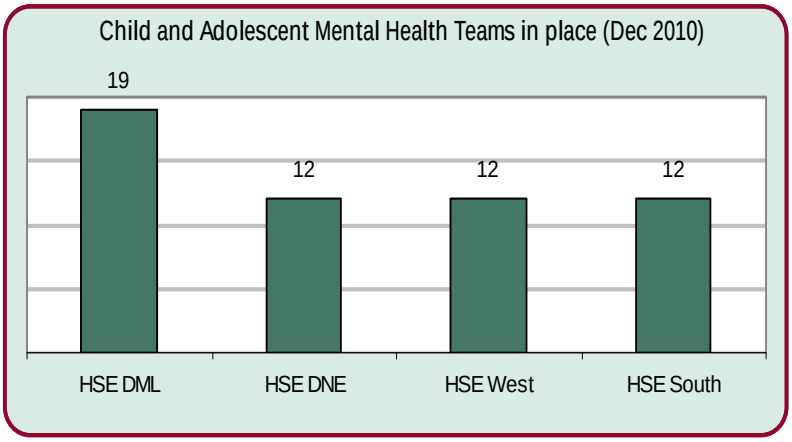
Waiting list:
There were 11,550 referrals to the 50 teams, 8,070 (70%) were Accepted, 8,430 were offered a first appointment and 7,477 were seen. In the period Dec 2009 – Dec 2010, there was a decrease of 4.2% in the number of children waiting to be seen by CAMHS Teams in the community.

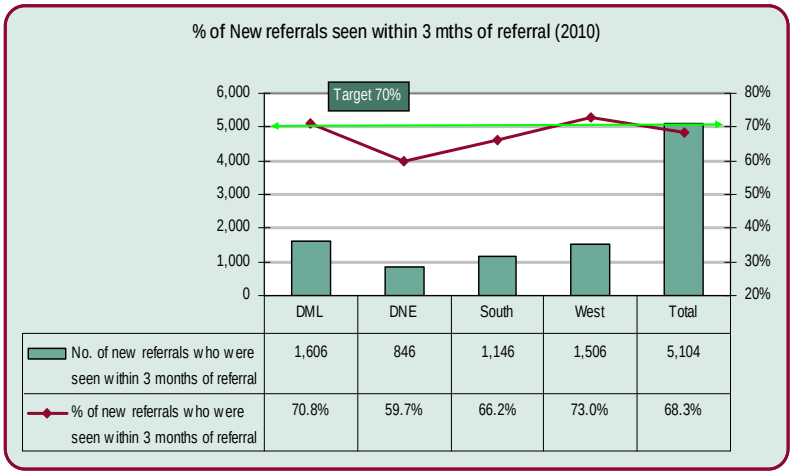
In the overall waiting list 2,509 children and adolescents were waiting to be seen (Dec 2010)

- 999 (40%) waiting <3 months
- 529 (21%) waiting 3-6 months
- 632 (25%) waiting 6-12 months
- 349 (14%) waiting >12 months

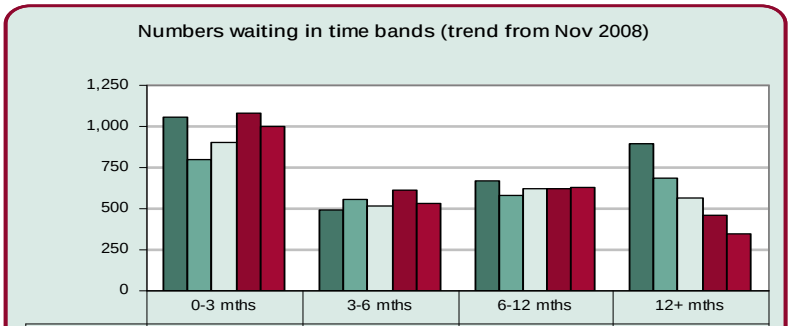
As size of waiting lists is not evenly distributed across the service, an overall reduction of 4.2% in the number on the waiting list was achieved. There was also a reduction of 223 (39.7%) in the number of children waiting greater than 12 months to be seen.

In Dec 2009, 21.5% of children were waiting longer than 12 months. This has been reduced to 14% (December 2010).

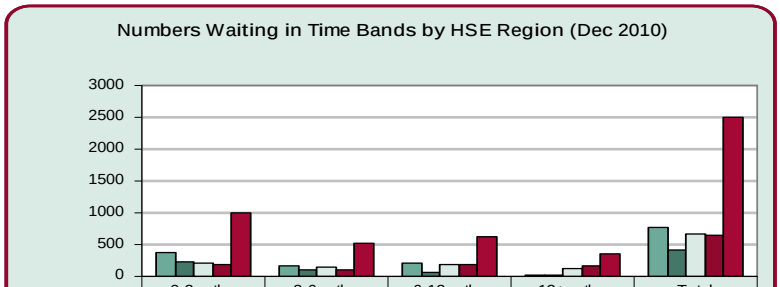




	DML	DNE	South	West	Total
No. of new referrals who were seen within 3 months of referral	1,606	846	1,146	1,506	5,104
% of new referrals who were seen within 3 months of referral	70.8%	59.7%	66.2%	73.0%	68.3%



	0-3 mths	3-6 mths	6-12 mths	12+ mths
Nov 2008	1,057	495	668	897
Sept 2009	797	555	578	687
Dec 2009	907	516	623	562
June 2010	1,079	615	624	461
Dec 2010	999	529	632	349



	0-3 mths	3-6 mths	6-12 mths	12+ mths	Total
HSE DML	373	160	214	25	772
HSE DNE	219	104	59	31	413
HSE West	210	154	179	125	668
HSE South	197	111	180	168	656
National	999	529	632	349	2509

Disability Assessments

Metric Used

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

Rationale

Part 2 of the Disability Act 2005 commenced on 1 June 2007 in respect of children aged under 5 years.

The Act provides qualifying people with disabilities with an entitlement to:

- An independent assessment of the health and education needs occasioned by the disability (this is carried out by, or arranged to be carried out by, an Assessment Officer who is independent in the performance of his or her functions).
- A statement of services (Service Statement) which will be provided to meet the needs identified. This is drawn up by a Liaison Officer (also known as a Case Manager).
- Pursue a complaint through an independent redress mechanism if there is a failure to provide these entitlements.

Data Source

Assessment Officer's System (AOS) Database (Quarterly Reports) Disabilities Information Unit / BIU Non Acute

Period Covered by Data

2009 – 2010

Target Information

100% of assessments should be completed within the timelines laid out in legislation.

Performance Overview

20.7% of assessments were completed within timelines laid out in legislation in 2010.

Commentary

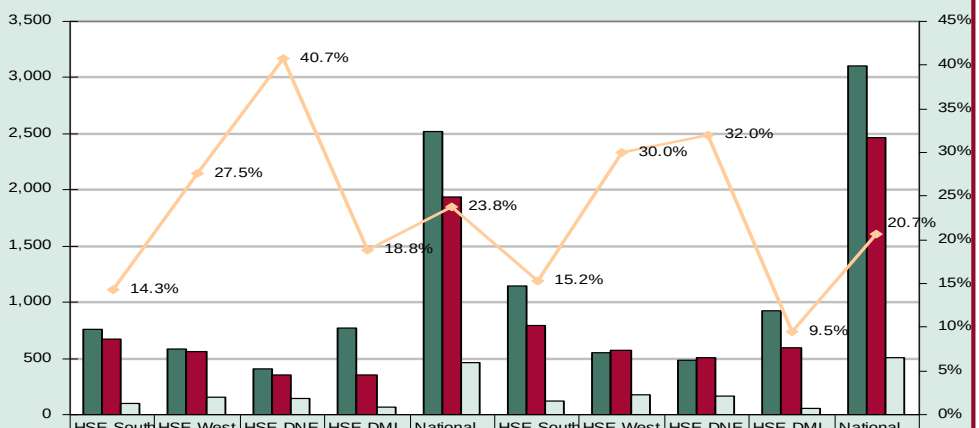
While the National percentage of assessments completed within timelines has decreased from 23.8% in 2009 to 20.7% in 2010, it should be noted that requests for assessments increased from 2,525 in 2009 to 3,100 in 2010 (+23%). In addition, applications commenced within the timelines increased from 1,878 in 2009 to 2,266 in 2010 (+21%) and assessments completed increased from 1,937 in 2009 to 2,461 in 2010 (+27%).

Across LHOs there is wide variation in the number of assessments which are overdue for completion. At the end of 2010, no assessments were overdue in 4 LHOs, in single figures in 11 LHO Areas, in excess of 40 in 4 areas and in excess of 100 in 2 areas. A particular focus is now being taken by the Management Team on those LHO Areas with the largest number of assessments overdue for completion. This performance is highlighted in both the HealthStat reports and forum and at Regional Performance Review Meetings. Action plans have been drawn up for each HSE Region and progress is monitored on a weekly basis.

In addition to the increase in demand, other issues impacting the HSE's ability to meet legislative obligations include:

- Prioritisation of the provision of clinical services for priority cases (e.g. Psychiatry / Paediatric) on existing waiting lists, over the assessment of need under the disability legislation.
- The management of waiting lists for interventions as a result of the focus placed on the assessment process.
- Staff resources - Non-replacement of the staff to carry out the assessments (e.g. Staff in therapy positions).
- Moratorium on recruitment.
- Significant pressure from schools to produce assessments which comply with the Department of Education and Skills (DES) resource allocation model.

Number of Disability Assessments Requested and Completed (Q4 2009 / Q4 2010)



	HSE South	HSE West	HSE DNE	HSE DML	National	HSE South	HSE West	HSE DNE	HSE DML	National
	Total 2009					Total 2010				
Requests for assessments received YTD	763	588	406	768	2,525	1,150	545	482	923	3,100
Assessments completed (as in regs) YTD	670	559	356	357	1,942	787	570	507	597	2,461
Assessments completed (within timelines) YTD	96	154	145	67	462	120	171	162	57	510
% assessments completed within timelines in reg YTD	14.3%	27.5%	40.7%	18.8%	23.8%	15.2%	30.0%	32.0%	9.5%	20.7%

Emergency Department: Patient Experience Time

Metric Used

Emergency Department (ED) waiting times from registration to admission or discharge.

Rationale

The time interval between onset of symptoms and treatment and / or admission to hospital can impact of the effectiveness of treatment therefore it is important to have an overview of the patient time in ED. The time taken between registration and admission or discharge in ED also influences satisfaction with the service received. Focusing on details of patients experience can help pinpoint problems with processes within the ED. Differences between hospitals also allow examples of good processes and practice to emerge which can be shared across management areas.

Data Source

ED data sets via the Business Intelligence Unit (BIU) (Acute). This data currently covers 20 hospitals.

Period Covered by Data displayed

June – December 2010

Target Information

Target 2008: no patient will wait in an ED for > 12 hours following decision to admit.
Target 2009 and 2010: 100% of patients treated and discharged or admitted within 6 hours of registration

Performance Overview

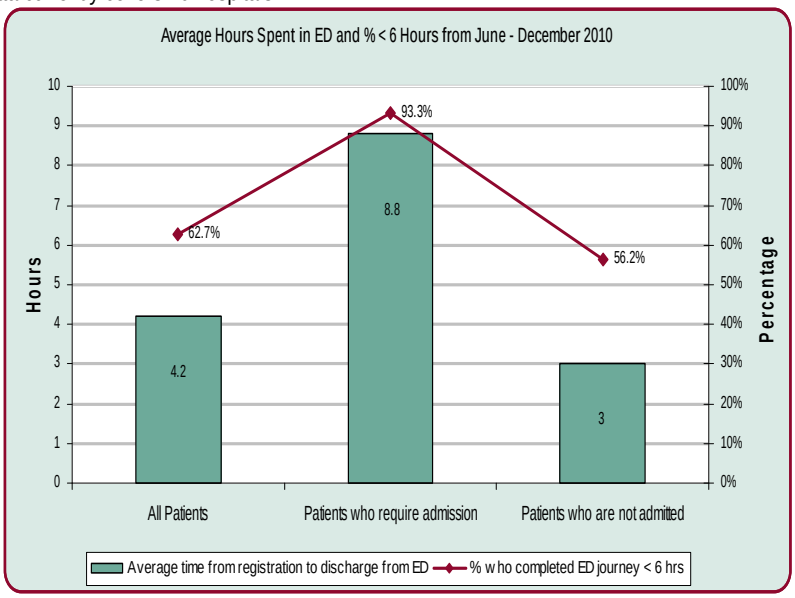
The average performance from June – December 2010

Average time from registration to discharge:

- All patients 4.2 hours
- Patients who require admission 8.8 hours
- Patients who are not admitted 3 hours

% of patients who completed their ED journey in < 6 hours:

- All patients 62.7%
- Patients who require admission 56.2%
- Patients who are not admitted 93.3%



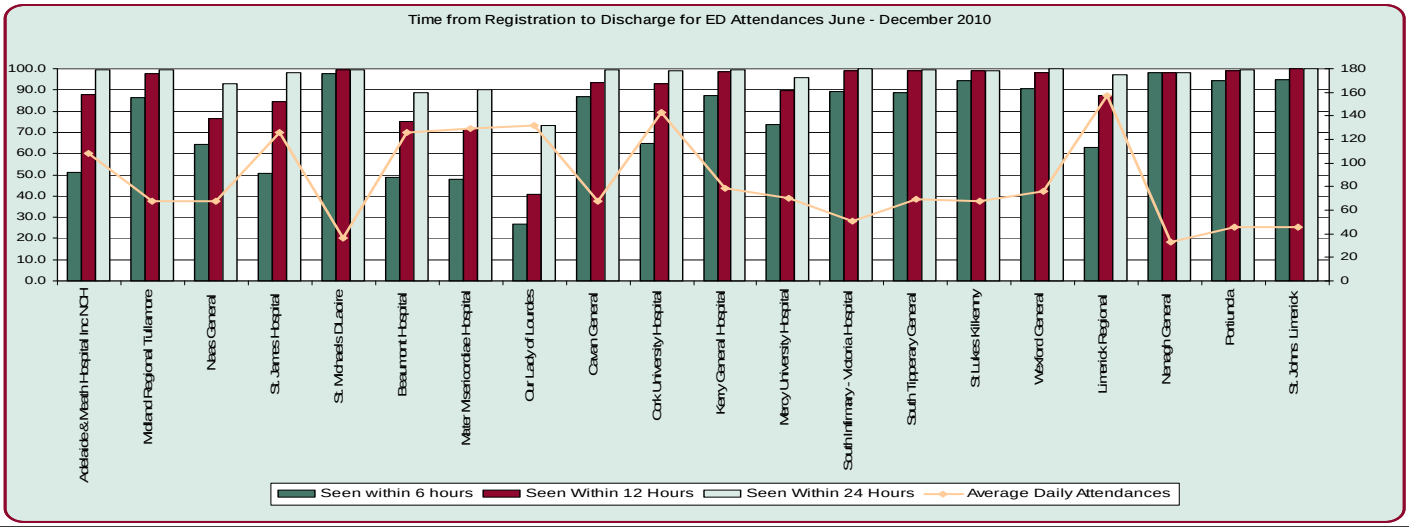
Commentary

There is no National ED system in place. As a result it is not possible to report and track ED performance across time or to compare performance across hospitals. From September 2010 performance was presented by hospital using mixed methods of tracking the data required. This allows a view across hospitals but comparisons between hospitals should be approached cautiously because of the variation in data collection.

Over the past three years the target for completion of a visit to ED has moved from 12 hours from point of decision to admit, to 6 hours for complete visit from registration to discharge or admission. This level of performance improvement is very challenging. There has been an improvement in performance. In December 2008 it was reported that 60% of those waiting for admission after decision to admit were waiting over 6 hours. In December 2010 43.8% of those who required admission were waiting over 6 hours from the time of registration. The average through time for this group is 8.8 hours in 2010.

We see in the average performance across the 20 hospitals reported on in 2010 that it is those hospitals with the greatest average daily attendances that are finding it hardest to reach the level of performance required. A management response to manage demand in ED is now in place, this has a series of alerts which in turn trigger a response to help to manage the service need: scheduling of elective procedures to free up beds, rostering of clinicians to ensure that the appropriate level of skill and decision making is available; manage discharge.

Performance in ED is symptomatic of wider performance in the hospital and the community. A total system solution, such as that being developed through the acute medical programme, is required. This will address the issues within ED and across the hospital and community. Coupled with a long term approach to managing chronic illness this should provide a more sustainable approach to managing acute episodic illness appropriately in ED.



Public / Private Hospital Activity

Metric Used
The percentage of discharges which are public patients.

Rationale
It is HSE policy that 80% of all patients treated in Public Hospitals are treated under the public health system. This metric is used to monitor the application of this policy, on average across all hospital discharges.

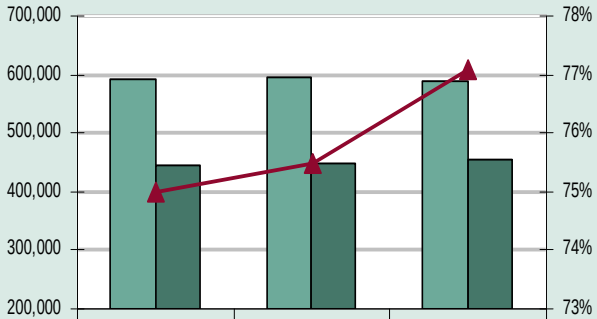
Data Source
Hospital data sets via the Business Intelligence Unit (Acute).

Period Covered by Data
2008 - 2010

Target Information
80% of all discharges should be public patients

Performance Overview
As of December 2010, 77.1% of in-patients discharged from HSE hospitals were public patients.

Number and % of Public Discharges 2008 - 2010



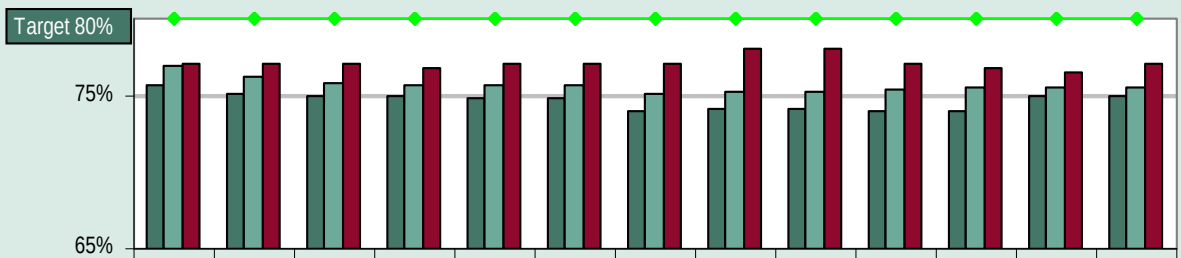
	2008	2009	2010
No. of In-pt discharges	593,359	595,022	588,860
No. of Public discharges	445,019	449,242	454,011
% Public	75.0%	75.5%	77.1%

Commentary
The numbers and percentage of people treated under the public health system in public hospitals has been increasing year or year. There are some seasonal fluctuations evident but even within these there has been an increase in the percentage of people treated in the public system each month when comparing the same period in 2008, 2009 and 2010.

This policy supports the management of public hospital resources and specialised medical time so that it translates in to an 80:20 split between public and private provision of care.

The factors influencing the level of public and private practice are different across hospitals. People have the right to choose to go privately to any consultant who holds a contract which allows both public and private practice. The level to which this private practice is carried out in public hospitals is in turn influenced by previously agreed practice arrangements, the availability and access to private facilities and the demand for a private service and the proportion of people who come in for planned procedures (elective) as opposed to emergency admissions. The new Consultant Contract allows this measure to be monitored by consultant and, over time, should result in further progress towards the target.

Public as a % of all patients (2008 / 2010)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	National
2008	75.7%	75.1%	75.0%	74.9%	74.8%	74.8%	74.0%	74.1%	74.1%	74.0%	74.0%	75.0%	75.0%
2009	76.9%	76.2%	75.8%	75.7%	75.6%	75.7%	75.1%	75.2%	75.2%	75.4%	75.5%	75.5%	75.5%
2010	77.0%	77.0%	77.0%	76.8%	77.0%	77.0%	77.0%	78.0%	78.0%	77.0%	76.8%	76.5%	77.1%
Target 80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Sustainable Services

Primary Care Teams

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

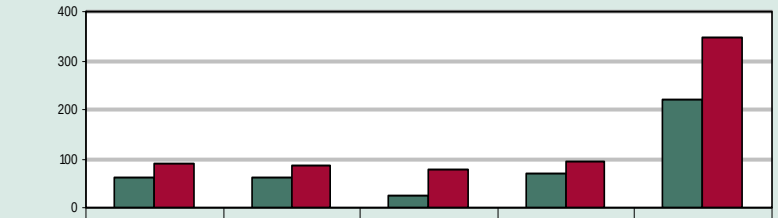
Rationale
PCT's are an inter-disciplinary team-based approach to primary care provision. The introduction of a team-based approach to primary care has advantages for users and providers.

Data Source
Business Intelligence Unit (BIU), HSE

Period Covered by Data
Jan 2009 – Dec 2010

Target Information
394 Teams by end 2010

No. of PCTs holding Clinical Meetings by HSE Region (Dec 2009 - Dec 2010)



	HSE South	HSE West	HSE DNE	HSE DML	National
Dec-09	63	61	26	69	219
Dec-10	89	87	78	94	348

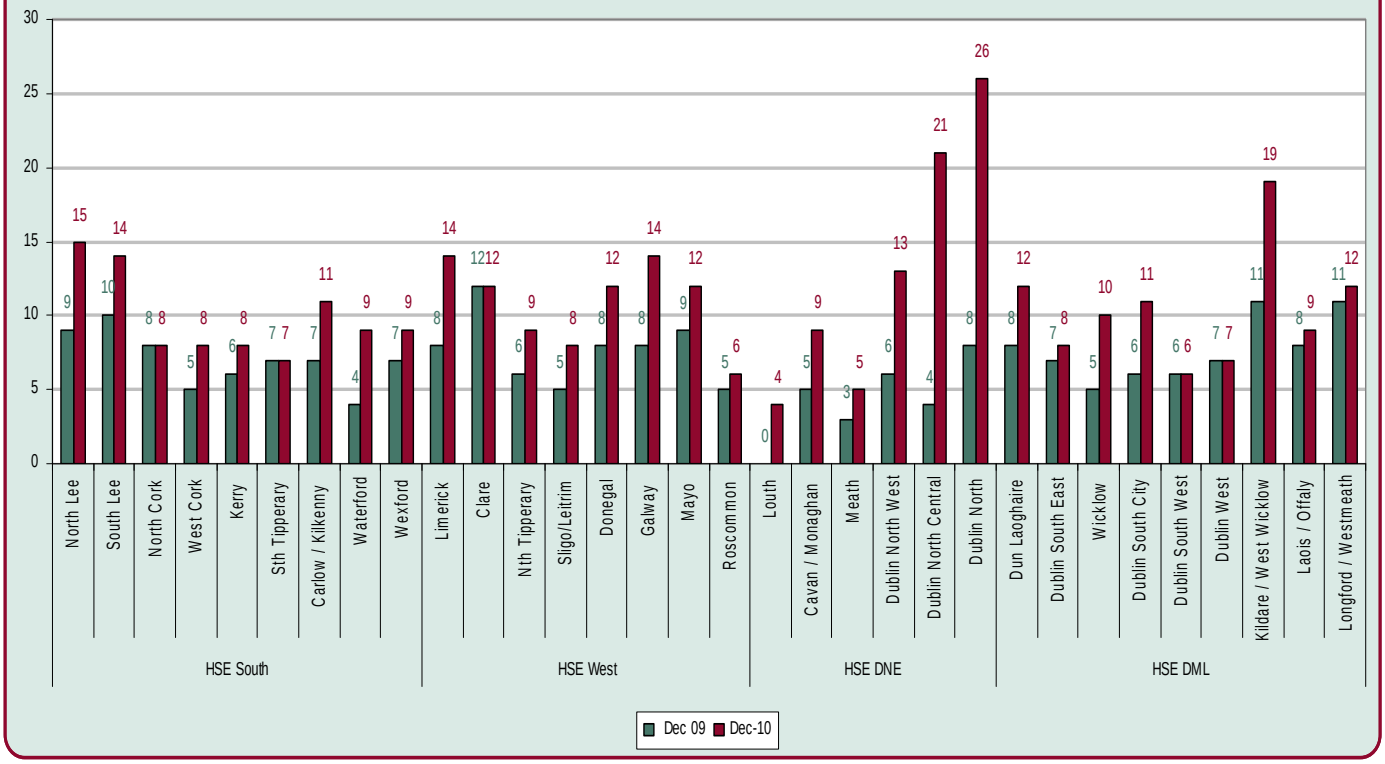
Performance Overview
348 PCT's are in place and holding clinical team meetings as of Dec 2010

Commentary
Development of PCTs is a key priority for the HSE where the aim is to facilitate access into, through and out of the healthcare system and to ensure that quality care is provided in a way that maximises convenience for clients / patients. In the region of 2.8 million people can now avail of health and social care through local PCT's. Holding 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.

As of end of December 2010 there were 348 PCT's operating across the country with a further 170 Teams in varying stages of development. This is an increase of 129 teams on the December 2009 position.

While building new Primary Care centres involves a longer lead in time, the programme is well under way with additional centres opening across the country between now and the end of 2013.

No. of PCTs by LHO holding Clinical Team Meetings (Dec 2009 / Dec 2010)



Elder Abuse

Metric Used

The % of Elder Abuse referrals receiving first response from a Senior Case Workers within 4 weeks.

Rationale

Elder Abuse is defined as a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights." *(Protecting our Future, Report of the Working Group on Elder Abuse, September 2002).*

65 years of age is taken as the point beyond which abuse may be considered to be elder abuse

Data Source

Elder Abuse Dataset, Older Persons Services, HSE

National Centre for the Protection of Older People
www.ncpop.ie

Period Covered by Data

2007 - 2010

Target Information

100% of all referrals to receive a first response from Senior Case Workers within 4 weeks.

Performance Overview

In 2010, 98% of Elder Abuse referrals received a response within 4 weeks.

Commentary

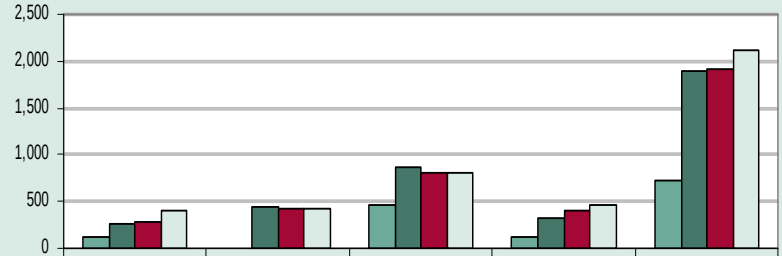
In 2007, the HSE established a dedicated Elder Abuse Service with Senior Case Workers in Elder Abuse now working in most Local Health Office Areas. Senior Case Workers are trained Social Workers and work in partnership with all relevant stakeholders and alongside the Dedicated Officer. However, it is the responsibility of all staff to take action where required to ensure the protection and welfare of older people.

The Senior Case Worker is responsible for the investigation and management of incidents of Elder Abuse in the Local Health Office Area. This is done by recording, assessing, managing and co-ordinating the response to Elder Abuse. The Senior Case Worker will also provide advice and guidance to anyone raising concerns of Elder Abuse.

The referring service will continue to be involved where necessary and may be required to participate in the investigation or the ongoing monitoring of the case. At any time the Senior Case Worker may be contacted for advice and guidance when staff are uncertain about appropriateness of the concerns raised and criteria for referral.

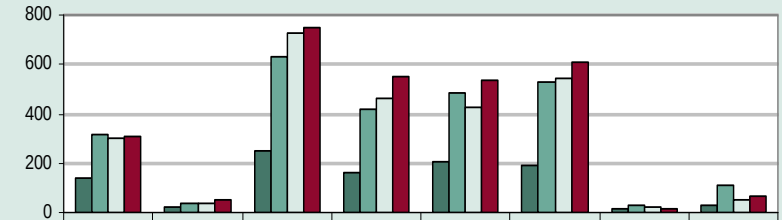
In 2010, the HSE received 2,110 referrals of cases of suspected elder abuse. In 70% of cases the elderly people involved have been aged over 75 years. Of these referrals, 26% were Psychological abuse, 19% Financial Abuse, 18.6 Neglect and 10.7% were Physical Abuse. 98% of these referrals received a response within 4 weeks. It is critical that the HSE, through the Senior Case Workers, responds to these cases as quickly as possible.

No. of Elder Abuse Referrals by HSE Area (2007 - 2010)



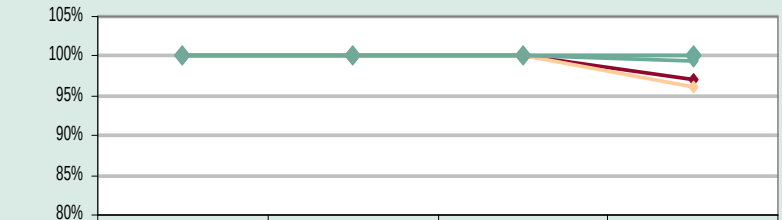
	DML	DNE	South	West	Nationally
2007	125	0	468	127	720
2008	254	434	877	323	1,888
2009	278	433	805	401	1,917
2010	406	429	810	465	2,110

Type of Elder Abuse Referrals (2007 - 2010)



	Physical	Sexual	Psych	FincI	Neglect	Self Neg	Discrim	Other
2007	138	19	249	160	204	194	18	33
2008	319	36	633	417	481	528	28	113
2009	303	34	728	466	426	542	22	51
2010	308	52	749	547	534	608	14	64

% of Referrals receiving 1st response from Senior Caseworkers within 4 weeks (2010)



	Q1	Q2	Q3	Q4
DML	100%	100%	100%	100%
DNE	100%	100%	100%	97%
South	100%	100%	100%	96.1%
West	100%	100%	100%	99.3%

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 2009.

Target Information
Monitoring is ongoing during with a view to future target setting. Equal opportunity of access would be a target aspired to.

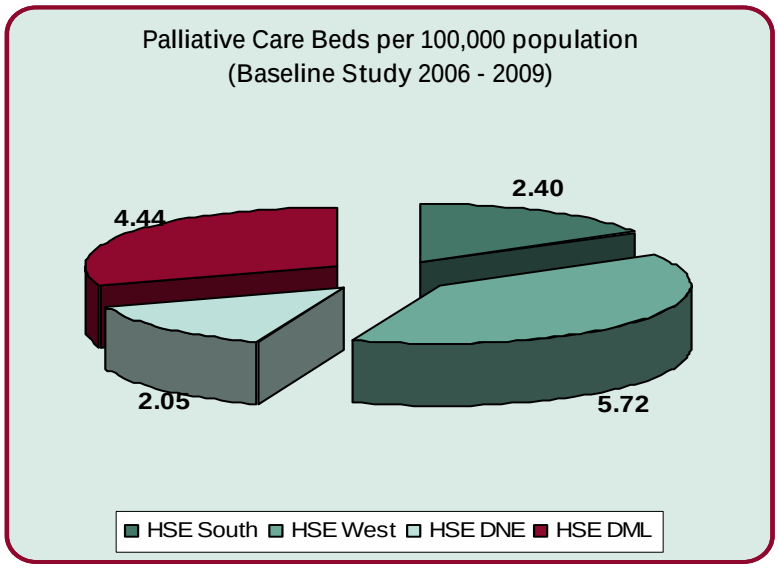
Performance Overview
There are 3.7 specialist palliative care beds per 100,000 population nationally ranging from 5.72 in the West to 2.05 in DNE.

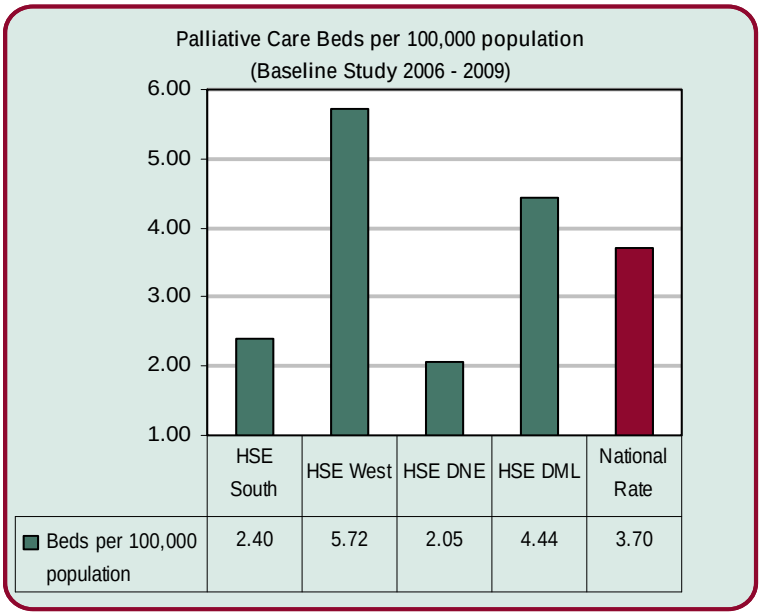
Commentary
There is wide regional and intra-regional variation in the availability of specialist inpatient beds. This variation is noted in the National Developmental Framework for Palliative Care Services and the priority deficits for immediate action are documented.

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

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

From 2011 performance is being tracked on the basis on timely access to in-patient and home based services and these measures will give a better indication of how this important service is meeting peoples needs.





Children in Residential Care

Metric Used
The number and percentage of children in residential care as a percentage of all children in care

Rationale
Monitoring of the placement of children is critical in order to ensure appropriate placement for the child and appropriate use of resources. Where possible and appropriate, the HSE strives to place children in need of care in as close to a home setting as possible with fostering being first choice of out of home care.

Data Source
Childcare Quarterly Performance Indicators Q4 2010 via the Business Intelligence Unit (Non Acute), HSE

Period Covered by Data
2008 - 2010

Target Information
That no more than 7% of all children in care should be in residential care.

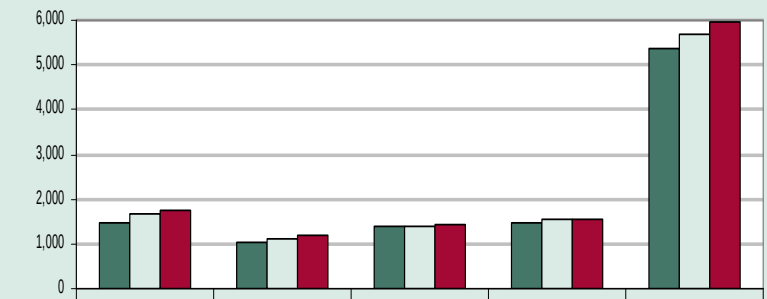
Performance Overview
Of all of the children in care at of Dec 2010, 440 or 7.4% children were in Residential Care.

Commentary
In December 2010, there were 5,964 children in care across the various care placement types. Of this total, 440 children were in residential care (7.4% of the national total).

There has been an overall increase in the number of children coming into care. There were 617 more children in care at the end of Dec 2010 than at Dec 2008 (an increase of 11.5%).

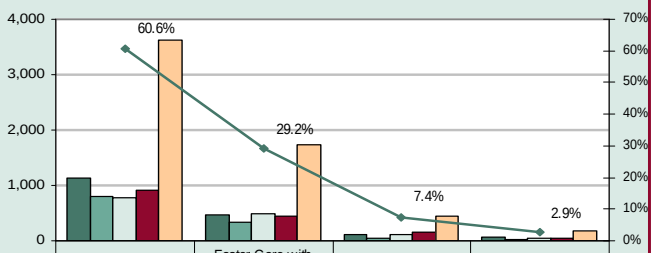
However the proportion of children in foster care has risen most, which is in line with HSE policy where, in so far as possible, those children are placed in a safe home environment.

Numbers of Children in Care (Dec 2008 - Dec 2010)



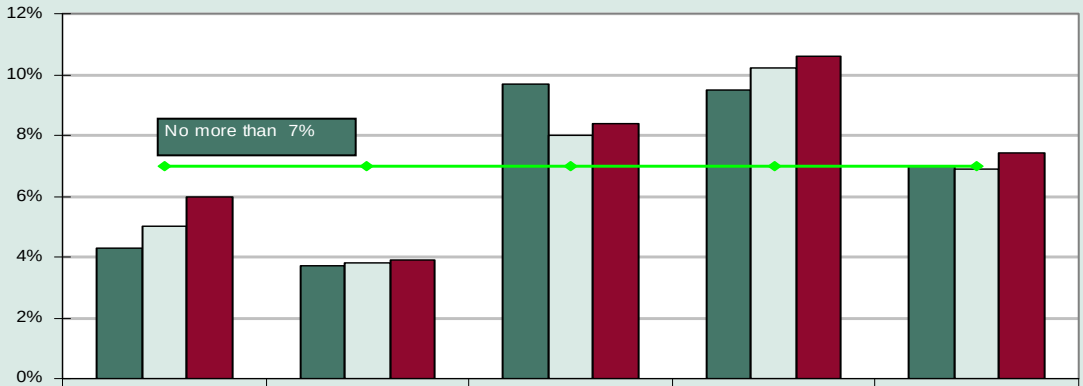
	HSE South	HSE West	HSE DNE	HSE DML	National
Dec 2008	1,457	1,036	1,397	1,457	5,347
Dec 2009	1,653	1,110	1,392	1,534	5,689
Dec 2010	1,758	1,206	1,440	1,560	5,964

No and % of Children in Care by Care Setting (Dec 2010)



	Foster Care	Foster Care with Relative	Res Care	Other Care Placement
HSE South	1,130	466	106	56
HSE West	799	333	47	27
HSE DNE	775	498	121	46
HSE DML	908	445	166	41
National	3,612	1,742	440	170
% in Care by Care Type	60.6%	29.2%	7.4%	2.9%

Children in Residential Care as a % of all Children in Care (Dec 2008 - Dec 2010)



	HSE South	HSE West	HSE DNE	HSE DML	National Total
Dec 2008	4.3%	3.7%	9.7%	9.5%	7.0%
Dec 2009	5.0%	3.8%	8.0%	10.2%	6.9%
Dec 2010	6.0%	3.9%	8.4%	10.6%	7.4%
Target	7%	7%	7%	7%	7%

Care Planning for Children

Metric Used
The number and percentage of children in care who currently have a written care plan, as defined by Child Care Regulations

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

The objective of this measure is to ensure a coordinated approach to supporting the development of children in care as well achieving compliance with the Child Care regulations (1995) and the Ryan Report.

Data Source
Childcare Dataset via the Business Intelligence Unit (Non Acute), HSE

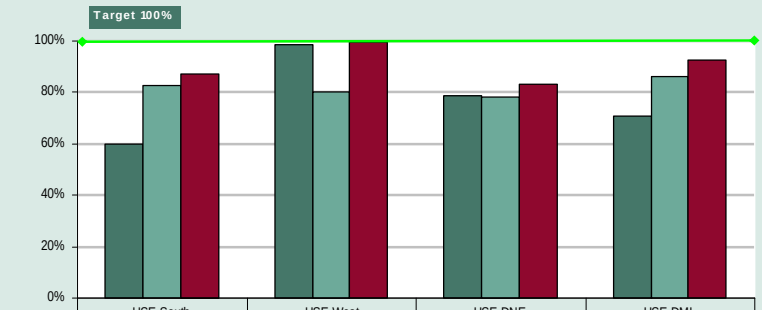
Period Covered by Data
Jun 2009 – Dec 2010

Target Information
Child Care Regulations (1995) and the Ryan Report state that 100% of all children in care must have a written care plan.

Performance Overview
5,376 of 5,964 Children in Care (90.1%) had a written care plan during 2010.

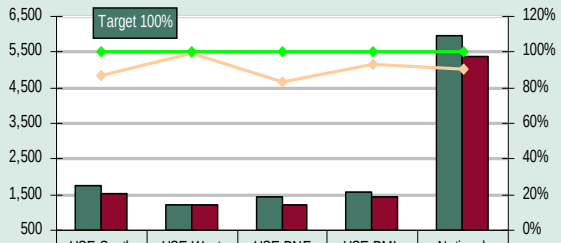
Commentary
In 2010, 90.1% of all children in HSE care had a written care plan. This is short of the target of 100% but represents an improvement on 2009 when the percentage stood at 81.4%. The graph shows considerable divergence across HSE Areas.

% of Children in Care with a Written Care Plan (Jun 2009 - Dec 2010)



	HSE South	HSE West	HSE DNE	HSE DML
June 2009	60.0%	98.5%	78.9%	70.9%
June 2010	82.5%	80.1%	78.4%	85.9%
Dec 2010	87.0%	99.6%	83.3%	92.7%

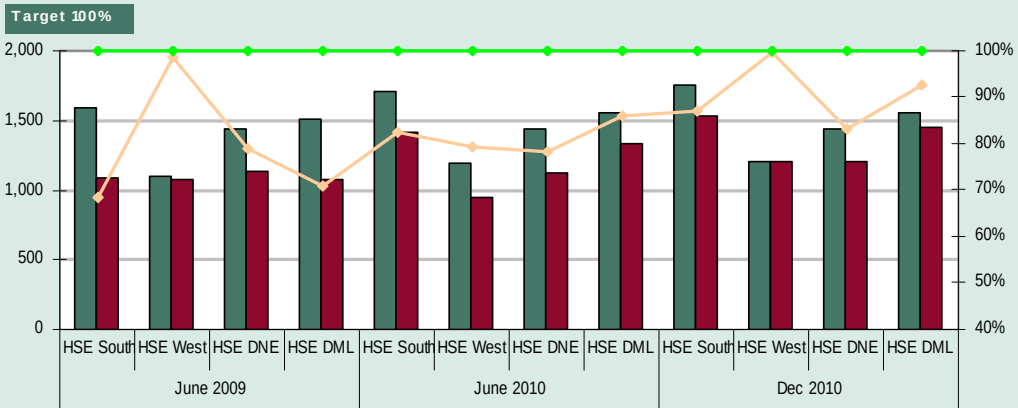
Children in Care who have a Written Care Plan (Dec 2010)



	HSE South	HSE West	HSE DNE	HSE DML	National
Numbers in Care	1,758	1,206	1,440	1,560	5,964
Numbers with Plan	1,530	1,201	1,199	1,446	5,376
% Children in care with a written Care Plan	87.0%	99.6%	83.3%	92.7%	90.1%
Target	100.0%	100.0%	100.0%	100.0%	100.0%

The HSE has committed to improve on performance to achieve 100% at national level based on:
- Ryan Report implementation plan to ensure all children in care have a written care plan
- Impact of social work recruitment.
- Impact of implementation of standardised care plan and guidance documentation.

No. of Children in Care with a Written Care Plan (Jun 2009 - Dec 2010)



	HSE South	HSE West	HSE DNE	HSE DML	HSE South	HSE West	HSE DNE	HSE DML	HSE South	HSE West	HSE DNE	HSE DML
	June 2009				June 2010				Dec 2010			
Numbers in Care	1,591	1,098	1,443	1,514	1,713	1,196	1,434	1,558	1,758	1,206	1,440	1,560
Numbers with Plan	1,091	1,081	1,138	1,073	1,414	948	1,124	1,339	1,530	1,201	1,199	1,446
% Children with a written Care Plan	68.6%	98.5%	78.9%	70.9%	82.5%	79.3%	78.4%	85.9%	87.0%	99.6%	83.3%	92.7%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Average Length of Stay

Metric Used
Average Length of Stay (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.

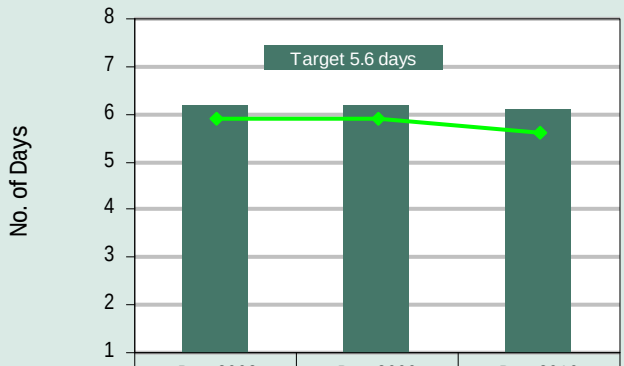
Data Source
Hospital data sets through the Business Intelligence Unit (Acute).

Period Covered by Data
2008 – 2010

Target Information
The average length of stay, as an acute in- patient, should be 5.6 days.

Performance Overview
The result is derived from taking the total bed days used and dividing by the total in patient discharges. This shows a performance at December 2010 of 6.1 bed days being an average stay for an in-patient in the public hospital system.

National Average Length of Stay (Dec 2008 - Dec 2010)



	Dec 2008	Dec 2009	Dec 2010
ALOS	6.2	6.2	6.1
Target	5.9	5.9	5.6

Commentary
This is a crude overview of the current ALOS position in Irish hospitals. The data is not casemix adjusted but is adjusted for delayed discharges. A customised, target ALOS has been set for each hospital. Variances against the target are then calculated through the HIPE system.

In 2009 and 2010, hospital services have been planned and delivered to maximise the number and type of procedures that can be carried out on a day case basis. These by their nature tend to be procedures which are less complex and less at risk of complication than those for which people are admitted. As the graph below shows, day case activity as a proportion of all activity has been increasing over these years. A consequence of this may be that the acuity and complexity of in-patient treatment increases and this has a direct impact on the average length of stay.

In the light of this, the continuing decrease observed in the overall length of stay is an indication of the management of those factors which can be influenced including discharge planning and preadmission clinics, which allow people to be admitted on the day of their procedure. The availability of Fair Deal to allow people to choose appropriate residential and continuing care and the development of services such as Community Intervention will support performance improvement in this area.

The current target for overall ALOS is 5.6 days. The HSE has adopted a programmatic approach to the delivery of medical and surgical services and it is planned to develop appropriate performance indicators and targets in relation to average length of stay for elective and emergency surgical and medical procedures. This may provide specific targets across specialties and factor in complexity and the age profile of hospitals' patients.

In patient and Day Case Discharges plotted against ALOS 2008 - 2010

	Dec 2008	Dec 2009	Dec 2010
In patient discharges	593,359	595,022	588,860
Day case discharges	641,974	669,955	728,269
ALOS	6.2	6.2	6.1
Target	5.9	5.9	5.6

Inpatient / Day Case Ratios

Metric Used
The percentage of day case surgeries, as a % of day case plus inpatients, for a specified basket of procedures. (General Surgery, ENT, Ophthalmology)

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.

This is to support the elective surgery programme and, in accordance with national standards, increase the rates of day surgery for selected common surgical procedures.

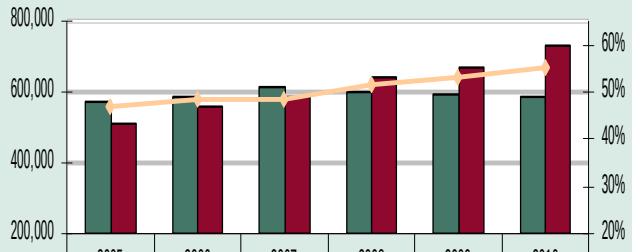
Data Source
HIPE via the Business Intelligence Unit (Acute)

Period Covered by Data
2010

Target Information
75% of procedures for the selected basket should be carried out as day cases.

Performance Overview
At the end of 2010 the reported position is that 70% of procedures for the selected basket are being carried out as day cases. This is up from 65% for the same period in 2009.

Inpatient Discharges / Day Cases (all activity including public and private) (2005 - 2010)

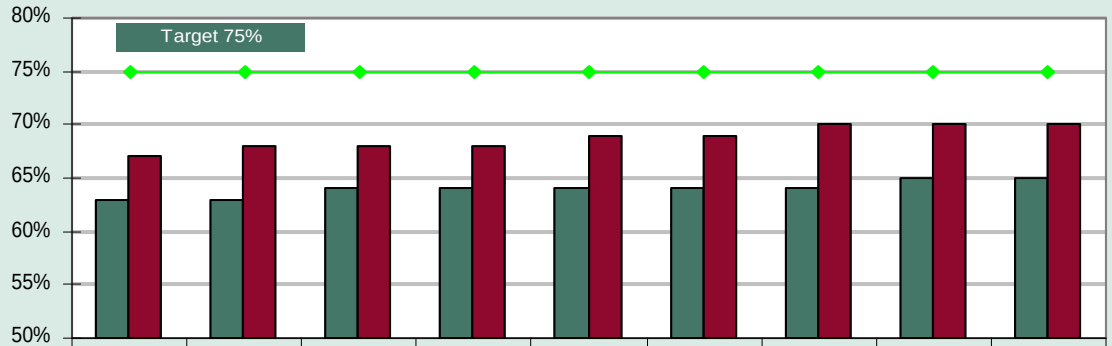


	2005	2006	2007	2008	2009	2010
Inpatient Discharges	575,476	588,875	612,346	599,910	593,359	588,860
Day Case	512,034	558,813	583,369	641,974	669,955	728,269
% Day Case all discharges	47.0%	48.6%	48.7%	51.6%	52.9%	55.2%

Commentary
The percentage of procedures conducted as day cases stands at 70% against a target of 75%. This is a significant improvement on the reported position on 65% in 2009. This pattern is mirrored in the overall trend in the proportion of all discharges, in patient and day case, which are day cases. The chart above shows the trend from 2007 which shows a steady increase from 47% to 55.2%. This is in line with the overall policy to increase the numbers and proportion of appropriate day cases.

The pathways of care being developed through the programmes will prevent admission in many cases and direct patients in to more appropriate avenues of care such as rapid access units and day service units. These, plus the development of care for chronic conditions in primary care, should contribute to more service being available without an in patient stay.

% Day Case Surgeries as a % of Day Case + Inpatients for specialised basket of procedures



	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2009	63.0%	63.0%	64.0%	64.0%	64.0%	64.0%	64.0%	65.0%	65.0%
2010	67.0%	68.0%	68.0%	68.0%	69.0%	69.0%	70.0%	70.0%	70.0%
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Quality & Safety

Caesarean Section

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

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

Data Source
National Perinatal Reporting System (NPRS), through the Business Intelligence Unit (Acute), HSE

Period Covered by Data
2008 – 2010

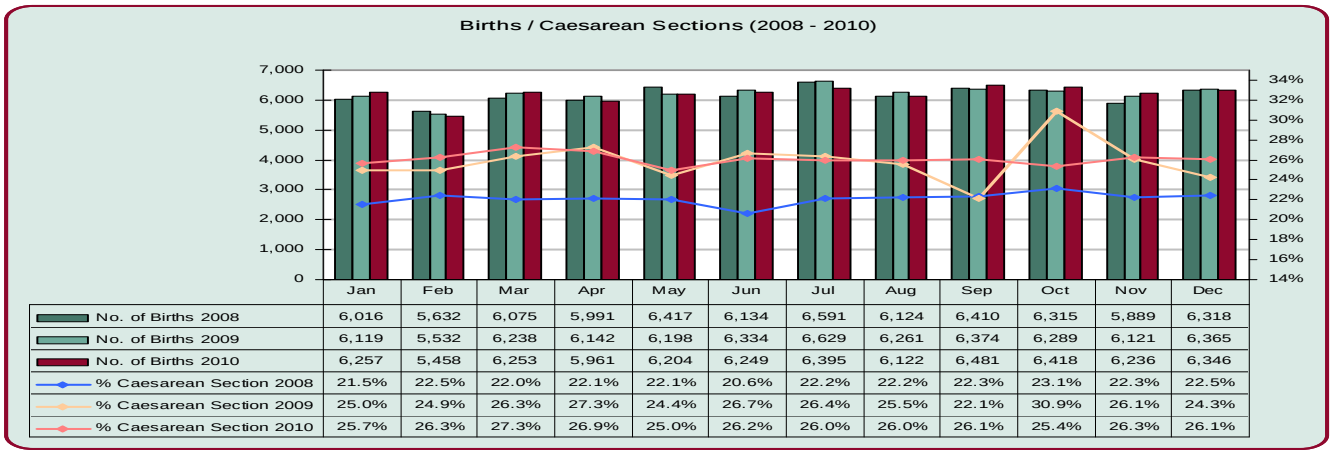
Target Information
There is no agreement on a target which, if adhered to, would ensure a safer and more cost effective birth environment. There is a need however for an examination of variation across maternity units to look at the populations served and the indicators within this population underpinning the level of Caesarean Section.

Performance Overview
26.1% of births nationally were delivered by Caesarean Section in 2010

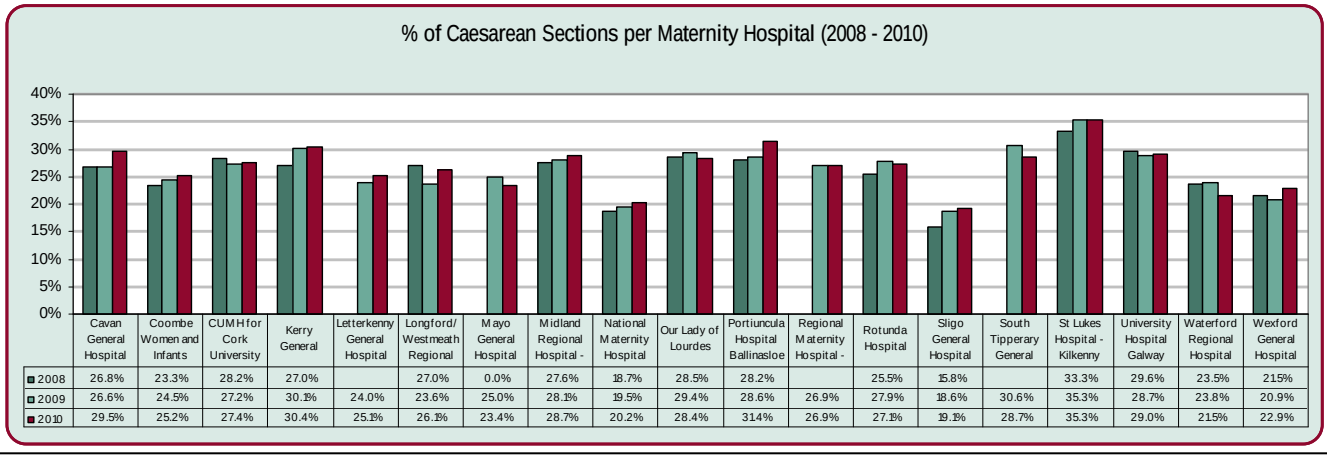
Commentary
The number of births registered in 2009 was the highest since the end of the 19th century (CSO). In addition, Ireland has the highest birth rate of any EU country (ESRI). The National Perinatal Reporting System (NPRS) gathers information on approximately 65,000 birth records every year from 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%). As of December 2010 the average rate of babies delivered by Caesarean section in Ireland stands at 26.1%. In effect, the rate of caesarean section has doubled in 17 years (1993 – 2010). Of particular note is the variation in performance across hospitals.

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

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



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
No. of Births 2008	6,016	5,632	6,075	5,991	6,417	6,134	6,591	6,124	6,410	6,315	5,889	6,318
No. of Births 2009	6,119	5,532	6,238	6,142	6,198	6,334	6,629	6,261	6,374	6,289	6,121	6,365
No. of Births 2010	6,257	5,458	6,253	5,961	6,204	6,249	6,395	6,122	6,481	6,418	6,236	6,346
% Caesarean Section 2008	21.5%	22.5%	22.0%	22.1%	22.1%	20.6%	22.2%	22.2%	22.3%	23.1%	22.3%	22.5%
% Caesarean Section 2009	25.0%	24.9%	26.3%	27.3%	24.4%	26.7%	26.4%	25.5%	22.1%	30.9%	26.1%	24.3%
% Caesarean Section 2010	25.7%	26.3%	27.3%	26.9%	25.0%	26.2%	26.0%	26.0%	26.1%	25.4%	26.3%	26.1%



	Cavan General Hospital	Coombe Women and Infants	CUMH for Cork University	Kerry General	Letterkenny General Hospital	Longford/ Westmeath Regional	Mayo General Hospital	Midland Regional Hospital -	National Maternity Hospital	Our Lady of Lourdes	Portiuncula Hospital Ballinasloe	Regional Maternity Hospital -	Rotunda Hospital	Sligo General Hospital	South Tipperary General	St Lukes Hospital - Kilkenny	University Hospital Galway	Waterford Regional Hospital	Wexford General Hospital
2008	26.8%	23.3%	28.2%	27.0%		27.0%	0.0%	27.6%	18.7%	28.5%	28.2%		25.5%	15.8%		33.3%	29.6%	23.5%	21.5%
2009	26.6%	24.5%	27.2%	30.1%	24.0%	23.6%	25.0%	28.1%	19.5%	29.4%	28.6%	26.9%	27.9%	18.6%	30.6%	35.3%	28.7%	23.8%	20.9%
2010	29.5%	25.2%	27.4%	30.4%	25.1%	26.1%	23.4%	28.7%	20.2%	28.4%	31.4%	26.9%	27.1%	19.1%	28.7%	35.3%	29.0%	21.5%	22.9%

Colposcopy

Metric Used
Waiting times (weeks) for colposcopy.

Rationale
Cervical cytology screening aims to reduce the incidence of and mortality from cancer of the cervix. Well-organised population based screening programmes have been proven to be effective.

Data Source
National Cancer Screening Service
www.cancerscreening.ie

Period Covered by Data
2009 - 2011

Target Information
< 2 weeks for urgent cases
< 4 weeks for women with high grade smear abnormalities
< 8 weeks for women with low grade smear abnormalities

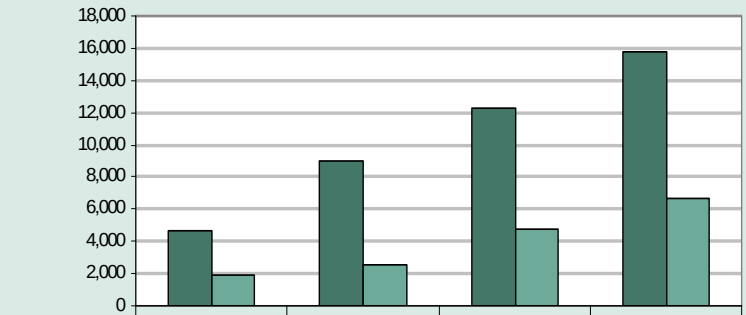
Performance Overview
By January 2011 all waiting lists had been abolished and the average waiting times for colposcopy had reached the target levels.

Commentary
CervicalCheck, the National Cervical Screening Programme was established in Ireland in September 2008. This programme aims to deliver screening at regular intervals to all women living in Ireland aged 25 to 60 years. Quality assurance standards for the programme were published in January 2010 and included standards for colposcopy largely based on those developed by the British Society of Colposcopy and Cervical Pathology (BSCCP). As part of the planning for the delivery of quality assured colposcopy, a gaps analysis was performed in 2007 and additional resources were put in place by the National Cancer Screening Service (NCSS) to establish fifteen selected services. The NCSS, together with local management and the HSE, agreed individualised service improvement plans that included the establishment of an infrastructure to enable the effective audit of performance against the CervicalCheck standards for colposcopy services. The aim was to deliver increased capacity and major improvements in the quality of the services offered to women.

There was a significant increase in the numbers of new patients attending colposcopy services between 2007 and 2010. As well as greater capacity, this reflected the large numbers of women screened with 284,833 women screened in the first year of the CervicalCheck programme from 1 September 2008 to 31 August 2009. Of 28,925 appointments generated, 2,186 women defaulted giving a percentage nationally of 7.6% (target <15%). 95% of treatments were performed as outpatients using local anaesthetic (target >85%) representing marked improvement when compared to 2000 when 23% of treatments were performed as inpatients under general anaesthetic. The death of television celebrity Jade Goody during 2009 resulted in unprecedented levels of cervical screening which resulted in long waiting times and a waiting list of 1,482 women in the summer of 2009. By January 2011 all waiting lists had been abolished and the average waiting times for colposcopy had reached the target levels of < 2 weeks for urgent cases, < 4 weeks for women with high grade abnormalities and < 8 weeks for women with low grade abnormalities.

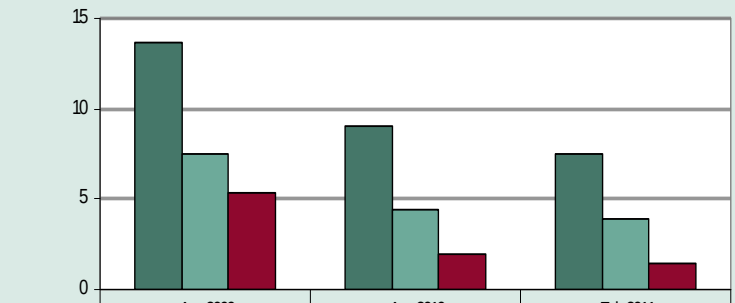
The provision of focused individualised plans with matching resources produced improvements within a short timeframe. The central collection of cytology, histology and colposcopy data has enabled the calculation of national results. Valuable lessons have been learned which should inform opportunities for improvement into the future.

Activity figures Colposcopy Services 2000-2010



	2000	2007	2008/9	2010
New Attendances	4,616	9,043	12,307	15,759
Treatments	1,922	2,504	4,714	6,711

Waiting Times (weeks) for New Referrals to Colposcopy



	Aug 2009	Aug 2010	Feb 2011
Low Grade	13.66	9	7.53
High Grade	7.46	4.4	3.93
Urgent	5.33	2	1.47

Cancer Survival Rates

Metric Used

The five year relative survival for Colorectal, Lung, Breast, Prostate (age standardised).

Rationale

Relative survival is the ratio of the survival observed among a group of patients to that expected among the general population of the same age and sex. For cancer patients, it measures the effect of the excess mortality associated with a cancer diagnosis, providing an indirect alternative to estimation of cause-specific survival.

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

Data Source

National Cancer Registry Ireland
www.NCRI.ie

Period Covered by Data

1994 - 2007 (follow-up to end of 2008)

Target Information

European average performance as listed in Patterns of Care and Survival of Cancer Patients in Ireland 1994- 2004

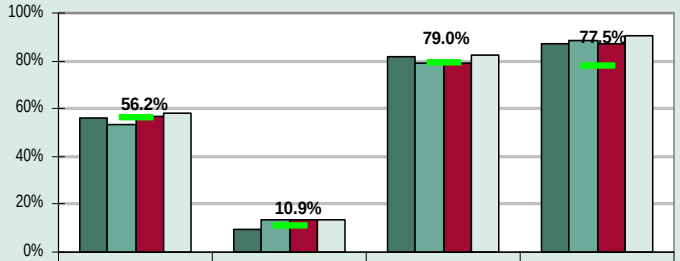
- Colorectal (56.2%)
- Lung (& Trachea) (10.9%)
- Breast (female) (79%)
- Prostate (77.5%)

Performance Overview

2003 – 2007 (Irish 5 year survival rate by diagnosis)

- Colorectal (56.2%)
- Lung (& Trachea) (12.6%)
- Breast (Female) (80.7%)
- Prostate (89.1%)

Age standardised 5 year relative cancer survival by HSE Area (2003-2007)



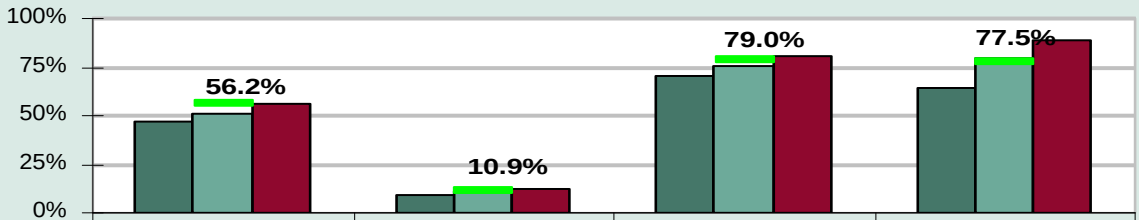
	Colorectal	Lung (& Trachea)	Breast (Female)	Prostate
HSE South	55.9%	9.7%	81.5%	86.9%
HSE West	53.5%	13.3%	79.3%	88.4%
HSE DNE	56.8%	13.5%	79.1%	87.1%
HSE DML	58.0%	13.7%	82.3%	90.8%
EU Average	56.2%	10.9%	79.0%	77.5%

Note: EU Average relates to Eurocare-4 (2000 – 2002)

Commentary

Statistically significant improvements (P<0.001) were seen (after adjusting for age) in the five-year relative survival of patients with colorectal, lung, prostate and female breast cancer in this time period compared with 1998-2002. Improvements between the 1994-1997 and 1998-2002 diagnosis periods were also statistically significant (except for lung cancer). The National Cancer Control Programme has endeavoured to address the issue of survival rates through the prioritisation of specialist consultant delivered high volume surgery for a number of cancers combined with standards for access to diagnostics, surgery and treatment.

Five year survival rate by diagnosis cohort (1994 - 2007)



	Colorectal	Lung (& Trachea)	Breast (Female)	Prostate
1994 - 1997	47.1%	9.2%	70.3%	63.9%
1998-2002	51.0%	10.9%	75.1%	79.2%
2003-2007	56.2%	12.6%	80.7%	89.1%
EU Average	56.2%	10.9%	79.0%	77.5%

Symptomatic Breast Cancer Services

Metric Used

The percentage of women with an urgent referral for breast cancer offered an appointment within 2 weeks.
The percentage of women with an non-urgent referral for breast cancer offered an appointment within1 2 weeks.

Rationale

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

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

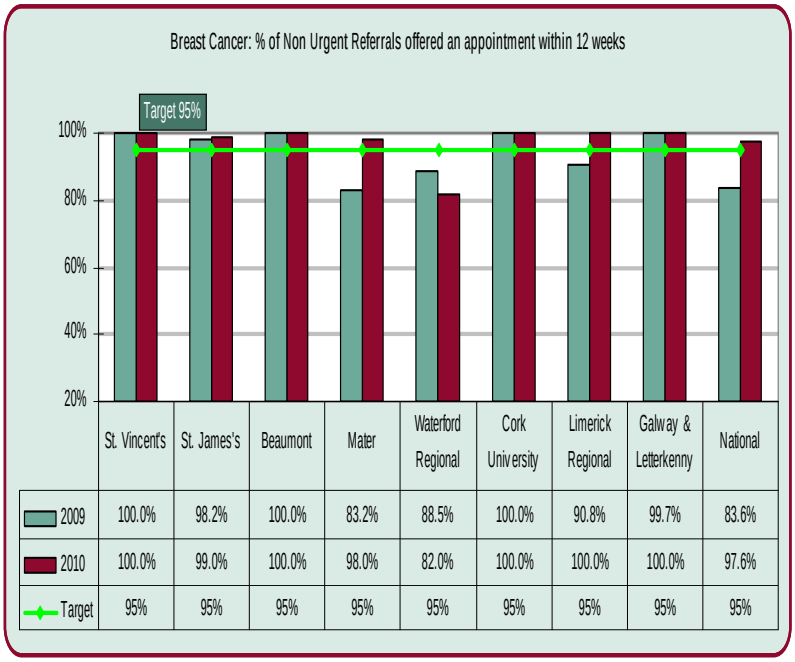
- Urgent – seen with 2 weeks
- Soon – seen within 6 weeks
- Non symptomatic – seen within 12 weeks
- HIQA requirement – 95% compliance

Data Source

National Cancer Control Programme (NCCP)

Period Covered by Data

2009 - 2010



	St. Vincent's	St. James's	Beaumont	Mater	Waterford Regional	Cork University	Limerick Regional	Galway & Letterkenny	National
2009	100.0%	98.2%	100.0%	83.2%	88.5%	100.0%	90.8%	99.7%	83.6%
2010	100.0%	99.0%	100.0%	98.0%	82.0%	100.0%	100.0%	100.0%	97.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%

Target Information

95% of all women with urgent referrals should be seen within 2 weeks.
95% of all women non-urgent referrals should be seen within 12 weeks

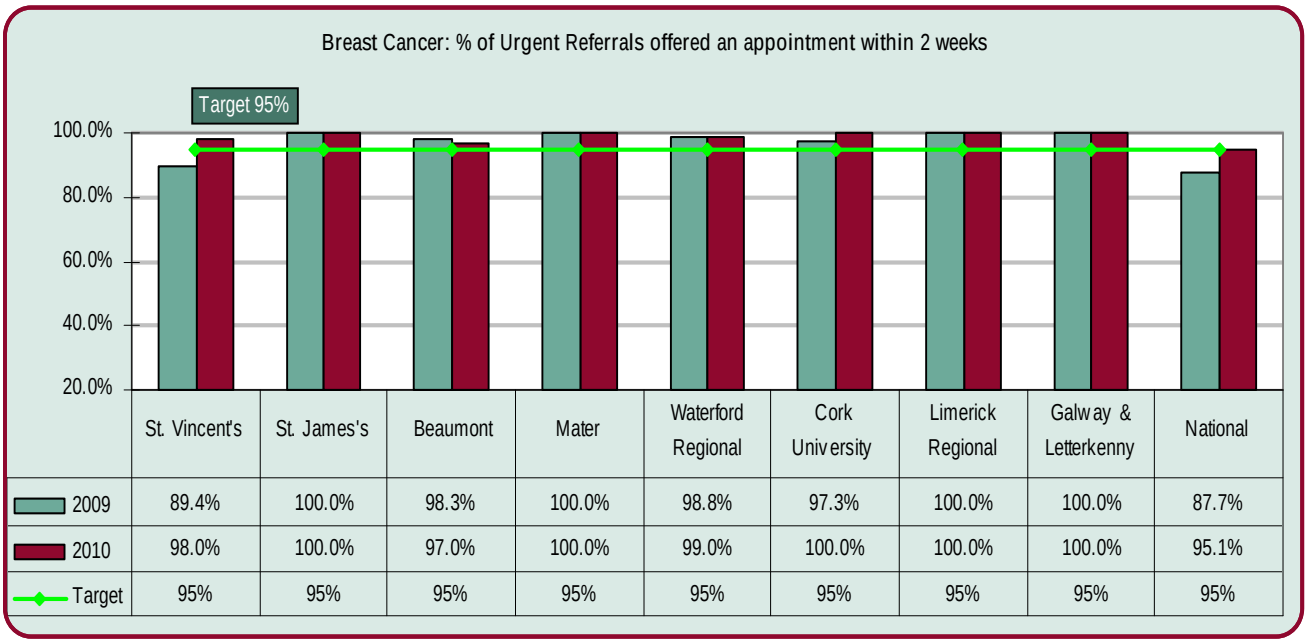
Performance Overview

95.1% of women with urgent referrals were seen within 2 weeks in 2010
97.6% of women with non-urgent referrals were seen within 12 weeks in 2010

Commentary

Since December 2009, breast cancer surgery takes places in 8 cancer centres, with a sub clinic of University College Hospital Galway (UCHG) in Letterkenny. Investment in these centres and amalgamation of services has provided the opportunity to improve access to breast services for urgent symptomatic breast disease.

The priority during 2009 / 2010 has been the achievement of the urgent target of 2 weeks and provision of an improved service for non symptomatic patients referred (target 12 weeks). The ongoing aim is consistent compliance of 95% compliance for all centres for both standards.



	St. Vincent's	St. James's	Beaumont	Mater	Waterford Regional	Cork University	Limerick Regional	Galway & Letterkenny	National
2009	89.4%	100.0%	98.3%	100.0%	98.8%	97.3%	100.0%	100.0%	87.7%
2010	98.0%	100.0%	97.0%	100.0%	99.0%	100.0%	100.0%	100.0%	95.1%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%

MRSA (Methicillin Resistant *Staphylococcus aureus*)

Metric Used

MRSA: MRSA blood stream infections as a proportion (%) of all *Staphylococcus aureus* (*S. aureus*) infection in hospital (using the EARS-Net case definition).

Rationale

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

Data Source

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

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

Period Covered by Data

1999 – 2010

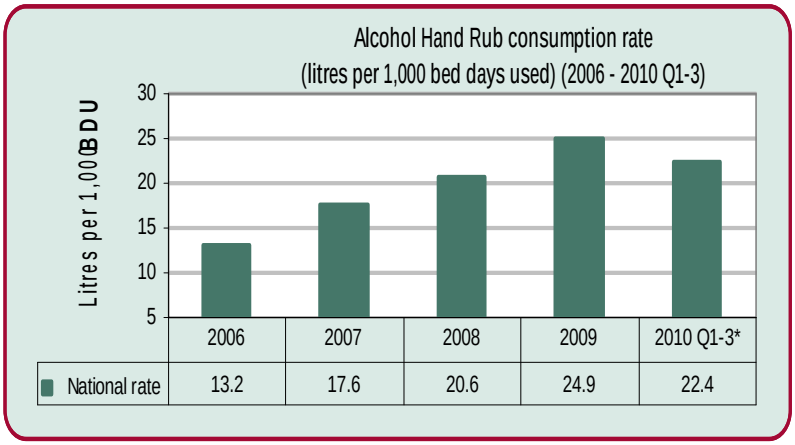
Target Information

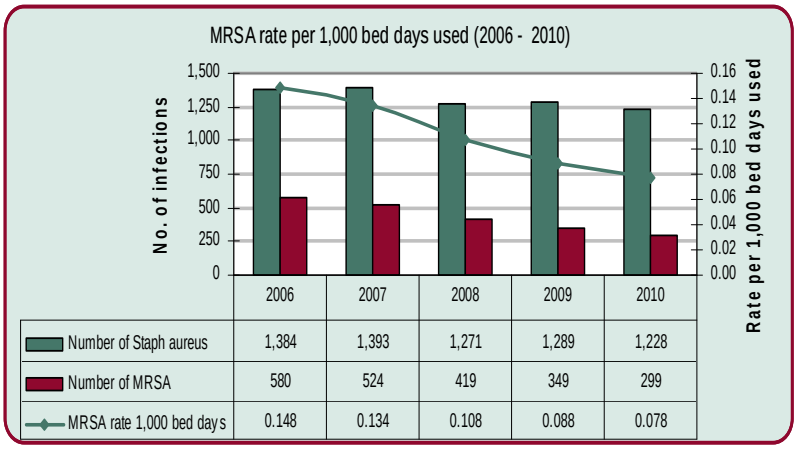
To reduce MRSA infections by 30% within 5 years from 2007 proportions.

In 2007 the proportion of infections in hospitals was 38.5%.
A reduction of 30% would give an approximate target of 27.0%.

Performance Overview

MRSA accounts for 24.3% of all *S. aureus* bloodstream infections in hospital in 2010, a reduction of 37% compared with 2007.





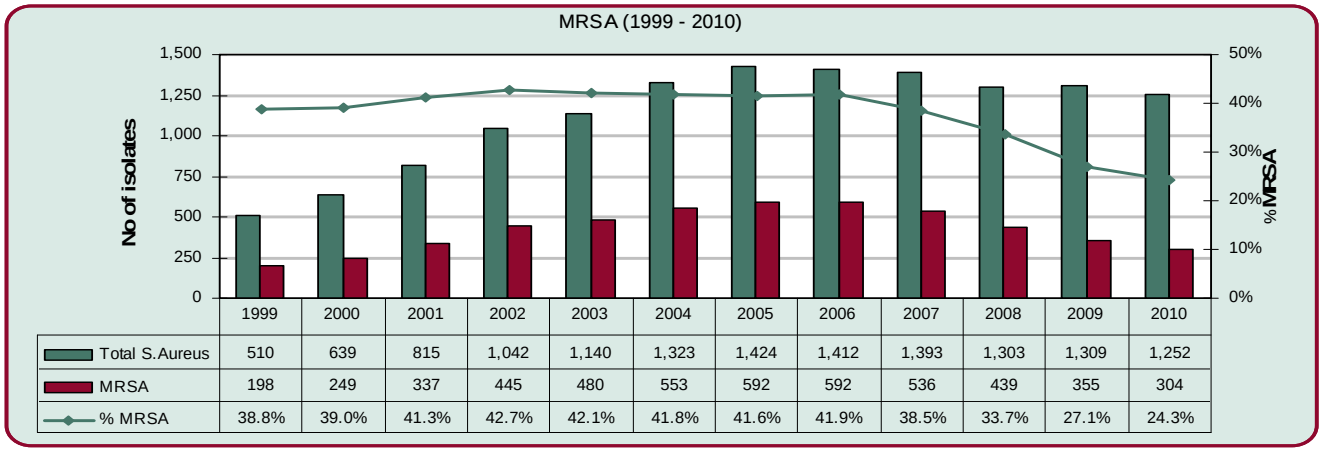
Commentary

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

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

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

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



Complaints

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

Rationale
To meet the legislative requirement:
*Section 8 (3), Health Act 2004 (Complaints) Regulations 2006; '*A complaint shall be investigated and concluded within 30 working days of it being acknowledged by the complaints officer'

Data Source
National Advocacy Unit, HSE (formerly Consumer Affairs)

Period Covered by Data
December 2008 - December 2010

Target Information
85% dealt with within 30 working days.

Performance Overview
In 2010, 8,434 complaints were recorded and managed by HSE complaints officers. Of this number, 76.9% (6,489 complaints) were addressed within 30 working days. This is a decrease of 2.3% on 2009 data; however, there was a 6% increase on the number of complaints recorded. Some complaints raise multiple issues and therefore fall into a number of categories. In 2010, the 8,434 complaints received were logged under 15 categories with 8,713 entries.

Commentary
The professional handing of patient and service user feedback promotes increased confidence in our service. Providing a prompt response to a complaint can emphasise that it is taken seriously and can lead to earlier satisfaction for those involved in the process and timely quality improvement measures.

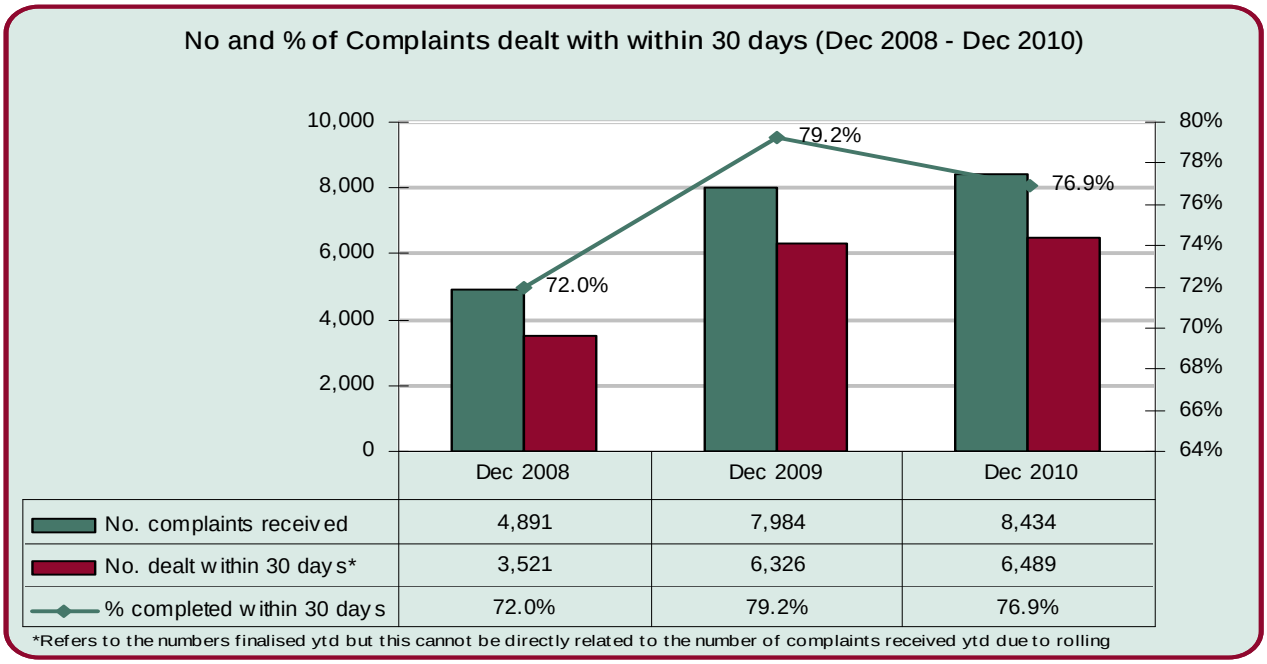
The number of review requests to the National Advocacy Unit increased in 2010, however, the percentage of complainants requesting one (2%) remained the same from 2008 - 2010.

The Health Act 2004 (Complaints) Regulations 2006 acknowledge that it is not possible to conclude every investigation within the recommended timeframe and in such cases advises that the complaints officer should notify relevant individuals of that fact.

The reasons for not concluding an investigation within the timeframe are varied and relate in many cases to the often complex nature of complaints, the multiple contacts with parties involved to identify and confirm the key items of concern and investigate same, difficulties progressing investigations whilst people are ill or on leave and the absence of IT supports to support the efficient tracking of complaints and generate reminder letters etc. As with all areas of service provision, a minority of individuals may take up a considerable period of time through their behaviour, sometimes unknowingly and at other times with vexatious or malicious intent.

In 2011, the team in the National Advocacy Unit will be examining ways in which we can continue to support complaints officers, updating the Your Service Your Say Policy and Procedures and identifying if the current processes and structures are meeting the needs of the organisation effectively.

Not all complaints are dealt with under Part 9, Health Act 2004. For certain types of complaints there are other policies which are followed (i.e. Trust in Care Policy and Children First).



	Dec 2008	Dec 2009	Dec 2010
No. complaints received	4,891	7,984	8,434
No. dealt within 30 days*	3,521	6,326	6,489
% completed within 30 days	72.0%	79.2%	76.9%

*Refers to the numbers finalised ytd but this cannot be directly related to the number of complaints received ytd due to rolling

Parliamentary Questions

Metric Used
The number and percentage of Parliamentary Questions (PQs) responded to within required timeframe.

Rationale
To monitor and report on the HSE performance in responding to Parliamentary Questions referred to the HSE for direct reply to deputies.

Data Source
Parliamentary Affairs Division (PAD), HSE

Period Covered by Data
2006 – June 2010

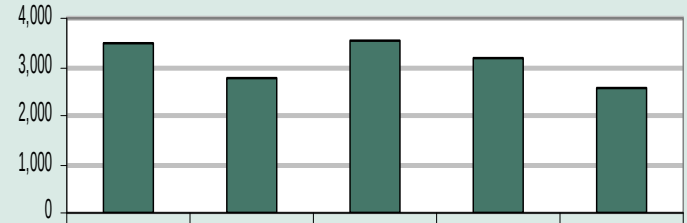
Target Information
75% of all PQs should receive a response within 15 working days

Performance Overview
In 2010 the HSE received 2,551 PQs for direct reply. The performance on the response rate target was seriously affected by industrial action in the civil and public service between January and July 2010 and this accounts for the 52.5% annual performance achieved in 2010.

Following the lifting of the industrial action in July 2010 the performance rate improved and was at 61% for the period July to December *. Time lines can also be affected because of the complexity of some PQs which request information that has to be gathered from a wide range of sources across the organisation.

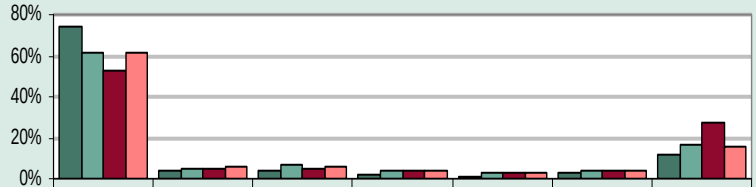
Commentary
The HSE is committed to improving on the response times and is introducing a new IT system which will assist in enhancing and improving the performance in processing of and replying to PQs.

Number of Parliamentary Questions received (2006 - 2010)



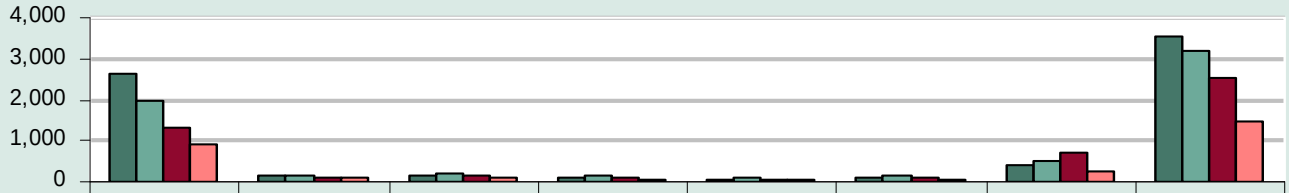
	2006	2007	2008	2009	2010
No of PQs received	3,505	2,757	3,553	3,168	2,551

Rate of Response (2008 - 2010)



	Answered on time	1-5 days overdue	6-10 days overdue	11-15 days overdue	16 - 20 days overdue	21-30 days overdue	31+ days overdue
2008	73.8%	3.7%	3.8%	2.2%	1.4%	3.3%	11.8%
2009	61.8%	4.8%	6.5%	4.1%	2.6%	4.0%	16.3%
2010	52.5%	4.9%	5.1%	3.5%	2.7%	3.7%	27.6%
2010 *	61.0%	6.0%	6.0%	4.0%	3.0%	4.0%	16.0%

Response Timeframes (2008 - 2010)



	Answered on time	1-5 days overdue	6-10 days overdue	11-15 days overdue	16 - 20 days overdue	21-30 days overdue	31+ days overdue	National Total
2008	2,628	145	143	85	50	108	394	3,553
2009	1,959	152	205	129	81	127	518	3,171
2010	1340	124	130	89	70	95	703	2,551
2010 *	891	77	87	53	48	63	233	1,452

Operational Excellence and Unlocking Our Potential

Budget Management

Metric Used
Budget management against planned position

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

Data Source
Finance Unit, HSE

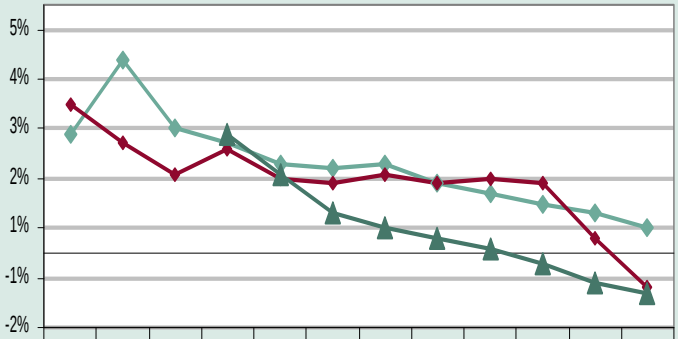
Period Covered by Data
2007 – 2010

Target Information
Management of budget with no variation within a fiscal year.

Performance Overview
HSE delivered a balanced vote in each of the years 2007 to 2010.

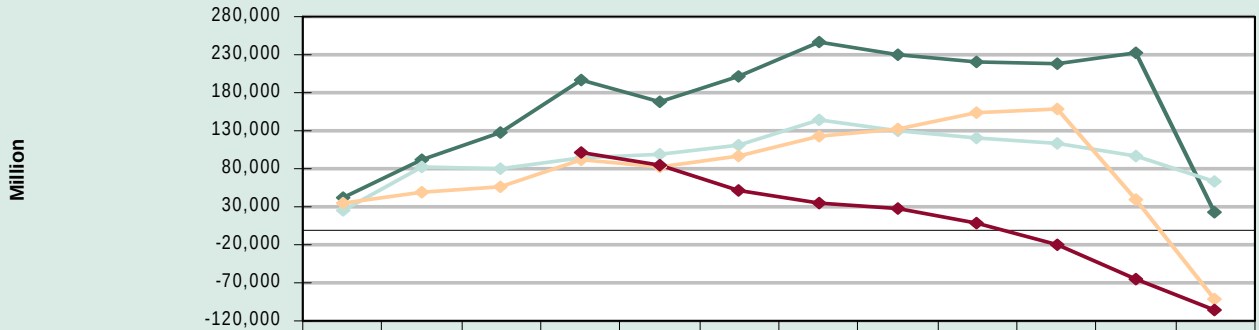
Commentary
There is evidence, based on the trend of budget variance over the past 3 years, of constantly improving performance in relation to budget management. In 2010 a lack of data until April created an environment in which budget control was less rigorous, underpinning the case for good financial data, and strong budget management was required across the system month on month to bring the HSE in on vote at year end. Overall there has been effective control of expenditure in the face of declining budgets and the challenge of managing growth in clinical and community schemes costs.

HSE Net Expenditure % Variance Actual v Budget YTD 2009 - 2010



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Variance 2008	2.4%	3.9%	2.5%	2.2%	1.8%	1.7%	1.8%	1.4%	1.2%	1.0%	0.8%	0.5%
Variance 2009	3.0%	2.2%	1.6%	2.1%	1.5%	1.4%	1.6%	1.4%	1.5%	1.4%	0.3%	-0.7%
Variance 2010				2.4%	1.6%	0.8%	0.5%	0.3%	0.1%	-0.2%	-0.6%	-0.8%

HSE Net Expenditure
Variance Actual v Budget YTD 2007 - 2010



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Variance 2007 €000	42,273	92,102	126,569	195,590	167,551	200,595	245,757	230,001	219,614	218,270	231,852	21,762
Variance 2008 €000	25,929	82,630	80,122	94,985	99,878	111,032	143,265	129,611	119,880	112,402	95,911	63,283
Variance 2009 €000	34,231	49,825	55,424	91,718	83,185	95,976	123,302	132,560	154,902	157,508	39,384	-90,457
Variance 2010 €000				100,522	84,137	52,420	35,162	26,762	8,223	-21,162	-65,522	-105,400

Note: Variance data for Jan – Mar 2010 was not available due to Industrial Action at this time.

Value for Money (VFM)

Metric Used
Delivery of Value for Money (VFM) targets.

Rationale
Sustainable delivery of services and sustainable health funding for these services are dependant on the focused use of resources with minimisation of waste and inefficiencies.

Data Source
VFM Unit within Finance, HSE

Period Covered by Data
2007, 2008, 2009, 2010

Target Information
When the broad VFM programme was established mid-year 2007, there was a €500m cost reduction target set for the four year period

Performance Overview
Year on year the VfM targets were reached. The detail below indicates **cost reduction of €688m** in the whole period covered.

Commentary

2010
The 2010 budget allocation required a reduction in allocation for **VfM non-pay cost efficiencies of €106m** which was delivered along with an additional €20.64m

2009
In 2009 there was a **VfM budget adjustment of €115m required.** Detailed VfM financial reporting confirmed the €115m was delivered including compensating efficiencies achieved beyond the required adjustments in areas such as Drugs & Medicines, Patient Transport, Maintenance, Advertising as well as other non-pay headings. The was additional breakeven of €100m achieved in 2009, above the VfM target, drawn from Medical and Surgical costs, reduced administrative costs and management of variable pay costs.

2008
A target of €300m was set at the beginning of 2008 with specific Directorate level reductions, actions and reporting frameworks. The end of year analysis reported **cost reductions of €283m** comprised of both VfM specified targets and other measures.

2007
No specific reductions or reporting framework was agreed at the start of 2007, but at the end of the year there was reported delivery of **€63m** largely through Procurement and Contracts management initiatives.

These ongoing economies were challenging not only because of the requirement to maintain VFM from previous years and to continue to manage cost growth, but also, and very significantly, in the context of managing areas of increasing spend and delivering on our broader service reconfiguration and improvement priorities. These reductions should be considered therefore alongside the detailed service and performance improvements reported since 2008.

These include: 19.5% more medical cards, 37.3% more GP visit cards and the ancillary services that go with these; an increase of 8.7% in out patient attendances; 15.7% more Day Case discharges while inpatient discharges only reduced by 2% over this time. Demand also grew, for example there was a 22.8% increase in requests for an assessment for children under 5 years with a disability. Over this period, above and beyond normal planned work, 1.1 million pandemic vaccines were also delivered. This was in an environment where there was a reduction of 3,053 WTEs.

VFM 2010	Reductions Achieved €m
Medical and Surgical Supplies	18.52
Payment to Voluntary Providers	10.00
Insurance	10.00
Drug Cost Management	9.31
Energy Management and Costs	4.11
Offices Expenses and Administrative Overheads	0.00
Maintenance	6.43
Legal	3.26
Patient Transport	0.44
Catering	7.48
Laboratory	0.00
Travel and Subsistence	5.20
Professional Services (reduced rates and usage)	2.42
Child Care Placements	3.08
Agency Fees and Costs	1.40
Computer Costs	0.88
Cleaning / Washing	3.64
Blood / Blood Products	9.40
Security (improved management of costs)	1.50
X-Ray / Imaging	3.15
Medical Gases	1.90
Banking Costs	2.20
Improved income collection in Non Acute Facilities	0.50
Education and Training	17.43
Furniture, Crockery	1.96
Bedding and Clothing	2.16
Other miscellaneous non pay reductions	0.27
TOTAL	126.64

VFM 2009	Reductions Achieved €m
Travel and Subsistence	8.1
Legal	2.3
Advertising	2.6
Education and Training	4.7
Drugs and Medicines	8.0
Maintenance	5.2
Patient Transport	5.0
Blood & Blood products	9.8
Laboratory	6.4
Reconfiguration of Administrative Processes	6.4
Reconfiguration of Child Care Services	6.2
Disability Services Efficiencies	9.5
Catering	5.7
Office Expenses Rents and Rates	10.0
Computers	1.0
Heat, Power & Light	2.5
Pay	
Reconfiguration of Mental Health Staff Costs	7.1
Reconfiguration of Hospital Staff Costs	8.6
Reconfiguration of Management/Admin Staff Costs	6.1
Additional Efficiencies in the year	100.0
TOTAL	215.1

Value for Money (VFM)

Commentary *(continued)*

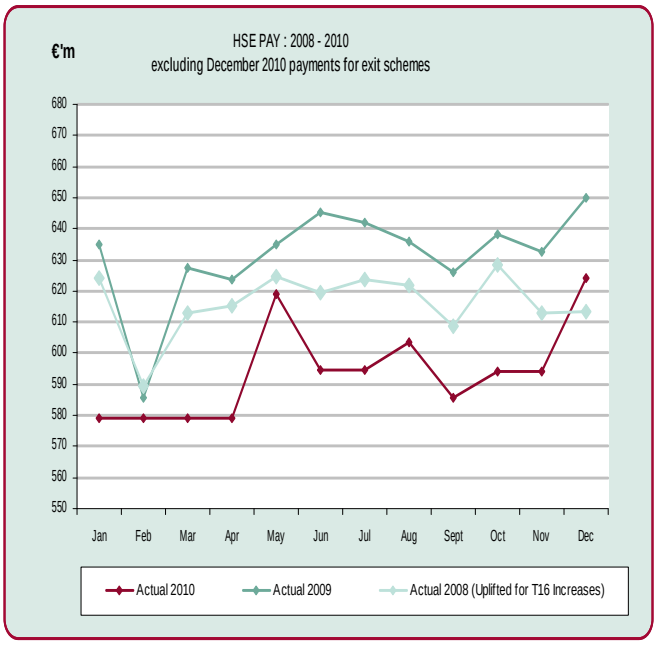
Managing Cost Growth 2007-2010 with cost avoidance of over €1bn
There is financial evidence of significant efficiencies being achieved by services and managers in the last three years in not just the delivery of actual cost reductions through the VfM and other budget management and service reconfiguration initiatives, but also through the management of non-pay cost growth and the resulting cost avoidance.

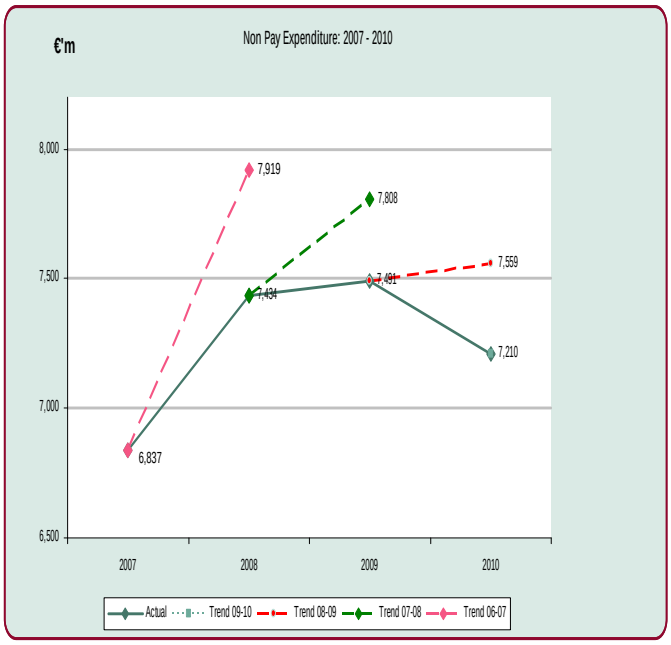
Non Pay Cost Management
This Non Pay graph shows that on the basis of comparison of the non-pay costs 2007-2010 and applying the rate of cost growth year on year from 2006 – 2010 there was a net non-pay cost avoidance in the HSE of up to €485m in 2008, a further €317m in 2009 and €348m in 2010.

Pay Cost Management
Although there were no Pay adjustments for VfM in 2010, included for information is a chart showing the Pay trend against the previous years, where 2008 Pay has been uplifted for the full year effect of Pay and Consultant Contract Awards in 2008 and 2009.

There was an approximate 6% reduction overall in Pay allocation in 2010 and the YTD comparison is showing a €351m reduction in spend (i.e. 5%). However, this increases to a **€450m reduction or 6.5% when Superannuation is excluded**. There is considerable performance in management of variable pay such as a **12% reduction in On Call costs and a 10% reduction in Overtime costs**.

VFM 2008	Reductions Achieved €m
Irish Pharmaceutical Healthcare Association (IPHA) Saving	40.1
Portfolio & Contracts Management	13.5
Travel & Subsistence	5.3
Telephony	0.5
ICT Framework & Licencing	1.9
Education and Training	33.6
Consultancy	4.0
Taxis	1.0
Capital IT	18.5
Grants to Outside Agencies Corporate	2.5
Income - Collection of Private Income	12.0
Health Promotion Campaign Efficiencies	2.5
Pay, Overtime & Agency costs	45.0
PCCC Non Pay Savings	63.0
NHO Non Pay Savings	31.0
Temporary Staff - non frontline	4.0
Unpaid Leave Initiatives	2.5
Non Replacement of Non Frontline Staff	2.0
TOTAL	282.9





Whole Time Equivalents (WTE)

Metric Used

The variance of Whole Time Equivalent staff numbers against the agreed ceiling.

Rationale

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

Data Source

HSE Human Resources Directorate (HR-Management Information)

Period Covered by Data

2008 – 2010

Target Information

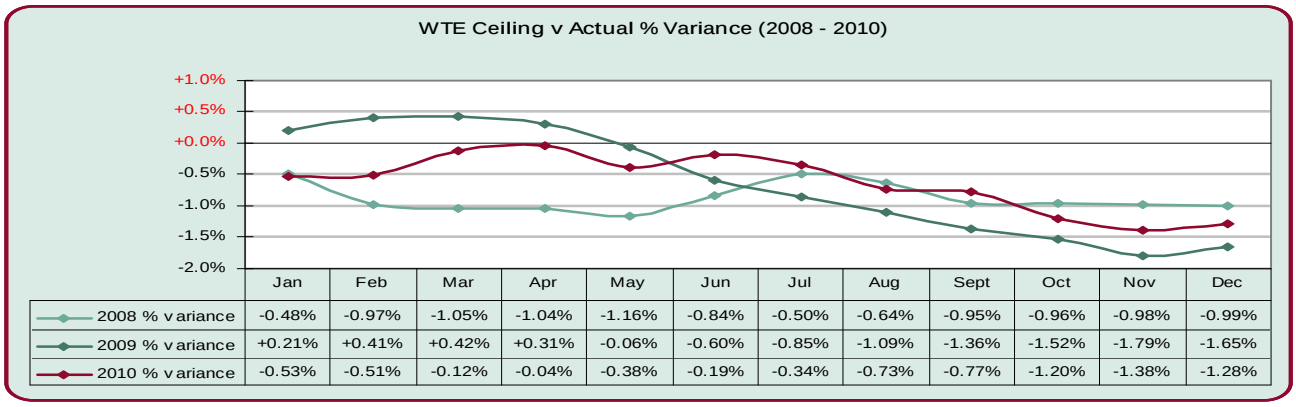
Manage delivery of WTE services within WTE complement

Performance Overview

At the end of 2010, the Health Sector had 107,972 (WTEs) employed, a reduction of 1,781 on end of 2009 figures. At the end of the year, the health sector was in full compliance with the government approved employment ceiling (1,400 WTE below ceiling) and created some capacity to address employment growth without breaching the overall approved employment ceiling going into 2011.

Commentary

In line with government policy to reduce the numbers of people employed in the public service, the moratorium was introduced (March 2009). Under this policy, the HSE was given a target to reduce WTEs by 6,000 over the next 4 years. The chart below shows the trend in employment levels from 2008 - 2010. Over this period the WTEs were reduced by 3,053.

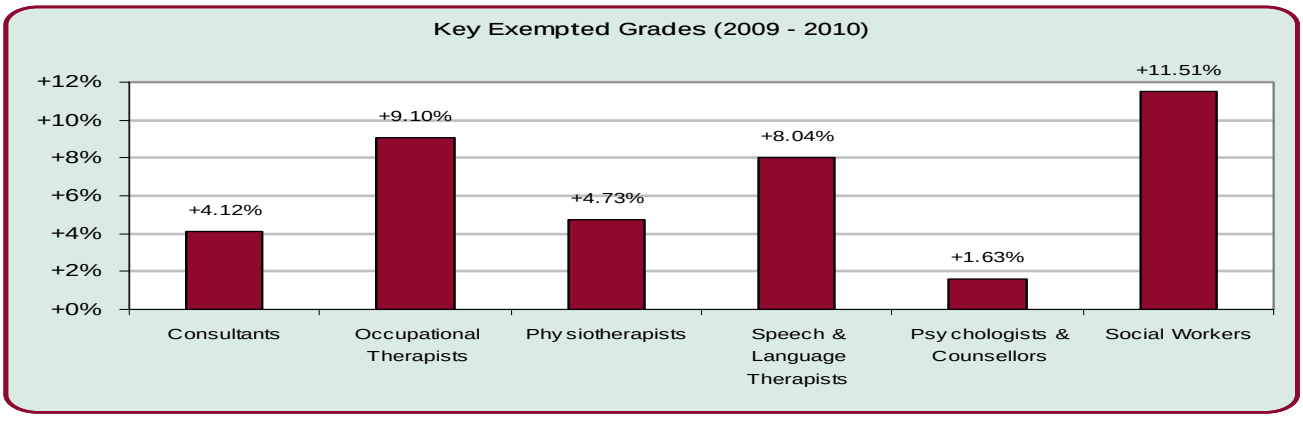


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2008 % variance	-0.48%	-0.97%	-1.05%	-1.04%	-1.16%	-0.84%	-0.50%	-0.64%	-0.95%	-0.96%	-0.98%	-0.99%
2009 % variance	+0.21%	+0.41%	+0.42%	+0.31%	-0.06%	-0.60%	-0.85%	-1.09%	-1.36%	-1.52%	-1.79%	-1.65%
2010 % variance	-0.53%	-0.51%	-0.12%	-0.04%	-0.38%	-0.19%	-0.34%	-0.73%	-0.77%	-1.20%	-1.38%	-1.28%

As a result, we have seen the following staff category shifts:

Staff Category	WTE Dec 2010	WTE Change (6 Mths)	% change since Jun 2010	WTE change (3 Years)	% change since Dec 2008
Medical/ Dental	8,096	32	0.40%	-14	-0.17%
Nursing	36,503	-995	-2.65%	-1,605	-4.21%
Health & Social Care Professionals	16,355	175	1.08%	376	2.35%
Management/ Admin	17,301	-71	-0.41%	-666	-3.71%
General Support Staff	11,421	-295	-2.51%	-1,210	-9.58%
Other Patient & Client Care	18,295	-256	-1.38%	65	0.36%
Total Health Service Staffing	107,972	-1,409	-1.29%	-3,053	-2.75%

Within this overall picture certain grades (Medical Consultants, Speech and Language Therapists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Behavioral Therapists, Counselors, and Social Workers) are exempted, under strict conditions, from the general moratorium on recruitment. The HSE continues to focus on the recruitment these key exempted grades. For example the change in 2010 over 2009 shows:



Absenteeism

Metric Used
The average rate of absenteeism in the Health Service, expressed as a percentage.

Rationale
The HSE is actively engaged in effective procedures that record and measure absenteeism. This allows the organisation to analyse absence levels and engage in absence-preventing activities and strategies on a proactive basis. While absenteeism is monitored on a national basis, effective management of absenteeism falls to local managers who must engage with their staff to remove unwarranted absenteeism.

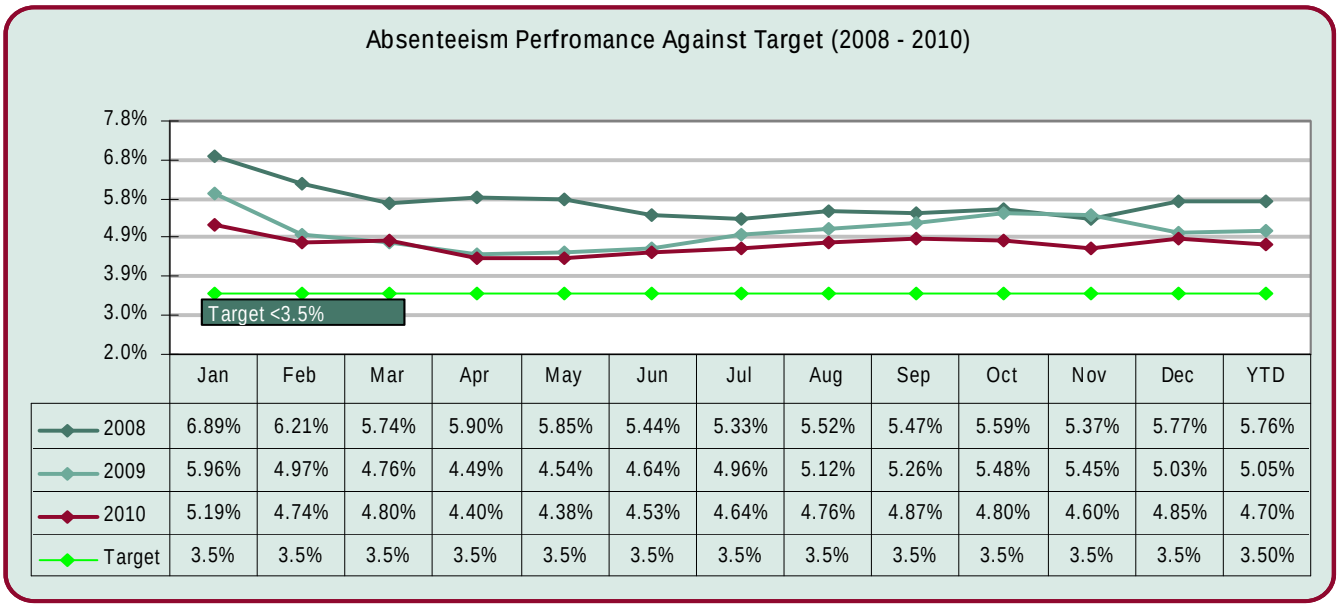
Data Source
Since 2008 the HSE Human Resources Directorate (HR-Management Information) has collated absenteeism data on a national basis. However, full national coverage was not realised until 2009 and therefore 2008 figures are indicative only. Absenteeism is reported for those currently on payroll but does not include absences due to maternity leave, carer's leave or other statutory approved leave.

Period Covered by Data
2008 – 2010

Target Information
No more than 3.5% of HSE staff, on average, should be absent from work through illness in a reporting period.

Performance Overview
4.7% of HSE staff were absent from work, on average, over 2010.

Commentary
Absence through illness is a normal incidence of working life and while absenteeism continues above the minimum target rate, we have seen good progress in many key areas. Combined absenteeism levels have reduced from 5.76% in 2008 to 5.05% in 2009 and to 4.70% for 2010. This represents a fall of 6.93% on 2009 and 18.4% on 2008. In 2010, rates of below 5% were maintained from Feb 2011 onwards. It is important to note that detailed scrutiny of returns undertaken in 2010 reveals that less than 15% of absenteeism is not certified by a medical practitioner. This will be further analysed and follow up in the coming year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2008	6.89%	6.21%	5.74%	5.90%	5.85%	5.44%	5.33%	5.52%	5.47%	5.59%	5.37%	5.77%	5.76%
2009	5.96%	4.97%	4.76%	4.49%	4.54%	4.64%	4.96%	5.12%	5.26%	5.48%	5.45%	5.03%	5.05%
2010	5.19%	4.74%	4.80%	4.40%	4.38%	4.53%	4.64%	4.76%	4.87%	4.80%	4.60%	4.85%	4.70%
Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.50%

Staff Category	2008 YTD	2009 YTD	2010 YTD	Change since 2008
Medical Dental	1.06%	1.14%	1.22%	-15%
Nursing	5.99%	5.20%	5.14%	14%
Health and Social Care Professionals	4.13%	3.63%	3.65%	12%
Management Admin	5.36%	4.82%	4.67%	13%
General Support Staff	7.75%	6.08%	5.65%	27%
Other Patient and Client Care	6.66%	6.36%	5.47%	18%
Total	5.76%	5.05%	4.70%	18%

Abbreviations

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

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