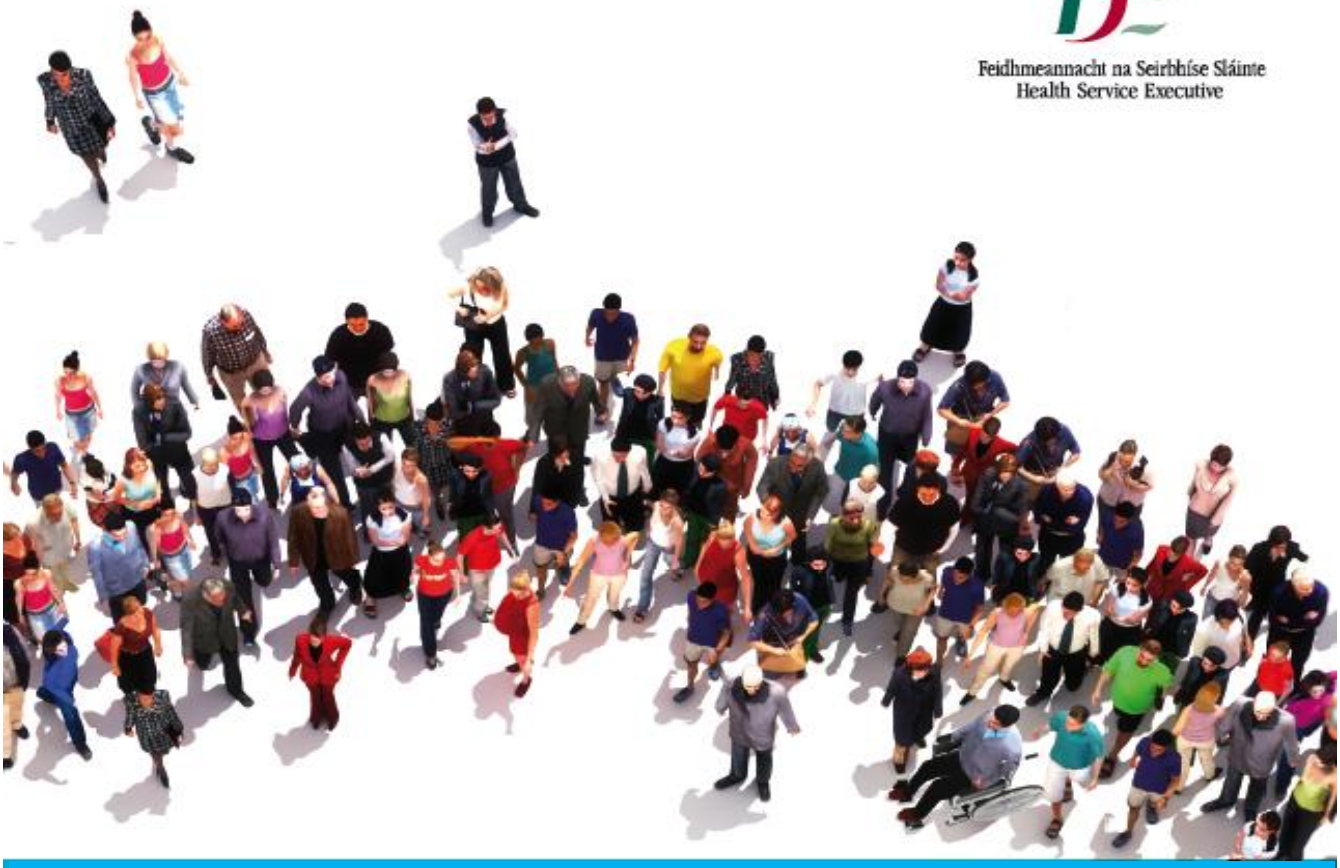
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Health Service Executive

BIU Acute Hospital Division

Key Performance Indicator Metadata 2016

Based on NSP and DOP 2016 KPIs

	Office Use Only KPI No. (source: target doc)	Office Use Only Active or Retired	Key Performance Indicators Service Planning 2016 KPI Title	QVA	Reported against NSP / DOP	Data Source to BIU	KPI Type Access/ Quality /Access Activity	Healthy Ireland / Corporate Plan / HI & CP	Report Period	Report Frequency	KPIs 2015		KPIs 2016								
											2015 National Target / Expected Activity	2015 Projected ACTUAL outturn	2016 National Target / Expected Activty	Reported at National / CHO / HG Level	CHO1 IEHG	CHO2 DMHG	CHO3 RCSI HG	CHO4 ULH HG	CHO5 SSWHG	CHO6 Saolta HG	CHO7 Childrens HG
Beds Available	A1	Active	**Beds Available** In-patient **		DOP	BIU	Access/Activity		M	M	10,514	10,503	10,804	National							
	A2	Active	Day Beds / Places **		DOP	BIU	Access/Activity		M	M	1,990	2,024	2,024	National							
Discharge Activity	A3	Active	**Discharge Activity ∞** Inpatient Cases		NSP	ABF	Access/Activity		M	M		621,205	621,205	National	128,488	94,669	95,207	45,502	120,480	111,927	24,931
	A4	Active	Inpatient Weighted Units		NSP	ABF	Access/Activity		M	M		623,627	623,627	National	133,632	110,892	94,948	40,440	118,750	96,030	28,934
	A5	Active	Daycase Cases (includes dialysis)		NSP	ABF	Access/Activity		M	M		1,013,718	1,013,718	National	181,415	213,957	145,858	56,470	202,988	185,300	27,730
	A6	Active	Day Case Weighted Units (includes dialysis)		NSP	ABF	Access/Activity		M	M		1,010,025	1,010,025	National	197,773	192,818	138,455	66,569	197,076	181,503	35,832
	A7	Active	Total inpatient & day cases Cases ∞		NSP	ABF	Access /Activity		M	M		1,634,923	1,634,923	National	309,903	308,626	241,065	101,972	323,468	297,227	52,661
Emergency Care	A8	Active	Shift of Day case procedures to primary care		NSP	TBC	Access/Activity		M	M	New KPI 2016	New KPI 2016	Up to 10000	National							
	A9	Active	Emergency Care - New ED attendances		NSP	BIU	Access/Activity		M	M	1,104,131	1,102,680	1,102,680	National	235,703	173,765	154,305	57,007	190,383	182,833	108,684
	A10	Active	- Return ED attendances		NSP	BIU	Access/Activity		M	M	84,042	94,948	94,948	National	23,781	14,785	13,258	4,113	22,032	10,146	6,833
	A11	Active	- Other emergency presentations		NSP	BIU	Access/Activity		M	M	89,276	94,855	94,855	National	14,155	2,768	6,709	27,375	22,318	21,249	281
	A12	Active	**Inpatient discharges (Note this section previously detailed Inpatient Admissions but has been modified to align with HIPE data which is discharged based)** Emergency Inpatient Discharges		NSP	ABF	Access/Activity		M	M	New KPI 2016	New KPI 2016	408,879	National	82,077	58,877	62,681	29,799	80,149	77,214	18,082
	A13	Active	Elective Inpatient Discharges		NSP	ABF	Access/Activity		M	M	New KPI 2016	New KPI 2016	95,430	National	18,172	13,625	9,838	8,543	21,812	16,591	6,849
	A14	Active	Maternity Inpatient Discharges		NSP	ABF	Access/Activity		M	M	New KPI 2016	New KPI 2016	116,890	National	28,239	22,167	22,686	7,158	18,518	18,122	0
Outpatients (OF	A15	Active	**Outpatients** No. of new and return outpatient attendances		NSP	BIU	Access/Activity		M	M	3,189,749	3,242,424	3,242,424	National	725,756	610,041	477,568	220,327	579,649	478,675	150,408
	A16	Active	Outpatient Attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)		NSP	BIU	Access/Activity		M	M	New KPI 2016	New KPI 2016	1 : 2	National	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2
Births	A17	Active	**Births** Total no. of births		NSP	BIU	Access/Activity		M	M	66,705	65,977	65,977	National	15,198	10,019	13,583	4,726	12,748	9,703	
	A18 a&b	Active	**Inpatient & Day Case Waiting Times** % of adults waiting <15 months for an elective procedure (inpatient or day case)		NSP	NTPF	Access/Activity	CP	M	M	100%	90%	95%	National							
nt & Day Case Waiting Times	A19 a&b	Active	% of adults waiting <8 months for an elective procedure (inpatient and day case)		NSP	NTPF	Access/Activity	CP	M	M	100%	66%	70%	National							
	A20 a&b	Active	% of children waiting <15 months for an elective procedure (inpatient and day case)		NSP	NTPF	Access/Activity	CP	M	M	100%	95%	95%	National							
	A21 a&b	Active	% of children waiting < 20 weeks for an elective procedure (inpatient and day case)		NSP	NTPF	Access/Activity	CP	M	M	100%	55%	60%	National							

Inpatie	A22	Active	% of people waiting < 15 months for first access to OPD services		NSP	NTPF	Access/Activity	CP	M	M	100%	90%	100%	National							
	A23	Active	% of people waiting < 52 weeks for first access to OPD services		NSP	NTPF	Access/Activity	CP	M	M	100%	85%	85%	National							
Colonoscopy / Gastrointestinal Service	A24	Active	**Colonoscopy / Gastrointestinal Service** % of people waiting < 4 weeks for an urgent colonoscopy		NSP	BIU	Access/Activity	CP	M	M	100%	100%	100%	National							
	A25	Active	% of people waiting < 13 weeks following a referral for routine colonoscopy or OGD		NSP	BIU	Access/Activity	CP	M	M	100%	52%	70%	National							
Emergency Care and Patient Experience Time	A26	Active	**Emergency Care and Patient Experience Time** % of all attendees at ED who are discharged or admitted within 6 hours of registration		NSP	BIU	Access/Activity	CP	M	M	95%	67.8%	75%	National							
	A27	Active	% of all attendees at ED who are admitted or discharged within 9 hours of registration		NSP	BIU	Access/Activity		M	M	100%	81.3%	100%	National							
	A28	Active	% of ED patients who leave before completion of treatment		NSP	BIU	Access/Activity		Q	Q	<5%	<5%	<5%	National							
	A29	Active	% of all attendees at ED <24 hours		NSP	BIU	Quality		M	M	100%	96%	100%	National							
	A30	Active	% of patients 75 years or over who were discharged or admitted from ED within 9 hours		NSP	BIU	Access/Activity		M	M	New KPI 2016	New KPI 2016	100%	National							
Patient Profile aged 75 years and over	A31	Active	**Patient Profile aged 75 years and over** % of patients attending ED aged 75 years and over **		DOP	BIU	Access/Activity		M	M	TBC	12.6%	13%	National							
	A32	Active	% of all attendees aged 75 years and over at ED who are discharged or admitted within 6 hours of registration **		DOP	BIU	Quality		M	M	95%	32.0%	95%	National							
Medical Patient	CPA1	Active	**Acute Medical Patient Processing** % of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration		NSP	AMP - CP	Quality		M	M	95%	65.5%	75%	National							
Access t	A33	Active	**Access to Services** % of routine patients on Inpatient and Day Case Waiting lists that are chronologically scheduled **		DOP		Access/Activity		M	M	90%	79.8%	90%	National							
Ambulance Turnaround Times	A34	Active	**Ambulance Turnaround Times** % of ambulances that have a time interval of ≤ 60 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available)		NSP	TBC	Access/Activity		M	M	New KPI 2015	New KPI 2015	95%	National							
	CPA2	Active	**Health Care Associated Infections** Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used		NSP	HPSC	Quality		Q1 mth in arrears	Q	<0.057	0.054	<0.055	National							
	CPA3	Active	Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used		NSP	HPSC	Quality		Q1 mth in arrears	Q	<2.5	2.1	<2.5	National							
	CPA4	Active	Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital		NSP	HPSC	Quality		Bi	Bi	83	86.4	80	National							
Health Care Associated Infections	CPA5	Active	Alcohol Hand Rub consumption (litres per 1,000 bed days used)		NSP	HPSC	Quality		Bi	Bi	25	28	25	National							
	CPA6	Active	% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool		NSP	HPSC	Quality		Bi	Bi	90%	87.2%	90%	National							
	CPA7	Active	Hospital acquired S. Aureus bloodstream infection/10,000 BDU **		DOP	HPSC	Quality		M	M	New KPI 2016	New KPI 2016	<1	National							
	CPA8	Active	Hospital acquired new cases of C. difficile infection/ 10,000 BDU **		DOP	HPSC	Quality		M	M	New KPI 2016	New KPI 2016	<2.5	National							

	CPA9	Active	% of current staff who interact with patients that have received mandatory hand hygiene training in the rolling 24 month **		DOP	HPSC	Quality		M	M	New KPI 2016	New KPI 2016	100%	National							
	CPA10	Active	Percentage of patients colonized with multi-drug resistant organisms (MDRO) that can not be isolated in single rooms or cohorted with dedicated toilet facilities as per national MDRO policy within 24 hours of laboratory detection of MDRO (in the cases of newly-identified cases), or immediatley on admission to hospital (in the case of previously identified cases) **		DOP	HPSC	Access		M	M	New KPI 2016	New KPI 2016	0%	National							
Adverse Events	A35	Active	**Adverse Events** Postoperative Wound Dehiscence - Rate per 1,000 inaptient cases aged 16 years+ **		DOP	Access/Activity			Q	Q		Data not available Q4 2015	TBC	National							
	A36	Active	In Hospital Fractures - Rate per 1,000 inpatient cases aged 16 years+ **		DOP	Access/Activity			Q	Q		Data not available Q4 2015	TBC	National							
	A37	Active	Foreign Body Left During Procedure - Rate per 1,000 inpatient cases aged 16 years+ **		DOP	Access/Activity			Q	Q		Data not available Q4 2015	TBC	National							
Activity Based Funding	A38	Active	**Activity Based Funding (MFTP) model** HIPE Completeness - Prior month: % of cases entered into HIPE		NSP	HPO	ccess/Activity		M	M	>95%	93%	>95%	National							
	CPA11	Active	**Average Length of Stay** Medical patient average length of stay (contingent on <500 delayed discharges)		NSP	HPO	Quality		M	M	5.8	7.2	7	National							
Average Length of Stay	CPA12	Active	Surgical patient average length of stay		NSP	HPO	Access/Activity		M	M	5.1	5.5	5.2	National							
	A39	Active	ALOS for all inpatient discharges excluding LOS over 30 days		NSP	HPO	Access/Activity		M	M	4.3	4.6	4.3	National							
	A40	Active	ALOS for all inpatients **		DOP	HPO	Access/Activity		M	M	5.0	5.5	5	National							
Outpatients (OPD)	A41	Active	**Outpatients (OPD)** New attendance DNA rates **		DOP	BIU	Access/Activity		M	M	12%	12.9%	12%	National							
Dermatology OP	CPA13	Active	**Dermatology OPD** No. of new dermatology patients seen **		DOP	BIU	Access/Activity		M	M	40,215	41,732	41,700	National							
	CPA14	Active	New: Return Attendance ratio **		DOP	BIU	Access/Activity		M	M	1 : 2	1 : 1.6	1 : 2	National							
Rheumatology OPD	CPA15	Active	**Rheumatology OPD** No. of new rheumatology patients seen **		DOP	BIU	Access/Activity		M	M	13,500	13,818	13,800	National							
	CPA16	Active	New: Return Attendance ratio **		DOP	BIU	Access/Activity		M	M	1 : 4	1 : 3.7	1 : 4	National							
Neurology OPD	CPA17	Active	**Neurology OPD** No. of new neurology patients seen **		DOP	BIU	Access/Activity		M	M	15,400	16,994	16,900	National							
	CPA18	Active	New: Return Attendance ratio **		DOP	BIU	Access/Activity		M	M	1 : 3	1 : 2.7	1 : 3	National							
Stroke	CPA19	Active	**Stroke** % acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit **		DOP	Stroke Prog	Access/Activity		Q6 mths in arrears	Q	50%	67.8%	50%	National							
	CPA20	Active	% of patients with confirmed acute ischaemic stroke who receive thrombolysis		NSP	Stroke Prog	Access/Activity		Q 6 mths in arrears	Q	9%	12.1%	9%	National							
	CPA21	Active	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit		NSP	Stroke Prog	Access/Activity		Q6 mths in arrears	Q	66%	53.7%	50%	National							

Heart Failure	CPA22	Active	**Heart Failure** Rate (%) re-admission for heart failure within 3 months following discharge from hospital **		DOP	HF programme	Access/Activity		Q6 mths in arrears	Q	20%	6.7%	20%	National							
	CPA23	Active	Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure **		DOP	HF programme	Access/Activity		Q6 mths in arrears	Q	6	7	6	National							
	CPA24	Active	% patients with acute decompensated heart failure who are seen by HF programme during their hospital stay **		DOP	HF programme	Access/Activity		Q6 mths in arrears	Q	80%	85.8%	80%	National							
Acute Coronary	CPA25	Active	**Acute Coronary Syndrome** % STEMI patients (without contraindication to reperfusion therapy) who get PPCI		NSP	ACS - CP	Access/Activity			Q	85%	83%	85%	National							
	CPA26	Active	% reperfused STEMI patients (or LBBB) who get timely PPCI		NSP	ACS - CP	Access/Activity			Q	80%	68.4%	80%	National							
Surgery	CPA27	Active	**Surgery** % of elective surgical inpatients who had principal procedure conducted on day of admission		NSP	HPO	Access/Activity		M	M	70%	69.4%	75%	National							
	CPA28	Active	% day case rate for Elecctive Laparoscopic Cholecystectomy		NSP	HPO	Access/Activity		M	M	>60%	38.3%	>60%	National							
	CPA29	Active	Reduction in bed day utilisation by acute surgical admissions who do not have an operation **		DOP	HPO	Access/Activity		M	M	5% Reduction	10%	5% Reduction	National							
Time to Surgery	A42	Active	**Time to Surgery** % of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)		NSP	HPO	Access/Activity		M	M	95%	84.5%	95%	National							
Surgery	A43	Active	**Surgery** Scheduled waiting list cancellation rate **		DOP		Access/Activity	CP		TBC	New KPI 2016	New KPI 2016	New KPI 2016	National							
Hospital Mortality	A44	Active	**Hospital Mortality** Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition **		DOP	CP	Access/Activity			A	New KPI 2016	New KPI 2016	TBC	National							
Re-admission	CPA30	Active	**Re-admission** % of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge		NSP	HPO	Access/Activity	CP	M	M	9.6%	10.8%	10.8%	National							
	A45	Active	% of surgical re-admissions to the same hospital within 30 days of discharge		NSP	HPO	Access/Activity		M	M	<3%	2.0%	<3%	National							
AMP	CPA31	New KPI 2016	% of all medical admissions via AMAU **		DOP	TBC	Quality	CP	M	M	New KPI 2016	New KPI 2016	35%	National							
Medication Safety	A46	Active	**Medication Safety** No. of medication incidents (as provided to the state claims agency) in acute hospitals reported as a % of bed days used'		NSP	Quality Prog	Quality		Q	Q	New KPI 2015	0.12%	≤0.12%	National							
Patient Exper	A47	Active	**Patient Experience** % of hospitals groups conducting annual patient experience surveys amongst representative samples of their patient population		NSP	CP	Access/Activity			A	100%	Not yet reported in 2015	100%	National							
Dialysis Modality	CPA32	Active	**Dialysis Modality Δ** Haemodialysis patients Treatments **		DOP	CP	Access/Activity		Bi	Bi	251,004 254,124	271,638- 275,226	288,096- 295,428	National	40,333- 41,360	51,857- 53,177	60,500- 62,040	25,929- 26,589	60,500- 62,040	48,977- 50,222	
	CPA33	Active	Home Therapies Patients Treatments **		DOP	CP	Access/Activity		Bi	Bi	85,060 94,440	86,300 - 87,161	90,647-93,259	National	9,065- 9,327	18,130- 18,652	23,568- 24,247	8,158- 8,393	23,568- 24,247	8,158- 8,393	
Delayed Discharges	A48	Active	**Delayed Discharges** No. of bed days lost through delayed discharges		NSP	BIU	Access/Activity		M	M	New KPI 2016	225,250	<183,000	National							
	A49	Active	No. of beds subject to delayed discharges		NSP	BIU	Access/Activity		M	M	New KPI 2016	577	<500	National							

HR-Compliance	A50	Active	**HR-Compliance** European Working Time Directive compliance for NCHDs - <24 hour shift		NSP	CP	Access/Activity		M in arrears	N	100%	98%	100%	National							
	A51	Active	European Working Time Directive compliance for NCHDs - < 48 hour working week		NSP	CP	Access/Activity		M in arrears	M	100%	75%	95%	National							
National Early Warning Score (NEWS)	A52	Active	**National Early Warning Score (NEWS)** % of Hospitals with implementation of NEWS in all clinical areas of acute Hospitals and single specialty hospitals		NSP	CP	Access/Activity		Q	Q	100%	100%	100%	National							
	A53	Active	% of all clinical staff who have been trained in the COMPASS programme		NSP	CP	Access/Activity		Q	Q	>95%	63.6%	>95%	National							
Irish Maternity Early Warning Score (IMEWS)	A54	Active	**Irish Maternity Early Warning Score (IMEWS)** % of maternity units/ hospitals with implementation of IMEWS		NSP	CP	Access/Activity		Q	Q	100%	100%	100%	National							
	A55	Active	% of hospitals with implementation of IMEWS for pregnant patients		NSP	CP	Access/Activity		Q	Q	100%	78%	100%	National							
	A56	Active	% of hospitals with implementation of PEWS (Paediatric Early Warning Score) **		DOP	CP	Quality		Q	Q	New KPI 2016	New KPI 2016	100%	National							
Clincial Guideance	A57	Active	**Clinical Guidance** % of maternity units/ hospitals with implementation of the guideline for clincial handover in maternity services		NSP	CP	Access/Activity		Q	Q	New KPI 2016	New KPI 2016	100%	National							
	A58	Active	% of acute hospitals with implementation of the guideline for clincial handover		NSP	CP	Access/Activity		Q	Q	New KPI 2016	New KPI 2016	100%	National							
National Standards	A59	Active	**National Standards** % of Hospitals who have commenced second assessment against the NSSBH		NSP	CP	Access/Activity		Q	Q	New KPI 2016	New KPI 2016	95%	National							
	A60	Active	% of Hospitals who have completed first assessment against the NSSBH		NSP	CP	Access/Activity		Q	Q	95%	80%	100%	National							
	A61	Active	% Maternity Units which have completed and published Maternity Patient Safety Statements and discussed at Hospital Management Team each month		NSP	Maternity Prog	Quality		M	M	New KPI 2016	New KPI 2016	100%	National							
	A62	Active	% of Acute Hospitals which have completed and published Patient Safety Statements and discussed at Hospital Management Team each month **		DOP	CP	Quality			M	New KPI 2016	New KPI 2016	100%	National							
	A63	Active	Number of nurses prescribing medication		NSP	CP	Quality			A	New KPI 2016	New KPI 2016	100	National							
	A64	Active	Number of nurses prescribing ionising radiation (x-ray)		NSP	CP	Quality			A	New KPI 2016	New KPI 2016	55	National							
COPD	CPA34	Active	**COPD** Mean and median LOS (and bed days) for patients admitted with COPD **		DOP	HPO	Access/Activity	CP	M	Q	7.8 5	7.6 5	7.6 5	National							
	CPA35	Active	% re-admission to same acute hospitals of patients with COPD within 90 days **		DOP	HPO	Access/Activity	CP	M	Q	24%	27%	24%	National							
	CPA36	Active	No. of acute hospitals with COPD outreach programme **		DOP	CP	Access/Activity	CP	M	Q	15	15	18	National							
	CPA37	Active	Access to structured Pulmonary Rehabilitation Programme in acute hospital services **		DOP	CP	Access/Activity		M	Bi	28 sites	27	33 sites	National							
sma	CPA38	Active	**Asthma** % nurses in secondary care who are trained by national asthma programme **		DOP	CP	Access/Activity		Q	Q	New KPI 2016	New KPI 2016	70%	National							

Asth	CPA39	Active	No. of asthma emergency inpatient bed days used **		DOP	HPO	Access/Activity		Q1 mth in arrears	Q	New KPI 2016	New KPI 2016	3% Reduction	National							
	CPA40	Active	No. of asthma emergency inpatient bed days used by <6 year olds **		DOP	HPO	Access/Activity		Q	Q	New KPI 2016	New KPI 2016	5% Reduction	National							
Diabetes	CPA41	Active	**Diabetes** **Number of** lower limb amputation performed on Diabetic patients **		DOP	HPO	Access/Activity			A	40%	Not yet reported	≤488	National							
	CPA42	Active	Average length of stay for Diabetic patients with foot ulcers **		DOP	HPO	Access/Activity			A	40%	Not yet reported	≤17.5 days	National							
	CPA43	Active	% increase in hospital discharges following emergency admission for uncontrolled diabetes **		DOP	HPO	Access			A	New KPI 2016	New KPI 2016	≤10%	National							
Epilepsy	CPA44	Active	**Epilepsy** **R**eduction in median LOS for epilepsy inpatient discharges **		DOP	HPO	Access/Activity		Q1 reported in Q3	Q	10% reduction	0%	2.5	National							
	CPA45	Active	% reduction in the number of epilepsy discharges **		DOP	HPO	Access/Activity		Q1 reported in Q3	Q	10% reduction	11.4%	10% reduction	National							
Blood Policy	CPA46	Active	**Blood Policy** No. of units of platelets ordered in the reporting period **		DOP	CP	Access/Activity			M	21,178	21,000	21,000	National							
	CPA47	Active	% of units of platelets outdated in the reporting period **		DOP	CP	Access/Activity			M	<8 %	<5%	<5%	National							
	CPA48	Active	% usage of O Rhesus negative red blood cells **		DOP	CP	Access/Activity			M	<11%	<14%	<14%	National							
	CPA49	Active	% of red blood cell units rerouted **		DOP	CP	Access/Activity			M	<5%	<4%	<4%	National							
	CPA50	Active	% of red blood cell units returned out of total red blood cell units ordered **		DOP	CP	Access/Activity			M	<1%	<1%	<1%	National							
Outpatients (OPD) reportable events	A65	Active	**Reportable events** % of hospitals that have processes in place for participative engagement with patients about design, delivery & evaluation of health services. **		DOP	June Bolger	ccess/Activity			A	New KPI 2016	Data not due to be reported until Q2 2016	100%	National							
	A66	Active	**Outpatients (OPD)** % of Clinicians with individual DNA rate of 10% or less **		DOP	Access/Activity				M	New KPI 2016	New KPI 2016	70%	HG							
	A67	Active	Ratio of compliments to complaints **		DOP	Access/Activity				M	New KPI 2016	New KPI 2016	TBC	National							
			National Cancer Programme																		
ncer Services	NCCP1	Active	**Symptomatic Breast Cancer Services** No. of patients triaged as urgent presenting to symptomatic breast clinics		NSP	NCCP	NCCP		M	M	16,000	16,800	16,800	National							
	NCCP2	Active	No. of non urgent attendances presenting to Symptomatic Breast clinics **		DOP	NCCP	NCCP		M	M	24,000	23,500	24,000	National							
	NCCP3	Active	Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals ~**		DOP	NCCP	NCCP		M	M	15,200	16,100	16,000	National							
	NCCP4	Active	% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals		NSP	NCCP	NCCP		M	M	95%	96%	95%	National							

Symptomatic Breast Ca	NCCP5	Active	Number of attendances whose referrals were triaged as non- urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals (No. offered an appointment that falls within 12 weeks) **		DOP	NCCP	NCCP		M	M	22,800	19,300	22,800	National							
	NCCP6	Active	% of attendances whose referrals were triaged as non- urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)		NSP	NCCP	NCCP		M	M	95%	82%	95%	National							
	NCCP7	Active	Clinic Cancer detection rate: no. of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer **		DOP	NCCP	NCCP		rolling 12 mths	M		>1,100	>1,100	National							
	NCCP8	Active	Clinic Cancer detection rate: % of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer		NSP	NCCP	NCCP		rolling 12 mths	M	>6%	11%	>6%	National							
Lung Cancer	NCCP9	Active	**Lung Cancer** No. of patients attending rapid access lung clinic in designated cancer centres		NSP	NCCP	NCCP		M	M	3,000	3,300	3,300	National							
	NCCP10	Active	Number of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres **		DOP	NCCP	NCCP		M	M	2,850	2,800	3,135	National							
	NCCP11	Active	% of patients attending lung rapid clinics who attended or were offered an appointment within 10 working days of receipt of referral in designated cancer centres		NSP	NCCP	NCCP		M	M	95%	86%	95%	National							
	NCCP12	Active	Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer **		DOP	NCCP	NCCP		rolling 12 mths	M		>825	>825	National							
	NCCP13	Active	Clinic Cancer detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer		NSP	NCCP	NCCP		rolling 12 mths	M	>25%	29%	>25%	National							
Prostate	NCCP14	Active	**Prostate** No. of centres providing surgical services for prostate cancers **		DOP	NCCP	NCCP		M	M	7	8	7	National							
	NCCP15	Active	No. of patients attending the prostate rapid access clinic in the cancer centres		NSP	NCCP	NCCP		M	M	2,500	2,600	2,600	National							
	NCCP16	Active	Number of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres **		DOP	NCCP	NCCP		M	M	2,250	1,630	2,340	National							
	NCCP17	Active	% of patients attending prostate rapid clinics who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centres		NSP	NCCP	NCCP		M	M	90%	62%	90%								
	NCCP18	Active	Clinic Cancer detection rate: Number of new attendances to clinic that have a subsequent diagnosis of prostate cancer **		DOP	NCCP	NCCP		rolling 12 mths	M		>780	>780	National							
	NCCP19	Active	Clinic Cancer detection rate: % of new attendances to clinic that have a subsequent diagnosis of prostate cancer		NSP	NCCP	NCCP		rolling 12 mths	M	>30%	38%	>30%	National							

Radiotheraphy	NCCP20	Active	**Radiotheraphy** No. of patients who completed radical radiotherapy treatment (palliative care patients not included) **		DOP	NCCP	NCCP		M	M	4,700	4,900	4,900	National							
	NCCP21	Active	No.of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included) **		DOP	NCCP	NCCP		M	M	4,230	4,153	4,410	National							
	NCCP22	Active	% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)		NSP	NCCP	NCCP		M	M	90%	84%	90%	National							
Recta l	NCCP23	Active	**Rectal** No. of centres providing services for rectal cancers **		DOP	NCCP	NCCP		M	M	8	13	8	National							
			System Wide KPI's																		
System Wide	A68	Activ	**Service Arrangements/ Annual Compliance Statement** % of number of Service Arrangements signed		NSP		Access/Activity		M	M	100%	100%	100%	National							
	A69	Activ	% of the monetary value of Service Arrangements signed		NSP		Access/Activity		M	M	100%	100%	100%	National							
	A70	Activ	% of Annual Compliance Statements signed		NSP		Access/Activity		M	A	100%	100%	100%	National							
	A71	Activ	**Service User Experience** % of complaints investigated within 30 working days of being acknowledged by the complaints officer		NSP		Access/Activity		M	M	75%	75%	75%	National							
	A72	Activ	**Serious Reportable Events** % of Serious Reportable Events being notified within 24 hours to the Senior Accountable Officer and entered on the National Incident Management System (NIMS)		NSP		Access/Activity		M	M	75%	75%	75%	National							
	A73	Activ	% of investigations completed within 120 days of the notification of the event to the Senior Accountable Officer		NSP		Access/Activity		M	M	90%	62%	90%	National							
	A74	Activ	**Safety Incident reporting** % of safety incidents being entered onto NIMS within 30 days of occurrence by hospital group/ CHO		NSP		Access/Activity		M	Q	New KPI 2016	New KPI 2016	90%	National							
	A75	Activ	% of claims received by State Claims Agency that were not reported previously as an incident		NSP		Access/Activity		M	A	New KPI 2016	New KPI 2016	To be set in 2016	National							

Dialysis Δ includes all hospitals, contracted units and home therapies

∞ Discharge Activity in Divisional Operational Plan target 2016 are based on Activity Based Funding (ABF) and weighted units (WU) activity supplied by HPO. Discharge Activity in NSP 2016 was based on data submitted by hospitals to BIU. Dialysis activity is included in day cases ABF and weighted units.

** These KPI's are not in NSP

	Acute Division - Beds Available	
1	**KPI title**	Beds Available - In-patient beds.
2	**KPI Description A1**	Average Inpatient Beds Available are beds which are currently occupied or ready for occupation.
3	**KPI Rationale**	To track the number of in-patient beds available in a hospital for use by inpatients.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 10,804
5	**KPI Calculation**	Count
6	**Data Source**	Sourced from Hospitals
	Data Completeness	Coverage all acute hospitals 100%
	Data Quality Issues	All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	Yes, this is an internationally recognised metric (AUS, CAN, GB, ECHI)
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ¨ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is noted in Divisional Operational Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Beds Available	
1	**KPI title**	Day Beds/ Places
2	**KPI Description** **A2**	Day Beds/Places provide areas for day cases (patients admitted for a medical procedure or surgery in the morning and released before the evening). Average available Day Beds/places are beds which are currently occupied or ready for occupation.
3	**KPI Rationale**	To track the number of beds/places funded in a hospital designated as a Day bed/place, where day case treatments will take place.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 2,024
5	**KPI Calculation**	Count
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals Coverage all acute hospitals 100% All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	Yes, this is an internationally recognised metric (AUS, CAN, GB, ECHI)
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is noted in Divisional Operational Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

KPI Metadata 2016

Discharge Activity

1	**KPI title**	Inpatient Cases
2	**KPI Description A3**	Number of Inpatient discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 621,205 IEHG 128,488 DMHG 94,669 RCSI HG 95,207 ULHG 45,502 SSWHG 120,480 Saolta HG 111,927 Childrens HG 24,931
5	**KPI Calculation**	Number of Inpatient discharges
6	**Data Source**	HIPE and uncoded PAS data
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Inpatients Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Inpatient Weighted Units
2	**KPI Description A4**	Total weighted units for inpatient discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 623,627 IEHG 133,632 DMHG 110,892 RCSI HG94,948 ULHG 40,440 SSWHG 118,750 Saolta HG 96,030 Childrens HG 28,934
5	**KPI Calculation**	Total weighted units for inpatient discharges
6	**Data Source**	HIPE, uncoded PAS data, HPO
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Inpatients Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type,HPO: weighted Units
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑ CompStat ☑ Other – give details: DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Daycase Cases (includes dialysis)
2	**KPI Description** **A5**	Total number of daycase discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 1,013,718 IEHG 181,415 DMHG 213,957 RCSI HG 145,858 ULHG 56,470 SSWHG 202,988 Saolta HG 185,300 Childrens HG 27,730
5	**KPI Calculation**	Total number of daycase discharges
6	**Data Source**	HIPE and uncoded PAS data
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Daycases Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Day Case Weighted Units (includes dialysis)
2	**KPI Description** **A6**	Total weighted units for daycase discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 1,010,025 IEHG 197,773 DMHG 192,818 RCSI HG 138,455 ULHG 66,659 SSWHG 197,076 Saolta HG 181,503 Childrens HG 35,832
5	**KPI Calculation**	Total weighted units for daycase discharges
6	**Data Source**	HIPE, uncoded PAS data, HPO
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Daycases Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type,HPO: weighted Units
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑ CompStat ☑Other – give details:
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Total Inpatient and Day Cases cases
2	**KPI Description** **A7**	Total number Inpatient and Day Case discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 1,634,923 IEHG 309,903 DMHG 308,626 RCSI HG 241,065 ULHG 101,972 SSWHG 323,468 Saolta HG 297,,227 Childrens HG 52,661
5	**KPI Calculation**	Total number Inpatient and Day Case discharges
6	**Data Source**	HIPE and uncoded PAS data
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Inpatient & Daycase Discharges
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Acute Division - Emergency Care	
1	KPI title	New ED Attendances
2	KPI Description A9	Total number of new patients who present themselves to hospital Emergency Department (ED). An ED is a hospital facility that provides 24/7 access for undifferentiated emergency and urgent presentations across the entire spectrum of medical, surgical, trauma and behavioural conditions. An Emergency Department "New Attendance" is an individual unscheduled visit by one patient to receive treatment from the Emergency Medicine Service.
3	KPI Rationale	It is an important measure for clinical audit/governance and planning of services and to measure the unplanned attendances to each hospital to measure demand on the entire service. Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target/ Expected Activity	Target 2016: 1,102,680
5	KPI Calculation	Count of Number of ED Attendances
6	Data Source	Sourced from Hospitals systems
	Data Completeness	Coverage all hospitals with recognised Emergency Departments
	Data Quality Issues	Reporting all acute hospitals with recognised Emergency Departments
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Emergency Attendance
9	Minimum Data Set	BIU – Acute MDR
10	International Comparison	Yes
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Emergency Care	
1	KPI title	Return ED attendances
2	KPI Description A10	Total number of scheduled and unscheduled return attendances at the Emergency Department. Return Attendances include: Scheduled Return: A planned follow-up attendance at the same department, and for the same incident as the first attendance. This includes patients attending EM review clinics. Unscheduled 24-hour Return: An unplanned attendance at the same department and for the same incident within 24 hours of the first attendance. Unscheduled Seven-day Return: An unplanned attendance at the same department and for the same incident within seven days of the first attendance. Unscheduled 28-day Return: An unplanned attendance at the same department and for the same incident within 28 days of the first attendance.
3	KPI Rationale	It is an important measure for clinical audit/governance and planning of services and to measure the unplanned attendances to each hospital to measure demand on the entire service. Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 94,948
5	KPI Calculation	Count of Number of Return ED Attendances
6	Data Source	Sourced from Hospitals systems
	Data Completeness	Coverage all hospitals with recognised Emergency Departments
	Data Quality Issues	Reporting all acute hospitals with recognised Emergency Departments
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		☑Daily ❑Weekly ☐ Monthly ☐Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	As per description no. 2 above
9	Minimum Data Set	BIU – Acute MDR
10	International Comparison	Yes
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑Hospital ☑Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Other presentations	
1	KPI title	Other Emergency Presentations
2	KPI Description A11	Total number of patients who present themselves to hospital as emergency other than New or Return at an Emergency Department. They include Local Injuries Unit (LIU), Paediatric Assessment Unit (PAU's) and Surgical Assessment Unit (SAU's), and emergency presentations direct to wards. A Local Injury Unit provides care to defined patient groups e.g. non-life or limb threatening injury for limited hours of patient access.
3	KPI Rationale	It is an important measure for clinical audit/governance and planning of services and to measure the unplanned attendances to each hospital to measure demand on the entire service.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 94,855
5	KPI Calculation	Count of Other Presentations
6	Data Source	Sourced from Hospitals systems
	Data Completeness	Coverage all hospitals with recognised Emergency Departments
	Data Quality Issues	Reporting all acute hospitals with recognised Emergency Departments
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Emergency Presentation other than New or Return
9	Minimum Data Set	BIU – Acute MDR
10	International Comparison	Yes
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑National ☐ Regional ❑ LHO Area ☑Hospital ☑Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Discharge Activity

1	**KPI title**	Emergency Inpatient Discharges
2	**KPI Description** **A12**	Total Number of Emergency Inpatient Discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 408,879 IEHG 82,077 DMHG 58,877 RCSI HG 62,681 ULHG 29,799 SSWHG 80,149 Saolta HG 77,214 Childrens HG 18,082
5	**KPI Calculation**	Total Number of Emergency Inpatient Discharges
6	**Data Source**	HIPE and uncoded PAS data
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Admission Type equal to 4, 5 or 7 Inpatients Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type, Admission Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Elective Inpatient Discharges
2	**KPI Description** **A13**	Total Number of elective inpatient discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 95,430 IEHG 18,172 DMHG 13,625 RCSI HG 9,838 ULHG 8,543 SSWHG 21,812 Saolta HG 16,591 Childrens HG 6,849
5	**KPI Calculation**	Total Number of elective inpatient discharges
6	**Data Source**	HIPE and uncoded PAS data
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Admission Type equal to 1 or 2 Inpatients Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type, Admission Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Discharge Activity	
1	**KPI title**	Maternity Inpatient Discharges
2	**KPI Description** **A14**	Total number of Maternity Inpatient Discharges
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: National 116,890 IEHG 28,239 DMHG 22,167 RCSI HG 22,686 ULHG 7,158 SSWHG 18,518 Saolta HG 18,122 Childrens HG 0
5	**KPI Calculation**	Total number of Maternity Inpatient Discharges
6	**Data Source**	HIPE
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Admission Type equal to 6 Inpatients Only
9	**Minimum Data Set**	HIPE: Discharge Date, Patient Type, Admission Type
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in August)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details:DOP
16	**Web link to data**	NA
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: Maureen Cronin Division: HPO

	Acute Division - Outpatient attendances	
1	**KPI title**	no. of new and return Outpatient Attendances
2	**KPI Description** **A15**	This metric includes the total number of both new and return attendances. New attendance = A first new attendances at a consultant led Outpatient clinic Return Attendance - Attendance by a patient who has been treated as an outpatient at least once previously, or as an inpatient or day case.
		Return Attendance - Attendance by a patient who has been treated as an outpatient at least once previously, or as an inpatient.
3	**KPI Rationale**	The monitoring of outpatient attendance levels
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	target 2016: 3,242,424
5	**KPI Calculation**	Count. Total New + Return Outpatient attendances
6	**Data Source**	Sourced from Hospitals PAS systems
	Data Completeness	Coverage all acute hospitals 100%
	Data Quality Issues	all acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ☐ Quarterly wBi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Qualifies as an outpatient attendance
9	**Minimum Data Set**	BIU- Acute OPD Template
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area þ Hospital
		❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) þ CompStat qOther – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		Ollie Plunkett, OSPIP, Ardee Business Park, Hale Street, Ardee, Co Louth and Ita Hegarty, OSPIP tel 041 6871516, 087 6786229

	Acute Division - Outpatient attendances	
1	**KPI title**	Outpatient Attendances - New : Return Ratio (excluding obstetrics and warfarin haematology clinics)
2	**KPI Description A16**	The number of new patients that attend a service compared to the number of review patients that attend a service. Expressed by setting out for each new patient attendance, how many review patients attendances occur. Trimmed to exclude large volume specialties of obstetrics and warfarin haematology clinics with expected ratios in excess of 2:1
3	**KPI Rationale**	This is an access indicator. Lower ratios of review patients will facilitate more new patients to be seen thus reducing waiting lists
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 = 1:2
5	**KPI Calculation**	Number of new patients and number of review (return) patients seen in hospital clinic expressed as a ratio. Exclude obstetrics patients (i.e., obstetrics, fetal assessment, ultrasound in Rotunda) and haematology/warfarin, then calculate new to review ratio
6	**Data Source**	Hospitals
	Data Completeness	Good
	Data Quality Issues	Exclusion process may not achieve goal. Roll out of new minimum data set and associated definitions required to ensure valid data
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU- Acute OPD Template
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ☑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually qOther – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑ Hospital Group ☑ Hospital
		❑ County ❑ Institution ☐Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Oliver Plunkett, OSPIP
National Lead and Division		Ollie Plunkett, OSPIP, Ardee Business Park, Hale Street, Ardee, Co Louth and Ita Hegarty, OSPIP tel 041 6871516, 087 6786229

	Acute Division - Births	
1	**KPI title**	Births - Total number of births
2	**KPI Description A17**	Includes the total number of live births and still births greater than or equal to 500grms.
3	**KPI Rationale**	Monitoring Function. Standard indicator of obstetric performance. An indicator needed for calculating population growth.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 : 65,977
5	**KPI Calculation**	Count: Number of Live Births + Number of Still Births
6	**Data Source**	Sourced from Hospitals PAS systems Coverage 19 hospitals 100% 19/19 hospitals reporting
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ☐Other
8	**Tracer Conditions**	Total number of live births and still births greater than or equal to 500grms.
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	KPI title	%. of adults waiting < 8 months for an elective procedure (inpatients)
2	KPI Description A19a	% of adults waiting <8 months for inpatient procedure excluding GI Endoscopy. Inpatient – A patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed.
3	KPI Rationale	No adult should wait more than 8 months for an IP procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 70%
5	KPI Calculation	Adult Inpatient < 8 months excluding GI endoscopy. Numerator: Number of adults waiting less than 8 months. Denominator Total number of adults on waiting list
6	Data Source	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Patient awaiting an inpatient procedure, waiting less than 8 months
9	Minimum Data Set	BIU report: data required by Month, Year, case_ind, Agency Cod,e hospital_name, case_ind Adult/Child, HIPE Spec, Specialty and waiting period.
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	**KPI title**	% of adults waiting < 8 months for an elective procedure (day case)
2	**KPI Description A19b**	% of adults waiting <8 months for day case procedure excluding GI endoscopy – A patient who is admitted to a designated day bed/place on an elective basis for care and/or treatment.
3	**KPI Rationale**	No adult should wait more than 8 months for a day case procedure.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 70%
5	**KPI Calculation**	Adult Day case < 8 months excluding GI endoscopy. Numerator: Number of adults waiting less than 8 months. Denominator Total number of adults on waiting list
6	**Data Source**	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	patient awaiting a day case procedure, waiting less than 8 months
9	**Minimum Data Set**	BIU report: data required by Month, Year, case_ind, Agency Cod,e hospital_name, case_ind Adult/Child, HIPE Spec, Specialty and waiting period.
10	**International Comparison**	Calculations of waiting lists and waiting times are to international best practice standards
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Hospital Manager
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times (Monthly)	
1	KPI title	% of children waiting < 20 weeks for an elective procedure (inpatient)
2	KPI Description A21a	% of children waiting <20 weeks for an inpatient procedure excluding GI Endoscopy. Inpatient – A patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated bed.
3	KPI Rationale	No child should wait more than 20 weeks for an inpatient procedure.
	Indicator Classification	National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 60%
5	KPI Calculation	numerator: No. of children waiting <20 Weeks on Inpatient waiting list excluding GI Endoscopy Denominator: Total number of patients waiting on children waiting list
6	Data Source	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	Child age is set at 15 (up to your 16th birthday) for hospitals that treat both Adults and Paeds. Everyone attending a children's only hospital would be considered a child and anyone attending Adults only hospital will be classed as an adult
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	child awaiting an elective procedure, waiting for less than 20 weeks
9	Minimum Data Set	BIU report: data required by Month, Year, case_ind, Agency Cod,e hospital_name, case_ind Adult/Child, HIPE Spec, Specialty and waiting period.
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Hospital Manager
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		❑ Monthly in arrears (June data reported in July)
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	**KPI title**	% of children waiting < 20 weeks for an elective procedure (day case)
2	**KPI Description A21b**	% of children waiting <20 Weeks for a day case procedure excluding GI endoscopy
3	**KPI Rationale**	No Child should wait more than 20 Weeks for a day case procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 60%
5	**KPI Calculation**	numerator: No. of children waiting <20 Weeks on Day case waiting list excluding GI Endoscopy Denominator: Total number of patients waiting on children waiting list
6	**Data Source**	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	Child age is set at 15 (up to your 16th birthday) for hospitals that treat both Adults and Paeds. Everyone attending a children's only hospital would be considered a child and anyone attending Adults only hospital will be classed as an adult
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	child awaiting an elective procedure, waiting for less than 20 weeks
9	**Minimum Data Set**	Basic demographic details, procedure details including urgency level
10	**International Comparison**	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ☑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	**KPI title**	% of adults waiting <15 months for an elective procedure (inpatient)
2	**KPI Description A18a**	% of adults waiting <15 months for inpatient procedure excluding GI Endoscopy. Inpatient – A patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed.
3	**KPI Rationale**	No adult should wait more than 15 months for an IP procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 95%
5	**KPI Calculation**	
6	**Data Source**	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patient awaiting an inpatient procedure, waiting less than 15 months
9	**Minimum Data Set**	Basic demographic details, procedure details including urgency level
10	**International Comparison**	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ☑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	**KPI title**	% of adults waiting <15 months for an elective procedure (daycase)
2	**KPI Description A18b**	% of adults waiting <15 months for day case procedure excluding GI endoscopy – A patient who is admitted to a designated day bed/place on an elective basis for care and/or treatment.
3	**KPI Rationale**	No adult should wait more than 15 months for a day case procedure.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 95%
5	**KPI Calculation**	
6	**Data Source**	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patient awaiting a daycase procedure, waiting less than 15 months
9	**Minimum Data Set**	Basic demographic details, procedure details including urgency level
10	**International Comparison**	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ☑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	KPI title	% of children waiting <15 months for an elective procedure (inpatient)
2	KPI Description A20a	% of children waiting <15 months for inpatient procedure excluding GI Endoscopy. Inpatient – A patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed.
3	KPI Rationale	No child should wait more than 15 months for an IP procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 95%
5	KPI Calculation	
6	Data Source Data Completeness Data Quality Issues	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU Child age is set at 15 (up to your 16th birthday) for hospitals that treat both Adults and Paeds. Everyone attending a children's only hospital would be
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	Basic demographic details, procedure details including urgency level
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ☑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Inpatient & Day Case Waiting Times	
1	KPI title	% of children waiting <15 months for an elective procedure (daycase)
2	KPI Description A20b	% of children waiting <15 months for day case procedure excluding GI endoscopy – A patient who is admitted to a designated day bed/place on an elective basis for care and/or treatment.
3	KPI Rationale	No child should wait more than 15 months for a day case procedure.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 95%
5	KPI Calculation	
6	Data Source Data Completeness Data Quality Issues	Data Sourced from NTPF. Data taken from last day of month and submitted to BIU Child age is set at 15 (up to your 16th birthday) for hospitals that treat both Adults and Paeds. Everyone attending a children's only hospital would be
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	Basic demographic details, procedure details including urgency level
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group
		❑ County ❑ Institution ☑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Outpatient attendances	
1	KPI title	% of people waiting <52 weeks for first access to outpatient services
2	KPI Description A23	% of people waiting less than 12 months to be seen in outpatient services
3	KPI Rationale	85% of patients should wait no more than 52 weeks for first access to outpatient services
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	target 2016: 85%
5	KPI Calculation	Numerator: Number of outpatient patients waiting to be seen less than 52 weeks Denominator: Total number of patients waiting to be seen in Outpatients
6	Data Source	Data Sourced from NTPF.
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	No. of patients waiting less than 52 weeks for first access to OPD services
9	Minimum Data Set	Basic demographic details, procedure details including urgency level
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	KPI report period	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in July)
14	KPI Reporting Aggregation	❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
15	KPI is reported in which reports?	❑ County ❑ Institution ☑ Other – give details:
		Indicate where the KPI will be reported: PR and NTPF
16	Web link to data	☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Outpatient attendances	
1	KPI title	% of people waiting <15 Months for first access to outpatient services
2	KPI Description A22	% of people waiting less than 15 months to be seen in outpatient services
3	KPI Rationale	100% of patients should not wait more than 52 weeks for first access to outpatient services
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	target 2016: 100%
5	KPI Calculation	Numerator: Number of outpatient patients waiting to be seen less than 15 months Denominator: Total number of patients waiting to be seen in Outpatients
6	Data Source	Data Sourced from NTPF.
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	No. of patients waiting less than 15 months for first access to OP services
9	Minimum Data Set	Basic demographic details, procedure details including urgency level
10	International Comparison	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: For 28 day periods commencing on national implementation start date
13	KPI report period	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in July)
14	KPI Reporting Aggregation	❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
15	KPI is reported in which reports?	❑ County ❑ Institution ☑ Other – give details:
		Indicate where the KPI will be reported: PR and NTPF
16	Web link to data	☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
17	Additional Information	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Colonoscopy / Gastrointestinal Service	
1	**KPI title**	% of people waiting < 4 weeks for an urgent colonscopy
2	**KPI Description** **A24**	% of patients waiting less than 4 weeks for an urgent colonscopy.
3	**KPI Rationale** **A24**	No patient should wait more than 4 weeks for urgent colonoscopy from time of referral. Recognised metric in providing rapid diagnosis of colon cancer; this leads to demonstrably improved patient outcomes.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		☐ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 : 100%
5	**KPI Calculation**	Numerator: Number of urgent colonoscopy waiting less than 4 weeks Denominator: Total number of patients waiting forr urgent colonscopy treatment. Colonoscopy data is taken as a snap shot of last week in reporting month.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Coverage 39 hospitals 100% 39/39 hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute - Urgent Colonoscopy Report
10	**International Comparison**	Often part of an indicator sub-set in international documents, may not be explicitly noted, but present in some form or another internationally.
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report √ Performance Report (NSP/CBP) ☑CompStat qOther – give details:
16	**Web link to data**	This KPI is noted in the Service Plan 2016
17	**Additional Information**	http://www.hse.ie/eng/services/Publications
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Colonoscopy / Gastrointestinal Service	
1	**KPI title**	% of people waiting <13 weeks following a referral for routine colonoscopy or OGD
2	**KPI Description** **A25**	% of people waiting less than 13 weeks for a routine colonoscopy or OGD
3	**KPI Rationale**	70% of patients should wait no more than 13 weeks for routing colonoscopy or OGD
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 70%
5	**KPI Calculation**	Numerator: Number of patients waiting to be seen less than 13 weeks Denominator: Total number of patients waiting to be seen for a colonoscopy or OGD
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data Sourced from NTPF.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	No of people waiting less than 13 weeks for a routine colonoscopy or OGD
9	**Minimum Data Set**	BIU report: data required by Month, Year, case_ind, Agency Cod,e hospital_name, case_ind Adult/Child, HIPE Spec, Specialty and waiting period.
10	**International Comparison**	Waiting times for inpatient and outpatient services are standard measures internationally (AUS, CAN, GB, ECHI).
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	This KPI is noted in the Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Brian Parsons, NTPF
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division	
Emergency Care & Patient Experience Time		
1	**KPI title**	% of all attendees at ED who are discharged or admitted within 6 hours of registration
2	**KPI Description** **A26**	% of all ED patients who wait less than 6 hours. Total Emergency Department Time (TEDT) is measured from Arrival to ED Departure Time.
3	**KPI Rationale**	a. A 6 hour target for ED has been included in the HSE service plan for a number of years and Patient Experience Time, which is equivalent to TEDT, has been collected at a number of EDs since 2010.
		b. TEDT includes both productive clinical time and delays. This indicator aims to reduce the delays without compromising on quality of care (1).
		c. Prolonged durations of stay in EDs are associated with poorer patient outcomes (2,3).
		d. Research in an Irish ED demonstrated that patient mortality increased exponentially after 6 hours total time spent in the ED(4).
		e. Prolonged waiting times are associated with adverse outcomes for patients discharged from EDs.(5)
		f. Patients waiting more than 6 hours should be cared for in a more appropriate care setting than an ED
		g. Patients who have completed their period of EM care draw on nursing and other ED resources that would be more effectively directed at new patients who require timely initial clinical assessment and nursing care.
		h. This indicator sets an upper limit on the duration of ED patient care. However, a small minority of patients may require longer than 6 hours care in an ED setting due to the complexity of their presenting problems. This is why a 95% compliance target has been set.
		i. An upper absolute limit of 9 hours is set to ensure that the 5% of patients who may not comply with the 6 hour target do not go on to have protracted waiting times.
		j. Monitoring the median, mean and centiles will allow EDs that do not achieve the target initially to monitor the timeliness of the care they provide, to better understand performance and demonstrate improvement towards achievement of the target. Secondary measures will also allow hospitals that meet the target to demonstrate exemplary performance in further reducing waiting times and will support benchmarking of hospital performance.
		k. The centile measures will also demonstrate any potentially unfavourable distortions in practice such as a rush to discharge or admit a disproportionate number of patients close to the 6-hour target time.
		l. Efficient care should not be rushed. Comparison of median and 75th centile data between similar EDs will indicate if a particular unit is managing patients at an unexpectedly quick rate This will flag the need to investigate whether this variance represents more efficient or unacceptably rushed care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 75%
5	**KPI Calculation**	Numerator - All ED patients who are admitted to a ward or discharged in less than 6 hours from their Arrival Time. Denominator - All patient attendances at Eds
6	**Data Source** **Data Completeness** **Data Quality Issues**	EDIS/PAS
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		☑Daily ❑Weekly ☐ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	All attendances to ED
9	**Minimum Data Set**	Emergency Care Unit Identifier ID of hospital (to be confirmed or included in EMP dataset) Local service-user identifier UHI Unique Health Identifier (not yet applicable) Patient attendance Data set identifier new and unscheduled returns Date patient presents ED dataset Time patient presents Arrival Time Time patient admitted ED Departure Time for patient Time patient discharged ED Departure Time for patient ID of EM clinician who discharged patient Propose Irish Medical Council Registration Number ID of non-EM clinician who discharged patient Propose Irish Medical Council Registration Number
10	**International Comparison**	(1) A&E Clinical Quality Indicators. Department of Health 17th December 2010. Available at
		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications
		PolicyAndGuidance/DH_122868. Accessed 13th January 2011
		(2) Sprivulis PC, Da Silva J-A, Jacobs IG, Frazer ARL, Jelinek GA (2006) The Association between
		hospital overcrowding and mortality among patients admitted via Western Australian emergency
		departments MJA 184 (5): 208
		(3) Richardson DB (2001) The access-block effect: relationship between delay to reaching an inpatient
		bed and in-patient length of stay MJA 177:49
		(4) Silke B, Plunkett P et al. European Journal of Emergency Medicine 2011 (in press)
		(5) Guttman A, Schull MJ, Vermullen MJ, Stukel TA. Association between waiting times and short
		term mortality and hospital admission after departure from emergency department: population based
		cohort study from Ontario, Canada. BMJ 2011;342:d2983doi:10.1136/bmj.d2983.

		(6) A six hour target for ED attendances is being used in New Zealand. New Zealand Ministry of
		Health. Available at http://www.moh.govt.nz/moh.nsf/indexmh/ed-target. Accessed 13th January 2011
11	KPI Monitoring	KPI will be monitored : ☑Daily ☐Weekly ☐Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat qOther – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	EDIS implementation will ensure data available from all sites. This KPI is on CIF. This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division	
Emergency Care & Patient Experience Time		
1	**KPI title**	% of all attendees at ED who are discharged or admitted within 9 hours of registration
2	**KPI Description** **A27**	% of all ED patients who wait less than 9 hours. Total Emergency Department Time (TEDT) is measured from Arrival to ED Departure Time.
3	**KPI Rationale**	a. A 9 hour target for ED has been included in the HSE service plan for a number of years and Patient Experience Time, which is equivalent to TEDT, has been collected at a number of EDs since 2010.
		b. TEDT includes both productive clinical time and delays. This indicator aims to reduce the delays without compromising on quality of care (1).
		c. Prolonged durations of stay in EDs are associated with poorer patient outcomes (2,3).
		d. Research in an Irish ED demonstrated that patient mortality increased exponentially after 9 hours total time spent in the ED(4).
		e. Prolonged waiting times are associated with adverse outcomes for patients discharged from EDs.(5)
		f. Patients waiting more than 9 hours should be cared for in a more appropriate care setting than an ED
		g. Patients who have completed their period of EM care draw on nursing and other ED resources that would be more effectively directed at new patients who require timely initial clinical assessment and nursing care.
		h. Monitoring the median, mean and centiles will allow EDs that do not achieve the target initially to monitor the timeliness of the care they provide, to better understand performance and demonstrate improvement towards achievement of the target. Secondary measures will also allow hospitals that meet the target to demonstrate exemplary performance in further reducing waiting times and will support benchmarking of hospital performance.
		i. The centile measures will also demonstrate any potentially unfavourable distortions in practice such as a rush to discharge or admit a disproportionate number of patients close to the 9-hour target time.
		j. Efficient care should not be rushed. Comparison of median and 75th centile data between similar EDs will indicate if a particular unit is managing patients at an unexpectedly quick rate This will flag the need to investigate whether this variance represents more efficient or unacceptably rushed care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 100%
5	**KPI Calculation**	Numerator - All ED patients who are admitted to a ward or discharged in less than 9 hours from their Arrival Time. Denominator - All patient attendances at EDs
6	**Data Source**	EDIS/PAS
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	All attendances to ED
9	**Minimum Data Set**	Emergency Care Unit Identifier ID of hospital (to be confirmed or included in EMP dataset) Local service-user identifier UHI Unique Health Identifier (not yet applicable) Patient attendance Data set identifier new and unscheduled returns Date patient presents ED dataset Time patient presents Arrival Time Time patient admitted ED Departure Time for patient Time patient discharged ED Departure Time for patient ID of EM clinician who discharged patient Propose Irish Medical Council Registration Number ID of non-EM clinician who discharged patient Propose Irish Medical Council Registration Number
10	**International Comparison**	(1) A&E Clinical Quality Indicators. Department of Health 17th December 2010. Available at
		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications

		PolicyAndGuidance/DH_122868. Accessed 13th January 2011
		Health. Available at http://www.moh.govt.nz/moh.nsf/indexmh/ed-target. Accessed 13th January 2011
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually qOther – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ¨ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	EDIS implementation will ensure data available from all sites. This KPI is on CIF. This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division	
Emergency Care & Patient Experience Time		
1	**KPI title**	% of all ED patients at ED who leave before completion of treatment
2	**KPI Description** **A28**	% of ED patients who attend ED but leave before their treatment is completed. These patients are recorded as did not wait on hospital system.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	All patients attending ED have a right to treatment. Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016:<5%
5	**KPI Calculation**	Numerator: number of patients that Did Not Wait Denominator: Total patients attending ED
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all hospitals with recognised Emergency Departments & Local Injury Units. Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is reported in the Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division	
Emergency Care & Patient Experience Time		
1	**KPI title**	% of all attendees at ED who are in ED <24 hours
2	**KPI Description** **A29**	% of patients who attend ED who are in ED less than 24 hours
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 100%
5	**KPI Calculation**	All attendances that have an experience time of less than 24 hours
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all hospitals with recognised Emergency Departments & Local Injury Units. Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ☑Daily ❑Weekly ☐Monthly ☐Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is on CIF. This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division	
Emergency Care & Patient Experience Time		
1	KPI title	% of patients 75 years or over who were admitted or discharged from ED within 9 hours
2	KPI Description A30	% of all ED patients 75 years who wait less than 9 hours. Total Emergency Department Time (TEDT) is measured from Arrival to ED Departure Time.
3	KPI Rationale	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 100%
5	KPI Calculation	Numerator - All ED patients aged >75 years of age, who are admitted to a ward or discharged in less than 9 hours from their Arrival Time. Denominator - All patient attendances at ED who are aged over 75 years of age who are admitted or discharged
6	Data Source Data Completeness Data Quality Issues	EDIS/PAS
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ☑Daily ❑Weekly ¨ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	All attendances to ED
9	Minimum Data Set	Emergency Care Unit Identifier ID of hospital (to be confirmed or included in EMP dataset) Local service-user identifier UHI Unique Health Identifier (not yet applicable) Patient attendance Data set identifier new and unscheduled returns Date patient presents ED dataset Time patient presents Arrival Time Time patient admitted ED Departure Time for patient Time patient discharged ED Departure Time for patient ID of EM clinician who discharged patient Propose Irish Medical Council Registration Number ID of non-EM clinician who discharged patient Propose Irish Medical Council Registration Number
10	International Comparison	(1) A&E Clinical Quality Indicators. Department of Health 17th December 2010. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868. Accessed 13th January 2011 (2) Sprivulis PC, Da Silva J-A, Jacobs IG, Frazer ARL, Jelinek GA (2006) The Association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments MJA 184 (5): 208 (3) Richardson DB (2001) The access-block effect: relationship between delay to reaching an inpatient bed and in-patient length of stay MJA 177:49 (4) Silke B, Plunkett P et al. European Journal of Emergency Medicine 2011 (in press) (5) Guttman A, Schull MJ, Vermullen MJ, Stukel TA. Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. BMJ 2011;342:d2983doi:10.1136/bmj.d2983. (6) A six hour target for ED attendances is being used in New Zealand. New Zealand Ministry of Health. Available at http://www.moh.govt.nz/moh.nsf/indexmh/ed-target. Accessed 13th January 2011
11	KPI Monitoring	KPI will be monitored : ☑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ¨ Regional ❑ LHO Area ☑ Hospital þHospital Group ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. tel 01-635 2000.

	Acute Division - Patient profile aged 75 years and over	
1	KPI title	% of patients attending ED > 75 years of age
2	KPI Description A31	% pf patients attending ED aged 75 years and over
3	KPI Rationale	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 13%
5	KPI Calculation	Numerator: number of patients aged over 75 years of age . Denominator - All patient attendances at ED who are aged over 75 years of age
6	Data Source Data Completeness Data Quality Issues	Sourced from Hospitals PAS systems Coverage all hospitals with recognised Emergency Departments & Local Injury Units. Reporting all acute hospitals with recognised Emergency Departments
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ☑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	
10	International Comparison	
11	KPI Monitoring	KPI will be monitored :
		☑Daily ❑Weekly ¨ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ¨ Performance Report (NSP/CBP) ¨CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is reported in Divisional Operational Report 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Patient profile aged 75 years and over	
1	**KPI title**	% of all attendees aged over 75 years and over at ED who are discharged or admitted within 6 hours of registration
2	**KPI Description A32**	% of all ED patients who wait less than 6 hours whom are aged over 75 years and over. Total Emergency Department Time (TEDT) is measured from Arrival to ED Departure Time.
3	**KPI Rationale**	a. A 6 hour target for ED has been included in the HSE service plan for a number of years and Patient Experience Time, which is equivalent to TEDT, has been collected at a number of EDs since 2010.
		b. TEDT includes both productive clinical time and delays. This indicator aims to reduce the delays without compromising on quality of care (1).
		c. Prolonged durations of stay in EDs are associated with poorer patient outcomes (2,3).
		d. Research in an Irish ED demonstrated that patient mortality increased exponentially after 6 hours total time spent in the ED(4).
		e. Prolonged waiting times are associated with adverse outcomes for patients discharged from EDs.(5)
		f. Patients waiting more than 6 hours should be cared for in a more appropriate care setting than an ED
		g. Patients who have completed their period of EM care draw on nursing and other ED resources that would be more effectively directed at new patients who require timely initial clinical assessment and nursing care.
		h. This indicator sets an upper limit on the duration of ED patient care. However, a small minority of patients may require longer than 6 hours care in an ED setting due to the complexity of their presenting problems.
		i. An upper absolute limit of 9 hours is set to ensure that the 5% of patients who may not comply with the 6 hour target do not go on to have protracted waiting times.
		j. Monitoring the median, mean and centiles will allow EDs that do not achieve the target initially to monitor the timeliness of the care they provide, to better understand performance and demonstrate improvement towards achievement of the target. Secondary measures will also allow hospitals that meet the target to demonstrate exemplary performance in further reducing waiting times and will support benchmarking of hospital performance.
		k. The centile measures will also demonstrate any potentially unfavourable distortions in practice such as a rush to discharge or admit a disproportionate number of patients close to the 6-hour target time.
		l. Efficient care should not be rushed. Comparison of median and 75th centile data between similar EDs will indicate if a particular unit is managing patients at an unexpectedly quick rate This will flag the need to investigate whether this variance represents more efficient or unacceptably rushed care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 95%
5	**KPI Calculation**	Numerator - All ED patients aged >75 years of age, who are admitted to a ward or discharged in less than 6 hours from their Arrival Time. Denominator - All patient attendances at ED who are aged over 75 years of age who are admitted or discharged
		presentation - (a) all ED patients and unscheduled returns (b) all (a) who are subsequently admitted (c) all (a) who are discharged by an EM clinician. (d) all (a) who are discharged by a non-EM clinician (b) to (d) = level II data for EMP For data definitions see EMP Report 2011. Numerator - All ED patients who are admitted to a ward or discharged in less than 9 hours from their Arrival Time
6	**Data Source**	EDIS/PAS
	Data Completeness	

	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ☐Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	All attendances to ED
9	**Minimum Data Set**	Emergency Care Unit Identifier ID of hospital (to be confirmed or included in EMP dataset) Local service-user identifier UHI Unique Health Identifier (not yet applicable) Patient attendance Data set identifier new and unscheduled returns Date patient presents ED dataset Time patient presents Arrival Time Time patient admitted ED Departure Time for patient Time patient discharged ED Departure Time for patient ID of EM clinician who discharged patient Propose Irish Medical Council Registration Number ID of non-EM clinician who discharged patient Propose Irish Medical Council Registration Number
10	**International Comparison**	(1) A&E Clinical Quality Indicators. Department of Health 17th December 2010. Available at
		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications
		PolicyAndGuidance/DH_122868. Accessed 13th January 2011
		Health. Available at http://www.moh.govt.nz/moh.nsf/indexmh/ed-target. Accessed 13th January 2011
11	**KPI Monitoring**	KPI will be monitored :
		☑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ¨ Performance Report (NSP/CBP) ¨CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is on CIF. This KPI is reported in Divisional Operational Report 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Acute Medical Patient Processing	
1	**KPI title**	% of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration
2	**KPI Description** **CPA1**	Total medical assessment time (TMAT) is measured from the time of arrival of a medical patient in the ED to the time of medical assessment unit departure time. The measures are the percentage of all new medical patients attending the AMAU/MAU * who are admitted or discharged within 6 hours.
3	**KPI Rationale**	a) A 6 hour target for patients to be assessed in AMAU/AMU* is a performance indicator for the Acute Medicine Programme. b) TMAT includes both productive clinical times and delays. This indicator aims to reduce the delays without compromising quality of care. c) Long durations of stay in all types of Assessment Units are associated with poorer patient outcomes. d) A major objective of the Acute Medicine Programme is to increase the efficiency of patient assessment and to stream patients to the most appropriate destination for further care which is either admission to a short stay unit, specialist ward or discharged home with or without out patient review. e) This indicator sets an upper limit for the duration of Assessment Unit care. However a small minority of patients may require more than 6 hours due to the complexity of their presenting problems, this is why a 75% compliance target has been set.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 = 75%
5	**KPI Calculation**	**Numerator** – All new patients attending an AMAU/MAU* who are admitted to a ward or discharged from the AMAU/MAU in less than 6 hours from their arrival time in ED. (or arrival in AMAU/MAU if they are directly referred to AMAU/MAU and do not go via ED) **Denominator** – All new patients attending an AMAU/AMU*
6	**Data Source** **Data Completeness** **Data Quality Issues**	ED/AMU system
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ☑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	All patients referred to an AMAU/MAU*.
9	**Minimum Data Set**	Medical Assessment Unit Identifier/ID of hospital Patient Hospital Medical Record Number Unique Health Identifier (not yet available) Patient attendance – new and unscheduled returns Date and Time patient registered in ED Date and Time patient discharged from AMAU/MAU (AMAU/MAU departure time)
10	**International Comparison**	Often part of an indicator sub-set in international documents, may not be explicitly noted, but present in some form or another internationally.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Group CEO
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area þ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑ CompStat qOther – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		Prof Garry Courtney, Garry.Courtney@hse.ie Dr Yvonne Symth yvonne.symth@hse.ie

HIPE Hospital Number	Hospital Name	MAU Ward Name
3	Loughlinstown	0708
4	Naas	0098
5	Mater	MELS
7	St Vincents	AMAU
22	Connolly	JCM021
37	Beaumont	AMU
41	Tallaght (AMNCH)	AU
100	Waterford	AMU5
101	St Lukes Kilkenny	MAU
103	Wexford	MAU
105	South Tipperary	AMAU
202	Bantry	BGHMAU
203	Mercy	AMAU
207	Mallow	MAU
235	CUH	AMAU
236	Kerry	AMAU
303	Limerick	AMU
305	St Johns	MAU
307	Ennis	MAU
308	Nenagh	0403
401	Roscommon	MAU
403	Portiuncula	AMAU
404	UHG	MAUTAR
405	Mayo	MAU
501	Tullamore	AMAU
503	Mullingar	MAU
601	Letterkenny	AMAU
602	Sligo	MAU
701	Drogheda	MAU
701	Drogheda	AMAU
702	Cavan	MAU
702	Cavan	AMAU
705	Navan	MAU

Access to Services

1	**KPI title**	% of routine patients on Inpatient and Day Case Waiting List that are chronologically scheduled
2	**KPI Description** **A33**	% of routine patients chronologically scheduled
3	**KPI Rationale**	Longer waiting routine patients should be scheduled for treatment before routine patients with shorter wait times.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☒ Person Centred Care ☒ Effective Care ☒ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	the national target is to have 90% of routine patients chronologically scheduled
5	**KPI Calculation**	The chronological scheduling rate is measured at procedure/consultant level (Routines only). It takes the number of patients with appointments (TCI) and compares them with those patients who have yet to receive an appintment date (Active) to see if the latter are waiting longer. A Chronological Scheduling compliance rate can thereby be derived (see further details in the explanatory notes provided in the report)
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data is provided by each hospital and data analytics are carried out by NTPF. Each hospital is responsible for the accuracy of data provided, assessed via ongoing NTPF data quality project and hospital audits. Analysis based on latest appointment assignment rate (TCI rate) by consultant rather than actual hospital capacity. This TCI rate is provided in the report for context.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ☒Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	weekly hospitals report on Inpatient / Daycase Waiting Lists to NTPF
9	**Minimum Data Set**	required data:details of routine patient with and without appointment dates, their repective wait time, by procedure and consultant for each hospital
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☒ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital group management responsible for monitoring Chronological scheduling
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☒Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☒ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☒ National ❑ Regional ☒Hospital ☒Hospital Group ☐CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ☒ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Report (NSP) ❑CompStat ☒Other – give details (operational Plan)
16	**Web link to data**	None. Report is emailed to various stakeholders on a monthly basis, typically within 7 days of month-end
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? This KPI is noted in DOP 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Brian Parsons Email: Brian.Parsons@ntpf.ie Tel: 01 642 7100 Specialist Lead: Aymeric Duffay Email: Aymeric.Duffay@ntpf.ie
National Lead and Division		Data Manager: Brian Parsons Email: Brian.Parsons@ntpf.ie Tel: 01 642 7100

Acute Division - Healthcare Associated Infections		
1	KPI Title	Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used
2	KPI Description CPA2	Number of MRSA blood stream infections reported via EARS-Net per 1000 bed days used per quarter for each acute hospital. MRSA blood stream infections as a % of all Staphylococcus aureus (S.Aureus) infection in hospitals.
3	KPI Rationale	To indicate progress towards the goal of reducing MRSA in acute settings against the National target setting within the "Say No to Infection Strategy".
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two).
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	<0.055
5	KPI Calculation	Under the case definition for EARSS, data are collected on the first bloodstream isolate of S. aureus per patient per quarter. The following data are included in each report: • The number of S. aureus isolates, including the number of MRSA isolates.
6	Data Source	Rate of MRSA comes from microbiology laboratories in acute hospitals and information on bed days used is provided by the HSE BIU acute Unit.
	Data Completeness	100% participation by hospital laboratories
	Data Quality Issues	Does not distinguish between true bloodstream infections and blood culture contaminants. Does not indicate where bloodstream infections were acquired (community, reporting hospital or other heathcare setting).
7	Data Collection Frequency	❑Daily ❑Weekly ☐ Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Patients demographic details as well as EARs-net core data reference www.HPSC.ie
9	Minimum Data Set	Quarterly data supply from Hospital Microbiology laboratories as per EARS-Net protocol, the European Antimicrobial Resistance Surveillance Network (EARS-Net) collects information on antibiotic resistance of bacteria causing invasive infection.
10	International Comparison	Yes, European surveillance system: data can be compared with results from other participating countries
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☐ Monthly ☑Quarterly ☐Bi-annually ☐Annually ☐Other Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly ☐ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		☑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	http://www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance/EuropeanAntimicrobial ResistanceSurveillanceSystemEARSS/EARSSSurveillanceReports/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data Manager / Specialist Lead		Mr Stephen Murchan, HPSC, stephen.murchan@hse.ie, Tel: 01 8765300
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI title	Rate of new cases of Clostridium difficile associated diarrhoea in acute hospitals per 10,000 bed days used
2	KPI Description CPA3	National rate of new cases of Clostridium difficile associated diarrhoea in acute hospitals
3	KPI Rationale	C. difficile is a potentially preventable healthcare associated infection that causes significant morbidity and mortality. It has caused a number of significant outbreaks in hospitals and long term care facilities. Rates are linked to antibiotic prescribing.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016:<2.5 cases per 10,000 bed days used
5	KPI Calculation	Numerator data: New cases of Clostridium difficile associated diarrhoea in acute hospitals as per national case definition. Denominator data: 10,000 bed days used
6	Data Source Data Completeness Data Quality Issues	Data provided by acute hospitals (microbiologists, infection control nurses, surveillance & laboratory scientists) to HPSC on a quarterly basis.
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Antibiotic consumption rates in hospitals and the community
9	Minimum Data Set	Protocol www.hpsc.ie
10	International Comparison	National case definition identical to EU and US case definitions therefore comparable with countries that use these case definitions.
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		☑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI Title	Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days used) per hospital
2	KPI Description CPA4	The total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital Antibiotic Consumption Rate: Bed Days Used
3	KPI Rationale	Antibiotic use in hospitals is a risk factor for antimicrobial resistance, and for MRSA and *C. difficile* infection rates. Antibiotic use also represents a major cost for hospitals
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two).
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	80 DDD per 100 bed days used
5	KPI Calculation	The principle measure of antibiotic consumption for each hospital is the inpatient antibiotic consumption rate, expressed as DDD (defined daily dose) per 100 bed days used.
6	Data Source	Hospital Pharmacies to HPSC
	Data Completeness	Data provided by 95% of acute hospitals
	Data Quality Issues	Does not represent prescription level data. Does not indicate appropriateness of antibiotic use (some hospitals may have a high level of antibiotic use that is appropriate to their patient population. Some hospital pharmacies are unable to provide data du
7	Data Collection Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Antibiotic consumption rate
9	Minimum Data Set	Protocol www.hpsc.ie
10	International Comparison	Hospital antibitoic consumption data collected as part of ESAC-Net: data comparible with other participating European countries
11	KPI Monitoring	❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
12	KPI Reporting Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		☐Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Bi-annual e.g. Q1 & Q2 2016 reported in Q3 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	http://www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance/EuropeanSurveillanceofAntimicrobialConsumptionESAC/SurveillanceReports/
17	Additional Information	Reports on hospital antibiotic consumption for participating European countries available at www.ecdc.eu. KPI noted in National Service Plan 2016
Contact details for Data		Mr Ajay Oza, HPSC, ajay.oza@hse.ie, Tel: 01 8765300
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI Title	Alcohol Hand Rub consumption (litres per 1,000 bed days used)
2	KPI Description CPA5	This is the volume of alcohol rub used by hospitals, which is an acceptable method of assessing hand hygiene compliance. It is expressed as volume (in litres) per 1000 beddays used in the hospital. It excludes alcohol rub that is used for pre-operative
3	KPI Rationale	Alcohol based hand rubs are recommended as a primary means of hand hygiene in the Irish national guidelines. Measurement of alcohol hand rub consumption is a process indicator for hand hygiene compliance.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two).
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	25 litres per 1000 bed days used
5	KPI Calculation	The rate of usage per hospital is calculated as per the total volume of hand rub consumed in litres per 1000 bed days used. This is measured quarterly and annually. Hospital activity data, bed days used are obtained from the Performance Management Unit
6	Data Source	Hospital pharmacies and supplies departments (reporting to HPSC)
	Data Completeness	Reported by all acute hospitals
	Data Quality Issues	Does not distinguish between staff, patient and visitor use of alcohol hand gel. Hospitals reporting via supplies departments may have artificially high rates of use, due to batch delivery of supplies.
7	Data Collection Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Alcohol Hand Rub consumption
9	Minimum Data Set	Protocol www.hpsc.ie
10	International Comparison	Internationally recognised process indicator, allowing direct comparison with data from other countries.
11	KPI Monitoring	❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
12	KPI Reporting Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		☐Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Bi-annual e.g. Q1 & Q2 2016 reported in Q3 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/Handwashing/AlcoholHandRubConsumptionSurveillance/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data		Mr Ajay Oza, HPSC, ajay.oza@hse.ie, Tel: 01 8765300
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI Title	% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool
2	KPI Description CPA6	Compliance of hospital staff with the World Health Organisations (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool. % compliance by healthcare staff with WHO 5 moments of hand hygiene
3	KPI Rationale	Hand hygiene is one of the most effective means of reducing healthcare associated infection (HCAI). However, compliance by healthcare workers with recommended hand hygiene frequencies and techniques has been reported as suboptimal.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two).
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 90%
5	KPI Calculation	Count
6	Data Source	Observational audit of hand hygiene compliance by healthcare staff in hospitals. National lead auditors trained and validated at national training sessions conduct audit.
	Data Completeness	Complete reporting by all acute hospitals.
	Data Quality Issues	No external validation of oberservational audits: risk obererver bias and "Hawthorne" effect
7	Data Collection Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Alcohol hand rub usage in hosptials, Clostridium Difficle and MRSA Rates
9	Minimum Data Set	Compliance with WHO 5 moments of hand hygiene
10	International Comparison	Broad comparisons can be made with other countries that use WHO methodology, however the exact method use to collect the data (sample size, auditor) varies from country to country
11	KPI Monitoring	❑Daily ❑Weekly ☐Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
12	KPI Reporting Frequency	❑Daily ❑Weekly ☐Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐ Monthly in arrears (June data reported in July)
		☐Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Bi-annual e.g. Q1 & Q2 2016 reported in Q3 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	http://www.hpsc.ie/hpsc/A-Z/Gastroenteric/Handwashing/HandHygieneAudit/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data		Ms Helen Murphy, HPSC, helen.murphy@hse.ie Tel: 01 8765300
National Lead and Directorate		Dr. Philip Crowley, National Director Quality and Patient Safety Tel: 01 635 2038 Dr. Eibhlin Connolly, Deputy Chief Medical Officer, Dept. of Health, Tel: 635 4025
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI title	Hospital acquired S. aureus bloodstream infection/10,000 BDU
2	KPI Description CPA7	The infection is considered hospital-acquired within the reporting hospital if a positive blood culture growing *S. aureus* was obtained from a patient who had been hospitalised within the reporting hospital for 48 hours or longer
3	KPI Rationale	To indicate progress towards the goal of reducing hospital acquired blood stream infection in acute settings.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	<1 case per 10,000 bed days used
5	KPI Calculation	**Numerator:** Number of positive blood cultures growing *S. aureus* obtained from patients who had been hospitalised within the reporting hospital for 48 hours or longer **Denominator**: acute bed days used, provided by the HSE BIU acute unit. This is based on the average number of available acute in patient beds during the previous month
6	Data Source	**Source:** Microbiology laboratories in acute hospitals laboratories
	Data Completeness	**Completeness:**100% of all acute hospitals must participate
	Data Quality Issues	**Quality:** Does not distinguish between true bloodstream infections and blood culture contaminants. Does not indicate where bloodstream infections were
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	Monthly data supplied by Acute Hospitals
10	International Comparison	N/A
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Nominated member of the senior management team of each hospital with responsibility for hygiene
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	KPI noted in Divisional Operation Plan 2016
Contact details for Data		Carley Impey carley.impey@hse.ie 6201687
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Division - Healthcare Associated Infections		
1	KPI title	Hospital acquired new caases of C.Difficile infection/10,000BDU
2	KPI Description CPA8	National rate of new cases of Clostridium difficile associated diarrhoea in acute hospitals
3	KPI Rationale	To indicate progress towards the goal of reducing hospital acquired blood stream infection in acute settings.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: <2.5 cases per 10,000 bed days used
5	KPI Calculation	**Numerator:** Number of positive blood cultures growing *S. aureus* obtained from patients who had been hospitalised within the reporting hospital for 48 hours or longer **Denominator**: acute bed days used, provided by the HSE BIU acute unit. This is based on the average number of available acute in patient beds during the previous month
6	Data Source Data Completeness Data Quality Issues	**Source:** Microbiology laboratories in acute hospitals laboratories **Completeness:**100% of all acute hospitals must participate **Quality:** Does not distinguish between true bloodstream infections and blood culture contaminants. Does not indicate where bloodstream infections were
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	Monthly data supplied by Acute Hospitals
10	International Comparison	N/A
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Nominated member of the senior management team of each hospital with responsibility for hygiene
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ❑ LHO Area ☑ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☐ Performance Assurance Report (NSP) ☐ CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	KPI noted in Divisional Operation Plan 2016
Contact details for Data		Carley Impey carley.impey@hse.ie 6201687
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

	Acute Services: HCAI	
1	KPI title	Percentage of current staff who interact with patients that have received mandatory hand hygiene training in the rolling 24 month
2	KPI Description CPA9	Percentage of current healthcare staff who interact with patients that have recieved mandatory hand hygiene training in the rolling 24 months
3	KPI Rationale	Hand hygiene education is part of mandatory induction training for all healthcare staff that interact with patients. Agency and temporary staff need to be included in this induction programme, unless there is documentary evidence that they have received equivalent training prior to commencing work. Note: - Rotating staff such as NCHD should attend hand hygiene training and education every two years; this may have been provided within the past 2 years in another hospital - Staff with direct patient contact that work between 2 or more sites need only attend training in one site - It is the responsibility of each member of staff to produce evidence of the date of their training on commencement of their new employment Sari guidelines link: http://www.hse.ie/eng/services/Publications/HealthProtection/Guidelines_for_Hand_Hygiene_in_Irish_Health_Care_Settings_.pdf
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 100%
5	KPI Calculation	**Denominator**: The number of current healthcare staff who interact with patients **Numerator:** The number of current healthcare staff who interact with patients that have received mandatory hand hygiene training or have documentary evidence that they have recived equivalent training within the rolling 24 months **KPI Calculation:** Proportion of staff trained expressed as a percentage. Achived by dividing the numerator by the denominator multipled by 100
6	Data Source Data Completeness Data Quality Issues	**Source:** Nominated member of the senior management team of each hospital with responsibility for hygiene **Completeness:**100% of all acute hospitals must participate **Quality:** Lack of standardised data collection method across acute hospitals
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	N/A
9	Minimum Data Set	Monthly data supplied by acute hospitals
10	International Comparison	N/A
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Nominated member of the senior management team of each hospital with responsibility for hygiene
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ☐ Performance Assurance Report (NSP) ☐ CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	KPI noted in Divisional Operation Plan 2016
Contact details for Data National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

Acute Services: HCAI		
1	KPI title	Percentage of patients colonized with multi-drug resistant organisims (MDRO) that can not be isolated in single room or cohorted with dedicated toilet facilities as per national MDRO policy
2	KPI Description CPA10	Percentage of inpatients in acute hospitals colonized with MDRO who are placed in appropriate isolation within 24 hours
3	KPI Rationale	Contact isolation precautions are a key component in preventing the spread of MDROs in healthcare settings, and are recommended in national guidelines on the control and prevention of MRSA and other MDROs. National guidelines on the control and prevention of MRSA are available at http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/EuropeanAntimicrobialResistanceSurveillanceSystemEARSS/ReferenceandEducationalResourceMaterial/SaureusMRSA/Guidance/ National guidelines on the control and prevention of MDROs (other than MRSA) are available at http://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Guidelines/
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016:0%
5	KPI Calculation	**Denominator**: The number of inpatients colonized with an MDRO during the previous month **Numerator:** The number of inpatients colonized with an MDRO during the previous month who were placed in appropriate isolation within 24 hours **KPI Calculation:** Numerator divided by the denominator and multiplied by 100
6	Data Source Data Completeness Data Quality Issues	**Source:** Nominated member of the senior management team of each hospital **Completeness:**100% of all acute hospitals must participate **Quality:** Lack of standardised data collection method across acute hospitals; variation in application of national MDRO screening guidelines
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	N/A
9	Minimum Data Set	Monthly data supplied by acute hospitals
10	International Comparison	N/A
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Nominated member of the senior management team of each hospital
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ☐ Performance Assurance Report (NSP) ☐ CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	KPI noted in Divisional Operation Plan 2016
Contact details for Data		Carley Impey carley.impey@hse.ie 6201687
National Lead and		Dr. Kevin Kelleher, Assistant National Director, kevin.kelleher@hse.ie

KPI Metadata 2016

Activity Based Funding (MFTP) Model

1	**KPI title**	HIPE Coverage - Prior Month - % of cases entered into HIPE
2	**KPI Description** **A38**	Percentage of all discharges from a given month coded by the end of the following month
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ❑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	2016 Target = 100%
5	**KPI Calculation**	**Numerator:** (Number of discharges exported to HIPE in report period)*100 **Denominator:** Total number of discharges on PAS elligible for HIPE coding in report period
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE and PAS data Only accurate if all PAS downloads are made e.g. Dialysis
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	NA
9	**Minimum Data Set**	HIPE and PAS data
10	**International Comparison**	NA
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA ❑ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	NA
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Emer Gallagher Email: emer.gallagher1@hse.ie Tel: 01 7718445 Specialist Lead: Fiachra Bane Email: fiachra.bane@hse.ie Tel: 01 7718443
National Lead and Division		National Lead: National Director Division: Acute Hospitals Division Tel: 01-635 2000

	Acute Division - ALOS	
1	**KPI title**	Medical patient average length of stay
2	**KPI Description CPA11**	The mean length of stay for patients admitted to the medical specialties as outlined in tracer conditions (contingent on <500 delayed discharges)
3	**KPI Rationale**	Overall length of stay is a useful indicator for the efficiency of hospital performance, and the improvements in efficiencies which will be delivered by the implementation of the Acute Medicine Programme. Length of stays for patients of medical specialties tend to be longer than other specialties and subsequent bed day usage of hospital bed stock tends to be greater. Therefore the monitoring of AvLOS in medical patients is important and the overall figure is useful as a summary measure at national level. More detailed monitoring of sub groups of AvLOS will be done through the Acute Medicine Programme.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 = 7
5	**KPI Calculation**	Mean: **Numerator:** Total medical Inpatient Beddays for patients in the period **Denominator:** Total number of medical inpatient discharges for those in same period
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE & Uncoded PAS data
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Discharges from medical specialties: - 0100 Cardiology , 0300 Dermatology , 0400 Endocrinology , 0402 Diabetes Melitus , 0700 Gastro-Enterology , 0800 Genito-Urinary Medicine, 0900 Geriatric Medicine , 1100 Haematology , 1102 Transfusion Medicine , 1300 Neurology , 1600 Oncology , 2300 Nephrology, 2400 Respiratory Medicine , 2500 Rheumatology , 2700 Infectious Diseases , 2702 Tropical Infectious Diseases , 3000 Rehabilitation Medicine , 3002 Spinal paralysis, 5000 General Medicine , 6700 Clinical (medical) Genetics , 7300 Palliative Medicine , 7700 Metabolic Medicine and 7900 Clinical Immunology - Age>=16 - Non-maternity admission: Admission Type not equal to 6 - Sameday discharges (admission date=discharge date) have a LOS=0
9	**Minimum Data Set**	HIPE: Specialty, Admission Date, Discharge Date, LOS, Age, Admission Type
10	**International Comparison**	Often part of an indicator sub-set in international documents, may not be explicitly noted, but present in some form or another internationally.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	The overall length of stay KPI is to be reported in the National Service Plan additional sub groupings of lengths of stay templates will be developed for reporting on AMP performance. KPI noted in Divisional Operational Plan report & National Service Plan 216.3
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		Prof Garry Courtney, Garry.Courtney@hse.ie Dr Yvonne Symth yvonne.symth@hse.ie

	Acute Division - ALOS	
1	**KPI title**	Surgical patient average length of stay
2	**KPI Description CPA12**	A specified individual hospital target for average length of hospital stay for surgical inpatients (reference baseline adjusted to 2010 equivalent volumes which includes a factor for day case conversion). A surgical inpatient is a patient who has a principal procedure as listed in the surgery programme procedure list (Appendix I) or is admitted to a specialty as listed in the surgery programme specialty list (Appendix II). Patients admitted to a surgical specialty may or my not have had a procedure carried out.
3	**KPI Rationale A44**	There is significant potential for improvement i.e. reduction in length of stay for surgical patients in Ireland. There is variation across hospitals and across case mix groupings which is demonstrated in 2011 HIPE analysis by Surgery Programme which allows individual hospitals to compare their performance against other anonymised hospitals and plan improvements. The NQAIS system allows users to compare their performance against optimum AvLoS for a selection of elective procedures. Reducing length of stay to optimum levels improves the patient pathway and experience, by reducing pre-operative and discharge delays. It also
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016 Target: for Jan'16 to Dec'16 will be set based on a reduction of 4.5% on 2014 baseline for hospitals deducted from 1.) their end of year annual average for 2015 where those hospitals have achieved or exceeded their 2015 target or 2.) deducted from the 2015 end of year target for hospitals that did not achieve the 2015 AvLOS target set by the National Clinical Programme in surgery for that hospital. Hospital groups will be assessed based on a appropriate volume weighted target derived from the targets for the hospitals in that group. Where target are set prior to year end, up to date 12 month rolling average figures will be used instead of 2015 year end figures.
5	**KPI Calculation**	The length of stay of all surgical inpatients divided by the numbers of surgical inpatients, adjusted for baseline and day case conversion. (See additional notes for more details)
6	**Data Source**	HIPE Data.
	Data Completeness	Will be dependant on accuracy and timely completion of Hospital HIPE coding
	Data Quality Issues	Coverage includes all acute hospitals except specialist paediatric and maternity hospitals.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patients who has a principal procedure as listed in the surgery programme procedure list (Appendix I - ICD-10-AM/ACHI/ACS) or is admitted to a specialty as listed in the surgery programme specialty list (Appendix II)
9	**Minimum Data Set**	- HIPE - Admission date, Discharge date, LOS, Specialty, Principal procedure - 2010 Individual Hospital Baseline Volumes (Inpatients, Daycases, Beddays, Alos)
10	**International Comparison**	Collected in UK and internationally, often for particular surgical procedures e.g. fractured neck of femur.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Groups, Hospitals, Surgery Anaesthesia Programme, ISD
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ☑ Other – give details: hospital groups as appropriate
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	N/A
17	**Additional Information**	2010 was taken as the base line year from which target reductions in average length of stay (AvLOS) / average bed day usage for treating inpatients were taken. Implied in the calculations was an assumption that over all volumes of surgical patients treated and the ratio split of day cases to inpatient for surgical patients would stay constant or equivalent to 2010 figures. In reality this assumption is not true, so to factor in actual figure for 2011, 2012 and so on, adjustments must be made before the target year figure can be compared with 2010 the base line figure. To compare a year to be measured with the base line year (2010), an adjustment for the overall volume change must be made. This can be expressed as the overall surgical patient volume for 2010 divided by the overall surgical patient volume for the year being measured. With this adjustment ratio it can be said that total bed usage in 2010 is equivalent to the total bed day usage in the target year multiplied by the adjustment for overall volume. To look at the equivalent inpatient bed day usage in the target year subtract the 2010 day case bed day usage from the total for that year (assume two day cases get done per day bed each day). This gives us a formula for actual bed day usage in the target year normalised for 2010 volumes and ratio of day case to inpatient in 2010: Target year day bed usage of bed days adjusted for 2010 volumes -2010 day case bed usage + Target year inpatient bed usage of bed days adjusted for 2010 volumes OR 2010 tot volume/target year tot volume * Num day cases in target year *0.5 - Num day cases in 2010 year *0.5 +2010 tot volume/target year tot volume *Num inpatient cases in target year * Ave length of stay for inpatient in target year
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Gerry Kelliher National Clinical Programme in Surgery gerrykelliher@rcsi.ie W: www.rcsi.ie T: 01-402-2143 M: 087-124-0759
National Lead and Division		Prof. Frank Keane, Ken Mealy joint leads for National Clinical Programme in Surgery: fkeane@rcsi.ie, kmealy@rcsi.ie; Colm Henry: National clinical lead for Acute Hospital directorate: ncagl.acutehospitals@hse.ie

	Acute Division - ALOS	
1	**KPI title**	ALOS for all inpatient discharges excluding LOS over 30 days
2	**KPI Description A39**	The average length of stay in days for all inpatient discharges and deaths excluding Length of Stay over 30 days. Length of stay is counted from the date of admission of the patient to an inpatient hospital bed until their date of discharge. For the purposes of this metric, ALOS values greater than 30 days are set to 30 days.
3	**KPI Rationale**	Average length of stay (ALOS) is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 4.3
5	**KPI Calculation**	Trimmed length of stay (days) is calculated as the maximum of (discharge date – admission date and 30 days.)Where a case has been admitted and discharged on the same date, the length of stay is set to 0.5 days. The overall average length of stay is then calculated as the total number of beddays, trimmed as above, across inpatient discharges/deaths in the reporting period divided by the total number of inpatient discharges/deaths in the reposting period. Reporting of this metric is based on a rolling 12 month period 3 months in arrears.
6	**Data Source**	Sourced from Hospitals PAS systems through HIPE
	Data Completeness	Coverage all acute hospitals 100%
	Data Quality Issues	All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	HIPE
10	**International Comparison**	Average Length of Stay, broken down by clinical condition, is a recognised international metric (GB, CAN, AUS, ECHI)
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ☑ LHO Area ☑ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	The overall length of stay KPI is to be reported in the National Service Plan additional sub groupings of lengths of stay templates will be developed for reporting on AMP performance.
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - ALOS	
1	**KPI title**	ALOS for all inpatients
2	**KPI Description** **A40**	The average number of patient days for an admitted patient episode.
3	**KPI Rationale**	Average length of stay (ALOS) is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		☑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 5
5	**KPI Calculation**	Total bed days used Total inpatient discharges = Average length of stay
6	**Data Source**	Sourced from HIPE
	Data Completeness	Coverage all acute hospitals 100%
	Data Quality Issues	All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	HIPE
10	**International Comparison**	Average Length of Stay, broken down by clinical condition, is a recognised international metric (GB, CAN, AUS, ECHI)
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☑ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☑ Regional ☑ LHO Area þ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	The overall length of stay KPI is to be reported in the Divisional Operation Plan additional sub groupings of lengths of stay templates will be developed for reporting on AMP performance.
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division

1	**KPI title**	New attendance DNA rates
2	**KPI Description** **A41**	An attendances where the patient is referred by the OPD Consultant or a member of that team following an ED attendance is considered to be a Return Attendance.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ❑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑Use of Resources ☑Governance, Leadership and Management
4	**KPI Target**	Target 2016: 12%
5	**KPI Calculation**	Total New & Return Outpatient attendances. Count
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems coverage all acute hospitals 100% all acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	as per description 2 above.
9	**Minimum Data Set**	BIU - Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑National ☑ Regional ❑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ☑ Other – give details: age band and speciality
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑Performance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? ICD code disaggregation will be considered in subsequent phases of Data Quality Programme.KPI noted in Divisional Operation Plan 2016
Contact details for Data Manager		Ollie Plunkett
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

KPI Metadata 2016

Dermatology OPD

1	**KPI title**	No. of new dermatology outpatients seen
2	**KPI Description** **CPA13**	Number of new outpatient seen at dermatology clinics in acute hospitals, for a planned treatment or consultation, who has not been treated at least once previously as an outpatient with the same condition (same consultant) within the previous 12 months.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	This indicator is a key access indicator. All Dermatology consultants should see a minimum number of new patients in out patients departments per year in order to meet demand and facilitate capacity planning. Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Acutes Operational Plan 2016: 41,700 National,
5	**KPI Calculation**	Number of new attendances to dermatology clinic in each hospital
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all acute hospitals 100% All acute hospitals reporting; need to ensure paediatrics data is included
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Management and Dermatology Departments
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑ Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: Performance Assurance Report (NSP) ☐CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Carley Impey Email: carley.impey@hse.ie Tel: 01 6201687 Specialist Lead: Dr Anne-Marie Tobin Sinead Fitzpatrick Programme ManagerTel: 01 8639625 Email: sineadfitzpatrick@rcpi.ie
National Lead and Division		Dr. Aine Carroll, National Director, Clinical Strategy and Programmes Directorate Tel: 01 6352322

Dermatology OPD

1	**KPI title**	New :Return Attendance Ratio
2	**KPI Description** **CPA14**	Number of new outpatient seen at dermatology clinics in acute hospitals, for a planned treatment or consultation, who has not been treated at least once previously as an outpatient with the same condition (same consultant) within the previous 12 months and the number of review(return) patient attendance expressed as a ratio
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	This indicator is a key access and performance indicator. To address demand and patients on long waiting lists consultants need to ensure minimum number of new patients are seen relative to return patients and that return patients are discharged as appropriate and as soon as possible to primary care. Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Operational Plan Acute Hospital Division 2016: 1 new: 2 review (return) National,
5	**KPI Calculation**	Number of new patients and number of review (return) patients seen in hospital clinic expressed as a ratio
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all acute hospitals 100% All acute hospitals reporting; need to ensure paediatrics data is included
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Management and Dermatology Departments
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ❑ National ❑ Regional ❑ Hospital Group ☐Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Carley Impey Email: carley.impey@hse.ie Tel: 01 6201687 Specialist Lead: Dr Anne-Marie Tobin Sinead Fitzpatrick Programme ManagerTel: 01 8639625 Email: sineadfitzpatrick@rcpi.ie
National Lead and Division		Dr. Aine Carroll, National Director, Clinical Strategy and Programmes Directorate Tel: 01 6352322

KPI Metadata 2016

Acute Division - Rheumatology OPD		
1	**KPI title**	Number of new rheumatology patients seen
2	**KPI Description CPA15**	Number of new outpatient seen at outpatient clinics in acute hospitals, for a planned treatment or consultation, who has not been treated at least once previously as an outpatient with the same condition (same consultant) within the previous 12 months.
3	**KPI Rationale**	This indicator is a key access indicator. All Rheumatology consultants should see a minimum number of new patients in out patients departments per year in order to meet demand and facilitate capacity planning.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016: 13,800 National
5	**KPI Calculation**	Count; Should be greater than target
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all acute hospitals 100% All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per KPI descripition above (Box. 2)
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery. Target number of new attendances per consultant post have been agreed, based on BSR recommendations
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ❑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	www.hse.ie/performanceassurancereports/
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Gary Killeen Tel: (01) 863 9620/(085) 084 3250 E-mail: garykilleen@rcpi.ie Carley Impey Tel: 01 6201687 E-mail: carley.impey@hse.ie
National Lead and Division		National Lead: Dr. Aine Carroll, National Director Division: Clinical Strategy and Programmes Directorate

	Acute Division - Rheumatology OPD	
1	**KPI title**	New:Return attendance ratio
2	**KPI Description** **CPA16**	This refers to the ratio of the number of return patients seen in a Rheumatology outpatient clinic over a certain time period to the number of new outpatients seen in that clinic over the same time period.
3	**KPI Rationale**	This indicator is a key access and performance indicator. To address demand and patients on long waiting lists consultants need to ensure minimum number of new patients are seen relative to return patients and that return patients are discharged as appropriate and as soon as possible to primary care.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016: 1:4 National
5	**KPI Calculation**	Ratio; New Patients:Return Patients; Should be less than or equal to target This refers to the ratio of the number of return patients seen in a Rheumatology outpatient clinic over a certain time period to the number of new outpatients seen in that clinic over the same time period.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Sourced from Hospitals PAS systems Coverage all acute hospitals 100% All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patients referred to Rheumatology OPD
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	www.hse.ie/performanceassurancereports/
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Gary Killeen Tel: (01) 863 9620/(085) 084 3250 E-mail: garykilleen@rcpi.ie Carley Impey Tel: 01 6201687 E-mail: carley.impey@hse.ie
National Lead and Division		National Lead: Dr. Aine Carroll, National Director Division: Clinical Strategy and Programmes Directorate

Acute Division - Neurology OPD

1	**KPI title**	No. of new neurology patients seen
2	**KPI Description** **CPA17**	Number of new outpatient seen at outpatient clinics in acute hospitals, for a planned treatment or consultation, who has not been treated at least once previously as an outpatient with the same condition (same consultant) within the previous 12 months.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	This indicator is a key access indicator Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016 : 16,900
5	**KPI Calculation**	Number of new neurology patients seen in hospital outpatient clinic
6	**Data Source** **Data Completeness** **Data Quality Issues**	Source is hospital PAS systems Coverage all acute hospitals 100% All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	Target number of new attendances per consultant post have been agreed, based on British Association of Neurologists recommendations.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Neurology Programme
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually qOther – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		*Name: Edina O'Driscoll Email address: edinaodriscoll@rcpi.ie* *Contact Number: Derek McCormack, BIU 6201697 derek.mccormack@hse.ie*
National Lead and Division		Dr. Aine Carroll, National Director, Clinical Strategy and Programmes Directorate Tel: 01 6352322

Acute Division - Neurology OPD

1	**KPI title**	New:Return attendance ratio
2	**KPI Description** **CPA18**	Number of new outpatient seen at dermatology clinics in acute hospitals, for a planned treatment or consultation, who has not been treated at least once previously as an outpatient with the same condition (same consultant) within the previous 12 months and the number of review(return) patient attendance expressed as a ratio
3	**KPI Rationale** **Indicator Classification** **(National Standards for Safer Better HealthCare)**	This indicator is a key access indicator. A high number of return appointments will limit the number of possible new appointments. Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	1:3 new to return ratio
5	**KPI Calculation**	Number of new attendances seen in hospital clinic This refers to the ratio of the number of return patients seen in a Neurology outpatient clinic over a certain time period to the number of new outpatients seen in that clinic over the same time period.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Source is hospital PAS systems Coverage all acute hospitals 100% All acute hospitals reporting
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	As per description no. 2 above
9	**Minimum Data Set**	BIU – Acute MDR
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Neurology Programme
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Name: Edina O'Driscoll Email address: edinaodriscoll@rcpi.ie Contact Number: Derek McCormack, BIU, 6201697 derek.mccormack@hse.ie
National Lead and Division		Dr. Aine Carroll, National Director, Clinical Strategy and Programmes Directorate Tel: 01 6352322

	Acute Division	
Hospital Services: Clinical Programmes - Stroke Care		
1	**KPI title**	Percentage of acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit
2	**KPI Description CPA19**	Care of patients with acute stroke in an acute, combined (acute and rehabilitation) or rehabilitation stroke unit Acute Stroke Patient: patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to Stroke Unit on HIPE Portal Dataset. Acute or Combined Stroke Unit: An identified area within a hospital used exclusively or predominantly for the care of stroke patients, supported by a trained specialist multidisciplinary team, with regular multidisciplinary team meetings, availability of equipment and skills for physiological monitoring (blood pressure, blood oxygen, blood glucose and heart rhythm), and defined structures for audit, governance, and education/training.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	To monitor development of acute and rehabilitation stroke services in accordance with the national stroke programme (national policy and national guidelines) and to assess patient access to acute stroke unit care Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☐ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 - 50%
5	**KPI Calculation**	Numerator = Number of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to Stroke Unit on HIPE Portal Dataset. Denominator = Total number of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES + NO response was made to Admitted to stroke unit on HIPE Portal Dataset. This is expressed as a percentage
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data for numerator will be collected through the HIPE Portal/Stroke Regsister. Data for the denominator will be collected through HIPE and HIPE Portal/Stroke Register. Information is available for 25 out of a possible 28 hospitals who can provide this service.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Data entered onto Stroke Register/HIPE Portal on an ongoing basis at each hospital
8	**Tracer Conditions**	Intracerebral Haemorrhage (ICD I61) Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	**Minimum Data Set**	Basic demographic information as well as information on principal diagnosis of: Intracerebral Haemorrhage (ICD I61), Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
10	**International Comparison**	Yes, Royal College of Physicians UK National Sentinel Stroke Clinical Audit 2010 Round 7 https://audit.rcplondon.ac.uk/SentinelStroke/page/page.aspx?pc=welcome
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Name: Paul Marsden Email address: paul.marsden@hse.ie Contact Number: 057 9359894
National Lead and Division		Dr. Aine Carroll, National Director, Clinical Strategy and Programmes Directorate Tel: 01 6352322

	Acute Division	
Hospital Services: Clinical Programmes - Stroke Care		
1	**KPI title**	The percentage of patients with confirmed acute ischaemic stroke who receive thrombolysis
2	**KPI Description CPA20**	Confirmed acute ischaemic stroke: principal diagnosis of Cerebral Infarction (Ischaemic Stroke) (ICD I63) or Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES/Combined IV & Intra-Arterial Thromb/Combined IV & Clot Retrieval/Intra-Arterial Thromb Only response was made to Treated with Thrombolysis Thrombolysis: Thrombolysis is the breakdown (lysis) of blood clots by pharmacological means. It is colloquially referred to as clot busting for this reason. It works by stimulating fibrinolysis by plasmin through infusion of analogs of tissue plasminogen activator (tPA), the protein that normally activates plasmin.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	To monitor development of acute and rehabilitation stroke services in accordance with the national stroke programme (national policy and national guidelines) To assess patient access to acute stroke care. Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☐ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 - 9%
5	**KPI Calculation**	Numerator = Number of patients with principal diagnosis of Cerebral Infarction (Ischaemic Stroke) (ICD I63) or Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES/Combined IV & Intra-Arterial Thromb/Combined IV & Clot Retrieval/Intra-Arterial Thromb Only response was made to Treated with Thrombolysis? Denominator = Number of patients with principal diagnosis of Cerebral Infarction (Ischaemic Stroke) (ICD I63) or Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES/NO/Combined IV & Intra-Arterial Thromb/Combined IV & Clot Retrieval/Thrombolysis Contraindicated/Intra-Arterial Thromb Only/Other response was made to Treated with Thrombolysis
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data for numerator and denominator will be collected through the HIPE Portal/Stroke Regsister. List of hospitals and date of commencement of Stroke Register forwarded to BIU. Completeness of data dependent on local data input by Stroke team and HIPE coders.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Data entered onto Stroke Register/HIPE Portal on an ongoing basis at each hospital
8	**Tracer Conditions**	Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	**Minimum Data Set**	NUMBER OF PATIENTS WITH PRINCIPAL DIAGNOSIS OF CEREBRAL INFARCTION (ISCHAEMIC STROKE) (ICD I63) or STROKE, NOT SPEC AS HAEMORRHAGE OR INFARCTION (ICD I64)FOR WHOM A 1. YES 3. COMBINED IV & INTRA-ARTERIAL THROMB 4. COMBINED IV & CLOT RETRIEVAL 6. INTRA-ARTERIAL THROMB ONLY RESPONSE WAS SELECTED TO TREATED WITH THROMBOLYSIS NUMBER OF PATIENTS WITH PRINCIPAL DIAGNOSIS OF CEREBRAL INFARCTION (ISCHAEMIC STROKE) (ICD I63) or STROKE, NOT SPEC AS HAEMORRHAGE OR INFARCTION (ICD I64) FOR WHOM A 1 YES 2 NO 3 COMBINED IV & INTRA-ARTERIAL THROMB 4 COMBINED IV & CLOT RETRIEVAL 5 THROMB CONTRAINDICATED 6 INTRA-ARTERIAL THROMB ONLY 7 CLOT RETRIEVAL ONLY 8 OTHER RESPONSE WAS MADE TO TREATED WITH THROMBOLYSIS
10	**International Comparison**	Yes, Royal College of Physicians UK National Sentinel Stroke Clinical Audit 2010 Round 7 https://audit.rcplondon.ac.uk/SentinelStroke/page/page.aspx?pc=welcome
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in National Service Plan report 2016
Contact details for Data Manager /Specialist Lead		Name: Paul Marsden Email address: paul.marsden@hse.ie Contact Number: 057 9359894
National Lead and Division		Dr Joe Harbison, Consultant Stroke Physican & Prof Peter kelly, Stroke Clinical Programme

Acute Division		
Hospital Services: Clinical Programmes - Stroke Care		
1	**KPI title**	Percentage of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit.
2	**KPI Description CPA21**	Care of patients with acute stroke in an acute, combined (acute and rehabilitation) or rehabilitation stroke unit. Acute Stroke Patient: patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to Stroke Unit on HIPE Portal Dataset. Acute or Combined Stroke Unit: An identified area within a hospital used exclusively or predominantly for the care of stroke patients, supported by a trained specialist multidisciplinary team, with regular multidisciplinary team meetings, availability of equipment and skills for physiological monitoring (blood pressure, blood oxygen, blood glucose and heart rhythm), and defined structures for audit, governance, and education/training.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	To monitor development of acute and rehabilitation stroke services in accordance with the national stroke programme (national policy and national guidelines), to assess patient access to acute stroke unit care. Patients with a principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) should spend at least 50% of their hospital stay in the stroke unit. Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☐ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 - 50%
5	**KPI Calculation**	Numerator = Number of stroke unit bed days of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to Stroke Unit on HIPE Portal Dataset and for whom the admission and discharge dates to stroke unit is known. Denominator = Total number of hospital bed days of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was was made to Admitted to stroke unit on HIPE Portal Dataset This is expressed as a percentage.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data for numerator will be collected through the HIPE Portal/Stroke Regsister. Data for the denominator will be collected through the HIPE and HIPE Portal/Stroke Register List of hospitals and date of commencement of Stroke Register forwarded to BIU. Completeness of
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Data entered onto Stroke Register/HIPE Portal on an ongoing basis at each hospital
8	**Tracer Conditions**	Intracerebral Haemorrhage (ICD I61) Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	**Minimum Data Set**	Number of stroke unit bed days of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to Stroke Unit on HIPE Portal Dataset and for whom the admission and discharge dates to stroke unit is known. Total number of hospital bed days of patients with principal diagnosis of Intracerebral Haemorrhage (ICD I61); Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64) for whom a YES response was made to Admitted to stroke unit on HIPE Portal Dataset.
10	**International Comparison**	Yes, Royal College of Physicians UK National Sentinel Stroke Clinical Audit 2010 Round 7 https://audit.rcplondon.ac.uk/SentinelStroke/page/page.aspx?pc=welcome
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☐Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in National Service Plan report 2016
Contact details for Data Manager /Specialist Lead		Name: Paul Marsden Email address: paul.marsden@hse.ie Contact Number: 057 9359894
National Lead and Division		Dr Joe Harbison, Consultant Stroke Physican & Prof Peter kelly, Stroke Clinical Programme

Acute Services		
Acute Hospitals including Clinical Programmes: Heart Failure		
1	**KPI title**	Rate (%) readmission for heart failure within 3 months following discharge from hospital
2	**KPI Description** **CPA22**	Rate of readmission for heart failure within 3 months following discharge from hospital
3	**KPI Rationale**	Patients are at highest risk of readmission to hospital within 90 days of discharge. International evidence shows that structured programmes for heart failure can greatly reduce the readmission rate and this is accepted as an excellent measure of quality
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 20%
5	**KPI Calculation**	Numerator: All patients admitted with heart failure who are referred to the Heart Failure Team who are readmitted as emergency admission with heart failure within 90 days of discharge. Denominator: all patients admitted with principal diagnosis of acute decompensated heart failure who are referred to the Heart Failure Team. (ICD 10 AM codes will be used – I50, I420, I426, I427, I429, I110)
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Portal Add on Screen for Heart Failure +F47
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	Minimum dataset collected via HIPE Portal Add on screen on all patients admitted with acute decompensated heart failure who are referred to the HF Team. Data collected at two time points – time of discharge and at 3-month follow up out-patient visit.
10	**International Comparison**	Readmission indicator used in a number of countries
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager		Name: Email address: Contact Number:
National Lead and Division		Prof. Ken McDonald, Clinical Lead, National Heart Failure Programme, Clinical Strategy & Programmes Division, HSE. 01-8131863

Acute Services		
Acute Hospitals including Clinical Programmes: Heart Failure		
1	**KPI title**	Median LOS for patients admitted with principal diagnosis of acute decompensated heart failure
2	**KPI Description** **CPA23**	Median length of stay for patients admitted to hospital with principal diagnosis of acute decompensated heart failure who are referred to the Heart Failure Team
3	**KPI Rationale**	Structured heart failure programmes should provide quicker access to specialist heart failure services resulting in quicker stabilisation and shorter time to discharge. Median LOS is preferred to mean LOS because of significant numbers of delayed discharges for non-medical reasons.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 6
5	**KPI Calculation**	Median: midpoint where LOS is such that half of the patients discharged with principle diagnosis of heart failure have an LOS above it and half below it Median length of stay for all patients discharged with principal diagnosis of heart failure who were referred to the Heart Failure Team (ICD 10 AM codes will be used – I50, I420, I426, I427, I429, I110)
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE but only for those patients who have data recorded on the HIPE Portal Add-On Screen for Heart Failure with a Principal Diagnosis of HF (ICD-10 I50, I420, I426, I427, I429, I110) This currently includes 11 hospitals
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	Minimum dataset collected via HIPE Portal Add on screen on all patients admitted with acute decompensated heart failure who are referred to the HF Team. Data collected at two time points – time of discharge and at 3-month follow up out-patient visit.
10	**International Comparison**	Length of stay data available from only a few countries.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		❑Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Regina Black, Programme Manager for Heart Failure ¦Clinical Strategy and Programmes Directorate Mobile: 086 3803841
National Lead and Division		Prof. Ken McDonald, Clinical Lead, National Heart Failure Programme, Clinical Strategy & Programmes Division, HSE. 01-8131863

Acute Services		
Acute Hospitals including Clinical Programmes: Heart Failure		
1	**KPI title**	Percentage of patients with acute decompensated heart failure who are seen by the HF programme during their hospital stay
2	**KPI Description** **CPA24**	The percentage of patients with acute decompensated heart failure who are seen by the heart failure programme during their hospital stay.
3	**KPI Rationale**	In order to achieve the planned benefits of the heart failure programme it is necessary that patients are seen by the heart failure programme and assessed by the lead consultant or his/her designate.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 80%
5	**KPI Calculation**	% of patients admitted with heart failure who are seen by the heart failure lead consultant or designated physician. Numerator: number of patients seen by HF Lead Consultant or designate as reported through heart failure minimum data set captured via HIPE Portal add-on screen Denominator: all patients admitted with principal diagnosis of acute decompensated heart failure as recorded by HIPE who were referred to the Heart Failure Team (ICD 10 AM codes will be used – I50, I420, I426, I427, I429, I110)
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Portal Add on Screen for Heart Failure
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	Minimum dataset collected via HIPE Portal Add on screen on all patients admitted with acute decompensated heart failure who are referred to the HF Team. Data collected at two time points – time of discharge and at 3-month follow up out-patient visit.
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☐ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☑ aQuarterly 6 MONTHS in arrears (quarter 1 data reported in quarter 3, etc.) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Regina Black, Programme Manager for Heart Failure ¦Clinical Strategy and Programmes Directorate Mobile: 086 3803841
National Lead and Division		Prof. Ken McDonald, Clinical Lead, National Heart Failure Programme, Clinical Strategy & Programmes Division, HSE. 01-8131863

	Acute Services	
Acute Hospitals including Clinical Programmes: Acute Coronary Syndrome		
1	**KPI Title**	Percentage of STEMI patients (without contraindication to Reperfusion therapy) who get PPCI
2	**KPI Description** **CPA25**	STEMI patients: STEMI is an acronym meaning "ST segment elevation myocardial infarction," which is a type of heart attack. This is determined by an electrocardiogram (ECG) test. Myocardial infarctions (heart attacks) occur when a coronary artery suddenly becomes at least partially blocked by a blood clot, causing at least some of the heart muscle being supplied by that artery to become infarcted (that is, to die). Heart attacks are divided into two types, according to their severity - STEMI and Non STEMI. A STEMI is the more severe type of heart attack LBBB: Left bundle branch block (LBBB) is a cardiac conduction abnormality seen on the electrocardiogram (ECG). In this condition, activation of the left ventricle is delayed, which causes the left ventricle to contract later than the right ventricle. PPCI: Primary percutaneous coronary intervention is an interventional procedure to open the cornonary artery to unblock it and allow flow of blood to the heart muscle. Information is reported on for patients who present both Out of Hours and In hours (9-5 Mon to Fri).
3	**KPI Rationale**	International evidence supports the treatment of primary percutaneous coronary intervention (PPCI) undertaken at a Cath lab centre with sufficient throughput where this treatment can be initiated within the time of 120 mins from first medical contact. A small % of patients will be unable to get to a PPCI centre and so will receive the treatment of thrombolysis (TL).
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 85%
5	**KPI Calculation**	Numerator: No of STEMI (or LBBB) patients who got PPCI. Denominator: Total no of STEMI (or LBBB) patients minus those contraindicated - Expressed as a percentage.
6	**Data Source**	A new system of electronic data collection (e-Heartbeat Portal) using HIPE portal in PCI centres commenced in 4 PPCI centres in 2012 and has expanded to all 9 PPCI/PCI centres.
	Data Completeness	Data is availabe for 8 out of a possible 9 hospitals for 2014/15 data.
	Data Quality Issues	Data is dependant on correct data input . A comprehensive manual is available and the software has some validation features.
7	Data Collection Frequency	❑Daily ❑Weekly ❑Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	STEMI = ICD 10 I21.0 – I21.3 (Interpreted from medical record by Heartbeat coillators)
9	Minimum Data Set	As set out in e-Heartbeat Manual Basic demographic information, patient was a STEMI (or LBBB), was the patient contraindicated to reperfusion, did the patient get reperfusion by PPCI and what was date of reperfusion.
10	International Comparison	Yes, MINAP (UK) and European Society of Cardiology ACS/STEMI Guideline 2012
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ❑Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Rolling 12 months (previous 12 month period) reported a quarter in arrears e.g. 1 July 2014 to 30 June 2015 and reported a quarter in arrears i.e. Oct 2015
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑Regional ☑Hospital Group ☑Hospital (PPCI/PCI centres) ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
National Lead and Directorate		Brendan Cavanagh (ACS Programme Manager) email: Brendan.Cavanagh@hse.ie Prof Kieran Daly

	Acute Services	
Acute Hospitals including Clinical Programmes: Acute Coronary Syndrome		
1	KPI Title	Percentage of reperfused STEMI patients (or LBBB) who get timely PPCI
2	KPI Description CPA26	STEMI (heart attack) patients who get timely reperfusion therapy are those that receive either PPCI or Thrombolysis within targeted times. LBBB: Left bundle branch block (LBBB) is a cardiac conduction abnormality seen on the electrocardiogram (ECG). In this condition, activation of the left ventricle is delayed, which causes the left ventricle to contract later than the right ventricle. PPCI: Primary percutaneous coronary intervention is an interventional procedure to open the cornonary artery to unblock it and allow flow of blood to the heart muscle. Timely PPCI reperfusion is defined as first medical contact (FMC) to balloon <= 120 mins or First door to balloon <= 120 mins. First Medical Contact (FMC) is defined as the date/time of the first 12 lead ECG that is positive to a STEMI.(or LBBB)
		STEMI, LBBB, PPCI and Thrombolysis are further defined in the European Society of Cardiology guideline "Acute Myocaridal Infraction in patients presending with ST-segment elevation (management of)' www.escardio.org/guidelines-surveys/esc-guidelines/ Information is reported on for patients who present both Out of Hours and In hours (9-5 Mon to Fri).
3	KPI Rationale	International evidence supports swift restoration of blood flow to blocked coronary artery as a medical emergency. Past treatment has mainly been rapid thrombolysis at local hospital (TL) but newest form of treatment is emergency primary angioplasty (PPCI) at a PPCI Centre.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016: 80%
5	KPI Calculation	Numerator: no of STEMI (or LBBB) patients receiving PPCI who got timely PPCI Denominator : Total no of STEMI (or LBBB) patients who got PPCI
6	Data Source	A new system of electronic data collection (e-Heartbeat Portal) using HIPE portal in PCI centres commenced in 4 PPCI centres in 2012 and has expanded to all 9 PPCI/PCI centres
	Data Completeness	Data is availabe for 8 out of a possible 9 hospitals for 2014/15 data.
	Data Quality Issues	Data is dependant on correct data input . A comprehensive manual is available and the software has some validation features.
7	Data Collection Frequency	Quarterly
8	Tracer Conditions	STEMI = ICD 10 I21.0 – I21.3 (Interpreted from medical record by Heartbeat coillators)
9	Minimum Data Set	As set out in e-Heartebat Manual In essence to enable reporting on this KPI we need: Was patient a STEMI (or LBBB)? Did patient get reperfusion therapy? Di patient get PPCI ? What was date/time of FMC? What was date/time of first hospital door? What was date/time of PPCI?
10	International Comparison	MINAP (UK) and European Society of Cardiology ACS/STEMI Guideline 2012
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ❑Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Rolling 12 months (previous 12 month period) reported a quarter in arrears e.g. 1 July 2014 to 30 June 2015 and reported a quarter in arrears i.e. Oct 2015
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑Regional ☑Hospital Group ☑Hospital (PPCI/PCI centres) ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports ?	☑ Performance Report (NSP) ❑CompStat ☑Other – give details:DOP+C103+A44
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
National Lead and Directorate		Brendan Cavanagh (ACS Programme Manager) email: Brendan.Cavanagh@hse.ie Prof Kieran Daly

	Acute Services - Surgery	
1	**KPI Title**	Percentage of elective surgical inpatients who had principal procedure conducted on day of admission
2	**KPI Description CPA27**	The percentage of inpatients having elective surgical procedures on the day of admission over the total number of all elective surgical inpatients who have surgery, will increase by a target of PLUS 5% to 10% within hospitals from end 2014 baseline (towards a maximum of 85%). Hospitals with a baseline above 70% will have a plus 5% increase, hospitals with a baseline below 60% will have a 10% increase and hospitals will have an increase of between 10% and 5% linearly adjusted for the baselines position in the range 60 to 70%, e.g.if baseline 40% target would be 50%, baseline 64% target 72%, baseline 82% target 85%, baseline 87% target 87%.See attached for further definitions. The baseline will be the higher of the hospitals 2014 target DoSA or the hospitals actual annual DoSA for 2014.
3	**KPI Rationale**	This indicator allows for measurement of the effect of improved pre-admission assessment services which facilitate day of surgery admission. The enhancement of pre-admission assessment is a key theme of the Surgery and Anaesthesia programmes' models of care as this service allows for the reduction in pre-operative bed usage, allows for optimising patients' conditions before admission and helps to avoid cancellation of operations.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two).
		☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016 Target will be set for each hospital and the target for hospital groups will be a volume weighted target based on the targets for the individual hospitals in that group. The individual hospital targets will be the higher of an increase of between PLUS 5% to 10% be set based on the 12 month rolling average at Sept 2015 annualised DOSA rate for hospital or the 2015 target for hospitals that are to far from their 2015 target to make a further improvement (towards a maximum of 85%). The increase for each will be determined by their 12 month rolling average at Sept 2015 annualised DOSA rate where Hospitals with a baseline above 70% will have a plus 5% increase, hospitals with a baseline below 60% will have a 10% increase and the remaining hospitals will have an increase of between 10% and 5% linearly adjusted for the baselines position in the range 60 to 70% (formula would be 10% minus half the percentage over 60% in the hospitals metric e.g. a hospital with a 12 month rolling average at Sept 2015 annualised DOSA rate of 64.6% would get a target of 10 – 4.6/2 = 7.7 so the new target would be 72.3% for 2016 DOSA)
5	**KPI Calculation**	**Numerator:** (The number of elective surgical inpatients, in the reporting period, who had their primary surgical procedure on date of admission)*100 **Denominator:** The total number of elective surgical inpatients, in the reporting period, who had a primary surgical procedure.
6	**Data Source**	HIPE Data. Will be dependant on accuracy (particularly rhe coding of primary procedures) and timely completion of Hospital HIPE coding. Coverage includes all acute hospitals except specialist paediatric and maternity hospitals. Surgery Programme mapping tables for surgical procedures and surgical specialities (Appendix I & II).
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	- Discharges with a primary surgical procedure= (Patients who had a Principal procedure in Appendix I **OR** (Patients who had a Specialty in Appendix II **and** had a principal procedure)) - Inpatients only (ie. stay in hospital one or more nights) - Elective discharges have an admission type =1 or 2 - Surgical procedure on date of admission = (date of admission=date of principal procedure) (Procedure classification ICD-10-AM/ACHI/ACS)
9	**Minimum Data Set**	HIPE- Admission Date, Discharge Date, Admission Type, Specialty, Primary Procedure, Date of primary procedure
10	**International Comparison**	Collected in UK and internationally, often referred to as DOA or Day of Admission rate.
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible for monitoring this KPI:Hospital Groups, Hospitals, Surgery and Anaesthesia Programmes, ISD
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	❑Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June discharges in August) ❑Quarterly in arrears (quarter 1 data reported in quarter 3) ❑Rolling 12 months (previous 12 month period) ❑Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ☑ Other – give details: hospital groups as appropriate
15	**KPI is reported in which reports ?**	☑ Performance Assurance Report (NSP) ☑CompStat ☑Other – give details: SDU/ Surgery Programme/ Anaesthesia Programme reports.
16	**Web link to data**	N/A
17	**Additional Information**	Notes for calculation of DOSA rate: Number of elective inpatients who have their primary procedure on date of admission includes All elective inpatient's who have one of the 1,011 commonly performed surgical procedures (**Appendix I**)as their primary procedure on the date of admission plus All elective inpatient who were surgically admitted (had a specialty from **Appendix II**), did not have one of the 1,011 commonly performed surgical procedures as their primary procedure but had their primary procedure on day of admission. Total number of elective inpatients who have their primary surgical procedure includes All elective inpatient's who have one of the 1,011 commonly performed surgical procedures **(Appendix I)**as their primary procedure plus All elective inpatient who were surgically admitted (had a specialty from **Appendix II**) and did not have one of the 1,011 commonly performed surgical procedures as their primary procedure.KPI noted in National Service Plan 2016
Contact details for Data Manager / Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Gerry Kelliher National Clinical Programme in Surgery gerrykelliher@rcsi.ie W: www.rcsi.ie T: 01-402-2143 M: 087-124-0759
National Lead and Directorate		Prof. Frank Keane, Ken Mealy joint leads for National Clinical Programme in Surgery: fkeane@rcsi.ie, kmealy@rcsi.ie; Colm Henry: National clinical lead for Acute Hospital directorate: ncagl.acutehospitals@hse.ie

Acute Services - Surgery		
1	**KPI title**	Percentage day case rate for Elective Laparoscopic Cholecystectomy
2	**KPI Description CPA28**	The percentage day case rate of Elective Laparoscopic Cholecystectomy should be at least 60%
3	**KPI Rationale**	It is better for the patient and a more efficient use of limited hospital resources to perform appropriate procedures as day cases on suitable patients, instead of keeping the patient unnecessarily in hospital for one of more nights. Elective Laparoscopic Cholecystectomy is a good example of surgical procedures which can be performed safely and effectively as a day case.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2014 Target: > 50% ; Target will be increased for NSP 2015 and beyond to > 60%
5	**KPI Calculation**	**Numerator:** (The number of elective daycase discharges, in the reporting period, who had a Laparoscopic Cholecystectomy performed as a primary procedure)*100 **Denominator:** All elective discharges (inpatient and daycase), in the reporting period, who had a Laparoscopic Cholecystectomy performed as a primary procedure.
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Data. Will be dependant on accuracy (particularly the coding of primary procedures) and timely completion of Hospital HIPE coding. Coverage includes all acute hospitals except specialist paediatric and maternity hospitals.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Primary Procedure = 3044500 (ICD-10-AM/ACHI/ACS **30445-00 Laparoscopic cholecystectomy**) For the numerator elective discharges have an admission type =1 or 2
9	**Minimum Data Set**	HIPE- Admission Date, Discharge Date, Admission Type, Specialty, Primary Procedure
10	**International Comparison**	Collected in UK and internationally.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Groups, Hospitals, Surgery Programme
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ☐ Institution ☐ Other – give details: hospital groups as appropriate
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	N/A
17	**Additional Information**	Note: Day case rates should be assessed at individual hospital and hospital group level. Some hospital groups choose to conduct elective day case surgical activity at a specialist model 2 hospital for lower risk patients (eg. ASA of 1 or 2) and send higher risk patients to a larger model 3 or 4 hospital to mitigate risk of complications during day case surgery posed by patients with higher risk (eg. ASA 3 or higher). Appropriately qualified Surgical and Anaesthetic personnel will select patients for model 2 day case activity and model 3 / 4 day case activity in a pre-admission assessment process.KPI noted in National Service Plan 2016
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National Lead and Division		Prof. Frank Keane, Ken Mealy joint leads for National Clinical Programme in Surgery: fkeane@rcsi.ie, kmealy@rcsi.ie; Colm Henry: National clinical lead for Acute Hospital directorate: ncagl.acutehospitals@hse.ie

Acute Services - Surgery		
1	KPI Title	Reduction in bed day utilisation by acute surgical admissions who do not have an operation
2	KPI Description CPA29	Achieve a 5% reduction in the relative bed days used (BDU) for acute surgical discharges from hospital that do not have a surgical primary procedure from the 2014 actual results as a baseline and individualised for each hospital. Note: Will exclude hospitals that do not admit acute surgical inpateints. Note Percentage is of the total BDU by acute inpatients for all surgery discharges in the period being reports.
3	KPI Rationale	There is significant potential for improvement in bed day utilisation by inpatients admitted by surgical consultants who subsequently do not have a surgical primary procedure. There is a patient care requirement and clinical need to admit patients, perform observations and test which subsequently result in a decision not to perform a surgical primary procedure. However an analysis of the data from 2010 to 2013 shows a significant variation across hospitals and across case mix groupings and indicates there is room for improvement in BDU's by this cohort of patients. An improvement in the number of bed days used by acute surgical discharges who did not have surgery during their stay in hospital allows for better use of bed day resources and improved access for patients awaiting surgical care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	NSP 2016 Target: Achieve a 5% reduction in the relative BDU by Acute surgical discharges who did not have a surgical primary procedure as a percentage of all BDU for acute surgical discharges. The 2016 Target will be set based on 2014 annual figure. Note: In future years the target will be reset to support further improvement. For example: In hospital X, 45.0% of Acute inpateint surgical bed days used were for patients who did not have a surgical primary procedure in 2014 so the 2016 target will be 42.75%.
5	KPI Calculation	Numerator: Total surgical inpatient beddays for emergency patients in the period who did not have surgery Denominator: Total surgical inpatient beddays for emergency patients for those in same period
6	Data Source Data Completeness Data Quality Issues	HIPE Data. Will be dependant on accuracy (particularly the coding of primary procedures) and timely completion of Hospital HIPE coding. Coverage includes all acute hospitals with emergency departments and excludes specialist paediatric, specialist maternity and specialist elective surgery (no acute surgery inpatient activity) hosptials. A list of hospitals to be included will be provided by the National Clinical Programme in Surgery.
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	- Sum of the LOS for Surgical inPatient who did not have surgery (numerator) -Patients who had a Specialty in Appendix II AND [had NO principal procedure or had a procedure from Appendix III] - Sum of the LOS for Surgical patient (denominator)- Discharges with a primary surgical procedure= (Patients who had a Principal procedure in Appendix I OR (Patients who had a Specialty in Appendix II AND [had NO principal procedure or had a procedure from Appendix III]) - Inpatients Only (ie who stay at least one night in hospital exclude sameday) - Emergency discharges have an admission type =4 and 5 (Procedure classification ICD-10-AM/ACHI/ACS)
9	Minimum Data Set	HIPE- Admission Date, Discharge Date, Admission Type, Specialty, Primary Procedure, Alos
10	International Comparison	Bed day utilisation is collected and assessed in UK and internationally.
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible for monitoring this KPI:Hospital Groups, Hospitals, Surgery and Anaesthesia Programmes, ISD
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	❑Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June discharges in August) ❑Quarterly in arrears (quarter 1 data reported in quarter 3) ❑Rolling 12 months (previous 12 month period) ❑Other – give details:
14	KPI Reporting Aggregation	☑ National ☑ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑Institution ☐ Other – give details: hospital groups as appropriate
15	KPI is reported in which reports ?	❑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	Web link to data	N/A
17	Additional Information	KPI noted in Divisional Operational Plan 2016
Contact details for Data Manager / Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Gerry Kelliher National Clinical Programme in Surgery gerrykelliher@rcsi.ie W: www.rcsi.ie T: 01-402-2143 M: 087-124-0759
National Lead and Directorate		Prof. Frank Keane, Ken Mealy joint leads for National Clinical Programme in Surgery: fkeane@rcsi.ie, kmealy@rcsi.ie; Colm Henry: National clinical lead for Acute Hospital directorate: ncagl.acutehospitals@hse.ie

Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
3030000	Sentinel lymph node biopsy	BREAST
3033200	Excision of lymph node of axilla	BREAST
3033500	Regional excision lymph nodes of axilla	BREAST
3033600	Radical excision of lymph nodes, axilla	BREAST
3150000	Excision of lesion of breast	BREAST
3150001	Open biopsy of breast	BREAST
3151500	Re-excision of lesion of breast	BREAST
3151800	Simple mastectomy, unilateral	BREAST
3151801	Simple mastectomy, bilateral	BREAST
3152400	Subcutaneous mastectomy, unilateral	BREAST
3152401	Subcutaneous mastectomy, bilateral	BREAST
3153600	Localisation of lesion of breast	BREAST
3154800	Core biopsy of breast	BREAST
3155400	Microdochotomy of breast	BREAST
3155700	Excision of duct (central) of breast	BREAST
4552201	Reduction mammoplasty, bilateral	BREAST
4553000	Recon breast using myocutaneous flap	BREAST
4554200	R/O breast tis expand & ins perm prosth	BREAST
4554500	Reconstruction of nipple	BREAST
4554600	Intraderm colour skin for nipple/areola	BREAST
4554800	Removal of breast prosthesis	BREAST
4554802	Adjustment of breast tissue expander	BREAST
4555200	R/O & replace breast prosth w exc capsl	BREAST
4556601	Injection into tissue expander	BREAST
3310300	Replace thoraco-aortic aneurysm w graft	CARDTO
3841800	Exploratory thoracotomy	CARDTO
3842100	Endoscopic pulmonary decortication	CARDTO
3842101	Pulmonary decortication	CARDTO
3842400	Pleurectomy	CARDTO
3842402	Pleurodesis	CARDTO
3843600	Thoracoscopy	CARDTO
3843800	Segmental resection of lung	CARDTO
3843801	Lobectomy of lung	CARDTO
3844000	Wedge resection of lung	CARDTO
3844001	Radical wedge resection of lung	CARDTO
3844100	Radical lobectomy	CARDTO
3844101	Radical pneumonectomy	CARDTO
3844801	Mediastinoscopy	CARDTO
3846400	Debridement of sternotomy wound	CARDTO
3847700	Mitral valve annuloplasty w ring ins	CARDTO
3848800	Replace aortic valve w mech prosthesis	CARDTO
3848801	Replace aortic valve w bioprosthesis	CARDTO
3848802	Replace mitral valve w mech prosthesis	CARDTO
3848803	Replacement of mitral valve w bioprosth	CARDTO
3849700	Coron art byps using 1 saph vein graft	CARDTO
3849701	Coron art byps using 2 saph vein grafts	CARDTO
3849702	Coron art byps using 3 saph vein grafts	CARDTO
3849703	Coron art byps usg >= 4 saph vein grafts	CARDTO
3850000	Coronary artery bypass, using 1 LIMA gft	CARDTO
3850300	Coronary artery bypass, >= 2 LIMA gft	CARDTO
3855900	Repair aortic arch & asc thoracic aorta	CARDTO
3860000	Cardiopulmonary bypass, central cannuln	CARDTO
3870001	Closure of patent ductus arteriosus	CARDTO
3874202	Closure of atrial septal defect	CARDTO
3875102	Closure of ventricular septal defect	CARDTO
3875700	Creat extrcardc cndt R ventrl & pulm art	CARDTO
9017100	Endoscopic pleurodesis	CARDTO

3007101	Rectal suction biopsy	COLORC
3007534	Biopsy of anus	COLORC
3037523	Endosc exam large intestine v laparotomy	COLORC
3037528	Temporary colostomy	COLORC
3037529	Temporary ileostomy	COLORC
3056200	Closure of loop ileostomy	COLORC
3056201	Cls ileostomy w restor conty wo resect	COLORC
3056301	Revision of stoma of large intestine	COLORC
3200000	Limited exc lrg intestine w stoma frm	COLORC
3200001	Right hemicolectomy w stoma formation	COLORC
3200300	Limited excision lrg intestine w anstms	COLORC
3200301	Right hemicolectomy with anastomosis	COLORC
3200400	Subtotal colectomy w stoma formation	COLORC
3200500	Subtotal colectomy w anstms	COLORC
3200501	Extended right hemicolectomy w anstms	COLORC
3200600	Left hemicolectomy with anastomosis	COLORC
3200601	Left hemicolectomy w stoma formation	COLORC
3200900	Total colectomy with ileostomy	COLORC
3201200	Total colectomy w ileorectal anastomosis	COLORC
3201500	Total proctocolectomy with ileostomy	COLORC
3202400	High anterior resection rectum	COLORC
3202500	Low anterior resection rectum	COLORC
3202600	U/l anterior resection rectum	COLORC
3202800	U/l ant resec rectum w hand sut anstms	COLORC
3203000	Rectosigmoidectomy w stoma formation	COLORC
3203300	Restor continuity after Hartmann's proc	COLORC
3203900	Abdominoperineal proctectomy	COLORC
3205101	Tot proctcolecty ileoanal anstms & stoma	COLORC
3206000	Restorative proctectomy	COLORC
3209600	Full thickness biopsy of rectum	COLORC
3209900	Per anal submucosal exc, lsn/tis rectum	COLORC
3210300	Per anal exc lsn rect via strscp rtscp	COLORC
3211100	Reduction rectal mucosa, rectal prolapse	COLORC
3211400	Per anal release of rectal stricture	COLORC
3211700	Abdominal rectopexy	COLORC
3213502	Rubber band ligation of rectal prolapse	COLORC
3213802	Stapled haemorrhoidectomy	COLORC
3215902	Ins seton & exc anal fist inv low sphc	COLORC
3216600	Insertion of anal seton	COLORC
3216601	Adjustment of anal seton	COLORC
3216602	Removal of anal seton	COLORC
3221300	Insertion of sacral nerve electrodes	COLORC
3559700	Laparoscopic sacral colpopexy	COLORC
9029702	Endosc mucosal resec lrg intes	COLORC
9031500	Endoscopic e/o lesion tissue anus	COLORC
9031501	Excision other lesion or tissue anus	COLORC
9033800	Incision of rectum or anus	COLORC
9034100	Other excision of lesion of rectum	COLORC
9095200	Incision of abdominal wall	COLORC
9220800	Anterior resec rectum level unspecified	COLORC
3002300	Excisional debridement of soft tissue	GENERL
3007501	Biopsy of soft tissue	GENERL
3007517	Biopsy of abdominal wall or umbilicus	GENERL
3007537	Biopsy of peritoneum	GENERL
3009400	Perc [needle] biopsy of soft tissue	GENERL
3018600	Removal of plantar wart	GENERL
3019507	Electrotherapy of multiple skin lesions	GENERL
3022300	Incision & drainage of haematoma of SSCT	GENERL
3022301	Incision & drainage of abscess of SSCT	GENERL

3022303	Incision & drain abscess, soft tissue	GENERL
3022400	Perc drainage abscess, soft tissue	GENERL
3029701	Subtot thyrdecty foll prev thyroid surg	GENERL
3030800	Subtotal thyroidectomy, bilateral	GENERL
3031000	Subtotal thyroidectomy, unilateral	GENERL
3031500	Subtotal parathyroidectomy	GENERL
3031501	Total parathyroidectomy	GENERL
3037300	Exploratory laparotomy	GENERL
3037504	Other colostomy	GENERL
3037505	Cholecystostomy	GENERL
3037507	Gastrostomy	GENERL
3037509	Excision of Meckel's diverticulum	GENERL
3037510	Suture of perforated ulcer	GENERL
3037519	Other repair of small intestine	GENERL
3037800	Division of abdominal adhesions	GENERL
3038400	Staging laparotomy for lymphoma	GENERL
3039000	Laparoscopy	GENERL
3039200	Debulking of intra-abdominal lesion	GENERL
3039300	Laparoscopic division abdo adhesions	GENERL
3039400	Drain intrabdo abscess haematoma cyst	GENERL
3039600	Debridement & lavage peritoneal cavity	GENERL
3040300	Repair of incisional hernia	GENERL
3040301	Repair of other abdominal wall hernia	GENERL
3040303	Reclosure postop disruption abdo wall	GENERL
3040501	Repair incisional hernia with prosthesis	GENERL
3040504	Repair other abdo wall hernia w prosth	GENERL
3041200	Intraoperative needle biopsy of liver	GENERL
3043902	Intraoperative u/s of biliary tract	GENERL
3044300	Cholecystectomy	GENERL
3044500	Laparoscopic cholecystectomy	GENERL
3044600	Lap cholecystectomy proceed open chole	GENERL
3044800	Lap chole R/O CBD calculus v cystic duct	GENERL
3044900	Lap chole R/O CBD calculus lap choledhty	GENERL
3045401	Cholecystectomy with choledochotomy	GENERL
3047900	Endoscopic laser therapy to oesophagus	GENERL
3056202	Closure of loop colostomy	GENERL
3056203	Cls colostomy w restor continuity	GENERL
3056300	Revision of stoma of small intestine	GENERL
3056302	Repair of parastomal hernia	GENERL
3056500	Resec small intestine w formation stoma	GENERL
3056600	Resec small intestine w anastomosis	GENERL
3057100	Appendicectomy	GENERL
3057200	Laparoscopic appendicectomy	GENERL
3059700	Splenectomy	GENERL
3060100	Repair diaphragmatic hernia, abdo appr	GENERL
3060900	Lap repair of femoral hernia, unilateral	GENERL
3060902	Lap repair inguinal hernia, unilateral	GENERL
3060903	Lap repair inguinal hernia, bilateral	GENERL
3061400	Repair of femoral hernia, unilateral	GENERL
3061402	Repair of inguinal hernia, unilateral	GENERL
3061403	Repair of inguinal hernia, bilateral	GENERL
3061500	Rep incarcerated obstr or strangd hernia	GENERL
3061700	Repair of umbilical hernia	GENERL
3061701	Repair of epigastric hernia	GENERL
3064401	Exploration of spermatic cord	GENERL
3067600	Incision of pilonidal sinus or cyst	GENERL
3067601	Excision of pilonidal sinus or cyst	GENERL
3120500	Exc lesion(s) of SSCT, other site	GENERL
3123005	Excision lesion(s) SSCT, genitals	GENERL

3123501	Excision lesion(s) of SSCT, neck	GENERL
3123503	Excision of lesion(s) SSCT, leg	GENERL
3135000	Excision of lesion of soft tissue, NEC	GENERL
3146200	Insertion of feeding jejunostomy tube	GENERL
3147000	Laparoscopic splenectomy	GENERL
3155100	Incision and drainage of breast	GENERL
3156600	Excision of accessory nipple	GENERL
3208402	Colonosc to heptc flexure w tattooing	GENERL
3213800	Haemorrhoidectomy	GENERL
3214200	Excision of anal skin tag	GENERL
3214201	Excision of anal polyp	GENERL
3214700	Incision of perianal thrombus	GENERL
3215300	Dilation of anus	GENERL
3217400	Drainage of intra-anal abscess	GENERL
3217401	Drainage of perianal abscess	GENERL
3217402	Drainage of ischiorectal abscess	GENERL
3217700	Removal of anal wart	GENERL
3572601	Staging laparotomy	GENERL
3650001	Total adrenalectomy, unilateral	GENERL
3743800	Partial excision of scrotum	GENERL
3760401	Exploration scrotal contents, bilateral	GENERL
3761300	Epididymectomy, unilateral	GENERL
3762303	Vasectomy, bilateral	GENERL
3783000	Hypospadias, staged repair, second stage	GENERL
4380100	Correction of malrotation of intestine	GENERL
4652800	Wedge resection of ingrown fingernail	GENERL
4790600	Debridement of toenail	GENERL
4791500	Wedge resection of ingrown toenail	GENERL
4791600	Partial resection of ingrown toenail	GENERL
4791800	Radical excision of ingrown toenail bed	GENERL
6137300	Gastro-oesophageal reflux study	GENERL
9028200	Excision of lymph node of other site	GENERL
9033100	Oth proc abdomen, peritoneum or omentum	GENERL
9040101	Other procedures on testis	GENERL
9207600	Removal of impacted faeces	GENERL
9209000	R/O FB from rectum or anus wo incision	GENERL
9220100	Removal of foreign body wo incision NEC	GENERL
9732308	Surg R/O ? teeth w R/O bone	GENERL
3550701	Destruction of vulval wart	GYNEAC
3550900	Hymenectomy	GYNEAC
3551300	Treatment of Bartholin's gland cyst	GYNEAC
3551800	Aspiration of ovarian cyst	GYNEAC
3552000	Treatment Bartholin's gland abscess	GYNEAC
3553300	Vulvoplasty	GYNEAC
3553600	Hemivulvectomy	GYNEAC
3553900	Laser destruction of lesion of vulva	GYNEAC
3553903	Biopsy of vagina	GYNEAC
3554800	Radical vulvectomy	GYNEAC
3555700	Excision of lesion of vagina	GYNEAC
3556600	Excision of vaginal septum	GYNEAC
3556800	Sacrospinous colpopexy	GYNEAC
3556900	Enlargement of vaginal orifice	GYNEAC
3557000	Repair of ant vag compt, vag appr	GYNEAC
3557100	Repair of post vag compt, vag appr	GYNEAC
3557300	Repair of ant & post vag compt, vag appr	GYNEAC
3557700	Repair of pelvic floor prolapse	GYNEAC
3559501	Abdominal pelvic floor repair	GYNEAC
3559900	Sling procedure for stress incontinence	GYNEAC
3559901	Revision sling proc, stress incontinence	GYNEAC

3560802	Biopsy of cervix	GYNEAC
3561100	Cervical polypectomy	GYNEAC
3561400	Colposcopy	GYNEAC
3561500	Biopsy of vulva	GYNEAC
3561800	Cone biopsy of cervix	GYNEAC
3562200	Endoscopic endometrial ablation	GYNEAC
3562300	Myomectomy of uterus via hysteroscopy	GYNEAC
3563000	Diagnostic hysteroscopy	GYNEAC
3563300	Division of intrauterine adhesions	GYNEAC
3563301	Polypectomy of uterus via hysteroscopy	GYNEAC
3563400	Division uterine septum, hysteroscopy	GYNEAC
3563702	Lap diathermy of lesion of pelvic cavity	GYNEAC
3563706	Biopsy of ovary	GYNEAC
3563707	Lap rupture ovarian cyst or abscess	GYNEAC
3563708	Laparoscopic ovarian drilling	GYNEAC
3563802	Laparoscopic oophorectomy, unilateral	GYNEAC
3563803	Laparoscopic oophorectomy, bilateral	GYNEAC
3563804	Laparoscopic ovarian cystectomy, uni	GYNEAC
3563805	Laparoscopic ovarian cystectomy, bil	GYNEAC
3563807	Laparoscopic partial salpingectomy, uni	GYNEAC
3563809	Laparoscopic salpingectomy, unilateral	GYNEAC
3563810	Laparoscopic salpingectomy, bilateral	GYNEAC
3563811	Laparoscopic salpingo-oophorectomy, uni	GYNEAC
3563812	Laparoscopic salpingo-oophorectomy, bil	GYNEAC
3564000	Dilation & curettage of uterus [D&C]	GYNEAC
3564001	Curettage of uterus without dilation	GYNEAC
3564700	Large loop excision transformation zone	GYNEAC
3564901	Myomectomy of uterus via laparoscopy	GYNEAC
3564903	Myomectomy of uterus	GYNEAC
3565300	Subtotal abdominal hysterectomy	GYNEAC
3565301	Total abdominal hysterectomy	GYNEAC
3565304	Abdo hystrectmy w R/O adnexa	GYNEAC
3565700	Vaginal hysterectomy	GYNEAC
3566400	Rad abdo hystrectmy rad exc pelv lymph n	GYNEAC
3567000	Abdo hystrectmy rad exc pelv lymph nodes	GYNEAC
3567302	Vagl hystrectomy w R/O adnexa	GYNEAC
3568800	Laparoscopic sterilisation	GYNEAC
3568801	Sterilisation via vaginal approach	GYNEAC
3569402	Laparoscopic salpingolysis	GYNEAC
3571304	Ovarian cystectomy, unilateral	GYNEAC
3571307	Oophorectomy, unilateral	GYNEAC
3571311	Salpingo-oophorectomy, unilateral	GYNEAC
3571314	Excision of lesion of pelvic cavity	GYNEAC
3571700	Ovarian cystectomy, bilateral	GYNEAC
3571701	Oophorectomy, bilateral	GYNEAC
3571704	Salpingo-oophorectomy, bilateral	GYNEAC
3572000	Debulking of lesion of pelvic cavity	GYNEAC
3572300	Lap pelv/abdo lymph sampling gyn malg	GYNEAC
3575000	Lap assisted vaginal hysterectomy	GYNEAC
3575302	Lap asst vag hystrectmy w R/O adnexa	GYNEAC
9043800	Other procedures on vagina	GYNEAC
9044000	Excision of lesion of vulva	GYNEAC
9044600	Other incision of vulva or perineum	GYNEAC
9044801	Total laparoscopic abdo hysterectomy	GYNEAC
9044802	Tot lap abdo hystrectmy w R/O adnexa	GYNEAC
9044900	Other repair of vagina	GYNEAC
9210400	Vaginal packing	GYNEAC
9210700	Insertion of other vaginal pessary	GYNEAC
9211400	Removal of other vaginal pessary	GYNEAC

4188100	Open tracheostomy, temporary	MXFDNT
4559000	Reconstruction of orbital cavity	MXFDNT
4572600	Osteotomy of mandible, bilateral	MXFDNT
4572601	Osteotomy of maxilla, bilateral	MXFDNT
4572900	Osteotomy mandible with IF, bilateral	MXFDNT
4572901	Osteotomy maxilla with IF, bilateral	MXFDNT
4586500	Arthrocentesis TMJ	MXFDNT
4776200	Open rdctn fx zygomatic bone	MXFDNT
4776500	Open rdctn fx zyg bone w ex fix, 1	MXFDNT
4776501	Open rdctn fx zyg bone w IF, 1 site	MXFDNT
4776801	Open rdctn fx zyg bone w IF, 2 sites	MXFDNT
4777700	Open reduction of fracture of mandible	MXFDNT
4778900	Open rdctn fx mandible w IF	MXFDNT
5210200	R/O pin/screw/wire maxilla/mandible/zygo	MXFDNT
9053002	Closed rdctn fx facial bone, NEC	MXFDNT
9621500	Incision & drain of lesion in orl cavity	MXFDNT
9724100	Tooth root resection, per root	MXFDNT
9731102	Removal of 2 teeth or part(s) thereof	MXFDNT
9731103	Removal of 3 teeth or part(s) thereof	MXFDNT
9731104	Removal of 4 teeth or part(s) thereof	MXFDNT
9731107	R/O >= 15 teeth or part(s) thereof	MXFDNT
9732201	Full dental clearance	MXFDNT
9732204	Surg R/O 4 teeth wo R/O bone / div	MXFDNT
9732205	Surg R/O 5 - 9 teeth wo R/O bone / div	MXFDNT
9732206	Surg R/O 10 - 14 teeth wo R/O bone / div	MXFDNT
9732208	Surg R/O ? teeth wo R/O bone / div	MXFDNT
9732301	Surg R/O 1 tooth w R/O bone	MXFDNT
9732302	Surg R/O 2 teeth w R/O bone	MXFDNT
9732303	Surg R/O 3 teeth w R/O bone	MXFDNT
9732304	Surg R/O 4 teeth w R/O bone	MXFDNT
9732305	Surg R/O 5 - 9 teeth w R/O bone	MXFDNT
9738100	Surg exp unerupted tooth w stimtn & pack	MXFDNT
9738200	Surg exp unerptd tooth w orthdntc tractn	MXFDNT
9757600	Stainless steel crown	MXFDNT
3901502	Ins ICP monitoring device w monitoring	NEUROS
3960000	Drainage of intracranial haemorrhage	NEUROS
3960301	Removal intrcran haematoma w crniectmy	NEUROS
3970300	Biopsy of brain via burr holes	NEUROS
3970600	Bx of brain via osteoplastic craniotomy	NEUROS
3970900	Removal of lesion of cerebrum	NEUROS
3970902	Removal of lesion of cerebellum	NEUROS
3971200	Removal of lesion of cerebral meninges	NEUROS
3971204	Removal of other intracranial lesion	NEUROS
3971501	Prt exc pituitary gland, trnsphndl appr	NEUROS
3972100	Postop reopn of crniotmy/crniectmy site	NEUROS
3980000	Clipping of cerebral aneurysm	NEUROS
3990000	Drainage of intracranial infection	NEUROS
4000302	Insertion of ventriculoperitoneal shunt	NEUROS
4000900	Revision of ventricular shunt	NEUROS
4000903	Removal of ventricular shunt	NEUROS
4001200	Endoscopic third ventriculostomy	NEUROS
4010300	Repair of myelomeningocele	NEUROS
4010600	Hind brain decompression	NEUROS
4030000	Discectomy, 1 level	NEUROS
4030300	Discectomy for rec disc lesion, l lvl	NEUROS
4030900	Removal of spinal extradural lesion	NEUROS
4031200	Removal of spinal intradural lesion	NEUROS
4033100	Decomp of cervical spinal cord, 1 level	NEUROS
4033200	Decomp cerv spin cord w ant fusion 1 lvl	NEUROS

4033300	Cervical discectomy, 1 level	NEUROS
4033400	Decomp cervical spinal cord >=2 levels	NEUROS
4035100	Ant decomp thoracolumbar spinal cord	NEUROS
4060003	Other cranioplasty	NEUROS
4070302	Partial lobectomy of brain	NEUROS
4157500	R/O lesion of cerebellopontine angle	NEUROS
6141300	Cerebrospinal fluid shunt patency study	NEUROS
9000702	Other proc on brain & cerebral meninges	NEUROS
9003300	Endovas occl cerebral aneur / AV malform	NEUROS
9033000	Revision CSF shunt at peritoneal site	NEUROS
1651100	Insertion of cervical suture	OBSTET
1652000	Elective classical caesarean section	OBSTET
1652001	Emergency classical caesarean section	OBSTET
1652002	Elective lower segment caesarean section	OBSTET
1652003	Emergency lower segment caesarean sect	OBSTET
1656400	Postpartum evacuation of uterus by D&C	OBSTET
1656401	Postpartum evac uterus suction curettage	OBSTET
1657300	Sut third / fourth deg tear of perineum	OBSTET
3564003	Suction curettage of uterus	OBSTET
3564303	Dilation and evacuation of uterus [D&E]	OBSTET
3567703	Fetotoxic management R/O ectopic preg	OBSTET
3567705	Salpingectomy w removal tubal pregnancy	OBSTET
3567800	Lap salpingotomy w R/O tubal pregnancy	OBSTET
3567801	Lap salpingectomy w R/O tubal pregnancy	OBSTET
9046502	Other medical induction of labour	OBSTET
9046505	Medical and surgical induction of labour	OBSTET
9046600	Med augment after onset labour	OBSTET
9046900	Vacuum extraction	OBSTET
9047200	Episiotomy	OBSTET
9047900	Suture current obst laceration of vagina	OBSTET
9048000	Sut obst lacr bladder/urethra wo perinl	OBSTET
9048100	Suture 1st/2nd degree tear of perineum	OBSTET
9048200	Manual removal of placenta	OBSTET
3005201	Repair of wound of eyelid	OPHTHA
3006102	Removal superficial FB from cornea	OPHTHA
3007102	Biopsy of eyelid	OPHTHA
3018900	Removal of molluscum contagiosum	OPHTHA
3123000	Exc of lesion(s) SSCT, eyelid	OPHTHA
4250300	Ophthalmological examination	OPHTHA
4250900	Enucleation eyeball w integrated implant	OPHTHA
4251500	Evisceration of eyeball w ins implant	OPHTHA
4252700	Revision of anophthalmic socket	OPHTHA
4253301	Exploratory orbitotomy with biopsy	OPHTHA
4255100	Rep perf eyeball wound w sut cornea lacr	OPHTHA
4255101	Rep perf eyeball wound w sut sclera lacr	OPHTHA
4257500	Excision of cyst of tarsal plate	OPHTHA
4258100	Cauterisation of ectropion	OPHTHA
4258400	Tarsorrhaphy	OPHTHA
4260800	Ins oth nasolacrm tube lacm/conjnct sac	OPHTHA
4261401	Probing lacrimal passages, unilateral	OPHTHA
4261501	Probing of lacrimal passages, bilateral	OPHTHA
4261700	Incision of lacrimal punctum	OPHTHA
4262200	Occlusion lacm punctum by cautery	OPHTHA
4265000	Epithelial debridement of cornea	OPHTHA
4265300	Full thickness transplantation of cornea	OPHTHA
4265601	Reoperation keratoplasty, second proc	OPHTHA
4266800	Removal of corneal sutures	OPHTHA
4267600	Biopsy of conjunctiva	OPHTHA
4268300	Excision lesion or tissue of conjunctiva	OPHTHA

4269805	Other extraction of crystalline lens	OPHTHA
4270100	Insertion of foldable artificial lens	OPHTHA
4270101	Insertion of other artificial lens	OPHTHA
4270204	Phacoem & aspr cataract w IOL foldable	OPHTHA
4270205	Phacoem & aspr cataract w IOL other	OPHTHA
4270209	Oth extracapsular lens extr w IOL, other	OPHTHA
4270210	Other extraction lens with IOL, foldable	OPHTHA
4270401	Repositioning of artificial lens	OPHTHA
4270700	Replacement of artificial lens	OPHTHA
4271901	Removal of vitreous, anterior approach	OPHTHA
4272201	R/O vitreous w division of vitreal bands	OPHTHA
4272500	R/O vitr & preretnl memb w div vitrl bnd	OPHTHA
4273100	Capsulectmy lens by sclerotmy w R/O vitr	OPHTHA
4273400	Capsulotomy of lens	OPHTHA
4274003	Admin therapeutic agt in post chamber	OPHTHA
4274300	Irrigation of anterior chamber	OPHTHA
4274604	Trabeculectomy	OPHTHA
4274605	Other filtering proc for glaucoma NEC	OPHTHA
4274900	Revision of scleral fistulisation proc	OPHTHA
4275200	Insertion of aqueous shunt for glaucoma	OPHTHA
4277301	Repair retinal detachment by cryotherapy	OPHTHA
4277600	Repair retinal detach w scleral buckling	OPHTHA
4280900	Destruction retina by photocoagulation	OPHTHA
4281200	R/O surg impl material, post segment eye	OPHTHA
4281800	Cryotherapy of retina w external probe	OPHTHA
4283300	Strabismus proc inv 1 or 2 muscles 1 eye	OPHTHA
4283301	Strabismus proc inv 1 or 2 musc, 2 eyes	OPHTHA
4283302	Reop strabms 1 / 2 musc 1 eye 2nd proc	OPHTHA
4285700	Resut op wound foll prev intraocul proc	OPHTHA
4286600	Rep ect/entropion by rep infer retrac	OPHTHA
4286601	Rep ect/entropion oth rep infer retrac	OPHTHA
4545100	Full thickness skin graft of eyelid	OPHTHA
4561400	Reconstruction of eyelid	OPHTHA
4561401	Tarsal strip procedure	OPHTHA
4561700	Reduction of upper eyelid	OPHTHA
4562301	Cor ptosis frtalis musc tech w fasc slg	OPHTHA
4562302	Cor ptosis resec / advance levator musc	OPHTHA
4562303	Cor ptosis by oth levator muscle tech	OPHTHA
4562305	Correction of ptosis by other techniques	OPHTHA
4562601	Cor ectropion/entropion w wedge resect	OPHTHA
4566501	Full thickness wedge excision of eyelid	OPHTHA
4567101	Reconstruction eyelid, flap sgl/1st stg	OPHTHA
4567401	Recon eyelid usg flap, second stg	OPHTHA
9006100	Other procedures on eyeball	OPHTHA
9006400	Other keratoplasty	OPHTHA
9006600	Other repair of cornea	OPHTHA
9006700	Other procedures on cornea	OPHTHA
9007500	Other procedures for glaucoma	OPHTHA
9007900	Other repair of retinal detachment	OPHTHA
9008400	Incision of eyelid	OPHTHA
1823300	Spinal blood patch	OTOLAR
3007500	Biopsy of lymph node	OTOLAR
3007525	Biopsy of tonsils and adenoids	OTOLAR
3007526	Pharyngeal biopsy	OTOLAR
3010400	Excision of pre-auricular sinus	OTOLAR
3024700	Total excision of parotid gland	OTOLAR
3025300	Partial excision of parotid gland	OTOLAR
3025600	Excision of submandibular gland	OTOLAR
3026602	Removal calculus salivary gland / duct	OTOLAR

3027200	Partial excision of tongue	OTOLAR
3027500	Radical excision of intraoral lesion	OTOLAR
3028600	Excision of branchial cyst	OTOLAR
3029600	Total thyroidectomy, bilateral	OTOLAR
3029700	Tot thyrdecty foll prev thyroid surg	OTOLAR
3030600	Total thyroid lobectomy, unilateral	OTOLAR
3031300	Excision of thyroglossal cyst	OTOLAR
3142300	Excision of lymph node of neck	OTOLAR
3142301	Regional excision of lymph nodes of neck	OTOLAR
3143500	Radical excision of lymph nodes of neck	OTOLAR
3532103	Trnscath embolisation bl vesl, fce & nek	OTOLAR
4150600	Excision of aural polyp, external ear	OTOLAR
4151200	Reconstruction external auditory canal	OTOLAR
4153000	Myringoplasty postaural or endaural appr	OTOLAR
4153300	Atticotomy	OTOLAR
4154200	Myringoplasty w ossicular chain recon	OTOLAR
4154500	Mastoidectomy	OTOLAR
4155100	Mstdecty, intact canal wall w myrgoply	OTOLAR
4155700	Modified radical mastoidectomy	OTOLAR
4156000	Modified rad mastoidectomy w myrgoply	OTOLAR
4156600	Rev intact canal wall tech mastoidectomy	OTOLAR
4156601	Revision modified radical mastoidectomy	OTOLAR
4160800	Stapedectomy	OTOLAR
4161700	Implantation cochlear prosthetic device	OTOLAR
4162600	Myringotomy, unilateral	OTOLAR
4162601	Myringotomy, bilateral	OTOLAR
4162900	Exploration of middle ear	OTOLAR
4163200	Myringotomy w insertion of tube, uni	OTOLAR
4163201	Myringotomy w insertion of tube, bil	OTOLAR
4163500	Excision of lesion of middle ear	OTOLAR
4164400	Excision rim perforated tympanic memb	OTOLAR
4165600	Arrest post nasal haem pack &/cauterise	OTOLAR
4166800	Removal of nasal polyp	OTOLAR
4167102	Septoplasty	OTOLAR
4167103	Septoplasty, submucous resec nasal sept	OTOLAR
4167200	Reconstruction of nasal septum	OTOLAR
4167400	Cauterisation/diathermy nasal turbinates	OTOLAR
4167401	Cauterisation or diathermy nasal septum	OTOLAR
4167700	Arrest ant nasal haem pack/cauterisation	OTOLAR
4168300	Division of nasal adhesions	OTOLAR
4170400	Aspr & lav nasal sinus thru nat ostium	OTOLAR
4171601	Intranasal maxillary antrostomy, uni	OTOLAR
4171602	Intranasal maxillary antrostomy, bil	OTOLAR
4171603	Intranasal R/O polyp, maxillary antrum	OTOLAR
4173702	Ethmoidectomy, unilateral	OTOLAR
4173703	Ethmoidectomy, bilateral	OTOLAR
4173706	Intranasal R/O polyp ethmoidal sinus	OTOLAR
4176400	Nasendoscopy	OTOLAR
4176402	Fibreoptic examination of pharynx	OTOLAR
4178900	Tonsillectomy without adenoidectomy	OTOLAR
4178901	Tonsillectomy with adenoidectomy	OTOLAR
4179700	Arrest haemorrhage following T & A	OTOLAR
4180100	Adenoidectomy without tonsillectomy	OTOLAR
4180700	Incision & drain peritonsillar abscess	OTOLAR
4181001	Uvulectomy	OTOLAR
4182500	Rigid oesophagoscopy w removal FB	OTOLAR
4183400	Total laryngectomy	OTOLAR
4185200	Laryngoscopy with removal of lesion	OTOLAR
4185500	Microlaryngoscopy	OTOLAR

4186400	Microlaryngoscopy w R/O lesion	OTOLAR
4188000	Percutaneous tracheostomy	OTOLAR
4188500	Tracheo-oesophageal fistulisation	OTOLAR
4190400	Bronchoscopy with dilation	OTOLAR
4190700	Insertion of nasal septal button	OTOLAR
4262300	Dacryocystorhinostomy [DCR]	OTOLAR
4520601	Simple and small local skin flap of nose	OTOLAR
4560500	Partial resection of mandible	OTOLAR
4563800	Total rhinoplasty	OTOLAR
4565000	Revision of rhinoplasty	OTOLAR
4579400	OI impl titanium fixture, atchmt BAHA	OTOLAR
4579700	OI, fix trnscut abtmt for atchmt BAHA	OTOLAR
4773800	Closed reduction fx nasal bone	OTOLAR
9011800	Other procedures on inner ear	OTOLAR
9013100	Local excision other intranasal lesion	OTOLAR
9013300	Other procedures on nose	OTOLAR
9013500	Excision of lesion of tongue	OTOLAR
9013800	Excision of lesion of salivary gland	OTOLAR
9014100	Local exc/destruction lesion bony plate	OTOLAR
9014400	Excision lesion of tonsils or adenoids	OTOLAR
9056300	Aspiration of soft tissue, NEC	OTOLAR
9609400	R/O asst/adaptive device/aid/equip	OTOLAR
1331200	Collection blood for dx purpose, neonate	PAEDIA
1421201	Gas reduction of intussusception	PAEDIA
3027800	Lingual fraenectomy	PAEDIA
3065300	Male circumcision	PAEDIA
3557201	Vaginotomy	PAEDIA
3734200	Urethroplasty - single stage procedure	PAEDIA
3743500	Fraenuloplasty of penis	PAEDIA
3760404	Expl scrotal contents fix testis, uni	PAEDIA
3760405	Expl scrotal contents fix testis, bil	PAEDIA
3780300	Orchidopexy for undescended testis, uni	PAEDIA
3780301	Orchidopexy for undescended testis, bil	PAEDIA
3780900	Rev orchidopexy for undscd testis, uni	PAEDIA
3781800	Glanuloplasty for hypospadias	PAEDIA
3782100	Distal hypospadias, single stage repair	PAEDIA
3782700	Hypospadias, staged repair, first stage	PAEDIA
4393000	Pyloromyotomy	PAEDIA
4565900	Correction of bat ear	PAEDIA
9040202	Dorsal or lateral slit of prepuce	PAEDIA
3001701	Exc debride brn < 10% BSA exc / debride	PLASTC
3002600	Repair wound SSCT, oth site superficial	PLASTC
3005203	Repair of wound of nose	PLASTC
3006800	Removal FB in soft tissue NEC	PLASTC
3016500	Lipectomy of abdominal apron	PLASTC
3017700	Lipectomy of abdominal apron, radical	PLASTC
3033000	Radical excision of lymph nodes of groin	PLASTC
3123001	Excision of lesion(s) SSCT, nose	PLASTC
3123002	Excision of lesion(s) SSCT, ear	PLASTC
3123003	Excision of lesion(s) SSCT, lip	PLASTC
3123500	Exc lesion(s) SSCT, oth site of head	PLASTC
3156000	Excision of accessory breast tissue	PLASTC
3930000	Primary repair of nerve	PLASTC
3932100	Transposition of nerve	PLASTC
3932402	R/O lsn from superficial perph nerve	PLASTC
3932702	R/O lsn from deep peripheral nerve	PLASTC
4501802	Fat graft	PLASTC
4520000	Simple & small local skin flap, oth site	PLASTC
4520300	Complicated/large local sk flap any site	PLASTC

4520609	Simp & sm loc sk flp of oth areas of fce	PLASTC
4522400	Small dir distant skin flap second stage	PLASTC
4523900	Revision of local skin flap	PLASTC
4540000	Split skin graft of sm granulating area	PLASTC
4540600	SSG to burn other sites inv < 3% BSA gft	PLASTC
4540900	SSG brn oth sit inv >= 3% & < 6% BSA gft	PLASTC
4543900	Small split skin graft of other site	PLASTC
4551500	Revision scar of other site <= 7 cm	PLASTC
4551501	Release of contracture of SSCT	PLASTC
4551800	Revision scar of other site > 7 cm	PLASTC
4551900	Revision of burn scar/contracture	PLASTC
4552200	Reduction mammoplasty, unilateral	PLASTC
4552800	Augmentation mammoplasty, bilateral	PLASTC
4553900	Recon breast w insertion tissue expander	PLASTC
4555100	R/O breast prosth w exc fibrous capsule	PLASTC
4555500	R/O silicone brst & replace oth prosth	PLASTC
4555600	Mastopexy	PLASTC
4558400	Liposuction	PLASTC
4563200	Rhinoplasty inv correction of cartilage	PLASTC
4565603	Composite graft to other site	PLASTC
4565901	Oth correction of external ear deformity	PLASTC
4566000	Reconstruction of ext ear, first stage	PLASTC
4566500	Full thickness wedge excision of lip	PLASTC
4567700	Primary repair of cleft lip, unilateral	PLASTC
4570700	Primary repair of cleft palate	PLASTC
4571000	Sec rep cleft palate, cls fist usg flap	PLASTC
4571601	Pharyngeal flap	PLASTC
4578502	Frntl advance w tot orbital advance, bil	PLASTC
4578503	Total cranial vault reconstruction	PLASTC
4637200	Palmar fasciectomy Dupuytren's, 1 digit	PLASTC
4642000	Primary repair extensor tendon of hand	PLASTC
4642600	Prim rep flexor tendon hand prx A1 pully	PLASTC
4643200	Prim rep flexor tend hand dstl A1 pully	PLASTC
4645000	Tenolysis of extensor tendon of hand	PLASTC
4646400	Amputation supernumerary digit of hand	PLASTC
4646500	Amputation of finger	PLASTC
4648000	Amputation finger incl metacarpal bone	PLASTC
4648300	Revision amputation stump of hand/finger	PLASTC
4648600	Primary repair of nail or nail bed	PLASTC
4649200	Correction contracture of digit of hand	PLASTC
4649501	Excision ganglion distal digit of hand	PLASTC
4653400	Radical excision of fingernail bed	PLASTC
4796302	Repair of tendon of hand, NEC	PLASTC
5233700	Repair of alveolar cleft	PLASTC
9011100	Other procedures on external ear	PLASTC
9054500	Incision of soft tissue of hand	PLASTC
9054700	Repair of muscle or fascia of hand, NEC	PLASTC
9058202	Suture of muscle or fascia, NEC	PLASTC
9067300	Correction of syndactyly	PLASTC
9068600	Nonexcisional debridement of burn	PLASTC
9068601	Non exc debridement skin & sbc tissue	PLASTC
4437600	Reamputation of amputation stump	TOLWRL
4704800	Closed reduction of dislocation of hip	TOLWRL
4705100	Open reduction of dislocation of hip	TOLWRL
4706601	Open rdctn dislocation of ankle with IF	TOLWRL
4751601	Closed reduction of fracture of femur	TOLWRL
4751900	IF fracture trochanteric/subcapitl femur	TOLWRL
4752200	Hemiarthroplasty of femur	TOLWRL
4752500	Clsd rdctn slip capital femoral epiphys	TOLWRL

4752501	Open rdctn slip capital femoral epiphys	TOLWRL
4752800	Open reduction of fracture of femur	TOLWRL
4752801	Open reduction fracture femur with IF	TOLWRL
4753100	Closed reduction fracture femur with IF	TOLWRL
4754600	Clsd rdctn fx mdl/lateral tibial plate	TOLWRL
4754601	Clsd rdctn fx mdl/lat tibial plate IF	TOLWRL
4754901	Open rdctn fx mdl/lat tibial plate w IF	TOLWRL
4756400	Closed reduction fracture shaft of tibia	TOLWRL
4756600	Closed rdctn fracture shaft tibia w IF	TOLWRL
4756601	Open rdctn fracture shaft of tibia w IF	TOLWRL
4758500	Internal fixation of fracture of patella	TOLWRL
4759400	Immobilisation of fracture of ankle, NEC	TOLWRL
4759700	Closed reduction of fracture of ankle	TOLWRL
4760000	Clsd rdctn fx ankle IF diats/fib/malus	TOLWRL
4760001	Open rdctn fx ankle IF diats/fib/malus	TOLWRL
4760301	Open rdctn fx ank IF 2 diats/fib/malus	TOLWRL
4761501	Open reduction fracture calcaneum w IF	TOLWRL
4761503	Open reduction fracture talus with IF	TOLWRL
4762401	Open rdctn fx tarsometatarsal jt w IF	TOLWRL
4763601	Closed rdctn fx of metatarsus with IF	TOLWRL
4763901	Open reduction fracture metatarsus w IF	TOLWRL
4771100	Application of halo	TOLWRL
4792701	R/O pin, screw or wire from femur	TOLWRL
4793301	Excision of exostosis of bne of foot	TOLWRL
4798200	Forage of neck and/or head of femur	TOLWRL
4840002	Osteotomy of metatarsal bone	TOLWRL
4840003	Osteotomy of toe	TOLWRL
4840004	Ostectomy of metatarsal bone	TOLWRL
4840300	Osteotomy metatarsal bone with IF	TOLWRL
4840301	Osteotomy of toe with internal fixation	TOLWRL
4841800	Osteotomy of tibia	TOLWRL
4842700	Osteotomy pelvis with internal fixation	TOLWRL
4842701	Osteotomy proximal femur with IF	TOLWRL
4842706	Osteotomy distal femur internal fixation	TOLWRL
4850000	Epiphysiodesis of femur	TOLWRL
4911200	Silastic replace of radial head of elbow	TOLWRL
4930300	Arthrotomy of hip	TOLWRL
4931200	Excision arthroplasty of hip	TOLWRL
4931500	Partial arthroplasty of hip	TOLWRL
4931800	Total arthroplasty of hip, unilateral	TOLWRL
4931900	Total arthroplasty of hip, bilateral	TOLWRL
4932400	Revision of total arthroplasty of hip	TOLWRL
4933900	Rev arthroplasty hip allogft acetabulum	TOLWRL
4936000	Arthroscopy of hip	TOLWRL
4950001	Arthrotomy of knee	TOLWRL
4950301	Patellofemoral stabilisation	TOLWRL
4951700	Hemiarthroplasty of knee	TOLWRL
4951800	Total arthroplasty of knee, unilateral	TOLWRL
4951900	Total arthroplasty of knee, bilateral	TOLWRL
4952700	Revision of total arthroplasty of knee	TOLWRL
4953900	Arthroscopic reconstruction of knee	TOLWRL
4953901	Reconstruction of knee	TOLWRL
4954200	Arthro recon cruc ligmt w rep meniscus	TOLWRL
4954201	Recon cruciate ligmt knee w rep meniscus	TOLWRL
4955700	Arthroscopy of knee	TOLWRL
4955701	Arthroscopic biopsy of knee	TOLWRL
4955800	Arthroscopic debridement of knee	TOLWRL
4955900	Arthro chondroplasty knee w dril/implant	TOLWRL
4956000	Arthroscopic removal of loose body, knee	TOLWRL

4956001	Arthroscopic trimming ligament of knee	TOLWRL
4956002	Arthroscopic lateral release of knee	TOLWRL
4956003	Arthroscopic meniscectomy of knee	TOLWRL
4956100	Arthro lat release knee w debride/plasty	TOLWRL
4956101	Arthro meniscectomy knee, debride/plasty	TOLWRL
4956102	Arthro R/O loose bd knee debride/plasty	TOLWRL
4956300	Arthroscopic repair of meniscus of knee	TOLWRL
4956600	Arthroscopic synovectomy of knee	TOLWRL
4956900	Quadricepsplasty of knee	TOLWRL
4970000	Arthroscopy of ankle	TOLWRL
4970301	Arthroscopic trimming osteophyte, ankle	TOLWRL
4970302	Arthroscopic removal loose body of ankle	TOLWRL
4970900	Stabilisation of ankle	TOLWRL
4971200	Arthrodesis of ankle	TOLWRL
4971800	Other repair of tendon of ankle	TOLWRL
4971801	Repair of Achilles' tendon	TOLWRL
4972401	Reconstruction of Achilles' tendon	TOLWRL
4972700	Lengthening of Achilles' tendon	TOLWRL
4980000	Prim repair flexor/extensor tendon foot	TOLWRL
4980900	Open tenotomy of foot	TOLWRL
4981500	Triple arthrodesis of foot	TOLWRL
4982100	Cor hallux valgus/rigidus arthroply uni	TOLWRL
4983300	Cor h-valgus osteotmy 1st metarsl uni	TOLWRL
4983600	Cor h-valgus osteotomy 1st metarsl bil	TOLWRL
4983700	Cor hal val osteot metarsl trsf tend uni	TOLWRL
4984500	Arthrodesis 1st metatarsophalangeal jt	TOLWRL
4984800	Correction of hammer toe	TOLWRL
4985100	Correction hammer toe, internal fixation	TOLWRL
5011800	Arthrodesis of subtalar joint	TOLWRL
5033300	Excision of tarsal coalition	TOLWRL
5034500	Release of hyperextension deformity toe	TOLWRL
5038100	Anterior release of hip contracture uni	TOLWRL
5039400	Multiple peri-acetabular osteotomies	TOLWRL
9055200	Other repair of hip	TOLWRL
9055800	Open reduction of fracture of ankle	TOLWRL
9055900	Arthrodesis of toe	TOLWRL
3002301	Debride sft tis incl bone or cart	TORTHO
3010700	Excision of ganglion, NEC	TORTHO
3011100	Excision of large bursa	TORTHO
3023500	Repair of ruptured muscle, NEC	TORTHO
3024100	Excision of lesion of bone, NEC	TORTHO
4633001	Repair ligament or capsule of MCP joint	TORTHO
4748600	Open rdctn fx pelvis w IF ant segment	TORTHO
4750100	Open rdctn fracture acetabulum with IF	TORTHO
4792100	Insertion internal fixation device NEC	TORTHO
4792700	Removal of pin, screw or wire, NEC	TORTHO
4793000	Removal of plate, rod or nail, NEC	TORTHO
4793001	Removal of plate, rod or nail from femur	TORTHO
4793600	Excision of exostosis of large bone	TORTHO
4795400	Repair of tendon, NEC	TORTHO
4795700	Lengthening of tendon, NEC	TORTHO
4796300	Open tenotomy, not elsewhere classified	TORTHO
4842400	Osteotomy of pelvis	TORTHO
5010600	Joint stabilisation, NEC	TORTHO
5013000	Application external fixation dev NEC	TORTHO
5030900	Adjustment ring fixator or similar dev	TORTHO
5032100	Release talipes equinovarus unilateral	TORTHO
9056801	Incision of bursa, NEC	TORTHO
9057200	Ostectomy, not elsewhere classified	TORTHO

9057401	Excision of joint, NEC	TORTHO
9057500	Excision of soft tissue, NEC	TORTHO
9058000	Debridement of open fracture site	TORTHO
9066500	Exc debridement skin & sbc tissue	TORTHO
3540000	Vertebroplasty, 1 vertebral body	TOSPIN
3540001	Vertebroplasty, >= 2 vertebral bodies	TOSPIN
4030001	Discectomy, >= 2 levels	TOSPIN
4033001	Spinal rhizolysis with laminectomy	TOSPIN
4033500	Decomp cervical spin cord w fus >= 2 lvl	TOSPIN
4768400	Immobilisation fracture/disloc of spine	TOSPIN
4769000	Clsd rdctn fx/disloc spine w immobils	TOSPIN
4864200	Posterior spinal fusion, 1 or 2 levels	TOSPIN
4864500	Posterior spinal fusion, >= 3 levels	TOSPIN
4864800	Posterolateral spinal fusion 1 or 2 lvl	TOSPIN
4865400	Post spinal fusion w laminectomy 1 level	TOSPIN
4865700	Post spinal fusion laminectomy >= 2 lvl	TOSPIN
4866000	Anterior spinal fusion, 1 level	TOSPIN
4867800	Simple internal fixation of spine	TOSPIN
9002400	Decomp lmbr spinal cnl, 1lvl	TOSPIN
9002401	Decomp lmbr spinal cnl, >= 2 lvl	TOSPIN
9002500	Rev spin proc w adjustment of spin fix	TOSPIN
9002501	Rev spin proc w R/O spinal fixation	TOSPIN
9002503	Other revision of spinal procedure	TOSPIN
3933100	Endoscopic release of carpal tunnel	TOUPRL
3933101	Release of carpal tunnel	TOUPRL
4630000	Arthrodesis interphalangeal joint, hand	TOUPRL
4633000	Repair ligament or capsule of IPJ hand	TOUPRL
4636300	Release of tendon sheath of hand	TOUPRL
4636600	Sbc fasciotomy Dupuytren's contracture	TOUPRL
4636900	Palmar fasciectomy Dupuytren's contract	TOUPRL
4637500	Palmar fasciectomy Dupuytren's, 2 digits	TOUPRL
4638100	Release IPJ capsule Dupuytren's contract	TOUPRL
4639602	Ostectomy of finger	TOUPRL
4641700	Transfer of tendon of hand	TOUPRL
4649400	Excision of ganglion of hand	TOUPRL
4650000	Excision of ganglion of dorsal wrist	TOUPRL
4650100	Excision of ganglion of volar wrist	TOUPRL
4700900	Closed reduction dislocation of shoulder	TOUPRL
4701201	Open reduction dislocation shoulder w IF	TOUPRL
4701800	Closed reduction of dislocation of elbow	TOUPRL
4703600	Closed reduction dislocation IPJ hand	TOUPRL
4703900	Open reduction dislocation IPJ hand	TOUPRL
4704200	Closed reduction dislocation MCP joint	TOUPRL
4730000	Closed reduction fx distal phalanx hand	TOUPRL
4730001	Closed rdctn fx distal phalanx hand IF	TOUPRL
4730601	Open rdctn fx distal phalanx hand w IF	TOUPRL
4731200	Closed rdctn fracture mid phalanx hand	TOUPRL
4731201	Closed rdctn fx mid phalanx hand w IF	TOUPRL
4731801	Open rdctn fx middle phalanx hand w IF	TOUPRL
4732400	Closed rdctn fx proximal phalanx hand	TOUPRL
4732401	Closed rdctn fx proximal phlx hand w IF	TOUPRL
4733001	Open rdctn fx proximal phalanx hand IF	TOUPRL
4733600	Closed reduction fracture of metacarpus	TOUPRL
4733601	Closed rdctn fracture metacarpus w IF	TOUPRL
4734201	Open rdctn fracture metacarpus w IF	TOUPRL
4735701	Open rdctn fracture carpal scaphoid IF	TOUPRL
4736000	Immobilisation fracture of distal radius	TOUPRL
4736300	Closed reduction fracture distal radius	TOUPRL
4736301	Closed rdctn fracture of distal ulna	TOUPRL

4736302	Closed rdctn fracture distal radius IF	TOUPRL
4736600	Open reduction fracture distal radius	TOUPRL
4736602	Open rdctn fracture distal radius w IF	TOUPRL
4736603	Open reduction fracture distal ulna w IF	TOUPRL
4738100	Closed rdctn fracture shaft of radius	TOUPRL
4738101	Closed rdctn fracture shaft of ulna	TOUPRL
4738102	Closed rdctn fracture shaft radius w IF	TOUPRL
4738402	Open rdctn fracture shaft radius w IF	TOUPRL
4738403	Open rdctn fracture shaft of ulna w IF	TOUPRL
4739001	Closed rdctn fx shaft radius & ulna IF	TOUPRL
4739301	Open rdctn fx shaft radius & ulna IF	TOUPRL
4739601	Closed reduction fracture olecranon w IF	TOUPRL
4739901	Open reduction fracture olecranon w IF	TOUPRL
4740500	Closed rdctn fracture radial head/neck	TOUPRL
4740501	Closed rdctn fx radial head/neck w IF	TOUPRL
4740801	Open rdctn fracture radial head/neck IF	TOUPRL
4742600	Closed rdctn fracture proximal humerus	TOUPRL
4742601	Closed rdctn fx proximal humerus w IF	TOUPRL
4742901	Open rdctn fx proximal humerus w IF	TOUPRL
4745001	Open reduction fracture shaft humerus IF	TOUPRL
4745100	Closed rdctn fx shaft of humerus w IF	TOUPRL
4745600	Closed reduction fracture distal humerus	TOUPRL
4745601	Closed rdctn fx distal humerus w IF	TOUPRL
4745901	Open rdctn fracture distal humerus w IF	TOUPRL
4746501	Open reduction fracture clavicle w IF	TOUPRL
4823300	Bone graft to scaphoid internal fixation	TOUPRL
4842100	Osteotomy tibia with internal fixation	TOUPRL
4890300	Decompression of subacromial space	TOUPRL
4890600	Repair of rotator cuff	TOUPRL
4890900	Rep rotator cuff decomp subacrom space	TOUPRL
4891500	Hemiarthroplasty of shoulder	TOUPRL
4891800	Total arthroplasty of shoulder	TOUPRL
4892100	Revision total arthroplasty of shoulder	TOUPRL
4893000	Stabilisation of shoulder	TOUPRL
4894500	Arthroscopy of shoulder	TOUPRL
4894800	Arthroscopic debridement of shoulder	TOUPRL
4895100	Arthro decomp subacrom space	TOUPRL
4895700	Arthroscopic stabilisation of shoulder	TOUPRL
4896000	Arthroscopic reconstruction of shoulder	TOUPRL
4910002	Release of elbow contracture	TOUPRL
4912104	Arthroscopic release elbow contracture	TOUPRL
4920000	Arthrodesis of radiocarpal joint	TOUPRL
4921800	Arthroscopy of wrist	TOUPRL
4922400	Arthroscopic debridement of wrist	TOUPRL
5033900	Transfer ant tibialis tend to lat column	TOUPRL
9053300	Other repair of shoulder	TOUPRL
3041500	Segmental resection of liver	UGIHPB
3041800	Lobectomy of liver	UGIHPB
3042100	Trisegmental resection of liver	UGIHPB
3044100	Intraop u/s for staging intrabdo lesion	UGIHPB
3046007	Hepaticoenterostomy	UGIHPB
3051101	Laparoscopic gastric reduction	UGIHPB
3051400	Surg reversal proc for morbid obesity	UGIHPB
3051801	Prt distal gastrectomy gastjejnl anstms	UGIHPB
3052100	Total gastrectomy	UGIHPB
3052300	Subtotal gastrectomy	UGIHPB
3052700	Fundoplasty, laparoscopic approach	UGIHPB
3052701	Lap fundoplasty w closure diaph hiatus	UGIHPB
3052702	Fundoplasty, abdominal approach	UGIHPB

3053500	Oesphecty w thor oesphgast anstms	UGIHPB
3053600	Oesphecty w cerv oesphgast anstms	UGIHPB
3054100	Trnshtl oesphecty w oesphgast anstms	UGIHPB
3058300	Distal pancreatectomy	UGIHPB
3058400	Pancreaticoduodenectomy w stoma frm	UGIHPB
9030600	Lap insertion feeding jejunostomy tube	UGIHPB
9031700	Transplantation of liver	UGIHPB
3007527	Biopsy of penis	UROLOG
3063100	Excision of hydrocele	UROLOG
3063500	Repair of varicocele	UROLOG
3064100	Orchidectomy, unilateral	UROLOG
3064102	Orchidectomy ins testicular prosth uni	UROLOG
3064407	Excision of lesion of testicle	UROLOG
3650300	Renal transplantation	UROLOG
3651600	Lap complete nephrectomy, unilateral	UROLOG
3651601	Complete nephrectomy, unilateral	UROLOG
3651604	Lap nephrectomy trnsplnt, living donor	UROLOG
3652200	Laparoscopic partial nephrectomy	UROLOG
3652201	Partial nephrectomy	UROLOG
3652800	Laparoscopic radical nephrectomy	UROLOG
3652801	Radical nephrectomy	UROLOG
3653101	Nephroureterectomy	UROLOG
3653701	Exploration of kidney	UROLOG
3655200	Nephrostomy	UROLOG
3656400	Laparoscopic pyeloplasty	UROLOG
3656401	Pyeloplasty	UROLOG
3660700	Ins uretc stnt balln dilat nphrstmy tbe	UROLOG
3660800	Percutaneous replacement ureteric stent	UROLOG
3662400	Percutaneous nephrostomy	UROLOG
3662702	Perc nephroscopy w extr renal calculus	UROLOG
3663900	Perc nephroscopy frag & extr <=2 calc	UROLOG
3665000	Removal pyelostomy or nephrostomy tube	UROLOG
3680300	Ureteroscopy	UROLOG
3680301	Endoscopic dilation of ureter	UROLOG
3680302	Endosc manip uretc calc w ureterosc	UROLOG
3680600	Endoscopic biopsy of ureter	UROLOG
3680602	Endosc extr ureteric calc via ureterosc	UROLOG
3680900	Endosc fragmentation ureteric calculus	UROLOG
3681101	Endoscopic insertion of urethral stent	UROLOG
3681200	Cystoscopy	UROLOG
3682101	Endoscopic insertion of ureteric stent	UROLOG
3682103	Endoscopic replacement of ureteric stent	UROLOG
3682400	Endoscopic ureteric cath, unilateral	UROLOG
3682700	Endosc controlled hydrodilation bladder	UROLOG
3683301	Endoscopic removal of ureteric stent	UROLOG
3683600	Endoscopic biopsy of bladder	UROLOG
3684000	Endosc dest bladder lsn / tiss <= 2 cm	UROLOG
3684002	Endosc resec lsn / tiss bladder <= 2 cm	UROLOG
3684200	Endosc lavage blood clots from bladder	UROLOG
3684500	Endosc dest single lesion bladder > 2 cm	UROLOG
3684501	Endosc dest of multiple lesions bladder	UROLOG
3684504	Endosc resec single lsn bladder > 2 cm	UROLOG
3684505	Endosc resection mult lesions bladder	UROLOG
3685400	Endoscopic incision of bladder neck	UROLOG
3686300	Litholapaxy of bladder	UROLOG
3700800	Laparoscopic cystotomy [cystostomy]	UROLOG
3700801	Cystotomy [cystostomy]	UROLOG
3700803	Cystolithotomy	UROLOG
3701100	Percutaneous cystotomy [cystostomy]	UROLOG

3701400	Total excision of bladder	UROLOG
3720004	Retropubic prostatectomy	UROLOG
3720300	Transurethral resection of prostate	UROLOG
3720302	Trnsureth electrl vaporisation prostate	UROLOG
3720900	Radical prostatectomy	UROLOG
3720901	Laparoscopic radical prostatectomy	UROLOG
3721000	Rad prostatectomy w bladder neck recon	UROLOG
3721100	Rad prstectmy w recon, lymphadenectomy	UROLOG
3721500	Endoscopic biopsy of prostate	UROLOG
3721900	Transrectal needle biopsy of prostate	UROLOG
3730300	Dilation of urethral stricture	UROLOG
3731500	Urethroscopy	UROLOG
3731802	Endosc frag/extr urethral calculus	UROLOG
3731803	Endosc laser frag/extr ureth calculus	UROLOG
3732401	Internal urethrotomy	UROLOG
3732700	Optical urethrotomy	UROLOG
3734000	Div ureth slg foll stres incont proc	UROLOG
3735400	Meatotomy & hemicircumcisn f hypospadias	UROLOG
3760102	Excision of epididymal cyst, unilateral	UROLOG
3760400	Exploration scrotal contents, unilateral	UROLOG
3783300	Hypospadias rep postop urethral fistula	UROLOG
5871801	Retrograde urethrography	UROLOG
9035400	Other procedures on kidney	UROLOG
9036000	Other excision of lesion of bladder	UROLOG
9040201	Division of penile adhesions	UROLOG
9040300	Local excision of lesion of penis	UROLOG
9210100	Irrigation other indwelling urinary cath	UROLOG
9212000	Removal of urethral stent	UROLOG
9615800	Bladder retraining	UROLOG
3250401	Interruption multiple tributaries of VV	VASCUL
3250800	Interruption sapheno-femoral jnct VV	VASCUL
3250801	Interruption sapheno-popliteal jnct VV	VASCUL
3251100	Interptn saphofemor saphopoptl jnct VV	VASCUL
3251400	Reoperation for varicose veins	VASCUL
3270300	Resection carotid artery w reanstms	VASCUL
3271801	Femoro-femoral crossover bypass	VASCUL
3274200	Fem-pop bypass usg vein below kne anstms	VASCUL
3275100	Fem-pop bypass usg synthc matrl abv knee	VASCUL
3275400	Fem-pop byps usg composite gft abv knee	VASCUL
3275401	Fem-pop byps usg composite gft blw knee	VASCUL
3311500	Replace infrarenal AAA with tube graft	VASCUL
3311600	Endovascular repair of aneurysm	VASCUL
3311800	Replace infrarnl AAA bifur gft iliac art	VASCUL
3315400	Replace rupt infrarenal AAA w tube gft	VASCUL
3350000	Carotid endarterectomy	VASCUL
3353900	Endarterectomy of extremities	VASCUL
3354200	Extended endarterectomy deep femoral art	VASCUL
3380601	Embolectomy/thrombectomy brachial artery	VASCUL
3380609	Embolectomy/thrombectomy, femoral artery	VASCUL
3380610	Embolectomy/thrombectomy, popliteal art	VASCUL
3380612	Emblectmy/thrmbectmy byps gft art extrem	VASCUL
3411200	Excision/ligation simple AV fistula limb	VASCUL
3450901	Arteriovenous anastomosis of upper limb	VASCUL
3451200	Construction AV fistula w graft of vein	VASCUL
3451800	Correction stenosis AV fistula	VASCUL
3453006	Revision of vascular access device	VASCUL
3480900	Femoral vein bypass	VASCUL
3530306	Perc transluminal balloon angioplasty	VASCUL
3530906	PTA perc w stenting, single stent	VASCUL

3530907	PTA perc w stenting, multiple stents	VASCUL
3532104	Trnscath embolisation bl vesl, chest	VASCUL
4433800	Amputation of toe	VASCUL
4435800	Amputation toe including metatarsal bone	VASCUL
4436401	Transmetatarsal amputation	VASCUL
4436700	Amputation above knee	VASCUL
4436702	Amputation below knee	VASCUL
4502701	Admin of agent into vascular anomaly	VASCUL
9001300	Biopsy of nerve	VASCUL
9023000	Embolectomy/thrombectomy of other artery	VASCUL

Appendix II - The HIPE Specialties that are desiganted as surgical clinicians

Specialty C	HIPE Specilty Description	SurgClasTyp
0600	Otolaryngology	Otolaryngology
0601	Paediatric ENT	Paediatric
1400	Neurosurgery	Neurosurgery
1402	Paediatric Neurosurgery	Paediatric
1500	Obstetrics/Gynaecology	Gynaecology
1503	Gynaecology	Gynaecology
1700	Opthalmology	Opthalmology
1702	Neuro Opthalmic Surgery	Opthalmology
1703	Vitro Retinal Surgery	Opthalmology
1800	Orthopaedics	Orthopaedics
1802	Paediatric Orthopaedic S	Paediatric
2000	Plastic Surgery	Plastics
2003	Maxillo-Facial	Maxillofacial
2600	General Surgery	General
2602	Gastro Intestinal Surger	Split UGI Colorectal
2603	Hepato Biliary Surgery	UGI - hepato biliary
2604	Vascular Surgery	Vascular
2605	Breast Surgery	Breast
7000	Dental Surgery	Dental
7001	Oral Surgery	Dental
7002	Orthodontics	Dental
7200	Paediatric Surgery	Paediatric
7600	Cardio Thoracic Surgery	Cardio
7701	Oral Surgery	Dental
7800	Urology	Urology
7802	Renal Transplantation	Urology
7803	Paediatric Urology	Paediatric

NON Surgical primary procedures as mapped following analysis of 2014, 2013, … 2010 data

PrcNum	PrcDesc	PrcShrt
1182000	Panendoscopy via camera capsule	XENSCP
3045102	Endoscopic replacement of biliary stent	XENSCP
3045103	Endoscopic removal of biliary stent	XENSCP
3047300	Panendoscopy to duodenum	XENSCP
3047301	Panendoscopy to duodenum with biopsy	XENSCP
3047302	Panendoscopy through artificial stoma	XENSCP
3047303	Oesophagoscopy	XENSCP
3047304	Oesophagoscopy with biopsy	XENSCP
3047305	Panendoscopy to ileum	XENSCP
3047500	Endoscopic dilation of gastric stricture	XENSCP
3047602	Endoscopic banding of oesophageal varice	XENSCP
3047603	Endoscopic banding of gastric varices	XENSCP
3047800	Panendoscopy to duodenum w R/O FB	XENSCP
3047804	Panendoscopy to duodenum w exc of lesion	XENSCP
3047805	Percutaneous endoscopic jejunostomy	XENSCP
3047810	Oesophagoscopy w removal foreign body	XENSCP
3047819	Oesophagoscopy with other coagulation	XENSCP
3047820	Panendoscopy to duodenum w other coagltn	XENSCP
3047821	Panendoscopy to ileum with other coagltn	XENSCP
3048500	Endoscopic sphincterotomy	XENSCP
3049000	Endoscopic ins oesophageal prosthesis	XENSCP
3049102	Endoscopic stenting of pancreatic duct	XENSCP
3207500	Rigid sigmoidoscopy	XENSCP
3207501	Rigid sigmoidoscopy with biopsy	XENSCP
3207800	Rigid sigmoidoscopy, polypectomy <= 9	XENSCP
3208400	Fibreoptic colonoscopy t hepatic flexure	XENSCP
3208401	Fibreoptic colonoscopy heptc flexure, Bx	XENSCP
3208700	Fibroptc colonsc to hepatic flexure w PP	XENSCP
3209000	Fibreoptic colonoscopy to caecum	XENSCP
3209001	Fibreoptic colonoscopy to caecum w Bx	XENSCP
3209002	Colonosc to caecum w tattooing	XENSCP
3209300	Fibreoptic colonoscopy to caecum w PP	XENSCP
3209400	Endoscopic dilation colorectal stricture	XENSCP
4181600	Rigid oesophagoscopy	XENSCP
4181900	Other endoscopic dilation of oesophagus	XENSCP
4182200	Rigid oesophagoscopy with biopsy	XENSCP
4183200	Endoscopic balloon dilation oesophagus	XENSCP
9030800	Endoscopic dest lesion, large intestine	XENSCP
1100000	Electroencephalography	XNOSRG
1101200	Electromyography [EMG]	XNOSRG
1101201	Conduction studies on 1 nerve	XNOSRG
1101202	Conduction studies on 1 nerve with EMG	XNOSRG
1101500	Conduction studies on 2 or 3 nerves	XNOSRG
1101501	Conduction studies on 2 or 3 nerve w EMG	XNOSRG
1101800	Conduction studies on >= 4 nerves	XNOSRG
1101801	Conduction studies >=4 nerves w EMG	XNOSRG
1101802	Conductn stud, EMG sgl fibres nrv & musc	XNOSRG
1121200	Examination of optic fundi	XNOSRG
1121500	Retinal photography of 1 eye	XNOSRG
1121800	Retinal photography of both eyes	XNOSRG
1122100	Full quantitative comput perimetry bil	XNOSRG
1130000	Brain stem evoked response audiometry	XNOSRG
1130600	Other audiometry	XNOSRG
1132400	Tympanometry using standard probe tone	XNOSRG
1150316	Contin monitor pulmonary function >=6 hr	XNOSRG

1150600	Other measurement, respiratory function	XNOSRG
1151200	Contin measure relatnshp b flow & vol	XNOSRG
1160000	Cardiac intracavity blood press monitor	XNOSRG
1160003	Systemic arterial pressure monitoring	XNOSRG
1170000	Other electrocardiography [ECG]	XNOSRG
1170900	Holter ambulatory continuous ECG rcrd	XNOSRG
1171200	Cardiovascular stress test	XNOSRG
1171800	Testing of other cardiac pacemaker	XNOSRG
1172400	Upright tilt table testing	XNOSRG
1180000	Oesophageal motility test	XNOSRG
1181000	Measure gastoesph reflux 24hr pH monitor	XNOSRG
1183000	Anal manometry	XNOSRG
1190000	Urine flow study	XNOSRG
1190300	Cystometrography	XNOSRG
1191700	Cystometrography with >= 1 measurements	XNOSRG
1191900	CMG w contrst mict cystourethrography	XNOSRG
1192100	Bladder washout test study	XNOSRG
1200000	Skin sensitivity test usg <= 20 allrgn	XNOSRG
1201500	Epicut patch test usg all std allergens	XNOSRG
1202100	Epicut patch test using >= 51 allergens	XNOSRG
1220300	Polysomnography	XNOSRG
1230600	Bone densitometry usg dual energy xray	XNOSRG
1253300	Carbon labelled urea breath test	XNOSRG
1310000	Haemodialysis	XNOSRG
1310001	Intermittent haemofiltration	XNOSRG
1310002	Continuous haemofiltration	XNOSRG
1310003	Intermittent haemodiafiltration	XNOSRG
1310004	Continuous haemodiafiltration	XNOSRG
1310007	Intermittent peritonl dialysis long term	XNOSRG
1310008	Continuous peritonl dialysis long term	XNOSRG
1310400	Education & training for home dialysis	XNOSRG
1310900	Ins & fix indwel peritonl cath long term	XNOSRG
1310901	Replace indwel peritonl cath f dialysis	XNOSRG
1311000	R/O indwel peritoneal cath for dialysis	XNOSRG
1340000	Cardioversion	XNOSRG
1370000	Procurement bone marrow for trnsplnt	XNOSRG
1370601	Administration of whole blood	XNOSRG
1370602	Administration of packed cells	XNOSRG
1370603	Administration of platelets	XNOSRG
1370605	Administration of gamma globulin	XNOSRG
1370606	Allo bm/sc trnsplnt rel don w in vitro	XNOSRG
1370607	Autolgs bm/stem cel trnsplnt wo in vitro	XNOSRG
1370608	Autolgs bm/stem cell trnsplnt w in vitro	XNOSRG
1370610	Allo bm/sc trnsplnt oth don w in vitro	XNOSRG
1375000	Therapeutic plasmapheresis	XNOSRG
1375001	Therapeutic leukopheresis	XNOSRG
1375002	Therapeutic erythropheresis	XNOSRG
1375004	Apheresis of stem cells	XNOSRG
1375005	Apheresis stem cells w cryopreservation	XNOSRG
1375006	Other therapeutic haemapheresis	XNOSRG
1375700	Therapeutic venesection	XNOSRG
1381500	Central vein catheterisation	XNOSRG
1381501	Perc central vein catheterisation	XNOSRG
1383900	Collection blood for dx purposes	XNOSRG
1384200	Intra-arterial cannuln, blood gas anlys	XNOSRG
1388200	Mgmt contin ventilatory sup <= 24 hours	XNOSRG
1388201	Mgmt contin ventilatry sup > 24 < 96 hr	XNOSRG
1388202	Mgmt contin ventilatory sup >= 96 hours	XNOSRG
1393902	Maintenance alone vascular access device	XNOSRG

1394202	Maintenance alone drug delivery device	XNOSRG
1405000	Psoralens & UV A therapy of other site	XNOSRG
1405001	Ultraviolet B therapy of other site	XNOSRG
1405002	Narrow band UV B therapy, other site	XNOSRG
1405300	Psoralens & ultraviolet A therapy, hand	XNOSRG
1405301	Psoralens & ultraviolet A therapy, foot	XNOSRG
1405302	Psoralens & UV A therapy of hand & foot	XNOSRG
1405303	Ultraviolet B therapy of hand	XNOSRG
1405305	Ultraviolet B therapy of hand and foot	XNOSRG
1405306	Narrow band ultraviolet B of hand	XNOSRG
1405307	Narrow band ultraviolet B of foot	XNOSRG
1405308	Narrow band ultraviolet B of hand & foot	XNOSRG
1410000	Laser photcoag continuous, blood vessels	XNOSRG
1410600	Laser photcoag pulsed vasc lesions	XNOSRG
1500000	Radiation treatment superficial, 1 field	XNOSRG
1500300	Radiation Rx superficial >= 2 fields	XNOSRG
1501201	Brachytherapy, eye, using scleral plaque	XNOSRG
1510000	Radiation Rx, orthovoltage, 1 field	XNOSRG
1510300	Radiation Rx, orthovoltage, >= 2 fields	XNOSRG
1522400	Radiation Rx mgvlt 1fld sgl modlty linac	XNOSRG
1523900	Radiat mgvlt >= 2 fld sgl modlty linac	XNOSRG
1525400	Radiat Rx mgvlt 1field dual modlty linac	XNOSRG
1526900	Radiat mgvlt >= 2 fld dual modlty linac	XNOSRG
1530400	Brachythrpy intrauterine high dose rate	XNOSRG
1531200	Brachythrpy intravaginal high dose rate	XNOSRG
1532000	Brachytherapy IU & intravaginal high ds	XNOSRG
1533800	Brachythrpy w impl perm impl, prostate	XNOSRG
1534200	Construct applicn radioactive surf mould	XNOSRG
1550000	Radiation field setg usg simultr simple	XNOSRG
1550300	Radiation field setg usg simultr intrmed	XNOSRG
1550600	Radiat field setg using simulator complx	XNOSRG
1550601	Radiat fld setting usg dedicated CT scan	XNOSRG
1550602	Radiation field setting for IMRT	XNOSRG
1551800	Dosimetry by CT interfac computer simple	XNOSRG
1552100	Dosimetry CT interfac computer, intrmed	XNOSRG
1552400	Dosimetry CT interfac computer, complex	XNOSRG
1552401	Dosimetry by CT interfac comput for IMRT	XNOSRG
1555601	Dosimetry non-CT interfac comput 3DCRT	XNOSRG
1560000	Stereotactic radiation Rx, single dose	XNOSRG
1560003	Total body irradiation	XNOSRG
1600900	Admin therapeutic dose of Iodine 131	XNOSRG
1650100	External version	XNOSRG
1651200	Removal of cervical suture	XNOSRG
1651400	Internal fetal monitoring	XNOSRG
1660600	Fetal blood sampling	XNOSRG
1661500	IU fetal intrapertl/vasc blood transfn	XNOSRG
1821600	Epidural infus local anaesthetic	XNOSRG
1821627	Epidural inj/o local anaesthetic	XNOSRG
1821629	Caudal inj/o local anaesthetic	XNOSRG
1823600	Admin anaes arnd perph br trigem nerve	XNOSRG
1824200	Admin anaes arnd occipital nerve	XNOSRG
1825000	Admin anaes arnd spin accessory nerve	XNOSRG
1825200	Admin anaes agent arnd cervical plexus	XNOSRG
1825400	Admin anaes agent arnd brachial plexus	XNOSRG
1825600	Admin anaes arnd suprascapular nrv	XNOSRG
1825800	Admin anaes arnd single intcstl nrv	XNOSRG
1826000	Admin anaes arnd mult intcstl nrv	XNOSRG
1826201	Admin anaes arnd ilio-inguinal nrv	XNOSRG
1826202	Admin anaes arnd genitofemoral nrv	XNOSRG

1826400	Admin anaes agent arnd pudendal nrv	XNOSRG
1826600	Admin anaes arnd ulnar nrv	XNOSRG
1826602	Admin anaes arnd median nrv	XNOSRG
1827000	Admin anaes arnd femoral nrv	XNOSRG
1827202	Admin anaes arnd popliteal nrv	XNOSRG
1827203	Admin anaes arnd sural nrv	XNOSRG
1827400	Admin anaes arnd paravert cervical nrv	XNOSRG
1827401	Admin anaes arnd paravert thoracic nrv	XNOSRG
1827402	Admin anaes arnd paravert lumbar nrv	XNOSRG
1827403	Admin anaes arnd paravert sacral nrv	XNOSRG
1827404	Admin anaes arnd paravert ccygl nrv	XNOSRG
1827600	Admin anaes arnd paravert nrv mult lvl	XNOSRG
1827800	Admin anaes arnd sciatic nrv	XNOSRG
1828400	Admin anaes arnd cervical portion SNS	XNOSRG
1828601	Admin anaes arnd lumbar portion SNS	XNOSRG
1828602	Admin anaes arnd oth sympathetic nrv	XNOSRG
1828800	Admin anaes arnd coeliac plexus	XNOSRG
1829200	Admin neurolytic into oth perph nrv	XNOSRG
1836000	Admin of botulinum toxin soft tis NEC	XNOSRG
1836600	Admin botulinum toxin for strabismus	XNOSRG
1836800	Admin of botulinum toxin into vocal cord	XNOSRG
1837000	Admin of botulinum toxin into eyelid	XNOSRG
2200700	Endotracheal intubation, single lumen	XNOSRG
2206500	Cold therapy	XNOSRG
3002900	Repair wnd SSCT oth site inv soft tis	XNOSRG
3003200	Repair wound SSCT face/neck superficial	XNOSRG
3003500	Repair wnd SSCT face/neck inv soft tis	XNOSRG
3005200	Repair of wound of external ear	XNOSRG
3005202	Repair of wound of lip	XNOSRG
3005500	Dressing of wound	XNOSRG
3006100	R/O foreign body from SSCT wo incision	XNOSRG
3006400	R/O foreign body from SSCT w incision	XNOSRG
3007100	Biopsy of skin & subcutaneous tissue	XNOSRG
3007516	Biopsy of pancreas	XNOSRG
3007519	Biopsy of tongue	XNOSRG
3007523	Biopsy of oral cavity	XNOSRG
3007524	Biopsy of soft palate	XNOSRG
3007528	Biopsy of external ear	XNOSRG
3008100	Biopsy of bone marrow	XNOSRG
3008400	Percutaneous biopsy of bone marrow	XNOSRG
3008700	Aspiration biopsy of bone marrow	XNOSRG
3009000	Percutaneous needle biopsy of pleura	XNOSRG
3009300	Needle biopsy of vertebra	XNOSRG
3009403	Percutaneous [needle] biopsy of spleen	XNOSRG
3009405	Percutaneous needle biopsy of pancreas	XNOSRG
3009406	Perc needle Bx intra-abdominal mass	XNOSRG
3009409	Perc needle Bx salivary gland or duct	XNOSRG
3009410	Perc [needle] biopsy of thyroid gland	XNOSRG
3009900	Excision of sinus of SSCT	XNOSRG
3010300	Excision sinus inv soft tissue NEC	XNOSRG
3018601	Removal of palmar wart	XNOSRG
3018901	Removal of other wart	XNOSRG
3019000	Laser to lesion of face or neck	XNOSRG
3019200	Other destruction of lesion of skin	XNOSRG
3019500	Curettage lesion of skin, single lsn	XNOSRG
3019501	Curettage lsn skin, multiple lsn	XNOSRG
3019502	Laser to lesion of skin, single lesion	XNOSRG
3019503	Laser to multiple skin lesions	XNOSRG
3019504	Cryotherapy of single skin lesion	XNOSRG

3019505	Cryotherapy of multiple skin lesions	XNOSRG
3019506	Electrotherapy of single skin lesion	XNOSRG
3020700	Administration of agent into skin lesion	XNOSRG
3021600	Aspiration haematoma of SSCT	XNOSRG
3021601	Aspiration abscess of SSCT	XNOSRG
3021602	Other aspiration of SSCT	XNOSRG
3022302	Other incision & drainage of SSCT	XNOSRG
3022401	Perc drain intrabdo abs haematoma cyst	XNOSRG
3028300	Excision of cyst of mouth	XNOSRG
3032900	Excision of lymph node of groin	XNOSRG
3040600	Abdominal paracentesis	XNOSRG
3040900	Percutaneous [closed] liver biopsy	XNOSRG
3044000	Perc transhepatic cholangiography	XNOSRG
3044001	Percutaneous biliary drainage	XNOSRG
3047306	Panendoscopy to ileum with biopsy	XNOSRG
3047307	Panendo to duodnm w tattooing	XNOSRG
3047600	Endosc admin agt nonbleed lsn oesoph	XNOSRG
3047801	Panendoscopy to duodenum with diathermy	XNOSRG
3047803	Panend to duodnm w laser coagulation	XNOSRG
3047806	Endosc admin agt bleeding lsn oesoph	XNOSRG
3047807	Endosc admin agt lsn stomach/duodenum	XNOSRG
3047808	Removal of gastrostomy tube	XNOSRG
3048100	Initial ins perc endosc gastrostomy tube	XNOSRG
3048200	Repeat ins perc endosc gastrostomy tube	XNOSRG
3048300	Ins perc nonendosc gastrostomy button	XNOSRG
3048400	ERCP	XNOSRG
3048401	Endoscopic retrograde cholangiography	XNOSRG
3048501	Endosc sphincterotomy extr calculus CBD	XNOSRG
3049100	Endosc stenting other prt biliary tract	XNOSRG
3049200	Percutaneous stenting of biliary tract	XNOSRG
3049201	Percutaneous replacement biliary stent	XNOSRG
3051500	Gastro-enterostomy	XNOSRG
3062800	Percutaneous aspiration of hydrocele	XNOSRG
3100000	Micro controlled serial exc lsn skin	XNOSRG
3120501	Excision of ulcer of SSCT	XNOSRG
3123004	Excision lesion(s) SSCT, finger	XNOSRG
3123502	Excision of lesion(s) SSCT, hand	XNOSRG
3123504	Excision of lesion(s) SSCT, foot	XNOSRG
3153300	Fine needle biopsy of breast	XNOSRG
3213200	Sclerotherapy for haemorrhoids	XNOSRG
3213500	Rubber band ligation of haemorrhoids	XNOSRG
3217100	Anorectal examination	XNOSRG
3250000	Micro injections of venular flares	XNOSRG
3250001	Multiple injections of varicose veins	XNOSRG
3410614	Interruption of other artery	XNOSRG
3410900	Biopsy of temporal artery	XNOSRG
3452400	Catheterisation/cannulation other artery	XNOSRG
3452802	Insertion of vascular access device	XNOSRG
3453004	Removal of venous catheter	XNOSRG
3453005	Removal of vascular access device	XNOSRG
3530700	PTA single carotid artery, single stent	XNOSRG
3531700	Perc cath w admin agt by contin infusion	XNOSRG
3532000	Open cath w admin thrmblytc/chemthpc agt	XNOSRG
3532105	Trnscath embolisation bl vesl, abdo	XNOSRG
3532106	Trnscath embolisation bl vesl, pelvis	XNOSRG
3532110	Trsncath embolisation oth bl vesl	XNOSRG
3533000	Perc insertion inferior vena cava filter	XNOSRG
3533100	Perc removal inferior vena cava filter	XNOSRG
3550000	Gynaecological examination	XNOSRG

3550300	Insertion intrauterine device	XNOSRG
3550600	Replacement of intrauterine device [IUD]	XNOSRG
3550602	Removal of intrauterine device [IUD]	XNOSRG
3560800	Cautery of cervix	XNOSRG
3560801	Other destruction of lesion of cervix	XNOSRG
3562000	Biopsy of endometrium	XNOSRG
3570300	Test for tubal patency	XNOSRG
3654600	ESWL of urinary tract	XNOSRG
3656100	Closed biopsy of kidney	XNOSRG
3660400	Passage ureteric stent v nephrostomy tbe	XNOSRG
3662701	Percutaneous nephroscopy with biopsy	XNOSRG
3664900	Replacement nephrostomy drainage tube	XNOSRG
3680000	Bladder catheterisation	XNOSRG
3680001	Endosc replace indwel urinary catheter	XNOSRG
3680002	Replacement of cystostomy tube	XNOSRG
3680003	Endosc R/O indwelling urinary catheter	XNOSRG
3681201	Cystoscopy through artificial stoma	XNOSRG
3681800	Endosc uretc cath fluorosc image UT uni	XNOSRG
3681801	Endosc uretc cath fluorosc image UT bil	XNOSRG
3685100	Endosc admin of agt into bladder wall	XNOSRG
3721200	Biopsy of prostate	XNOSRG
3721800	Percutaneous [needle] biopsy of prostate	XNOSRG
3733900	Inj/o paraurethral bulk, female incont	XNOSRG
3741500	Administration of agent into penis	XNOSRG
3820000	Right heart catheterisation	XNOSRG
3820300	Left heart catheterisation	XNOSRG
3820900	Card electrophysiological study <=3 cath	XNOSRG
3821200	Card electrophysiological study >=4 cath	XNOSRG
3821500	Coronary angiography	XNOSRG
3821800	Coronary angiography w left heart cath	XNOSRG
3821801	Coronary angiography w right heart cath	XNOSRG
3821802	Coronary angiography w L & R heart cath	XNOSRG
3827001	Perc balloon aortic valvuloplasty	XNOSRG
3827500	Bx myocardium by cardiac catheterisation	XNOSRG
3828500	Ins subcutaneously implanted monitor dev	XNOSRG
3828600	R/O subcutaneously implanted monitor dev	XNOSRG
3828701	Cath abltn arhytm crct / fcs NEC	XNOSRG
3828702	Cath abltn arhytm crct / fcs L atrl cham	XNOSRG
3829001	Cath abltn arhytm crct bth atrl chambers	XNOSRG
3830000	PTCA, 1 coronary artery	XNOSRG
3830300	PTCA, multiple coronary arteries	XNOSRG
3830600	Perc ins trnslml stent, sgl coron artery	XNOSRG
3830601	Perc ins mult trnslml stnt sgl coron art	XNOSRG
3830602	Perc ins >=2 trnslml stnt coron arteries	XNOSRG
3835000	Ins perm trnsven elec oth cham pcmkr	XNOSRG
3835001	Replace trnsven elec oth cham pcmkr	XNOSRG
3835300	Insertion of cardiac pacemaker generator	XNOSRG
3835301	Replacement cardiac pacemaker generator	XNOSRG
3835302	R/O cardiac pacemaker generator	XNOSRG
3835900	Pericardiocentesis	XNOSRG
3836800	Ins perm trnsven elec L ventrl pcmkr	XNOSRG
3839300	Insertion of cardiac defib generator	XNOSRG
3839301	Replace cardiac defibrillator generator	XNOSRG
3841500	Incision of pleura	XNOSRG
3841802	Biopsy of lung	XNOSRG
3874200	Perc closure of atrial septal defect	XNOSRG
3880000	Diagnostic thoracentesis	XNOSRG
3880300	Therapeutic thoracentesis	XNOSRG
3880600	Insertion intercostal catheter for drain	XNOSRG

3881200	Percutaneous needle biopsy of lung	XNOSRG
3900000	Lumbar puncture	XNOSRG
3901300	Admin agent into zygo-apophyseal joint	XNOSRG
3901301	Admin agent into costotransverse joint	XNOSRG
3901302	Admin anaes post prim rami spin nrv	XNOSRG
3901500	Insertion of external ventricular drain	XNOSRG
3910900	Trigeminal gangliotomy by radiofrequency	XNOSRG
3911800	Perc nrotmy, facet jt denrv by radiofreq	XNOSRG
3911801	Perc nrotmy, facet jt denrv by cryoprobe	XNOSRG
3912600	Rev of impl spinal infus dev / pump	XNOSRG
3912700	Ins of impl spinal infusion dev / pump	XNOSRG
3913000	Perc insertion of epidural electrodes	XNOSRG
3913102	Testing of implanted neurostimulator	XNOSRG
3913401	Ins sbc impl neurostimulator	XNOSRG
3913500	R/O sbc impl neurostimulator	XNOSRG
3914000	Epidural injct for lysis of adhesions	XNOSRG
3932300	Other perc neurotomy by radiofrequency	XNOSRG
3933000	Open neurolysis of peripheral nerve, NEC	XNOSRG
4033000	Spinal rhizolysis	XNOSRG
4080300	Intracranial stereotactic localisation	XNOSRG
4150000	R/O FB from auditory canal wo incision	XNOSRG
4164700	Ear toilet, unilateral	XNOSRG
4164701	Ear toilet, bilateral	XNOSRG
4165000	Inspection tympanic membrane, unilateral	XNOSRG
4165001	Inspection tympanic membrane, bilateral	XNOSRG
4165300	Exam nasal cavity &/or postnasal space	XNOSRG
4165900	Removal of intranasal foreign body	XNOSRG
4176100	Exam nasal cavity &/or postnasal spc, Bx	XNOSRG
4176401	Sinoscopy	XNOSRG
4176403	Fibreoptic laryngoscopy	XNOSRG
4183100	Endoscopic pneumatic dilation oesophagus	XNOSRG
4184900	Laryngoscopy	XNOSRG
4186100	Microlaryngoscopy R/O lesion by laser	XNOSRG
4188900	Bronchoscopy	XNOSRG
4189200	Bronchoscopy with biopsy	XNOSRG
4189500	Bronchoscopy w removal foreign body	XNOSRG
4189800	Fibreoptic bronchoscopy	XNOSRG
4189801	Fibreoptic bronchoscopy with biopsy	XNOSRG
4258700	Correction trichiasis by cryothrpy 1 eye	XNOSRG
4258704	Correction trichiasis electrolysis 1 eye	XNOSRG
4258705	Correction trichiasis electrolysis, eyes	XNOSRG
4259000	Lateral canthoplasty	XNOSRG
4262000	Occlusion of lacrimal punctum by plug	XNOSRG
4268600	Excision of pterygium	XNOSRG
4269802	Phacoemulsification & aspr cataract	XNOSRG
4270208	Oth extrcpslr lens extr w IOL, foldable	XNOSRG
4271902	Mechanical fragmentation sec membrane	XNOSRG
4273101	Extr lens post cham sclerotmy w R/O vitr	XNOSRG
4274002	Admin therapeutic agt into ant chamber	XNOSRG
4277000	Destruction of ciliary body	XNOSRG
4278200	Trabeculoplasty by laser	XNOSRG
4278500	Iridotomy by laser	XNOSRG
4278800	Capsulotomy of lens by laser	XNOSRG
4280600	Destruction of lesion of iris by laser	XNOSRG
4280901	Repair retinal detach w photocoagulation	XNOSRG
4281500	Removal of silicone oil	XNOSRG
4282401	Subconjunctival administration of agent	XNOSRG
4502502	CO2 laser resurfacing to other site	XNOSRG
4503000	Exc vasc anomaly SSCT/mucous surf, small	XNOSRG

4503306	Excision vascular anomaly oth site	XNOSRG
4550600	Revision scar face <= 3 cm in length	XNOSRG
4562600	Correction ectropion/entropion by suture	XNOSRG
4566502	Full thickness wedge excision of ear	XNOSRG
4651600	Debridement of fingernail	XNOSRG
4651601	Removal of fingernail	XNOSRG
4754000	Application of hip spica	XNOSRG
4770800	Application of plaster jacket	XNOSRG
4790601	Removal of toenail	XNOSRG
4863600	Percutaneous lumbar discectomy	XNOSRG
4955702	Arthro exc meniscal margin/plica knee	XNOSRG
5095000	Radiofrequency ablation of liver	XNOSRG
5502800	Ultrasound of head	XNOSRG
5503000	Ultrasound of orbital contents	XNOSRG
5503200	Ultrasound of neck	XNOSRG
5503600	Ultrasound of abdomen	XNOSRG
5503800	Ultrasound of urinary tract	XNOSRG
5505400	Intra-operative ultrasound of other site	XNOSRG
5507000	Ultrasound of breast, unilateral	XNOSRG
5511300	M-mode & 2D real time u/s of heart	XNOSRG
5511800	2D real time transoesophageal u/s heart	XNOSRG
5524400	Duplex u/s of vein in low limb, uni	XNOSRG
5524401	Duplex u/s of vein in low limb, bil	XNOSRG
5527400	Duplex u/s extracranial/carotid & vert	XNOSRG
5560000	Trnsrectl u/s prostate, bladder, urethra	XNOSRG
5573100	Ultrasound of female pelvis	XNOSRG
5580800	Ultrasound of shoulder or upper arm	XNOSRG
5581600	Ultrasound of hip	XNOSRG
5583200	Ultrasound of lower leg	XNOSRG
5584800	Intraoperative musculoskeletal u/s	XNOSRG
5600100	Computerised tomography of brain	XNOSRG
5600700	CT of brain with IV contrast medium	XNOSRG
5601000	Computerised tomography pituitary fossa	XNOSRG
5601300	Computerised tomography of orbit	XNOSRG
5601301	CT orbit with IV contrast medium	XNOSRG
5601604	CT middle ear & temporal bone, bil	XNOSRG
5602200	CT of facial bone	XNOSRG
5602201	CT of paranasal sinus	XNOSRG
5603000	CT facial bone paranasal sinus and brain	XNOSRG
5610100	CT of soft tissue of neck	XNOSRG
5610700	CT soft tissue neck w IV contrast medium	XNOSRG
5622000	CT of spine cervical region	XNOSRG
5622100	CT of spine thoracic region	XNOSRG
5622300	CT of spine lumbosacral region	XNOSRG
5623300	CT of spine multiple regions	XNOSRG
5630100	Computerised tomography of chest	XNOSRG
5630101	Computerised tomography chest & abdomen	XNOSRG
5630700	CT of chest w IV contrast medium	XNOSRG
5630701	CT chest & abdomen w IV contrast medium	XNOSRG
5640100	Computerised tomography of abdomen	XNOSRG
5640700	CT abdomen w IV contrast medium	XNOSRG
5640900	Computerised tomography of pelvis	XNOSRG
5641200	CT of pelvis with IV contrast medium	XNOSRG
5650100	CT of abdomen & pelvis	XNOSRG
5650700	CT abdomen & pelvis w IV contrast medium	XNOSRG
5654900	Computerised tomography of colon	XNOSRG
5661900	Computerised tomography of limb	XNOSRG
5680100	CT of chest, abdomen & pelvis	XNOSRG
5680700	CT chest abdo & pelvis IV contrst medium	XNOSRG

5700100	Computerised tomography of brain & chest	XNOSRG
5735000	Spr ang CT head &/ neck w IV CM	XNOSRG
5735001	Spr Ang CT upp extrem w IV CM	XNOSRG
5735002	Spr ang CT chest w IV CM	XNOSRG
5735003	Spr ang CT abdo w IVCM	XNOSRG
5735004	Spr ang CT AA bil ifem low extrem w IVCM	XNOSRG
5735005	Spr ang CT spine w IVCM	XNOSRG
5735007	Spr ang CT low extrem w IVCM	XNOSRG
5735008	Spr ang CT other site w IVCM	XNOSRG
5850000	Radiography of chest	XNOSRG
5870000	Radiography of urinary tract	XNOSRG
5870600	Intravenous pyelography	XNOSRG
5871500	Antegrade pyelography	XNOSRG
5872100	Retrograde micturating CUG	XNOSRG
5890900	Opaque meal phrynx/oesoph/stomch/duodnm	XNOSRG
5891200	Opaque meal pharynx through to colon	XNOSRG
5892100	Other opaque enema	XNOSRG
5930000	Radiography of breast, bilateral	XNOSRG
5930300	Radiography of breast, unilateral	XNOSRG
5970000	Discography	XNOSRG
5971200	Hysterosalpingography	XNOSRG
5971800	Phlebography	XNOSRG
5973903	Other sinography	XNOSRG
5975100	Arthrography	XNOSRG
5990300	Left ventriculography	XNOSRG
5990303	Aortography	XNOSRG
5997002	Cerebral angiography	XNOSRG
5997003	Peripheral arteriography	XNOSRG
5997004	Other arteriography	XNOSRG
6010000	Tomography	XNOSRG
6050300	Fluoroscopy	XNOSRG
6130200	Stress myocardial perfusion study	XNOSRG
6132001	Cardiac first pass blood flow study	XNOSRG
6132800	Lung perfusion study	XNOSRG
6134800	Lung perfusion and ventilation study	XNOSRG
6136800	Meckel's diverticulum study	XNOSRG
6138600	Renal study	XNOSRG
6138601	Renal cortical study	XNOSRG
6138700	Renal cortical study with SPECT	XNOSRG
6138900	Renal stud w preproc admin diuretic/ACE	XNOSRG
6139000	Renal stud diuretic admin second stud	XNOSRG
6139700	Nuclear medicine cystoureterography	XNOSRG
6142100	Whole body bone study	XNOSRG
6144600	Localised bone study	XNOSRG
6144601	Localised joint study	XNOSRG
6144900	Localised bone study with SPECT	XNOSRG
6146900	Lymphoscintigraphy	XNOSRG
6147300	Thyroid study	XNOSRG
9001601	Other procedure on nerves	XNOSRG
9001800	Epidural inj/o other/cmb thrpc subs	XNOSRG
9002200	Admin anaes arnd other perph nrv	XNOSRG
9002800	Epidural injection of steroid	XNOSRG
9002801	Epidural infusion of steroid	XNOSRG
9002802	Caudal injection of steroid	XNOSRG
9002900	Administration of sympatholytic agent	XNOSRG
9004700	Aspiration of thyroid	XNOSRG
9011400	Other proc on eardrum or middle ear	XNOSRG
9011900	Otoscopy	XNOSRG
9014101	Excision of other lesion of mouth	XNOSRG

9016900	Endoscopic wedge resection of lung	XNOSRG
9017200	Sequential single lung trnsplnt bil	XNOSRG
9020300	Adjust trnsven elec for card pacemaker	XNOSRG
9020305	Adjustment cardiac pacemaker generator	XNOSRG
9020306	Adjust cardiac defibrillator generator	XNOSRG
9020307	R/O cardiac defibrillator generator	XNOSRG
9022000	Catheterisation/cannulation of oth vein	XNOSRG
9022400	Repair of transposition of great vessels	XNOSRG
9023400	Testing of cardiac defibrillator	XNOSRG
9028100	Incision of lymphatic structure	XNOSRG
9029500	Endosc ins of colonic prosth	XNOSRG
9029600	Endosc cntl PU or bleeding	XNOSRG
9029700	Endosc mucosal resec oesophagus	XNOSRG
9029800	Transjugular liver biopsy	XNOSRG
9033400	Trnsjugular intrahep portosystemic shunt	XNOSRG
9034401	Admin/o thrpc agent to anorectal rgn	XNOSRG
9034800	Percutaneous aspiration of gallbladder	XNOSRG
9035301	Test for peritoneal dialysis adequacy	XNOSRG
9036300	Other diagnostic procedures on bladder	XNOSRG
9046200	Ins prostaglndn supostry induct abortion	XNOSRG
9046500	Medical induction of labour, oxytocin	XNOSRG
9046501	Medical induction labour, prostaglandin	XNOSRG
9046503	Surgical induction of labour by ARM	XNOSRG
9046601	Surgical augmentation of labour	XNOSRG
9046602	Medical & surgical augmentation labour	XNOSRG
9046700	Spontaneous vertex delivery	XNOSRG
9046800	Low forceps delivery	XNOSRG
9046801	Mid-cavity forceps delivery	XNOSRG
9046901	Failed vacuum extraction	XNOSRG
9047000	Spontaneous breech delivery	XNOSRG
9047001	Assisted breech delivery	XNOSRG
9056000	Admin of other agt into soft tissue NEC	XNOSRG
9057400	Excision of lesion of joint, NEC	XNOSRG
9059300	Oth dx proc muscle tend fascia bursa NEC	XNOSRG
9059400	Other dx proc on bone or joint NEC	XNOSRG
9060601	Removal of other soft tissue implant	XNOSRG
9066000	Administration of agent into SSCT	XNOSRG
9066100	Other incision of SSCT	XNOSRG
9066200	Laser to tattoo	XNOSRG
9067600	Other proc on skin & subcutaneous tissue	XNOSRG
9067700	Other phototherapy, skin	XNOSRG
9072300	Injection breast for augmentation, uni	XNOSRG
9072400	Breast stereotactic localisation	XNOSRG
9072500	Aspiration of breast	XNOSRG
9076401	Brachythrpy intracavitary high dose rate	XNOSRG
9076500	Construct & fitting immobils dev simple	XNOSRG
9076501	Construct, fitting immobils dev intrmed	XNOSRG
9090100	Magnetic resonance imaging of brain	XNOSRG
9090101	Magnetic resonance imaging of head	XNOSRG
9090102	Magnetic resonance imaging of neck	XNOSRG
9090103	Magnetic resonance imaging of spine	XNOSRG
9090104	Magnetic resonance imaging of chest	XNOSRG
9090105	Magnetic resonance imaging of abdomen	XNOSRG
9090106	Magnetic resonance imaging of pelvis	XNOSRG
9090107	Magnetic resonance imaging of extremity	XNOSRG
9090108	Magnetic resonance imaging of other site	XNOSRG
9090109	Functional MRI of brain	XNOSRG
9090200	Magnetic resonance angiography head/neck	XNOSRG
9090204	Magnetic resonance angiography, abdomen	XNOSRG

9090206	Magnetic resonance angiography low limb	XNOSRG
9090502	Whole body study with PET	XNOSRG
9091200	CT of spine unspecified region	XNOSRG
9200100	Other physiological assessment	XNOSRG
9200300	Alcohol detoxification	XNOSRG
9200400	Alcohol rehabilitation & detoxification	XNOSRG
9200600	Drug detoxification	XNOSRG
9200900	Combined alcohol & drug detoxification	XNOSRG
9201100	Video & radiotelemetered EEG monitoring	XNOSRG
9201200	Other sleep disorder function tests	XNOSRG
9201300	Intracarotid amobarbital test	XNOSRG
9201600	Tonometry	XNOSRG
9203500	Other intubation of respiratory tract	XNOSRG
9203600	Insertion of nasogastric tube	XNOSRG
9204300	Resp medication administered nebuliser	XNOSRG
9204400	Other oxygen enrichment	XNOSRG
9204600	Replacement of tracheostomy tube	XNOSRG
9204900	R/O thoracotomy tube/pleural cv drain	XNOSRG
9205200	Cardiopulmonary resuscitation	XNOSRG
9205500	Other conversion of cardiac rhythm	XNOSRG
9205600	Monitoring cardiac output/blood flow NEC	XNOSRG
9205700	Telemetry	XNOSRG
9205800	Irrigation of vascular catheter	XNOSRG
9206000	Administration of autologous blood	XNOSRG
9206100	Administration of coagulation factors	XNOSRG
9206200	Administration of other serum	XNOSRG
9206400	Administration of other blood product	XNOSRG
9206800	Endoscopic insertion of duodenal prosth	XNOSRG
9207700	Other rectal irrigation	XNOSRG
9207800	Replace nasogastric/oesophagostomy tube	XNOSRG
9207900	Replace tube/enterostomy dev, sm intest	XNOSRG
9208200	Removal of peritoneal drainage device	XNOSRG
9209700	R/O T-tube other bile duct or liver tube	XNOSRG
9210900	Replacement of other vaginal pessary	XNOSRG
9211900	Removal other urinary drainage device	XNOSRG
9213000	Papanicolaou smear study	XNOSRG
9213800	Removal FB from head/neck wo incision	XNOSRG
9214100	Removal of device from abdomen	XNOSRG
9214200	Removal of other device from trunk	XNOSRG
9214400	Vaccination agnst typhoid & paratyphoid	XNOSRG
9214900	Admin diphtheria-tetanus-pertussis, cmb	XNOSRG
9215600	Admin of measles-mumps-rubella vaccine	XNOSRG
9215700	Vaccination against viral diseases, NEC	XNOSRG
9215900	Prophylactic vaccination agnst influenza	XNOSRG
9216300	Administration of botulism antitoxin	XNOSRG
9216500	Vaccination against pneumococcus	XNOSRG
9216800	Vaccination against hepatitis B	XNOSRG
9216900	Vaccination against hepatitis A	XNOSRG
9217100	Other vaccination or inoculation	XNOSRG
9217200	Passive immunis w norm immunoglobulin	XNOSRG
9217300	Passive immunisation with Rh(D) Ig	XNOSRG
9217400	Passive immunis w varicella-zoster Ig	XNOSRG
9217600	Passive immunisation w hepatitis B Ig	XNOSRG
9217900	Immunisation for allergy	XNOSRG
9219900	Extracorporeal shockwave lithotripsy NEC	XNOSRG
9220000	Removal of sutures, NEC	XNOSRG
9220200	R/O therapeutic device, NEC	XNOSRG
9220400	Noninvas dx tests/measure/investgtn NEC	XNOSRG
9220900	Management NIV support <= 24 hours	XNOSRG

9220901	Management NIV support > 24 < 96 hr	XNOSRG
9220902	Management NIV support >= 96 hours	XNOSRG
9250000	Routine preoperative anaes assessment	XNOSRG
9250610	Neuraxial block during labour, ASA 10	XNOSRG
9250619	Neuraxial block during labour, ASA 19	XNOSRG
9250629	Neuraxial block during labour, ASA 29	XNOSRG
9250699	Neuraxial block during labour, ASA 99	XNOSRG
9250719	Nrxl blck dur labour & delv proc, ASA 19	XNOSRG
9250799	Nrxl blck dur labour & delv proc, ASA 99	XNOSRG
9250899	Neuraxial block, ASA 99	XNOSRG
9251199	Regnl block nerve of upp limb ASA 99	XNOSRG
9251499	General anaesthesia, ASA 99	XNOSRG
9251599	Sedation, ASA 99	XNOSRG
9251800	IV postproc infus pt cntrl analgesia	XNOSRG
9251999	Intravenous regional anaesthesia, ASA 99	XNOSRG
9334100	Electroconvulsive therapy [ECT] unsp Rx	XNOSRG
9334101	Electroconvulsive therapy [ECT] 1 Rx	XNOSRG
9334108	Electroconvulsive therapy [ECT] 8 Rx	XNOSRG
9555000	Allied health intervention, dietetics	XNOSRG
9555001	Allied health intervention, social work	XNOSRG
9555002	AH intervention, occupational therapy	XNOSRG
9555003	Allied health intervtn, physiotherapy	XNOSRG
9555004	Allied health intervention, podiatry	XNOSRG
9555005	Allied health intervtn, speech pathology	XNOSRG
9555006	Allied health intervention, audiology	XNOSRG
9555008	AH intervtn, prosthetics & orthotics	XNOSRG
9555009	Allied health intervention, pharmacy	XNOSRG
9555010	Allied health intervention, psychology	XNOSRG
9555011	Allied health intervention, other	XNOSRG
9555012	Allied health intervtn, pastoral care	XNOSRG
9555013	Allied health intervtn, music therapy	XNOSRG
9555014	AH intervention diabetes education	XNOSRG
9601000	Swallowing function assessment	XNOSRG
9602000	Skin integrity assessment	XNOSRG
9602100	Self care/self maintenance assessment	XNOSRG
9602200	Health maintenance or recovery assess	XNOSRG
9602600	Nutritional/dietary assessment	XNOSRG
9602700	Prescribed/self-selected medicatn assess	XNOSRG
9603400	Alcohol and other drug assessment	XNOSRG
9603700	Other assessment/consultation/evaluation	XNOSRG
9606300	Rotating chair evaln vestibular function	XNOSRG
9607200	Pscbd/self-sel medicatn counsel/eductn	XNOSRG
9607300	Substance addiction counsel/education	XNOSRG
9607600	Counsel/eductn hlth maintenance/recovery	XNOSRG
9609000	Other counselling or education	XNOSRG
9609200	Applicn/fit/adjust/replace oth dev/equip	XNOSRG
9613000	Skills train body position/mobility/move	XNOSRG
9613900	Exercise therapy, cardioresp/C-V system	XNOSRG
9614000	Skills train act self care/maintenance	XNOSRG
9614100	Skills train in act rel hlth maintenance	XNOSRG
9614200	Skills train use asst/adapt dev/equip	XNOSRG
9615300	Hydrotherapy	XNOSRG
9615500	Stimulation therapy, NEC	XNOSRG
9617500	Mental/behavioural assessment	XNOSRG
9617600	Behaviour therapy	XNOSRG
9618800	Other photography of eye	XNOSRG
9619100	Hyperbaric oxygen therapy, <= 90 minutes	XNOSRG
9619500	Administration of venom protein, other	XNOSRG
9619501	Admin of venom protein, rush protocol	XNOSRG

9619600	Intrartrl admin of pharmac agt antineopl	XNOSRG
9619603	Intrartrl admin of pharmac agt steroid	XNOSRG
9619609	Intrartrl admin pharmac agt oth & unsp	XNOSRG
9619700	IM admin of pharmac agt antineoplastic	XNOSRG
9619703	IM admin of pharmac agent steroid	XNOSRG
9619709	IM admin of pharmac agt oth & unsp agent	XNOSRG
9619800	Intrathcl admin of pharmac agt antineopl	XNOSRG
9619809	Intrathcl admin pharmac agt oth & unsp	XNOSRG
9619900	IV admin of pharmac agent antineoplastic	XNOSRG
9619901	IV admin of pharmac agent thrombolytic	XNOSRG
9619902	IV admin of pharmac agent anti-infective	XNOSRG
9619903	IV admin of pharmac agent steroid	XNOSRG
9619904	IV admin of pharmac agent antidote	XNOSRG
9619906	IV admin of pharmac agent insulin	XNOSRG
9619907	IV admin of pharmac agt nutritional subs	XNOSRG
9619908	IV admin of pharmac agent electrolyte	XNOSRG
9619909	IV admin of pharmac agt oth & unsp agent	XNOSRG
9620000	Sbc admin of pharmac agt antineoplastic	XNOSRG
9620001	Sbc admin of pharmac agent thrombolytic	XNOSRG
9620002	Sbc admin of pharmac agt anti-infective	XNOSRG
9620003	Sbc admin of pharmac agt steroid	XNOSRG
9620004	Sbc admin of pharmac agt antidote	XNOSRG
9620006	Sbc admin of pharmac agent, insulin	XNOSRG
9620007	Sbc admin pharmac agent nutritional subs	XNOSRG
9620008	Sbc admin of pharmac agent electrolyte	XNOSRG
9620009	Sbc admin of pharmac agt oth & unsp agt	XNOSRG
9620100	Intracv admin of pharmac agent antineopl	XNOSRG
9620103	Intracv admin of pharmac agent steroid	XNOSRG
9620109	Intracv admin pharmac agent oth & unsp	XNOSRG
9620202	Enteral admin pharmac agent anti-infect	XNOSRG
9620203	Enteral admin of pharmac agent steroid	XNOSRG
9620207	Enteral admin pharmac agent nutrit subs	XNOSRG
9620300	Oral admin of pharmac agent antineopl	XNOSRG
9620309	Oral admin of pharmac agent oth & unsp	XNOSRG
9620500	Other admin of pharmac agent antineopl	XNOSRG
9620503	Other admin of pharmac agent steroid	XNOSRG
9620509	Other admin of pharmac agent oth & unsp	XNOSRG
9620900	Load drug delv dev antineopl agent	XNOSRG
9620903	Load drug delv device steroid	XNOSRG
9620909	Load drug delv device oth / unsp agt	XNOSRG
9701100	Comprehensive oral examination	XNOSRG
9703900	Tomography of skull, or prt of skull	XNOSRG
9711100	Removal of plaque or stain of teeth	XNOSRG
9716100	Fissure sealing, per tooth	XNOSRG
9721300	Treatment acute periodontal infection	XNOSRG
9731101	Removal of 1 tooth or part(s) thereof	XNOSRG
9731105	R/O 5 - 9 teeth or part(s) thereof	XNOSRG
9731106	R/O 10 - 14 teeth or part(s) thereof	XNOSRG
9731108	R/O ? teeth or part(s) thereof	XNOSRG
9732200	Surg R/O 1 tooth wo R/O bone / div	XNOSRG
9732202	Surg R/O 2 teeth wo R/O bone / div	XNOSRG
9732203	Surg R/O 3 teeth wo R/O bone / div	XNOSRG
9732401	Surg R/O 1 tooth w R/O bone / div	XNOSRG
9738500	Surgical repositioning unerupted tooth	XNOSRG
9751101	Metallic restoration tooth 1 surf direct	XNOSRG
1821606	Epdl infus other/cmb thrpc subs	XTORTH
4739000	Closed rdctn fx shaft radius & ulna	XTORTH
4794800	Removal of external fixation device	XTORTH
5010000	Arthroscopy joint, NEC	XTORTH

5011500	Manipulation/mobilisation of joint NEC	XTORTH
5012400	Aspiration jt/oth synovial cavity NEC	XTORTH
5012401	Admin agt into jt/oth synovl cavity NEC	XTORTH
5020000	Biopsy of bone, not elsewhere classified	XTORTH
9001900	Caudal inj/o oth/cmb therapeutic subs	XTORTH

Adjusted Surgical ALOS Calculator

Hospital

	Baseline Year 2010	Current Values	Adjusted Current Values
Total number of Cases	400,625	420,606	400,625
Number of Daycases	240,336	263,223	250,719
Number of Inpatients	160,289	157,383	149,906
Inpatient ALOS	6.628	6.461	6.075
Inpatient Beddays	1,062,395	1,016,911	973,794

Basline values for 2010 have been provided by the Surgery and Anaesthesia Programme and should not be changed.
Baseline values are hospital specific. This file cannot be used to determine the current adjusted ALOS for another hospital.
Current values should be taken from the HIPE Portal and entered directly into this sheet.
Sameday cases are assigned a length of stay 0.5 days. The HIPE Portal assigns 1 day as default therefore this needs to be adjusted prior to entering the values into this file.
Current ALOS values are adjusted for total number of cases and inpatient/daycase conversions.

KPI Metadata 2016

	Time to Surgery - Hip Fracture	
1	**KPI title**	% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0,1 or 2)
2	**KPI Description A42**	The % of emergency hip fracture surgeries with the principal procedure carried out on days 0, 1 or 2 of the stay.
3	**KPI Rationale Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 95%
5	**KPI Calculation**	Numerator: (The number of inpatient discharges in the reporting period where an emergency hip fracture surgery was carried on days 0 , 1 or 2 for a patients aged over 65)*100 Denominator: The number of inpatient discharges in the reporting period where an emergency hip fracture surgery was carried out for a patients aged over 65.
6	**Data Source Data Completeness Data Quality Issues**	HIPE
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Emergency admissions only (Admission Type =4 and 5) Hip fracture:a principal diagnosis of S72.0, S72.1 or S72.2 (including sub diagnoses) and a principal procedure in procedure blocks 1479, 1486, 1489, 1487, 1488, 1491 or 1492. Pre-op LOS: Date of principal procedure - date of admission Age>65
9	**Minimum Data Set**	HIPE: Date of admission, date of principal procedure, ICD10-AM principal diagnosis, ACHI principal procedure, age
10	**International Comparison**	British Orthopaedic Association and British Geriatrics Society. Blue Book. British Geriatrics Society. 2007. National Institute for Health and Care Excellence. The Management of Hip Fracture in Adults. 2011. National Institute for Health and Care Excellence. Scottish Intercollegiate Guidelines Network. Management of Hip Fracture in Older People. A national Clinical Guideline. Scottish Intercollegiate Guidelines Network 2009. National Hip Fracture Database, UK, NHFD 2009-2014.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑ Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ☑ Hospital Group ☑ Hospital ❑ CHO ❑ ISA q LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑ CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Derek McCormack, BIU Acute , Email: derek.mccormack@hse.ie Tel: 01 620 1690 .
National Lead and Division		Ms. Catherine Farrell ,Programme Manager, Trauma & Orthopaedic Programme email: catherinefarrell@rcsi.ie Specialist Lead: Joint Clinical Leads, National Clinical Programme for Trauma and Orthopaedic Surgery

KPI Metadata 2016

Scheduled Waiting List

1	**KPI title**	Scheduled waiting list cancellation rate
2	**KPI Description A43**	The percentage of the scheduled inpatient / day case waiting list that has been cancelled in the current month (ie month being reported).
3	**KPI Rationale**	It is better for the patient and a more efficient use of limited hospital resources to perform surgery on scheduled patients on the first scheduled date for their procedure then to have there procedure deferred or cancellled and scheduled for a later date. While some patients have to be cancelled becasue of medical reasons, many cancellations occur becasue of bed availability and schedulling administrative reasons which should be minimised.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑Person Centred Care ☑Effective Care
	(National Standards for Safer Better HealthCare)	Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce ☑ Use of Resources☐ Governance, Leadership and Management ☐
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016:
5	**KPI Calculation**	Number of elective scheduled inpatient / day case patients who have a had been cancelled in the current month being reported excluding Patient did not attend (code 12) and Cancelled by Patient / Guardian (code 22) devided by the number of patiented passed /processed from the waiting list in the current month being reported and espressed as a percentage. Passed / Processed includes all pateint with a wait list category of TCIed, Planned Past date, Planned with date, Planned and Suspended (excluding: Removals and Admissions)
6	**Data Source** **Data Completeness** **Data Quality Issues**	National Treatment Purchase Fund (NTPF) scheduled inpatient and day case patient treatment register data. Will be dependant on accuracy (particularly the coding of TCI cancellations and TCI cancellations reasons) and timely completion of Hospital scheduled inpatient / day case pateint treatment register coding and transmission of that data to the NTPF. Coverage includes all acute hospitals.
7	**Data Collection Frequency**	Daily Weekly ☑ Monthly ☑Quarterly ☐Bi-annually ☑Annually ☐Other – give details: Starts Jan 2016
8	**Tracer Conditions**	ICD 10 Codes= International Classification of Disease (ICD) 10.
9	**Minimum Data Set**	HIPE recorded data for every episode for surgical admissions.
10	**International Comparison**	Collected in UK and internationally.
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑Monthly Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:Hospital Groups, Hospitals, Surgery and Anaesthesia Programmes, ISD
12	**KPI Reporting Frequency**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June metric to be reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☐Rolling 12 months (previous 12 month period)
		❑ Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		❑ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		❑ Other – give details:
14	**KPI Reporting Aggregation**	☑National ☑Regional ☐ LHO Area ☑ Hospital ☑ Hospital Group ☐ County ☐ Institution yes Other – give details: hospital groups as appropriate
15	**KPI is reported in which reports?**	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☐CompStat ☐Other – give details:
16	**Web link to data**	N/A
17	**Additional Information**	KPI noted in Divisional Operational Plan 2016
Contact details for Data Manager /Specialist Lead		Brian Parsons, NTPF: brian.parsons@ntpf.ie Ph: 353 1 6427108
National Lead and Division		Jennifer Hogan, Performance Lead for Scheduled Care SDU/NTPF: Jennifer.Hogan@ntpf.ie Ph: 087 967 8610

Acute Division - Hospital Mortality

1	**KPI title**	Standardised Mortality Rate (SMR) for inpatients deaths by hospital and clincial Condition
2	**KPI Description** **A44**	The SMR is the ratio of the actual versus expected number of in-hospital deaths by diagnosis, with adjustment for potential confounding factors.
3	**KPI Rationale**	Differences in SMRs can signal statistically unusual mortality patterns which can arise for a number of reasons including random variation, differences in patient characteristics, and variation in the quality of data. Quality of care is a potential explanation for differences when the other factors have already been taken into consideration. SMRs are a "screening test", and should be interpreted in light of the above factors and always be used in conjunction with other indicators of the quality of care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing Use of Information ❑ Workforce Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	TBC
5	**KPI Calculation**	The SMR is the ratio of observed deaths to expected deaths multiplied by 100. The SMR logistic regression (risk) computation uses currently available hospital data to identify statistically usual and unusual patterns of mortality in the national context. The model adjusts for potential confounders including: age; gender; admission type (elective or emergency); admission source (home, hospital transfer, nursing home, other); previous emergency admissions (last 12 months); deprivation indicator (medical card yes/no); palliative care; and the Charlson Index (key medical co-morbidity conditions with attached weights that predict the risk of death within one year). Confidence intervals (95.0%, 99.8%) are computed around each SMR value. Where the confidence interval overlaps 100, it suggests that there is no significant difference between the hospital's mortality rate and the national average; where the lower confidence interval does not reach 100, the hospital mortality rate is considered higher than national average; and where the upper confidence interval does not reach 100 the hospital mortality rate is considered lower than the national average
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data source: HIPE Inclusions and exclusions: All public hospital discharge episodes recorded in HIPE for 2015 will be included. Maternity and day case discharges are EXCLUDED.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	The observed and expected number of deaths per institution is extracted from HIPE discharge data.
10	**International**	Not possible
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ❑Quarterly Bi-annually ☑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Quality and Patient Safety Committee and Clinical Director
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ❑Quarterly Bi-annually ☑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ☑ Other – give details: annual one year in arrears, i.e. Jan to Dec 2015 will be reported in quarter 1 of 2017
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑Performance Report (NSP/CBP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	
Contact details for Data Manager /Specialist Lead		Name: Dr Jennifer Martin Email address:Jennifer.martin@hse.ie Contact Number:0876111291. Howard Johnson. Email: Howard.johnson@hse.ie Contact number:01 6352040
National Lead and Division		Dr. Philip Crowley, National Director Quality and Patient Safety National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-6352000.

Acute Division - Re-Admission (Monthly)

1	**KPI title**	% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge
2	**KPI Description** **CPA30**	Percentage of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 = 10.8%
5	**KPI Calculation**	Numerator: (Number of medical inpatient discharges in the denominator period which resulted in an emergency readmission to the same hospital within 28 days)*100 Denominator: Number of medical inpatient discharges (elective and emergency) in the denominator period (denominator period is set 28 days in arrears) Example: April 2016 Numerator: (Number of medical inpatient discharges in the denominator period which were readmitted as an emergency within 28 days of a previous discharge i.e. an emergency readmission occuring between 04MAR2016 and 30APR2016 inclusive)*100 Denominator: Number of medical inpatient discharges in the denominator period (denominator period is set 28 days in arrears i.e. medical inpatients discharged between 04MAR2016 and 02APR2016 inclusive)
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE and uncoded PAS data
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Discharges from medical specialties: - 0100 Cardiology , 0300 Dermatology , 0400 Endocrinology , 0402 Diabetes Melitus , 0700 Gastro-Enterology , 0800 Genito-Urinary Medicine, 0900 Geriatric Medicine , 1100 Haematology , 1102 Transfusion Medicine , 1300 Neurology , 1600 Oncology , 2300 Nephrology, 2400 Respiratory Medicine , 2500 Rheumatology , 2700 Infectious Diseases , 2702 Tropical Infectious Diseases , 3000 Rehabilitation Medicine , 3002 Spinal paralysis, 5000 General Medicine , 6700 Clinical (medical) Genetics , 7300 Palliative Medicine , 7700 Metabolic Medicine and 7900 Clinical Immunology - Age>=16
9	**Minimum Data Set**	HIPE: Specialty, Admission Date, Discharge Date, LOS, Age, Admission Type, Discharge Code
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Repor ☑ Performance Report (NSP/CBP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		Prof Garry Courtney, Garry.Courtney@hse.ie Dr Yvonne Symth yvonne.symth@hse.ie

	Acute Division	
1	**KPI title**	Percentage of surgical re-admissions to the same hospital within 30 days of discharge
2	**KPI Description** **A45**	Unplanned re- admission, 30 days post acute or elective, inpatient or day-case surgical admission to same hospital should remain below 3%.
3	**KPI Rationale**	As hospitals are encouraged to reduce surgical length of stay, it is important that re admission reates re monitored to ensure that there is not an associated inappropriate increase in vigilant HIPE coding of readmissions to surgical servcies in Ireland is considered a priority in terms of monitoring quality, the inclusion of this KPI will encourage compliance.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016 Target: <3%
5	**KPI Calculation**	Numerator: (Number of Surgical discharges (inpatient & daycase) in the denominator period which resulted in an emergency readmission to the same hospital within 30 days)*100 Denominator: Number of Surgical discharges (elective and emergency) in the denominator period (denominator period is set 30 days in arrears) Example: April 2016 Numerator: (Number of Surgical discharges in the denominator period which were readmitted as an emergency within 30 days of a previous discharge i.e. an emergency readmission occuring between 02MAR2016 and 30APR2016 inclusive)*100 Denominator: Number of Surgical discharges in the denominator period (denominator period is set 30 days in arrears i.e. Surgical patients discharged between 02MAR2016 and 31MAR2016 inclusive)
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE Data. Will be dependant on accuracy (particularly precise coding of "type of admission" field) and timely completion of Hospital HIPE coding. Coverage includes all acute hospitals except specialist paediatric and maternity hosptials. Surgery Programme mapping tables for surgical procedures and surgical specialities.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Denominator - Surgical Discharges = (Patients who had a Principal procedure in Appendix I OR (Patients who had a Specialty in Appendix II) - Discharges following Emergency with an admission type of 4 or 5 or Elective with an admission type of 1 or 2 Numerator - Emergency readmissions have an Admission Type of 4 or 5 within 30 days of the Original surgical discharges (ie. with an MRN and hospital the same as prior surgical discharge) - Death are excluded from the denominator (Discharge code=6 or 7) (Procedure classification ICD-10-AM/ACHI/ACS)
9	**Minimum Data Set**	HIPE: Specialty, ACHI principal procedure, Admission Date, Discharge Date, Admission Type, Discharge Code
10	**International Comparison**	Collected in UK and internationally, often for particular surgical procedures e.g. fractured neck of femur.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Groups, Hospitals, Surgery Anaesthesia Programme, ISD
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ☑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ☑ Other – give details: hospital groups as appropriate
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	N/A
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Gerry Kelliher National Clinical Programme in Surgery gerrykelliher@rcsi.ie W: www.rcsi.ie T: 01-402-2143 M: 087-124-0759
National Lead and Division		Prof. Frank Keane, Ken Mealy joint leads for National Clinical Programme in Surgery: fkeane@rcsi.ie, kmealy@rcsi.ie; Colm Henry: National clinical lead for Acute Hospital directorate: ncagl.acutehospitals@hse.ie

Acute Division - Admission (Monthly)

1	KPI title	% of all medical admissions via AMAU
2	KPI Description CPA31	The percentage of total medical admissions to the hospital which are admitted via the Acute Medicine Assessment Unit or Medical Assessment Unit.
3	KPI Rationale Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	Target 2016 = 35%
5	KPI Calculation	Numerator: (Total medical inpatient discharges (including sameday discharges) admitted via AMAU in the period)*100 Denominator: Total number of inpatient medical discharges (elective and emergency) for those in same period
6	Data Source Data Completeness Data Quality Issues	HIPE and uncoded PAS data
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Discharges from medical specialties: - 0100 Cardiology , 0300 Dermatology , 0400 Endocrinology , 0402 Diabetes Melitus , 0700 Gastro-Enterology , 0800 Genito-Urinary Medicine, 0900 Geriatric Medicine , 1100 Haematology , 1102 Transfusion Medicine , 1300 Neurology , 1600 Oncology , 2300 Nephrology, 2400 Respiratory Medicine , 2500 Rheumatology , 2700 Infectious Diseases , 2702 Tropical Infectious Diseases , 3000 Rehabilitation Medicine , 3002 Spinal paralysis, 5000 General Medicine , 6700 Clinical (medical) Genetics , 7300 Palliative Medicine , 7700 Metabolic Medicine and 7900 Clinical Immunology - Age>=16 - Non-maternity admission: Admission Type not equal to 6 - AMAU/MAU admission is based if case is admitted through AMAU/MAU ward (List of Wards in Appendix I)
9	Minimum Data Set	HIPE: Specialty, Admission Ward, Admission Date, Discharge Date, LOS, Age, Admission Type, Discharge Code
10	International Comparison	
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually qOther – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details: Hospital Group
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑ CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		Prof Garry Courtney, Garry.Courtney@hse.ie Dr Yvonne Symth yvonne.symth@hse.ie

Acute Division - Dialysis

1	**KPI title**	Dialysis Modality - Haemodialysis - (ESKD Patient Treatments)
2	**KPI Description CPA32**	The KPI assists monitoring the incremental growth in ESKD Haemodialysis activity.
3	**KPI Rationale**	This KPI allows the National Renal Office to strategically plan for Haemodialysis requirements each year and also to plan ahead and anticipate additional patient requirements. It assists in the operation and planning needs of the current network of Renal Units in the country. Haemodialysis is a type of treatment that replicates many of the functions of the kidneys. It is often used to treat cases of permanent kidney failure, which is also known as End Stage Kidney Disease (ESKD).
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: Haemodialysis Expected Activity Treatments 288,096- 295,428
5	**KPI Calculation**	ESKD Patients will receive Haemodialysis Treatments 3 times per week /52 weeks totalling 156 treatments per year. Patients receiving ESKD Haemodialysis are counted by Census twice yearly, half yearly on 30th June and full year 31st December in the 14 HSE Renal Units, 7 Contracted Satellite Haemodialysis Units and 2 Northern Ireland Satellite Haemodialysis Units.
6	**Data Source** **Data Completeness**	National Renal Office twice yearly Activity Census of Renal Units within each of the Hospital Groups. Complete. The Kidney Disease Clinical Patient Management System(KDCPMS)will capture the KPI data when it is fully operational within all the Parent Renal Units and Contracted Satellite Haemodialysis Units.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patients with ESKD, receive Haemodialysis treatment normally 3 times per week,156 times a year. Haemodialysis is a treatment that replicates many of the functions of the kidneys.
9	**Minimum Data Set**	Number of Haemodialysis patients recorded by the National Renal Office on the twice Yearly Census of Renal Units taken in June and December each year.
10	**International Comparison**	The closest jurisdiction with which comparisons can be made is the United Kingdom.The UK Renal Registry reports on an Annual basis.Within this dataset are available comparative metrics from Northern Ireland.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Dr Liam Plant, NCD,NRO
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ❑Quarterly ☑Bi-annually Annually ☑Other –give details: Kidney Disease Clinical Patient Management System will allow for real time data reporting.
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ☑Other – give details: Bi annually half year to June and full year to December
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ☑Other – give details: 1)DOH Statistics for submission to EU. 2)Irish Kidney Association 3)United States International Renal Data System. 4)Irish Nephrology Society
16	**Web link to data**	Data and Information is recorded on the National Renal Office Website@www.hse/go/nro and HSE National Clinical Programmes http://www.hse.ie/eng/about/Who/clinical/natclinprog/listofprogrammes.html
17	**Additional Information**	The roll out of the Kidney Disease Clinical Patient Management System(KDCPMS) will increase the quality of data available.KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Pat O'Connor, National Renal Office. Email: patj.oconnor@hse.ie Tel: 01-6201806 Specialist Lead: Pat O'Connor
National Lead and Division		National Lead: Dr Liam Plant, National Clinical Director, National Renal Office Division: Clinical Strategy and Programmes Division.nro@hse.ie

Acute Division - Dialysis

1	**KPI title**	Dialysis Modality: Home Therapies - (ESKD Patient Treatments)
2	**KPI Description** **CPA33**	The KPI assists monitoring the incremental growth in Home Haemodialysis and Peritoneal Dialysis activity.
3	**KPI Rationale**	This KPI allows the National Renal Office to strategically plan for Home Haemodialysis and Peritoneal Dialysis requirements each year and also to plan ahead and anticipate additional patient requirements. It assists in the operation and planning needs of the current network of Renal Units in the country. Haemodialysis is a type of treatment that replicates many of the functions of the kidneys. It is often used to treat cases of permanent kidney failure, which is also known as End Stage Kidney Disease (ESKD).
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: Home Therapies Dialysis Expected Activity Treatments 90,647 - 93,259.Target that 20 percent of all ESKD patients treated by dialysis are treated in their home.
5	**KPI Calculation**	ESKD Patients will normally receive Home Haemodialysis and Peritoneal Dialysis up to 7 times per week/52 weeks totalling up to 364 treatments per year. Patients receiving Home Haemodialysis and Peritoneal Dialysis are counted twice yearly, half yearly on 30th June and full year 31st December in the 14 HSE Renal Units .
6	**Data Source** **Data Completeness** **Data Quality Issues**	National Renal Office twice yearly Activity Census of Renal Units within each of the Hospital Groups. Complete. It is envisaged that the Kidney Disease Clinical Patient Management System(KDCPMS)will capture the KPI data when it is fully operational within all the Parent Renal Units .
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Patients with ESKD dialysis at home up to 7 times per week. Dialysis Therapies replicate many of the functions of the kidneys.
9	**Minimum Data Set**	Number of Home Haemodialysis patients recorded by the National Renal Office on the twice Yearly Census of Renal Units taken in June and December each year.
10	**International Comparison**	The closest jurisdiction with which comparisons can be made is the United Kingdom.The UK Renal Registry reports on an Annual basis.Within this dataset are available comparative metrics from Northern Ireland.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Dr Liam Plant, NCD,NRO
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ❑Quarterly ☑Bi-annually ❑Annually ☑Other – give details: Kidney Disease Clinical Patient Management System will allow for real time data reporting.
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ☑Other – give details: Bi annually half year to June and full year to December
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ☑Other – give details: 1)DOH Statistics for submission to EU. 2) Irish Kidney Association 3)United States International Renal Data System. 4) Irish Nephrology Society
16	**Web link to data**	Data and Information is recorded on the National Renal Office Website@www.hse/go/nro and HSE National Clinical Programmes http://www.hse.ie/eng/about/Who/clinical/natclinprog/listofprogrammes.html
17	**Additional Information**	The roll out of the Kidney Disease Clinical Patient Management System(KDCPMS) will increase the quality of data available..KPI noted in Divisional Operational Plan report 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Pat O'Connor, National Renal Office. Email: patj.oconnor@hse.ie Tel: 01-6201806 Specialist Lead: Pat O'Connor
National Lead and Division		National Lead: Dr Liam Plant, National Clinical Director, National Renal Office Division: Clinical Strategy and Programmes Division.

	Acute Division - Delayed Discharges	
1	**KPI title**	Number of bed days lost through delayed discharges
2	**KPI Description** **A48**	This metric looks at the number of bed days lost due to delayed discharge. Delayed Discharge: A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged. New categorisation of delayed discharges grouped under Type A - Destination Home, Type B - Destination Long Term Nursing Care, Type C - Other Destination and Outcomes.
3	**KPI Rationale**	Delayed discharge is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: <183,000
5	**KPI Calculation**	Count of bed days lost to patients who are Delayed Discharges.
6	**Data Source** **Data Completeness** **Data Quality Issues**	National Delayed Discharge database to BIU Acute
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ☑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	bed days lost
9	**Minimum Data Set**	New categorisation of delayed discharges grouped under Type A - Destination Home, Type B - Destination Long Term Nursing Care, Type C - Other Destination and Outcomes
10	**International Comparison**	Yes, similar information gathered in other countries
11	**KPI Monitoring**	KPI will be monitored : ☑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ☑ Daily ❑Weekly √Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☐ Corporate Plan Report ☑ Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - Delayed Discharges (monthly)	
1	**KPI title**	Number of people subject to delayed discharges
2	**KPI Description** **A49**	This metric looks at the number of people subject to delayed discharge. Delayed Discharge: A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged. New categorisation of delayed discharges grouped under Type A - Destination Home, Type B - Destination Long Term Nursing Care, Type C - Other Destination and Outcomes.
3	**KPI Rationale**	Delayed discharge is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		❑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: <500
5	**KPI Calculation**	Count of bed days lost to patients who are Delayed Discharges.
6	**Data Source** **Data Completeness** **Data Quality Issues**	National Delayed Discharge database to BIU Acute.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ☑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	People subject to delayed discharge.
9	**Minimum Data Set**	New categorisation of delayed discharges grouped under Type A - Destination Home, Type B - Destination Long Term Nursing Care, Type C - Other Destination and Outcomes.
10	**International Comparison**	Yes, similar information gathered in other countries
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data in June report ☐Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑National ☐ Regional ❑ LHO Area ☑ Hospital ☑Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☐ Corporate Plan Report √ Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is reported in National Service Plan 2016
Contact details for Data Manager		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division - HR Compliance

1	**KPI title**	European Working Time Directive compliance for NCHDs - <24 hour shift
2	**KPI Description** **A50**	Compliance with aspects of the European Working Time Directive and associated European Commission reporting requirements for Non-Consultant Hospital Doctors (NCHDs) employed in HSE and HSE-funded agencies European Working Time Directive requirements are set out in SI 494 of 2004, SI 593 of 2010 and related HSE and DoH guidance the most recent of which is 'Guidance on EWTD requirements - 18th Jan 12'. European Commission reporting requirements are set out in correspondence from the European Commission to the Minister for Health of 13th February 2013 and 24th August 2013
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ☑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016: 100%
5	**KPI Calculation**	NCHD Contract 2010 and LRC proposals of October 2013 require NCHD compliance with a maximum shift on-site on-call of 24 hours. The KPI is calculated in the case of the target by expressing the numerator (those NCHDs compliant with the target) as a percentage of the denominator (the total population of NCHDs). Data is provided in respect of each grade of NCHD - Intern, Senior House Officer, Registrar and Specialist / Senior Registrar - and for all NCHDs.
6	**Data Source** **Data Completeness** **Data Quality Issues**	HR data provided via the Office of the National Director of HR HR data relies on a individual hospital returns for all NCHDs employed to the Office of the National Director of HR
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	working hours - defined as time spent on-call on-site
9	**Minimum Data Set**	see attached appendix
10	**International Comparison**	No - Ireland and Greece are only two EU states with significant non-compliance with the EWTD
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Management / Medical Manpower Management
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) e.g. Mar data reported in Mar report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) √CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Andrew Condon Email: andrew.condon@hse.ie Tel: 01 6352113 / 087 1215490 Specialist Lead:
National Lead and Division		National Lead: Rosarii Mannion Division: Human Resources

Acute Division - HR Compliance

1	**KPI title**	European Working Time Directive compliance for NCHDs - <48 hour working week
2	**KPI Description** **A51**	Compliance with aspects of the European Working Time Directive and associated European Commission reporting requirements for Non-Consultant Hospital Doctors (NCHDs) employed in HSE and HSE-funded agencies European Working Time Directive requirements are set out in SI 494 of 2004, SI 593 of 2010 and related HSE and DoH guidance the most recent of which is 'Guidance on EWTD requirements - 18th Jan 12'. European Commission reporting requirements are set out in correspondence from the European Commission to the Minister for Health of 13th February 2013 and 24th August 2013
3	**KPI Rationale**	
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ❑ Use of Information ☑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016: 95%
5	**KPI Calculation**	NCHD Contract 2010 and LRC proposals of October 2013 require NCHD compliance with a maximum shift on-site on-call of 24 hours. The KPI is calculated in the case of the target by expressing the numerator (those NCHDs compliant with the target) as a percentage of the denominator (the total population of NCHDs). Data is provided in respect of each grade of NCHD - Intern, Senior House Officer, Registrar and Specialist / Senior Registrar - and for all NCHDs.
6	**Data Source** **Data Completeness** **Data Quality Issues**	HR data provided via the Office of the National Director of HR HR data relies on a individual hospital returns for all NCHDs employed to the Office of the National Director of HR
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	working hours - defined as time spent on-call on-site
9	**Minimum Data Set**	see attached appendix
10	**International Comparison**	No - Ireland and Greece are only two EU states with significant non-compliance with the EWTD
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Management / Medical Manpower Management
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) e.g. Mar data reported in Mar report ☐ Monthly in arrears (June data reported in July) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Andrew Condon Email: andrew.condon@hse.ie Tel: 01 6352113 / 087 1215490 Specialist Lead:
National Lead and Division		National Lead: Rosarii Mannion Division: Human Resources

Metric Description	Year	Month Number	Please insert name of your hospital / agency in the first green box below
Guidance: ***Please insert numbers in the cells shaded green in column D. Do NOT insert numbers or text in any other cell. Please note that total figures and % figures will appear automatically once you start entering data in the green cells.***			
Number of Interns employed	2016	3	
Number of SHOs employed	2016	3	
Number of Registrars employed	2016	3	
Number of Senior / Specialist Registrars employed	2016	3	
Number of NCHDs employed	2016	3	0
% Compliance with a maximum 24 hour shift (EU Commission reporting requirement) - Interns	2016	3	
Number compliant with a maximum 24 hour shift (EU Commission reporting requirement) - Interns	2016	3	
% Compliance with a maximum 24 hour shift (EU Commission reporting requirement) - SHOs	2016	3	
Number compliant with a maximum 24 hour shift (EU Commission reporting requirement) - SHOs	2016	3	
% Compliance with a maximum 24 hour shift (EU Commission reporting requirement) - Registrars	2016	3	
Number compliant with a maximum 24 hour shift (EU Commission reporting requirement) - Registrars	2016	3	
% Compliance with a maximum 24 hour shift (EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
Number compliant with a maximum 24 hour shift (EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
% Compliance with a maximum 24 hour shift (EU Commission reporting requirement) - All NCHDs	2016	3	
Number compliant with a maximum 24 hour shift (EU Commission reporting requirement) - All NCHDs	2016	3	0
% Compliance with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
Number compliant with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
% Compliance with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
Number compliant with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
% Compliance with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
Number compliant with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
% Compliance with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
Number compliant with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
% Compliance with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	
Number compliant with an average 48 hour working week (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	0
% Compliance with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
Number compliant with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
% Compliance with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
Number compliant with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
% Compliance with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
Number compliant with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
% Compliance with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
Number compliant with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
% Compliance with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	
Number compliant with a 30 minute break every 6 hours worked (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	0
% Compliance with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
Number compliant with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
% Compliance with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
Number compliant with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
% Compliance with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
Number compliant with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
% Compliance with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
Number compliant with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
% Compliance with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	
Number compliant with an 11 hour daily rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - All NCHDs	2016	3	0
% Compliance with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
Number compliant with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Interns	2016	3	
% Compliance with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
Number compliant with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - SHOs	2016	3	
% Compliance with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
Number compliant with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Registrars	2016	3	
% Compliance with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
Number compliant with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement - EU Commission reporting requirement) - Specialist and Senior Registrars	2016	3	
% Compliance with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement EU Commission reporting requirement) - All NCHDs	2016	3	
Number compliant with a 35 hour weekly rest period or 59 hour fortnightly rest period or equivalent compensatory rest before return to work (EWTD legal requirement EU Commission reporting requirement) - All NCHDs	2016	3	0

	Acute Division - National Early Warning Score (NEWS)	
1	**KPI title**	% of Hospitals with full implementation of NEWS in all clinical areas of acute Hospitals and single speciality hospitals
2	**KPI Description A52**	This indicator describes the total number of hosptials dealing with adult non-pregnant patients where the NEWS is operational on a defined group of patients (predominately in-patients). There is a standardised definition of implementation used across all hospitals
3	**KPI Rationale**	The National Early Warning Score (NEWS) education programme for non-pregnant adult patients is an interdisciplinary education programme designed to enhance healthcare professionals' understanding of patients who are clinically deteriroating, and the significance of altered clinical observations. It also seeks to improve communication between health care professionals and adopt a patient centred, quality driven approach, enhancing the timely management of patients. The National Early Warning Score (NEWS) for non-pregnant adult patients is based on patients vital signs for the early detection and management of deterioration in a patient's condition.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		☑ Better Health and Wellbeing ☑ Use of Information ☑ Workforce
		☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	100%
5	**KPI Calculation**	Numerator: Total number of Hospitals who have completed implementation of the NEWS in all appropriate clinical areas (see below for definition of implemented). Denominator: Total number of acute hospitals in the HSE
6	**Data Source**	Q1 Baseline questionnaire reponse - Q2-Q4 BIU self-report
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other –
8	**Tracer Conditions**	
9	**Minimum Data Set**	Full implementation records in each acute hospital
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored :
		❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other –
		Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other –
13	**KPI report period**	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐Monthly in arrears (June data reported in July)
		☐ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: Quarterly i.e. Jan to March 2016 reported in April 2016.
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National Regional ❑ LHO Area ❑ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ❑ Performance Report (NSP/CBP) ❑ CompStat ❑Other –
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Gemma Leacy | Project Coordinator, Clinical Programmes, Royal College of Physicians of Ireland, Dublin 2 Direct Line 01 8639 628 | Email gemmaleacy@rcpi.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division - National Early Warning Score (NEWS)	
1	KPI title	% of all clinical staff who have been trained in the COMPASS programme
2	KPI Description A53	This indicator describes the number of clinical staff (head count not WTE & excludes paediatric staff) in all clinical areas who have been trained in the COMPASS Programme in acute hospitals.
3	KPI Rationale	The COMPASS programme is an interdisciplinary education programme designed to enhance our healthcare professionals' understanding of patients who are clinically deteriorating, and the significance of altered clinical observations. It also seeks to improve communication between health care professionals and adopt a patient centred, quality driven approach, enhancing the timely management of patients.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
		☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		☑ Better Health and Wellbeing ☑ Use of Information ☑ Workforce
		☑ Use of Resources ☑ Governance, Leadership and Management
4	KPI Target	End of 2016 95% of doctors, nurses and appropriate HSCP (headcount) trained in the COMPASS education programme.
5	KPI Calculation	Numerator: Total number of Doctors, Nurses and Health and Social Care professionals (Headcount) who are involved in direct patient care and monitoring who are trained in the COMPASS Programme Denominator: Total number of Doctors, Nurses and Health and Social Care Professionals (headcount) working in Acute Hospital.
6	Data Source Data Completeness Data Quality Issues	Q1 Baseline questionnaire reponse - Q2-Q4 BIU MDR self-report 100% Manual collection. Training records need to be verified at staff member level (named)
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other
8	Tracer Conditions	
9	Minimum Data Set	Organisational training records on COMPASS education programme; data reoprt from HSEland
10	International Comparison	
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other –
		Please indicate who is responsible at a local level for monitoring this KPI:
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other –
13	KPI report period	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐Monthly in arrears (June data reported in July)
		☐ Quarterly in arrears (quarter 1 data reported in quarter 2)
		❑ Rolling 12 months (previous 12 month period)
		☑ Other – give details: data reported from hospitals to BIU. It is reported as a snap shot of data based on last day of each quarter i.e. 30th June returned in 15th July, 30th Sept
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		q National Regional ❑ LHO Area ❑ Hospital
		❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		❑ Corporate Plan Report ❑ Performance Report (NSP/CBP) ❑CompStat ❑Other –
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Gemma Leacy | Project Coordinator, Clinical Programmes, Royal College of Physicians of Ireland, Dublin 2 Direct Line 01 8639 628 | Email gemmaleacy@rcpi.ie
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Paediatric Early Warning System (PEWS)	
1	**KPI title**	% of hospitals with implementation of PEWS (paediatric early warning score)
2	**KPI Description A56**	The Irish Paediatric Early Warning System (PEWS) should be used in any inpatient setting where children are admitted and observations are routinely required. This indicator describes the total number of hospitals dealing with paediatric inpatients where the Irish PEWS is operational. There is a standardised definition of implementation used across all hospitals, defined by the NCG No.12 PEWS comprising 18 recommendations, attached to this document.
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	To monitor the implementation of PEWS according to the recommendations laid out in the NCG No.12 PEWS. Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ❑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target NSP 2016: 100% • By the end of December 2016 all 19 paediatric units will have begun implementation of the national PEWS • By the end of December 2017 all units admitting children will have fully implemented the Irish PEWS
5	**KPI Calculation**	Denominator : the number of paediatric inpatient units in Ireland that have implemented the Irish PEWS by meeting the 18 recommendations of the NCG No.12 PEWSNumerator: the total number of paediatric inpatient units in Ireland requiring PEWS implementation to meet the standards of the NCG no.12 PEWS (n=19) Aim: 100% compliance
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data to be collected manually in hospitals and BIU Acute to collect and report this data. There are 19 hospitals with paediatric inpatient services however the PEWS is currently being offered to 31 hospitals who admit children. In 2016 the data available from each of hospital will depend on the stage each hospital group has reached in the centrally facilitated national roll out plan.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ❑ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	n/a
9	**Minimum Data Set**	2016 data collection tool attached with this document. Note that 2017 data will not include the pre-implementation processes.
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: NCPPN CAG or Paediatric Patient Safety Group (HSE) or ERS Group (Acute Hospitals Group)
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) ☑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Assurance Report (NSP) ❑CompStat ☑Other – give details: Divisional Operational Report
16	**Web link to data**	
17	**Additional Information**	this data is included in Divisional Operational Plan 2016
Contact details for Data Manager /Specialist Lead		Rachel MacDonell | National Paediatric Early Warning System Coordinator, Clinical Strategy and Programmes Division | Health Service Executive | Stewart's Hospital | Palmerstown | Dublin 20
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

PEWS appendix

Section	Recommendations
Measurement and documentation of observations 01-May	• The Paediatric Early Warning System (PEWS) should be used in any inpatient setting where children are admitted and observations are routinely required. • PEWS should complement care, not replace clinical judgement. • The core physiological PEWS parameters must be completed and recorded for every set of observations. • Observations and monitoring of vital signs should be undertaken in line with recognised, evidence-based standards. • Nurse or family concern is a core parameter and an important indicator of the level of illness of a child, which may prompt a greater level of escalation and response than that indicated by the PEWS score alone.
Escalation of care and clinical communication 06-Oct	• The PEWS escalation guide should be followed in the event of any PEWS trigger. • The ISBAR communication tool should be used when communicating clinical information. Where a situation is deemed to be critical, this must be clearly stated at the outset of the conversation. • Management plans following clinical review must be in place and clearly documented as part of the PEWS response. • A parameter amendment should only be decided by a doctor of registrar grade or above, for a child with a pre-existing condition that affects their baseline physiological status. • If an unwell but stable child has an elevated PEWS score, a decision to conditionally suspend escalation may be made by a doctor of registrar grade or above.
Paediatric sepsis 11	• Once a diagnosis of sepsis has been made, it is recommended that the Paediatric Sepsis 6 is undertaken within one hour.
Governance Dec-13	• The Chief Executive Officer / General Manager, Clinical Director and Director of Nursing of each hospital or hospital group are accountable for the operation of the Paediatric Early Warning System (PEWS). A formal governance structure, such as a PEWS group or committee, should oversee and support the local resourcing, implementation, operation, monitoring and assurance of the Paediatric Early Warning System. • The PEWS governance committee should identify a named individual(s) to coordinate local PEWS implementation.
Supporting practices	• Hospitals should support additional safety practices that enhance the Paediatric Early Warning System and lead to greater situation awareness among clinicians and multidisciplinary teams.

14-15	• The Paediatric Early Warning System should be supported through the application of quality improvement methods, such as engagement strategies, testing, and measurement to ensure successful implementation, sustainability and future progress.
Education 16-17	• The PEWS governance committee in each hospital must ensure that PEWS education is provided to all clinicians. • Clinicians working with paediatric patients should maintain knowledge and skills in paediatric life support in line with mandatory or certification standards.
Audit 18	• Audit should be used to aid implementation and to regularly quality assure the Paediatric Early Warning System.

PEWS KPI Data Collection 2016

Please answer the following questions in relation to your hospital:

Q 1. Is there a named PEWS Governance Group?

Q 2. Is there a named medical consultant lead?

Q 3. Is there a named nurse lead for PEWS?

Q 4. Is there a named, resourced coordinator for PEWS implementation?

Q 5. Please indicate the stage you consider your hospital to be at:

Pre-implementat *go to Q6*

Implementation <3mont *go to Q7*

Implementation >3 mon go to Q8

Q 6a. has PEWS education commenced for nurses?

Q 6b. Has PEWS education commenced for doctors?

Q 7. Has audit to support implementation been completed using the national tools at weeks:

-2

-6

- 12?

Q 8. Is the national tool for QI audit to monitor PEWS being utilised at least monthly?

All sites to answer the following questions:

Q 9. Is the minimum recommended dataset for clinical outcomes (NCG No.12 p18) being recorded?

Acute Division - National Standards

1	**KPI title**	% of hospitals who have commenced second assessment against the NSSBH
2	**KPI Description** **A59**	Each hospital may adopt its own approach to the process of assessment. For this KPI commencement of assessment can be confirmed if there is a lead for the process identified and in place at the site; there is access to the QA+I tool to record the process; and an initial meeting has been held on site to start the process.
3	**KPI Rationale**	In preparation for the licensing process and associated monitoring programme by HIQA against the Safer Better Healthcare this measure sets out to establish the level of implementation of the Natioanl Standards at hospital level.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 : 95%
5	**KPI Calculation**	Numerator 1: Number of hospitals who report that they have commenced the assessment process; Denominator 1: The number of acute hospitals (including specialist acute hospitals.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Source: Hospital Completeness:100% of all acute hospitals Quality: not known
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	N/A
9	**Minimum Data Set**	Quarterly data supplied by Acute Hospitals
10	**International Comparison**	N/A
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ☑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑Hospital ☑ Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Margaret Brennan | Head of Quality and Patient Safety Acute Hospitals Division| Health Service Executive | Dr. Steevens Hospital | Steevens Lane | Dublin 8 tel 086 8197270
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2352.

	Acute Division	
1	**KPI title**	% of hospitals who have completed first assessment against the NSSBH
2	**KPI Description A60**	Each hospital may adopt its own approach to the process of assessment. For this KPI completion of first assessment can be confirmed if there has been an assessment completed at hospital level; the information is logged on the QA+I tool; and quality improvement plans have been agreed and recorded to address gaps identified in the assessment process.
3	**KPI Rationale**	In preparation for the licensing process and associated monitoring programme by HIQA against the Safer Better Healthcare this measure sets out to establish the level of implementation of the National Standards at hospital level.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	❑ Person Centred Care ❑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: 100%
5	**KPI Calculation**	Numerator 1: Number of hospitals who report that they have completed the assessment process; Denominator 1: The number of acute hospitals (including specialist acute hospitals.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Source: Hospital Completeness:100% of all acute hospitals must participate
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	N/A
9	**Minimum Data Set**	Quarterly data supplied by Acute Hospitals
10	**International Comparison**	N/A
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager/CEO
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ☑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☐ Regional ❑ LHO Area ☑ Hospital ☑ Hospital Group ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Margaret Brennan | Head of Quality and Patient Safety Acute Hospitals Division| Health Service Executive | Dr. Steevens Hospital | Steevens Lane | Dublin 8 tel 086 8197270
National Lead and Division		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2352.

	Maternity	
1	**KPI title**	% maternity units which have completed and published maternity patient safety statement and discussed same at hospital management team meetings each month
2	**KPI Description** **A61**	% the 19 maternity units which have completed and published maternity patient safety statement (see attached template) and discussed same at hospital management team meetings each month (verified by signature in statement or published directly on hospital websites including 3 Dublin Maternity Hospitals by the last day of month following the month that is being reported on- i.e. jan info published on HSE or Hospitals own website end of Feb and reported in March to BIU)
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ❑ Use of Resources ☑ Governance, Leadership and Management This Statement is used to inform local hospital and hospital Group management in carrying out their role in safety and quality improvement. The objective in publishing the Statement each month is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure. It is not intended that the monthly Statement be used as a comparator with other units or that statements would be aggregated at hospital Group or national level. It assists in an early warning mechanism for issues that require local action and/ or escalation. It forms part of the recommendations in the following reports: • HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, Report to the Minister for Health from Dr. Tony Holohan, Chief Medical Officer, 24 February 2014; and • HIQA Report of the Investigation into the Safety, Quality and Standards of Services Provided by the HSE to patients in the Midland Regional Hospital, Portlaoise, 8 May 2015. It is important to note tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies), therefore clinical activity in these centres will be higher and therefore no comparisons should be drawn with units that do not look after complex cases.
4	**KPI Target**	NSP 2016: 100% all units
5	**KPI Calculation**	No of hospitals which have completed (as above)X 100, divided by No. of maternity Units (19 see list attached)
6	**Data Source** **Data Completeness** **Data Quality Issues**	Statements completed by maternity units, signed by Hospital Group CEO and Clinical Director or and published by Hospital Group or HSE as appropiate or completed and published directly on hospital websites including 3 Dublin Maternity Hospitals.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	No. of statements, wether completed, signed and published.
9	**Minimum Data Set**	No. of safety statements completed and published and signed and No. of Maternity units (19 in total, See attached)
10	**International Comparison**	No. HSE Leading international safety management tool for maternity services.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Group CEO and Clinical Director.
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☑Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ❑Other – give details: Published on websites by Hospital Groups or HSE.
16	**Web link to data**	TBC Hospital Websites and *www.hse.ie*
17	**Additional Information**	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Derek McCormack Email:derek.mccormack@hse.ie Tel: 01 620 1690 Specialist Lead:
National Lead and Division		National Lead: Liam Woods Division: Acute Hospital Division Contact Eileen Ruddin General manager Acute Hospital Division 041 687 1519

Full list of Hospitals
Cappagh National Orthopaedic Hospital
Mater Misericordiae University Hospital
Midland Regional Hospital Mullingar
National Maternity Hospital
Our Lady's Hospital Navan
Royal Victoria Eye and Ear Hospital
St. Columcilles Hospital
St Luke's Hospital Kilkenny
St. Michael's Hospital
St. Vincent's University Hospital
Wexford General Hospital
Ireland East Hospital Group
Coombe Women's and Infants University Hospital
Midland Regional Hospital Portlaoise
Midland Regional Hospital Tullamore
Naas General Hospital
St. James's Hospital
St. Luke's Radiation Oncology Network
Tallaght Hospital - Adults
Dublin Midlands Hospital Group
Beaumont Hospital
Cavan General Hospital
Connolly Hospital Blanchardstown
Louth County Hospital
Monaghan *
Our Lady of Lourdes Hospital Drogheda
Rotunda Hospital
RCSI Hospitals Group
Bantry General Hospital
Cork University Hospital
Cork University Maternity Hospital
Kerry General Hospital
Lourdes Orthopaedic Hospital Kilcreene
Mallow General Hospital
Mercy University Hospital Cork
South Infirmary/Victoria University Hospital Cork
South Tipperary General Hospital
University Hospital Waterford
South/South West Hospital Group
Croom Hospital
Ennis Hospital
Nenagh Hospital
St. John's Hospital
University Hospital, Limerick
University Maternity Hospital, Limerick
University of Limerick Hospital Group
Galway University Hospitals
Letterkenny General Hospital
Mayo General Hospital
Portiuncula Hospital Ballinasloe
Roscommon Hospital
Sligo Regional Hospital
Saolta University Health Care Group
Children's University Hospital Temple Street
National Children's Hospital at Tallaght Hospital
Our Lady's Children's Hospital, Crumlin
Children's Hospital Group

* Please note Monaghan General H

List of maternity hospitals or general hospital with Maternity section
Midland Regional Hospital Mullingar
National Maternity Hospital
St Luke's Hospital Kilkenny
Wexford General Hospital
Ireland East Hospital Group
Coombe Women's and Infants University Hospital
Midland Regional Hospital Portlaoise
Dublin Midlands Hospital Group
Cavan General Hospital
Our Lady of Lourdes Hospital Drogheda
Rotunda Hospital
RCSI Hospitals Group
Cork University Maternity Hospital
Kerry General Hospital
South Tipperary General Hospital
University Hospital Waterford
South/South West Hospital Group
University Maternity Hospital
University of Limerick Hospital Group
Galway University Hospitals
Letterkenny General Hospital
Mayo General Hospital
Portiuncula Hospital Ballinasloe
Sligo Regional Hospital
Saolta University Health Care Group

	Nursing & Midwifery	
1	KPI title	Number of nurses prescribing medication
2	KPI Description A63	The number of nurses and midwives who are currently in practice in the voluntary and statutory services of HSE as registered nurse prescribers (RNP) with the Nursing and midwifery Board of Ireland. (NMBI)
3	KPI Rationale	One of the ONMSD priorities is to support increasing the number of nurses and midwives to become Registered Nurse Prescribers across the HSE. This is supported by a number of trends both in Ireland and internationally supports the continued advancement of nurse midwife prescribing within the Irish healthcare system. These trends encompass the following: social and demographic change, for example, the aging population in Ireland changing health service provision and reconfiguration, for example the development of group hospitals and community healthcare organisations. increased specialisation of services, such as chronic disease management, nurse and midwifery led services, integrated nursing and midwifery roles etc. value for money including a return on investment in the education of health care professionals Implementation of the European working time directive. greater focus on community based services
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☐ Use of Information ☑ Workforce
		❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	NSP 2016: 100 (to increase number of RNPs by 100 by end of 2016 from a baseline of 767 at 31 Dec 2015)
5	KPI Calculation	KPI is calculated on a count of the number of RNPs registered with NMBI as reported to ONMSD currently employed by the vountary and statuttory services of the HSE at end of Dec 2016.
6	Data Source Data Completeness Data Quality Issues	**Data source:** NMBI register and prescribing team spreadsheet reportd to BIU via ONMSD **Data completness**: this is counting the number RNPs currently employed by the vountary and statuttory services of the HSE. For next point Depentdant of information provided by third parties
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily Weekly ❑ Monthly quarterly ☑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	N/A
9	Minimum Data Set	NMBI register, Spreadsheets and Database by Q3
10	International Comparison	None
11	KPI Monitoring	KPI will be monitored : ❑Daily Weekly ❑ Monthly ☐Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:Director of Nursing/Midwifery/ PHN or Prescribing Site Coordinator as designated officer
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly Quarterly ❑Bi-annually xAnnually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ☑ Other – give details: as per 31 Dec 2016 reported in January 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑Hospital Group ☐ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ☑ Performance Assurance Report (NSP) ❑CompStat ☑Other – give details: ONMSD business plan, National Report on Nurse and Midwife Medicinal Product Prescribing
16	Web link to data	www.hse.ie/go/nurseprescribing
17	Additional Information	KPI noted in National Service Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Annette Cuddy/Rose Lorenz Email: annette.cuddy@hse.ie/ rose.lorenz@hse.ie Tel: 041 6850658/0949049013 Specialist Lead: Clare MacGabhann ONMSD
National Lead and Division		Division: Mary Wynne,Interim Director ONMSD. Dr Aine Carroll, Clinical Strategy and Programmes

Nursing Prescribing Ionising Radition (X-Ray)

1	**KPI title**	Number of Nurses Prescribing Ionising Radition (X-Ray)
2	**KPI Description** **HWB1**	The number of nurses registered on "The National Nurse Prescribing Ionising Radiation Data Collection System" authorised to prescribe ionising radiation in the voluntary and statutory services of the HSE.
3	**KPI Rationale** **A64** **Indicator Classification** (National Standards for Safer Better HealthCare)	HSE and Government priority. The ONMSD are supporting the education programmes to increase the number of nurses who may prescribe Ionising Radiation. Maximising the number of Nurse Prescribers of ionising radiation (X-Ray) within the health care service will lead to increased levels of patient/service user satisfaction by providing the a more responsive, accessible, effective, timely and efficient service that improves and expedites the patient/service user iournev. Please tick Indicator Classification this indicator applies to: x Person Centred Care x Effective Care x Safe Care ❑ Better Health and Wellbeing ❑ Use of Information x Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	2016: 55 (To increase number of nurses registered on to prescribe ionising radiation by 55 at end of 2016 from a baseline of 203 at 31 Dec 2015)
5	**KPI Calculation**	KPI is calculated on a count of the number of nurses registered on "The National Nurse Prescribing Ionising Radiation Data Collection System" at end of Dec 2016 compared with 2015 baseline.
6	**Data Source** **Data Completeness** **Data Quality Issues**	The HSE Database "The National Nurse Prescribing Ionising Radiation Data Collection System" , the Programme Providers and the Prescribing Site CoOrdinators for Ionising Radiation. Ongoing validation process being carried out by ONSMD to ensure all those completing the programme are registered on HSE database. Dependant on information provided by third parties.
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ❑ Monthly x Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	N/A
9	**Minimum Data Set**	The National Nurse Prescribing Ionising Radiation (X-Ray) Minimum Dataset • Site: Name (title) of employer (specific organisation /service) where the nurse X-Ray prescriber is employed. • Prescriber's name: Name on An Bord Altranais (ABA) Register An Bord Altranais • Personal Identification Number: 8 number numerical strand • Clinical Area: Clinical area of authorised prescriber's practice within the place of employment e.g. Emergency Department, Occupational Health,Diabetic Services • Date: Date on which prescription was written, expressed in European format e.g.DD/MMM/YYYY (three-letter month). • Time: 24-hour clock • X-Ray prescribed: X-Ray title e.g. Chest X-Ray
10	**International Comparison**	is there any comparisons that you could benchmark KPI with? Nurse Prescribing of Ionising Radiation is practiced in a number of countries including the United Kingdom, Canada USA and Austrailia. I am not aware of any international KPIs that are similar to this one: whether any of them maintain a database of the number of nurses prescibing Ionising Radiation, though it would be difficult to compare like with like.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly x Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Prescribing Site Coordinators for Ionising Radiation, nominated by the Director of Nursing in each location, who reports to the Local Implementation Group(LIG).
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly x Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) □ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) x Other – give details: as per 31 Dec 2016 reported in April 2017
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: X National ❑ Regional ❑Hospital Group ☐ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: x Performance Assurance Report (NSP) □CompStat X Other – give details:OMNSD Business Plan
16	**Web link to data**	www.hse.ie
17	**Additional Information**	Is the data for this KPI available through Corporate Information Facility (CIF)? No
Contact details for Data Manager /Specialist Lead		Data Manager: Maureen Nolan, Director of Nursing, National Lead for the Implementation and Audit of Nurse Prescribing of Ionising Radiation Email: maureen.nolan1@hse.ie Tel: 086 6012195 Supported by IT Expert Glenn Hussler Specialist Lead: Maureen Nolan
National Lead and Division		Mary Wynne, Interim Nursing and Midwifery Services Director & Assistant National Director, Office of the Nursing & Midwifery Services Director. Division: Dr. Aine Carroll, Clinical Strategy and Programmes

Acute Division - COPD

1	**KPI title**	Mean and Median LOS (and bed days) for patients admitted with COPD
2	**KPI Description CPA34**	Mean and Median Acute hospital stay – excluding day cases – as recorded on HIPE of COPD inpatients which are aged 15yrs or older with a principal diagnosis of COPD. Bed Days Used (BDU): number of days used for patients with principal diagnosis of COPD COPD: Chronic obstructive pulmonary disease (COPD) is chronic progressive irreversible airway obstruction which limits airflow to and from the lungs, causing shortness of breath (dyspnea).
3	**KPI Rationale**	COPD is a chronic disease which can largely be dealt with in Primary Care. Ireland has the 2nd highest hospitalisation rate for "avoidable" COPD admissions. COPD in the OECD. COPD is the commonest disease cause of emergency admission of adults in Ireland.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care q Safe Care ☑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	7.6 mean and 5 median for 2016
5	**KPI Calculation**	***Mean:*** **Numerator:** Total Inpatient Beddays for patients with principal diagnosis of COPD in the period. **Denominator:** Total number of inpatient discharges with principla diagnosis of COPD in same period. ***Median:*** midpoint where LOS is such that half of the inpatient discharges with principal diagnosis of COPD have a LOS above it and half below it. **Beddays:** Total Inpatient Beddays for discharges with principal diagnosis of COPD in the period .i.e. sum of length of stays for inpatient discharges with COPD in the period
6	**Data Source**	HIPE Data
	Data Completeness	omits private hospitals
	Data Quality Issues	
7	**Data Collection Frequency**	❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	- Principal diagnosis of COPD(J41,42,43,44,47 (ICD-10-AM)) or (a principal diagnosis of J40 and a secondary Dx of J41,43,44 or 47 (ICD-10-AM)) - Age>=15 -Inpatients Only
9	**Minimum Data Set**	HIPE :Diagnosis 1- Diagnosis 30, Admission Type, Admission Date, Discharge Date, Length of Stay , Age
10	**International Comparison**	Comparison with OECD including UK
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Group CEO
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area þ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP/CBP) ❑CompStat ❑ Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	Median LOS is more useful indicator especially for chronic conditions due to asymmetric distribution KPI noted in Divisional Operational Plan report 2016
	Contact details for Data Manager / Specialist Lead	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie Prof. Tim McDonnell, Clinical Lead, NCP COPD, Email: timothymcdonnell@icloud.com Dr Máire O'Connor, Specialist Public Health Medicine, Department of Public Health, HSE East. Email maire.oconnor@hse. Linda Kearns, NCP COPD Programme Manager. Email: lindakearns@rcpi.ie
	National Lead and Directorate	Dr Aine Carroll, National Director, Clinical Strategy and Programmes Directorate. Tel: 01 635 2322. Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124

	Acute Division - COPD	
1	**KPI Title**	Percentage re-admission to same acute hospitals of patients with COPD within 90 days
2	**KPI Description CPA35**	Re-admission to same hospital excluding day cases – as recorded on HIPE of patients admitted with a principal Diagnosis of COPD - within 90 days of discharge.
3	**KPI Rationale**	Appropriate care in appropriate setting.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ☑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	24% for 2016
5	**KPI Calculation**	**Numerator:** Number of COPD inpatient discharges as principal diagnosis in the denominator period which resulted in an emergency readmission to the same hospital within 90 days*100 **Denominator:** Number of COPD inpatient discharges in the denominator period (denominator period is set 90 days in arrears) **Example: Quarter 1 2016** Numerator: (Number of COPD inpatient discharges in the denominator period which were readmitted as an emergency within 90 days of a previous discharge i.e. an emergency readmission occuring between 03OCT2015 and 31MAR2016 inclusive)*100 Denominator: Number of COPD inpatient discharges in the denominator period (denominator period is set 90 days in arrears i.e. COPD inpatients discharged between 03OCT2015 and 01JAN2016 inclusive)
6	**Data Source**	HIPE
	Data Completeness	Omits private hospitals.
	Data Quality Issues	Only allows for re-admission to same hospital
7	**Data Collection Frequency**	❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	- Principal diagnosis of COPD(J41,42,43,44,47 (ICD-10-AM)) or (a principal diagnosis of J40 and a secondary Dx of J41,43,44 or 47 (ICD-10-AM)) - Age>=15 - Emergency readmissions (Admission Type of 4 or 5) - Death are excluded from the denominator (Discharge code=6 or 7) -Inpatients only
9	**Minimum Data Set**	HIPE :Diagnosis 1-30, Admission Type, Admission Date, Discharge Date, Length of Stay , Age
10	**International Comparison**	International including UK – NHS
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Hospital Group CEO
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP/CBP) ❑CompStat ☑ Other – give details: Clinical Programme Reports,Repors to NCP COPD Clinical Advisory Group
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
	Contact details for Data Manager / Specialist Lead	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie Prof. Tim McDonnell, Clinical Lead, NCP COPD, Email: timothymcdonnell@icloud.com Dr Máire O'Connor, Specialist Public Health Medicine, Department of Public Health, HSE East. Email maire.oconnor@hse. Linda Kearns, NCP COPD Programme Manager. Email: lindakearns@rcpi.ie
	National Lead and Directorate	Dr Aine Carroll, National Director, Clinical Strategy and Programmes Directorate. Tel: 01 635 2322. Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124

	Acute Division - COPD	
1	**KPI Title**	Number of acute hospitals with COPD outreach programme
2	**KPI Description** **CPA36**	The number of acute hospitals with COPD Early supported discharge programme, by a COPD Outreach service, for specified patients with uncomplicated Acute Exacerbation COPD within 72 hrs of presentation that would otherwise require acute in-patient care/additional in-patient care
3	**KPI Rationale**	Appropriate care in appropriate setting. Defined in the Model of Care.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ☑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	18 hospitals in 2016
5	**KPI Calculation**	Count - number of hospitals who have COPD outreach service in place
6	**Data Source**	Hospital Managers supply to National Clinical Programme for COPD who then send to BIU acute
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Acute Hospital with a COPD Outreach Programme
9	**Minimum Data Set**	Hospitals by name/type COPD outreach programme in place
10	**International Comparison**	UK
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: COPD Programme
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in July) ☑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area þ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP/CBP) ❑CompStat ☑ Other – give details: Clinical Programme Reports,Repors to NCP COPD Clinical Advisory Group
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	KPI noted in Divisional Operational Plan report 2016
	Contact details for Data **Manager / Specialist Lead**	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie Prof. Tim McDonnell, Clinical Lead, NCP COPD, Email: timothymcdonnell@icloud.com Dr Máire O'Connor, Specialist Public Health Medicine, Department of Public Health, HSE East. Email maire.oconnor@hse. Linda Kearns, NCP COPD Programme Manager. Email: lindakearns@rcpi.ie
	National Lead and **Directorate**	Dr Aine Carroll, National Director, Clinical Strategy and Programmes Directorate. Tel: 01 635 2322. Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124

	Acute Division - COPD	
1	**KPI Title**	Access to structured Pulmonary Rehabilitation Programme in Acute Hospital Services
2	**KPI Description** **CPA37**	Pulmonary Rehabilitation is defined "as evidence based multidisciplinary and comprehensive intervention for patients with chronic respiratory diseases. Integrated into the individualised treatment of the patient, pulmonary rehabilitation is designed to reduce symptoms, optimize functional status, increase participation and reduce health care costs through stabilizing or reversing systemic manifestations of the disease. It includes strategies for life-long management.
3	**KPI Rationale**	Evidence of improved quality of life for patients. High levels of scientific evidence have demonstrated improved exercise capacity and health related quality of life and decreased breathlessness, fatigue and health care utilization following pulmonary rehabilitation. It is also recognised as one of the most cost effective interventions for people with COPD.
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑ Effective Care ❑ Safe Care ☑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ☑ Governance, Leadership and Management
4	**KPI Target**	33 sites
5	**KPI Calculation**	Count
6	**Data Source**	The National Clinical Programme for COPD maintains a record of hospitals and local health areas which provide/ have access to a structured pulmonary rehabilitation programme. This is achieved by contacting each site and requesting updates on the status of the service and activity levels.
	Data Completeness	Data completeness and quality is dependant on sites responding to requests for information from the programme.
	Data Quality Issues	
7	**Data Collection Frequency**	❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Acute Hospital with access to a structured Pulmonary Rehabilitation Programme
9	**Minimum Data Set**	Hospitals Name/Type
10	**International Comparison**	Yes, Global Initiative for Chronic Obstructive Lung Disease (GOLD).
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: COPD Programme
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Monthly ❑Quarterly ☑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ☑ Other – give details: Biannual January-June reported in August
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP/CBP) ❑CompStat ☑ Other – give details: Clinical Programme Reports,Repors to NCP COPD Clinical Advisory Group
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
	Contact details for Data **Manager / Specialist Lead**	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie Prof. Tim McDonnell, Clinical Lead, NCP COPD, Email: timothymcdonnell@icloud.com Dr Máire O'Connor, Specialist Public Health Medicine, Department of Public Health, HSE East. Email maire.oconnor@hse. Linda Kearns, NCP COPD Programme Manager. Email: lindakearns@rcpi.ie
	National Lead and **Directorate**	Dr Aine Carroll, National Director, Clinical Strategy and Programmes Directorate. Tel: 01 635 2322. Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124

Acute Division including Clinical Programmes - Asthma

1	**KPI Title**	Percentage of nurses in secondary care who are trained by national asthma programme
2	**KPI Description** **CPA38**	% of nurses in secondary care who are trained by the National Clinical Programme for Asthma The first phase of National Asthma Training Programme is targeting: • secondary care nurses in ED departments and AMAUs. • Training is as defined by the asthma programme
3	**KPI Rationale**	Completion of the Asthma Education programme is required in order to implement National Clinical Programme for Asthma guideline concordant care. Competence in managing asthma is a necessary competence for all health care providers. There is agreement at National and Hospital level to implement the National Asthma Programme, therefore the National Clinical Programme for Asthma is making the reasonable assumption that when nurses are trained they will provide guideline concordant asthma management. The National Asthma Programme in Finland, which achieved significant improvements in asthma care and outcomes, trained the staff that were at the forefront of delivering the programme*. * T Haahtela, L E Tuomisto, A Pietinalho, T Klaukka, M Erhola, M Kaila, M M Nieminen, E Kontula,L A Laitinen. " A 10 year asthma programme in Finland: major change for the better" Thorax 2006;61:663–670
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	70%
5	**KPI Calculation**	Numerator is the number of nurses in ED/AMAU who are trained. Denominator is the total number of all ED and AMAU nurses.
6	**Data Source**	For Numerators, Clinical Nurse Specialist records details of nurses who has been trained, and currently submits to National Clinical Programme for Asthma. Denominator data is sought from Clinical Nurse Managers. Data collection systems may change due to changing structures and to ensure valid data.
	Data Completeness	Validation survey would indicate level of data completeness
	Data Quality Issues	Data quality issues - numbers trained can change with staff movement
7	**Data Collection Frequency**	❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: data collected when training course run by clinical nurse specialist
8	**Tracer Conditions**	Nurse demographic details and confirmation that training is complete
9	**Minimum Data Set**	NAP, RDOs, Hospital and Unit need the following on all nurses: • Name of nurse • Place of work – for hospitals, include hospital and unit • Grade of staff Asthma training completed Y/N
10	**International Comparison**	Similar training being carried out in other EU countries e.g. Finland
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: National Asthma Programme
12	**KPI Reporting Frequency**	Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager/CEO ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) Monthly in arrears (June data reported in July) ☑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑Regional ☑Hospital Group ☑Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Report (NSP) ❑CompStat ☑Other – give details: TBC
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	Trained staff members may move in or out of a health care facility, therefore regular confirmation of trained status of staff important KPI noted in Divisional Operational Plan 2016
		KPI noted in Divisional Operational Report 2016
	Contact details for Data Manager / Specialist Lead	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
	National Lead and Directorate	Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124 Prof Pat Manning, NCPA Clinical Lead, Midlands Regional Hospital Mullingar Email: pjmanning@eircom.net Dr Máire O'Conner, Consultant Public Health Medicine, HSE Email: maire.oconner@hse.ie Linda Kearns, NCPA Programme Manager. Email: lindakearns@rcpi.ie

Acute Division including Clinical Programmes - Asthma

1	**KPI Title**	Number of asthma emergency inpatient bed days used by <6 year olds
2	**KPI Description** **CPA 40**	Number of emergency inpatient asthma bed days used by <6 year olds
3	**KPI Rationale**	OECD reports on avoidable admission rates for asthma which indicates that there is room for improvement in Ireland. see http://www.oecd.org/dataoecd/55/2/44117530.pdf It is predicted that with implementation of National Asthma Programme guideline concordant care in primary care and secondary care and particularly, following the introduction of the GP under-six contract, young children with asthma should achieve better asthma control and: • The number of children under six with asthma who develop acute exacerbations should be reduced as should the number of inpatient beddays used for same. Based on the Finnish model this should be 10% by the end of 2017. The baseline will be the average of the 3 years (2012, 2013, 2014) ie 1106. • The quality of treatment will be optimised, therefore the number of children under six with acute asthma exacerbations, who require hospital admission, should be reduced.
	Indicator Classification (National Standards for Safer Better HealthCare)	❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources Governance, Leadership and Management
4	**KPI Target**	5% Reduction
5	**KPI Calculation**	Total Inpatient Beddays for emergency patients with asthma in the period, aged <6 years
6	**Data Source**	HIPE
	Data completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Emergency admissions only (Admission Type =4 and 5) Asthma - ICD-10-AM - Principal Diagnosis J45* OR J46* Asthma, acute asthma, asthma exacerbation, predominantly allergic asthma, non-allergic asthma, mixed asthma, asthma unspecified, status asthmaticus, acute severe asthma Excludes: chronic asthmatic (obstructive) bronchitis J44* Age<6 Inpatients only
9	**Minimum Data Set**	HIPE - Principal Diagnosis, Admission Date, Discharge Date, LOS, Admission Type, Age
10	**International Comparison**	National Asthma Programme targets based on the experience of Asthma Programmes in Finland and British Colombia, Canada
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:BIU/national Asthma Programme
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ❑Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Report (NSP) ❑CompStat ☑Other – give details: TBC
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
	Contact details for Data Manager / Specialist Lead	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
	National Lead and Directorate	Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124 Prof Pat Manning, NCPA Clinical Lead, Midlands Regional Hospital Mullingar Email: pjmanning@eircom.net Dr Máire O'Conner, Consultant Public Health Medicine, HSE Email: maire.oconner@hse.ie Linda Kearns, NCPA Programme Manager. Email: lindakearns@rcpi.ie

Acute Division including Clinical Programmes - Asthma

1	**KPI Title**	Number of asthma emergency inpatient bed days used
2	**KPI Description** **CPA 39**	Number of emergency inpatient asthma bed days used
3	**KPI Rationale**	OECD reports on avoidable admission rates for asthma which indicates that there is room for improvement in Ireland. see http://www.oecd.org/dataoecd/55/2/44117530.pdf With implementation of Model of Care, GP progogramme for <6yr olds and National Asthma Programme guideline concordant care in primary care and secondary care people with asthma should achieve better asthma control with reduction of inpatient beddays used by emergency admissions for asthma • The number of people with asthma who develop acute exacerbations should be reduced with an associated reduction in inpatient hospital beddays. baselines (average of 3yrs: 2012,2013, 2014 ie 1966) • The quality of treatment will be optimised, therefore the number of people with acute asthma exacerbations, who require hospital admission, should be reduced
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources Governance, Leadership and Management
4	**KPI Target**	3% reduction
5	**KPI Calculation**	Total Inpatient Beddays for emergency patients with asthma in the period
6	**Data Source**	HIPE
	Data Completeness	omits private hospitals
	Data Quality Issues	
7	**Data Collection Frequency**	❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Emergency admissions only (Admission Type =4 and 5) Asthma - ICD-10-AM - Principal Diagnosis J45* OR J46* Asthma, acute asthma, asthma exacerbation, predominantly allergic asthma, non-allergic asthma, mixed asthma, asthma unspecified, status asthmaticus, acute severe asthma Excludes: chronic asthmatic (obstructive) bronchitis J44* Inpatients only
9	**Minimum Data Set**	HIPE - Principal Diagnosis, Admission Date, Discharge Date, LOS, Admission Type
10	**International Comparison**	National Asthma Programme targets based on the experience of Asthma Programmes in Finland and British Colombia, Canada
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ☑Quarterly ❑Bi-annually yAnnually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:BIU/national Asthma Programme
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ☑ Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Report (NSP) ❑CompStat ☑Other – give details: TBC
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
	Contact details for Data Manager / Specialist Lead	Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
	National Lead and Directorate	Dr. Orlaith O'Reilly, National Clinical Advisor and Group Lead, Health & Wellbeing, Tel: 056 7784124 Prof Pat Manning, NCPA Clinical Lead, Midlands Regional Hospital Mullingar Email: pjmanning@eircom.net Dr Máire O'Conner, Consultant Public Health Medicine, HSE Email: maire.oconner@hse.ie Linda Kearns, NCPA Programme Manager. Email: lindakearns@rcpi.ie

Acute Hospitals including Clinical Programmes: Diabetes

1	KPI Title	Number of lower limb amputations performed on Diabetic patients
2	KPI Description	Number of Diabetes discharges with a lower limb amputation
3	KPI Rationale CPA41	Diabetes is one of the leading causes of lower limb amputations. The Diabetes Programme aims to provide improved diabetic control through integrated care and improved recognition and management of diabetic foot complications which may lead to amputation. A reduction in lower limb amputations in patients with diabetes is expected on a population basis following the introduction of comprehensive integrated care and foot care for the population.On a backdrop of rising prevalence of DM, numbers of amputations should not rise more than 10% on 2014 (444 cases) as prevention and care is improving.
	Indicator Classification	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	≤488
5	KPI Calculation	Number of Diabetes discharges with a lower limb amputation in the given year
6	Data Source	HIPE
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	- Any diagnosis of Diabetes E10-E14 (ICD-10-AM) - And an amputation procedure of lower limb at any level (ACHI): amputation at hip (4437000), hindquarter amputation (4437300), amputation above the knee (4436700), amputation below the knee (4436702), disarticulation at knee (4436701), amputation of toe (4433800), amputation of toe including metatarsal bone (4435800), disarticulation through toe (9055700), disarticulation through ankle (4436100), midtarsal amputation (4436400), transmetatarsal amputation (4436401), amputation of ankle through malleoli of tibia and fibula (4436101) -Inpatients and Daycases
9	Minimum Data Set	HIPE: Date of discharge, ICD10-AM Diagnoses 1-30, ACHI procedures 1-20
10	International Comparison	No specific comparator.
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ❑Daily ❑Weekly Monthly Quarterly ❑Bi-annually ☑Annually ❑Other – give details: Please indicate who is responsible for monitoring this KPI: Diabetes Programme Lead
12	KPI Reporting Frequency	❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ☑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ☑Other – give details: Annual. 2016 data reported in April 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	KPI is reported in which reports ?	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Report 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email: Derek.mccormack@hse.ie
National Lead and Directorate		Dr Ronan Canavan, Clinical lead for diabetes. Telephone number 01 2214407 Dr Mairin Boland MD MRCPI FFPHMI, Consultant in Public Health Medicine Phone 01 6201654 / 086 7810381 email: Mairin.Boland@hse.ie Dr. Orlaith O Reilly, National Clinical Advisor and Programme Lead, Health & Wellbeing,HSE – South (SE), Tel 056 7784124

Acute Hospitals including Clinical Programmes: Diabetes

1	KPI title	Average length of Stay for Diabetic patients with foot ulcers
2	KPI Description CPA42	Mean length of stay for Diabetic inpatients with foot ulcers
3	KPI Rationale	Diabetes is one of the leading causes of foot ulcers, which may lead to lower limb amputations. The
	Indicator Classification	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ❑ Safe Care ☑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ☑ Governance, Leadership and Management
4	KPI Target	≤17.5 days
5	KPI Calculation	**Numerator:** Total Inpatient Beddays for diabetes discharges with a foot ulcer excluding amputations in the
6	Data Source	HIPE
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	❑Daily ❑Weekly ☑ Monthly Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	Ulcers in lower limb in Diabetics, excluding amputations Discharges from hospital (inpatients only) with: - Any diagnosis (ICD-10-AM) E10.73, E11.73, E13.73, E14.73 - **AND** did **NOT** have an amputation of the lower limb (ACHI): NOT (4437000, 4437300, 4436700, 4433800, 4435800, 9055700, 4436100, 4436400, 4436401, 4436101, 4436701, 4436702).
9	Minimum Data Set	HIPE: Date of discharge, ICD10-AM Diagnoses 1-30, ACHI procedures 1-20
10	International Comparison	Specific comparators not given
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ❑Daily ❑Weekly Monthly Quarterly ❑Bi-annually ☑Annually ❑Other – give details: Please indicate who is responsible for monitoring this KPI: Diabetes Programme Lead
12	KPI Reporting Frequency	❑Daily ❑Weekly Monthly Quarterly ❑Bi-annually ☑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ☑Other – give details: Annual. 2016 data reported in April 2017
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	KPI is reported in which reports ?	Indicate where the KPI will be reported: ❑ Corporate Plan Report ☑ Performance Report (NSP/CBP) ❑CompStat ❑Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Report 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email: Derek.mccormack@hse.ie
National Lead and Directorate		Dr Ronan Canavan, Clinical lead for diabetes. Telephone number 01 2214407 Dr Mairin Boland MD MRCPI FFPHMI, Consultant in Public Health Medicine Phone 01 6201654 / 086 7810381 email: Mairin.Boland@hse.ie Dr. Orlaith O Reilly, National Clinical Advisor and Programme Lead, Health & Wellbeing,HSE – South (SE), Tel 056 7784124

Acute Hospitals including Clinical Programmes: Diabetes

1	**KPI title**	Percentage increase in hospital discharges following emergency admission for uncontrolled diabetes.
2	**KPI Description** **CPA43**	Percentage increase in number of hospital discharges following admission with uncontrolled diabetes resulting in hyper or hypoglycaemia +/- other manifestations of poor control compared to 2014.
3	**KPI Rationale**	Uncontrolled diabetes may result in hyper or hypoglycaemia with various resultant clinical manifestations necessitating hospital admission. In 2014 there were 2723 hospital discharges following admission for uncontrolled diabetes. The corresponding figure in 2013 was 2818 and in 2012 was 2687. The Diabetes Programme aims to provide improved diabetic control through integrated care which should result in reduced hospital admissions with uncontrolled diabetes.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Proposed target: ≤10% increase.
5	**KPI Calculation**	**Numerator:** (Number of discharges following an emergency admission for uncontrolled diabetes in the current year minus Number of discharges following an emergency admission for uncontrolled diabetes in 2014)*100 **Denominator:** Number of discharges following an emergency admission for uncontrolled diabetes in 2014
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE data
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Diabetes Mellitus with hyperglycaemia or other manifestations of poor control - ICD-10-AM - Principal Diagnosis E10.65, E11.65, E13.65, E14.65, E10.64, E11.64, E10.1, E11.1, E10.0, E10.01, E10.02, E11.0, E11.01, E11.02, E13.0, E13.01, E13.02, E14.0, E14.01, E14.02. (The latter 12 codes refer to various kinds of hyperosmolarity.) Emergency admissions only (Admission Type =4, 5 and 7)
9	**Minimum Data Set**	HIPE - Principal Diagnosis, Admission Date, Discharge Date, Admission Type
10	**International Comparison**	No specific international comparators.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ❑ Monthly ❑Quarterly ❑Bi-annually ☑ Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Diabetes Programme Lead
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ❑Quarterly ❑Bi-annually ☑ Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ❑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ☑Other – give details: Annual. 2016 data reported in April 2017
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑Performance Assurance Report (NSP) ❑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
Contact details for Data		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email: Derek.mccormack@hse.ie
National Lead and Division		Dr Ronan Canavan, Clinical lead for diabetes. Telephone number 01 2214407 Dr Mairin Boland MD MRCPI FFPHMI, Consultant in Public Health Medicine Phone 01 6201654 / 086 7810381 email: Mairin.Boland@hse.ie Dr. Orlaith O Reilly, National Clinical Advisor and Programme Lead, Health & Wellbeing,HSE – South (SE), Tel 056 7784124

Acute Services - Epilepsy

1	**KPI title**	Reduction in median LOS for epilepsy inpatient discharges
2	**KPI Description** **CPA44**	A reduction in median LOS for epilepsy patients from 3.5 days to 2.5 days Median (50th percentile) for length of stay for hospital inpatients with a principal diagnosis of epilepsy/ Status epilepticus/fit or seizure NOS. Epilepsy ICD codes G40, G41 and R568
3	**KPI Rationale**	Adherence to model of care should lead to more efficient use of resources and reduction in median LOS
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources Governance, Leadership and Management
4	**KPI Target**	Target 2016: 2.5 days
5	**KPI Calculation**	**Median:** midpoint where LOS is such that half of the epilepsy inpatient discharges have a LOS above it and half below it
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Epilepsy - ICD-10-AM - Principal Diagnosis G40*, G41* or R56.8
9	**Minimum Data Set**	HIPE - Principal Diagnosis, Discharge Date, Admission Date
10	**International Comparison**	Not available
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ❑Monthly ☑Quarterly ❑Bi-annually ❑ Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Groups
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ❑ Performance Report (NSP/CBP) ❑CompStat ☑Other – give details: TBC
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
National Lead and Division		Edina O'Driscall, Edina O'Driscoll [Edina.O'Driscoll@NRH.IE] Dr. Colin Doherty, colinpdoherty@gmail.com

Acute Services - Epilepsy

1	**KPI title**	% reduction in the number of epilepsy discharges
2	**KPI Description** **CPA45**	10 % reduction in no. of epilepsy inpatients discharges with principal diagnosis of Epilepsy ICD codes G40, G41 and R568.
3	**KPI Rationale**	Adherence to model of care should lead to more efficient use of resources and reduction in bed days
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information Workforce ❑ Use of Resources Governance, Leadership and Management
4	**KPI Target**	Target 2016: 10% reduction (based on 2014 data where discharge total was 7096)
5	**KPI Calculation**	**Numerator:** (Number of Epilepsy inpatient discharges in the reporting period minus Number of epilepsy inpatient discharges in the same quarter in 2014)*100 **Denominator:** Number of epilepsy inpatient discharges in the same quarter of 2014
6	**Data Source** **Data Completeness** **Data Quality Issues**	HIPE
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Epilepsy - ICD-10-AM - Principal Diagnosis G40*, G41* or R56.8
9	**Minimum Data Set**	HIPE - Principal Diagnosis, Discharge Date
10	**International Comparison**	Not available
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ❑ Monthly in arrears (June data reported in August) ☑ Quarterly in arrears (quarter 1 data reported in quarter 3) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑ LHO Area ☑ Hospital ❑ County ❑ Institution ☑ Other – give details: Hospital Groups
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Corporate Plan Report ❑ Performance Report (NSP/CBP) ❑CompStat ☑Other – give details: TBC
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Report 2016
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 Email:Derek.mccormack@hse.ie
National Lead and Division		Edina O'Driscall, Edina O'Driscoll [Edina.O'Driscoll@NRH.IE] Dr. Colin Doherty, colinpdoherty@gmail.com

Acute Division including Clinical Programmes - Blood Policy		
1	**KPI title**	Number of units of platelets ordered in the reporting period
2	**KPI Description** **CPA46**	To record the number of units of platelet ordered per hospital on a monthly basis and trend the National usage monthly.
3	**KPI Rationale**	To review usage and evaluate. To trend the usage of platelets month on month and year on year. This data is collected on a monthly basis from each hospital and provides data for monitoring and trending the use of platelets on a hospital, regional and national basis.
	Indicator Classification (National Standards for Safer Better HealthCare)	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☐Person Centred Care ☑Effective Care
		Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐ Use of Resources ☑ Governance, Leadership and Management ☐
4	**KPI Target**	Target 2016 - 21,000
5	**KPI Calculation**	Total number of platelets ordered
6	**Data Source** **Data Completeness** **Data Quality Issues**	Utilising data from IBTS and monthly retrieval of data from each hospital Laboratory 36 Hospitals
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	**Tracer Conditions**	Total number of platelets ordered by each hospital per month
9	**Minimum Data Set**	Core data required from each hospital is the total platelet order for each month with the associated platelet usage.
10	**International Comparison**	No
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2)
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☑ Hospital ☐ County ☐ Institution ☑Other – give details: Hospital Group
15	**KPI is reported in which reports ?**	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Plan 2016
Contact details for Data		Specialist Lead: Tony Finch, Chief Scientist.
National Lead and Directorate		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division including Clinical Programmes - Blood Policy		
1	KPI Title	Percentage of units of platelets outdated in the reporting period
2	KPI Description CPA47	To record the percentage of platelet units outdating per hospital on a monthly basis and trend the National usage quarterly.
3	KPI Rationale	To review usage and evaluate. This data is collected on a monthly basis for each hospital and provides data for monitoring and trending the outdating rate for platelets on a hospital, regional and national basis.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☐Person Centred Care ☑Effective Care
		Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐ Use of Resources ☑ Governance, Leadership and Management ☐
4	KPI Target	Target 2016 = <5%
5	KPI Calculation	Number of outdated units Total number of units x 100 =
6	Data Source	Utilising data from IBTS and monthly retrieval of data from each hospital Laboratory 36 Hospitals
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Total number of platelets outdated to be ordered for each hospital.
9	Minimum Data Set	The core data required from each hospital is the total platelet order for each month with the associated outdating figure.
10	International Comparison	No
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☐Rolling 12 months (pr
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☑ Hospital ☐ County ☐ Institution ☑Other – give details: Hospital Group
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Plan 2016
Contact details for Data		Specialist Lead: Tony Finch, Chief Scientist.
National Lead and Directorate		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division including Clinical Programmes - Blood Policy		
1	**KPI Title**	Percentage usage of O Rhesus negative red blood cells
2	**KPI Description CPA48**	To monitor and minimise the % of O Rhesus Negative units nationally, as a percentage of all red blood cells units.
3	**KPI Rationale**	Minimise over usage of O Rhesus negative red blood cells units. This data is collected on a monthly basis form each hospital and provides data for monitoring and trending use of O Rh Negative Red Cell units as a percentage of the total.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☐Person Centred Care ☑Effective Care
		Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐ Use of Resources ☑ Governance, Leadership and Management ☐
4	**KPI Target**	Target <14%
5	**KPI Calculation**	Total number of O Rhesus Negative units Total number of all red blood cells x 100 =
6	**Data Source**	Utilising data from IBTS and monthly retrieval of data from each hospital Laboratory 36 Hospitals
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	**Tracer Conditions**	The total number of O Rh Negative Red Cell units issued to each hospital to be recorded and total number of all red blood cells.
9	**Minimum Data Set**	Core data required from each hospital is the total issue of all Red Cell units and the associated issue of O Rh Negative Red Cell units.
10	**International Comparison**	No
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☐Rolling 12 months
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☑ Hospital ☐ County ☐ Institution ☑Other – give details: Hospital Group
15	**KPI is reported in which reports ?**	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Plan 2016
Contact details for Data		Specialist Lead: Tony Finch, Chief Scientist.
National Lead and Directorate		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division including Clinical Programmes - Blood Policy		
1	KPI Title	Percentage of red blood cell units rerouted
2	KPI Description CPA49	To record the number of red cell units re-routed in order to utilise short dated units and reduce outdating.
3	KPI Rationale	Minimising of outdated products and utilisation of short date units. This data is collected on a monthly basis from each hospital and provides data for monitoring and trending the re-routing of all Red Cell units between hospitals.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☐Person Centred Care ☑Effective Care
		Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐ Use of Resources ☑ Governance, Leadership and Management ☐
4	KPI Target	Target 2016 = <4%
5	KPI Calculation	Number of red blood cell units rerouted Total red cell units x 100 = %
6	Data Source	Utilising data from IBTS and monthly retrieval of data from each hospital Laboratory 36 Hospitals
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Total number of Red Cell units re-routed between hospitals in their network group and total red cell units.
9	Minimum Data Set	Core data required from each hospital is the total red cell unit order and the number of Red Cell units re-routed
10	International Comparison	No
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☐Rolling 12 months (pr
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☑ Hospital ☐ County ☐ Institution ☑Other – give details: Hospital Group
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Plan 2016
Contact details for Data		Specialist Lead: Tony Finch, Chief Scientist.
National Lead and Directorate		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

Acute Division including Clinical Programmes - Blood Policy		
1	KPI Title	Percentage of red blood cell units returned out of total red blood cell units ordered
2	KPI Discription CPA50	To record the number of red cell units outdated per hospital on a monthly basis and trend the National outdating monthly.
3	KPI Rationale	To review outdating and evaluate. This data is collected on a monthly basis from each hospital and provides data for monitoring and trending of Red Cell units outdated as a percentage of the total Red Cell unit.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☐Person Centred Care ☑Effective Care
		Safe Care☐ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐ Use of Resources ☑ Governance, Leadership and Management ☐
4	KPI Target	Target 2016 = <1%
5	KPI Calculation	Total number of Red Cell Units outdated x 100 = Total number of Red Cell units issued
6	Data Source	Utilising data from IBTS and monthly retrieval of data from each hospital Laboratory 36 Hospitals
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	The total number of Red Cell units outdated at each hospital to be recorded and total number of red cell units.
9	Minimum Data Set	Core data required from each hospital is the total issue of all Red Cell units and the associated outdating figures.
10	International Comparison	No
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☐Rolling 12 months
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☑ Hospital ☐ County ☐ Institution ☑Other – give details: Hospital Group
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	Additional Information	KPI noted in Divisional Operational Plan 2016
Contact details for Data		Specialist Lead: Tony Finch, Chief Scientist.
National Lead and Directorate		National Director Acute Hospitals Division, Dr. Steevens Hospital, Dublin 8. Tel 01-635 2000.

	Acute Division -Outpatients	
1	**KPI title**	% of clinicians with individual DNA rate of 10% or less
2	**KPI Description** **A66**	Proportion of clinicians with a failure to attend rate of 10% or less
3	**KPI Rationale**	Assess appropriate utilisation of resources
	Indicator Classification *(National Standards for Safer Better HealthCare)*	Please tick Indicator Classification this indicator applies to: ❑ Person Centred Care ❑ Effective Care ❑ Safe Care ❑ Better Health and Wellbeing ❑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016 = 70%
5	**KPI Calculation**	DNA rate per individual clinician, then % of all clinicians with a rate of 10% or less
6	**Data Source** **Data Completeness** **Data Quality Issues**	Hospitals
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	Qualifies as an outpatient attendance
9	**Minimum Data Set**	BIU- Acute OPD Template
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually
13	**KPI report period**	Indicate the period to which the data applies
		☑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) June data reported in June report
		☐ Monthly in arrears (June data reported in July)
		❑ Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ❑ Other – give details:
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐ Regional ❑ LHO Area þ Hospital
		❑ County ❑ Institution ☑ Other – give details: Hospital Group
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☑ Performance Assurance Report (NSP) ☐CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/performanceassurancereports/
17	**Additional Information**	KPI noted in Divisional Operational Plan
Contact details for Data Manager /Specialist Lead		Derek McCormack, BIU Acute, Tel: 01 620 1690 E:Derek.mccormack@hse.ie Oliver Plunkett, OSPIP
National Lead and Division		Ollie Plunkett, OSPIP, Ardee Business Park, Hale Street, Ardee, Co Louth and Ita Hegarty, OSPIP tel 041 6871516, 087 6786229

Ratio of Compliments to Complaints

1	**KPI title**	Ratio of Compliments to Complaints
2	**KPI Description** **A67**	As per data source below
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Potential for improvement if performance is known Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ❑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	2:1
5	**KPI Calculation**	The numerator is the number of complaints. The denominator is the total number of compliments.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Data Source: a combination of excel sheets and the NIMS Complaints Module. Data Completeness: data provided by Complaints Officers and Complaints Managers. Data Quality Issues: 2016 will include a transition from spreadsheets to national use of the NIMS Complaints Module by HSE Complaints Officers, this transition could potentially result in duplication of data. KPI Coverage 100%
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	Complaints, Occurance [NIMS field], Compliments, Positive Feedback
10	**International Comparison**	
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: Complaints Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ❑ Rolling 12 months (previous 12 month period) ☐ Other – give details: Bi-Annual and Annual
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ☑ Regional ☑ Hospital Group ☐ Hospital ☑CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ❑ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ❑ Performance Assurance Report (NSP) ❑CompStat ☑Other – give details: Annual Publication, Data on Complaints Statistics. Quarterly Casebook
16	**Web link to data**	Available q2 2016
17	**Additional Information**	This KPI is noted in Divisional Operational Plan 2016
Contact details for Data Manager /Specialist Lead		Data Manager: Aoife Hilton Email: aoife.hilton@hse.ie Tel: 061 48 3209
National Lead and Division		National Lead: Chris Rudland Division: Quality Assurance and Verification Division: National Complaints Governance and Learning Team

National Cancer Control Programme - Symptomatic Breast Cancer Services

1	KPI Title	No. of patients triaged as urgent presenting to symptomatic breast clinics
2	KPI Description NCCP1	The number of new patients who attended the symptomatic breast clinic, whose referrals were triaged as urgent by the cancer centre.
3	KPI Rationale	Monitoring activity and breakdown of urgent/routine attendances.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	NSP 2016: 16,800
5	KPI Calculation	A sum of the number of new patients who attended the cancer centre in the previous calendar month, whose referrals were triaged as urgent according to NCCP SOPs and referral guidelines for Symptomatic Breast Disease Services, by the specialist team. Calculation undertaken by the cancer centre.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for urgent referral to the clinic as defined by the NCCP SOP for referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The level of urgency assigned to the referral by the cancer centre. 2. The date of attendance at the symptomatic breast clinic
10	International Comparison	Activity data used to compile information on access standards are defined in the strategy for implementation of safer better healthcare in the symptomatic breast services which has been developed by the NCCP in accordance with the HIQA 2012 National Standards. The UK NHS have introduced a '2 week rule' for their cancer referrals in line with the Calman Hine report (1995)
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	Performance Report (NSP/CBP) ☑ CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in National Service Plan 2016
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	KPI Title	Number of non urgent attendances presenting to Symptomatic Breast Clinics
2	KPI Description NCCP2	The number of new patients who attended the symptomatic breast clinic, whose referral was triaged as non-urgent by the cancer centre.
3	KPI Rationale	Monitoring activity and breakdown of urgent/routine attendances
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	DOP 2016: 24,000
5	KPI Calculation	A sum of the number of new patients who attended the cancer centre in the previous calendar month, whose referrals were triaged as non urgent according to NCCP SOPs and referral guidelines for Symptomatic Breast Disease Services, by the specialist team. Calculation undertaken by the cancer centre.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑Monthly Quarterly ☐Bi-annually ☐Annually ☐ Other – give details:
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for non-urgent referral to the clinic as defined by the NCCP SOP for Referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The level of urgency assigned to the referral by the cancer centre. 2. The date of attendance at the symptomatic breast clinic
10	International Comparison	Activity data used to compile information on access standards are defined in the strategy for implementation of safer better healthcare in the symptomatic breast services which has been developed by the NCCP in accordance with the HIQA 2012 National Standards.
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly oQuarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑ Monthly in arrears (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in Divisional Operational Report 2016 only
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	KPI Title	Number of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals.
2	KPI Description NCCP3	The number of attendances, whose referrals were triaged as urgent by the cancer centre and were offered an appointment within 10 working days of the date of receipt of a letter of referral in the cancer office
3	KPI Rationale	Monitoring timely access to breast rapid access clinics
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	DOP 2016: 16,000
5	KPI Calculation	Numerator: The number of patients triaged as urgent by the cancer centre who attended a symptomatic breast clinic (during the reporting month) within 10 working days of the date of receipt of the referral letter in the cancer office or were offered an appointment to attend a symptomatic breast clinic within 10 working days of the date of receipt of the referral letter in the cancer office Denominator: The total number of patients triaged as urgent by the cancer centre who attended a symptomatic breast clinic during the reporting month.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☐ Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☑Other – give details: At the end of the clinic
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for urgent referral to the clinic as defined by the NCCP SOP for referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The date of the first appointment offered to the patient 4. The date of attendance at the symptomatic breast cli
10	International Comparison	Access standard as defined in the Irish National Quality Assurance Standards for Symptomatic Breast Disease Services, HIQA, 2006. Similar access standard in the UK – NHS Cancer Plan 2000.
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly Monthly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Quarterly ☑ Monthly in arrears (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☑CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. KPI noted in Divisional Operational Report 2016 only
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr.Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	KPI Title	Percentage of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals.
2	KPI Description NCCP4	Percentage of attendances, whose referrals were triaged as urgent by the cancer centre and were offered an appointment within 10 working days ii of the date of receipt of a letter of referral in the cancer office
3	KPI Rationale	Monitoring timely access to breast rapid access clinics
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	NSP 2016: 95%
5	KPI Calculation	Numerator: The number of patients triaged as urgent by the cancer centre who attended a symptomatic breast clinic (during the reporting month) within 10 working days of the date of receipt of the referral letter in the cancer office or were offered an appointment to attend a symptomatic breast clinic within 10 working days of the date of receipt of the referral letter in the cancer office Denominator: The total number of patients triaged as urgent by the cancer centre who attended a symptomatic breast clinic during the reporting month.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☐ Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☑Other – give details: At the end of the clinic
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for urgent referral to the clinic as defined by the NCCP SOP for referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The date of the first appointment offered to the patient 4. The date of attendance at the symptomatic breast cli
10	International Comparison	Access standard as defined in the Irish National Quality Assurance Standards for Symptomatic Breast Disease Services, HIQA, 2006. Similar access standard in the UK – NHS Cancer Plan 2000.
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis:NCCP/Group CEO/Hospital Manager ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly Monthly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Quarterly ☑ Monthly in arrears (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. KPI noted in National Service Plan 2016
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr.Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	KPI Title	Number of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non urgent referrals. (No. offered an appointment that falls within 12 weeks).
2	KPI Description NCCP5	The number of attendances whose referrals were triaged as non-urgent by the cancer centre and were offered an appointment for a symptomatic breast clinic within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office.
3	KPI Rationale	Monitoring access and adherence to HIQA standards
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	DOP 2016 : 22,800
5	KPI Calculation	Numerator:The number of patients triaged by the cancer centre as non-urgent who attended a symptomatic breast clinic (during the reporting month) within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office or were offered an appointment to attend a symptomatic breast clinic within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office. Denominator:The total number of patients triaged by the cancer centre as non-urgent who attended a symptomatic breast clinic during the reporting month. Percentage calculation undertaken by NCCP.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☑Other – give details: At the end of the clinic
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for non-urgent referral to the clinic as defined by the NCCP SOP for Referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The date of the first appointment offered to the patient 4. The date of attendance at the symptomatic breast clinic
10	International Comparison	Activity data used to compile information on access standards are defined in the strategy for implementation of safer better healthcare in the symptomatic breast services which has been developed by the NCCP in accordance with the HIQA 2012 National Standards. Internationally, wait times of up to 12 weeks have been shown not to influence survival: Association of Breast Surgery (EJSO), 2009. Clinical standards - management of breast cancer services. Scotland 2008
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Quarterly ☑ Monthly in arrears (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in Divisional Operational Report 2016 only.
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	KPI Title	Percentage of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the HIQA standard of 12 weeks for non urgent referrals. (Percentage offered an appointment that falls within 12 weeks).
2	KPI Description NCCP6	percentage of attendances whose referrals were triaged as non-urgent by the cancer centre and were offered an appointment for a symptomatic breast clinic within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office.
3	KPI Rationale	Monitoring access and adherence to HIQA standards
	Indicator Classification (National Standards for	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
	Safer Better HealthCare)	Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	NSP 2016 : 95%
5	KPI Calculation	Numerator:The number of patients triaged by the cancer centre as non-urgent who attended a symptomatic breast clinic (during the reporting month) within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office or were offered an appointment to attend a symptomatic breast clinic within 12 weeks (less than or equal to 84 days) of the date of receipt of the referral letter in the cancer office. Denominator:The total number of patients triaged by the cancer centre as non-urgent who attended a symptomatic breast clinic during the reporting month. Percentage calculation undertaken by NCCP.
6	Data Source	Symptomatic breast database in the cancer centres
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	All patients who attend the symptomatic breast disease clinic and who adhere to the criteria for non-urgent referral to the clinic as defined by the NCCP SOP for Referral & Triage (2008) and the NCCP GP referral guideline
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The date of the first appointment offered to the patient 4. The date of attendance at the symptomatic breast clinic
10	International Comparison	Activity data used to compile information on access standards are defined in the strategy for implementation of safer better healthcare in the symptomatic breast services which has been developed by the NCCP in accordance with the HIQA 2012 National Standards. Internationally, wait times of up to 12 weeks have been shown not to influence survival: Association of Breast Surgery (EJSO), 2009. Clinical standards - management of breast cancer services. Scotland 2008
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☑Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Quarterly ☑ Monthly in arrears (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in National Service Plan 2016.
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	**KPI title**	Clinic cancer detection rate: No. of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer
2	**KPI Description NCCP7**	The number of patients who were triaged as urgent that were subsequently diagnosed with a breast cancer
3	**KPI Rationale** **Indicator Classification** (National Standards for Safer Better HealthCare)	Monitoring adequacy of GP referral criteria and hospital triage process Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑ Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	Target 2016: >1,100
5	**KPI Calculation**	Numerator: The total number of patients triaged by the cancer centre as urgent (during the reporting month) who were subsequently diagnosed with breast cancer. Denominator:The number of patients triaged by the cancer centre as urgent who attended a symptomatic breast clinic (during the reporting month) Percentage calculation undertaken by NCCP.
6	**Data Source** **Data Completeness** **Data Quality Issues**	Symptomatic breast database in the cancer centre 100% coverage No data quality issues
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The patients diagnosis 4. The date of discussion at MDM
10	**International Comparison**	International studies have found that between 6 and 10% of patients who attend rapid access clinics for symptomatic breast disease are subsequently diagnosed with cancer (Cochrane, 1997; Patel, 2000)
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ☑Monthly ☐Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☐ Quarterly in arrears (quarter 1 data reported in quarter 2) ☐ Rolling 12 months (previous 12 month period) ☑ Other – give details: rolling 12 months (Jan to Dec 2015 reported in Jan 2016)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑Hospital Group ☐ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in Divisional Operational Report 2016 only.
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control Programme - Symptomatic Breast Cancer Services		
1	**KPI title**	Clinic cancer detection rate: % of new attendances to clinic, triaged as urgent, which have a subsequent diagnosis of breast cancer
2	**KPI Description NCCP8**	% of patients who were triaged as urgent that were subsequently diagnosed with a breast cancer
3	**KPI Rationale Indicator Classification** (National Standards for Safer Better HealthCare)	Monitoring adequacy of GP referral criteria and hospital triage process Please tick Indicator Classification this indicator applies to: ☑ Person Centred Care ☑Effective Care ☑ Safe Care ❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce ☑ Use of Resources ❑ Governance, Leadership and Management
4	**KPI Target**	NSP 2016: >6%
5	**KPI Calculation**	Numerator: The total number of patients triaged by the cancer centre as urgent (during the reporting month) who were subsequently diagnosed with breast cancer. Denominator:The number of patients triaged by the cancer centre as urgent who attended a symptomatic breast clinic (during the reporting month) Percentage calculation undertaken by NCCP.
6	**Data Source Data Completeness Data Quality Issues**	Symptomatic breast database in the cancer centre 100% coverage No data quality issues
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	1. The date of receipt of the referral letter in the cancer centre. 2. The level of urgency assigned to the referral by the cancer centre. 3. The patients diagnosis 4. The date of discussion at MDM
10	**International Comparison**	International studies have found that between 6 and 10% of patients who attend rapid access clinics for symptomatic breast disease are subsequently diagnosed with cancer (Cochrane, 1997; Patel, 2000)
11	**KPI Monitoring**	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported: ❑Daily ☑Monthly ☐Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐ Monthly in arrears (June data reported in July) ☐ Quarterly in arrears (quarter 1 data reported in quarter 2) ☐ Rolling 12 months (previous 12 month period) ☑ Other – give details: rolling 12 months (Jan to Dec 2015 reported in Jan 2016)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ❑Hospital Group ☐ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1 http://www.hiqa.ie/system/files/Symptomatic_breast_Disease_Standards.pdf KPI noted in National Service Plan 2016.
Contact details for Data		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control - Lung Cancer

1	**KPI Title**	No. of patients attending the rapid access lung clinic in designated cancer centres
2	**KPI Description NCCP9**	Total number of new, return attendances to the rapid access lung clinic
3	**KPI Rationale**	Monitor activity of rapid access clinics to enable future planning of services
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	NSP 2016 : 3,300
5	**KPI Calculation**	A sum of the number of new and return attendances at a lung cancer rapid access clinic on a date between the first and the last date inclusive of any given month. Calculation undertaken by the cancer centre.
6	**Data Source**	Cancer Centre
	Data Completeness	100% coverage
	Data Quality Issues	None
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☑ Other – give details: At the end of the clinic
8	**Tracer Conditions**	All patients referred to the rapid access lung clinic who adhere to the criteria for referral to the rapid access lung clinic as defined by the National Lung Cancer Rapid Access Service GP Referral Guidelines, NCCP1 New attendance is defined as an attendance by a patient who has not been investigated at least once previously as an outpatient at a lung cancer rapid access clinic with the same condition/complaint within the previous 12 months and has not been treated previously for lung cancer in the cancer centre at any time. Return attendance is defined as an attendance by a patient who has been seen at least once previously as an outpatient at a lung cancer rapid access clinic with the same condition/complaint within the previous 12 months.
9	**Minimum Data Set**	1. The date of new patient attendance at the rapid access lung clinic 2. The date of return patient attendance at the rapid access lung clinic
10	**International Comparison**	No
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports ?**	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in National Service Plan 2016.
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control - Lung Cancer

1	**KPI Title**	Number of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the designated cancer centre
2	**KPI Description** **NCCP10**	Number of patients attending the rapid access clinic that attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre.
3	**KPI Rationale**	Monitoring timely access to Rapid Access Clinics
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	DOP 2016 : 3,135
5	**KPI Calculation**	Numerator:The number of patients who attended or were offered an appointment to attend a rapid access lung clinic (during the reporting month) within 10 working days of the date of receipt of the referral letter in the cancer centre. Denominator:The total number of patients who attended a rapid access lung clinic during the reporting month. Percentage calculation undertaken by NCCP.
6	**Data Source**	Cancer Centre
	Data Completeness	100% coverage
	Data Quality Issues	None
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	**Tracer Conditions**	All patients referred to the rapid access lung clinic who adhere to the criteria for referral to the rapid access lung clinic as defined by the National Lung Cancer Rapid Access Service GP Referral Guidelines, NCCP1
9	**Minimum Data Set**	1. The date of receipt of the referral letter in the cancer centre. 2. The date of the first appointment offered to the patient 3. The date of attendance at the rapid access lung clinic
10	**International Comparison**	Similar access standard in the UK – NHS Cancer Plan 2000
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports ?**	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in Divisional Operational Plan only.
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control - Lung Cancer

1	**KPI Title**	Percentage of patients attending lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the designated cancer centres
2	**KPI Description** **NCCP11**	Percentage of patients attending lung rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the designated cancer centres
3	**KPI Rationale**	Monitoring timely access to Rapid Access Clinics
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	NSP 2016 : 95%
5	**KPI Calculation**	Numerator:The number of patients who attended or were offered an appointment to attend a rapid access lung clinic (during the reporting month) within 10 working days of the date of receipt of the referral letter in the cancer centre. Denominator:The total number of patients who attended a rapid access lung clinic during the reporting month. Percentage calculation undertaken by NCCP.
6	**Data Source**	Cancer Centre
	Data Completeness	100% coverage
	Data Quality Issues	None
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐ Other – give details:
8	**Tracer Conditions**	All patients referred to the rapid access lung clinic who adhere to the criteria for referral to the rapid access lung clinic as defined by the National Lung Cancer Rapid Access Service GP Referral Guidelines, NCCP1
9	**Minimum Data Set**	1. The date of receipt of the referral letter in the cancer centre. 2. The date of the first appointment offered to the patient 3. The date of attendance at the rapid access lung clinic
10	**International Comparison**	Similar access standard in the UK – NHS Cancer Plan 2000
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports ?**	☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in National Service Plan 2016.
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control - Lung Cancer

1	**KPI title**	Clinic Cancer detection rate: Number of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer
2	**KPI Description NCCP12**	The number of patients who attended the rapid access lung clinic and were subsequently diagnosed with a lung cancer
3	**KPI Rationale**	Monitoring adequacy of GP referral criteria and hospital triage process
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	Target 2016: >825
5	**KPI Calculation**	Numerator: The total number of patients hat attended the lung rapid access clinic (during the reporting month) who were subsequently diagnosed with a primary lung cancer. Denominator:The number of patients that attended the lung rapid access clinic (during the reporting month) Percentage calculation undertaken by NCCP.
6	**Data Source** **Data Completeness** **Data Quality Issues**	RALC database in the cancer centre 100% coverage No data quality issues
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐ Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	1. The date of attendance in the cancer centre. 2. The patient's diagnosis
10	**International Comparison**	No equivalent international studies available
11	**KPI Monitoring**	KPI will be monitored :
		KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☐Quarterly ☑Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ☐Quarterly ☑Rolling 12 months (previous 12 month period) (e.g. Jan to Dec 2015 reported in Jan 2016)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐Regional ☐ LHO Area ☑Hospital Group ☐ County ☐ Institution o Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in Divisional Operational Plan only.
Contact details for Data Manager /Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

National Cancer Control - Lung Cancer

1	**KPI title**	Clinic Cancer detection rate: % of new attendances to clinic, triaged as urgent, that have a subsequent diagnosis of lung cancer
2	**KPI Description NCCP13**	% of patients who attended the rapid access lung clinic and were subsequently diagnosed with a lung cancer
3	**KPI Rationale**	Monitoring adequacy of GP referral criteria and hospital triage process
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑ Effective Care
		☑ Safe Care Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	NSP 2016: 25%
5	**KPI Calculation**	Numerator:The total number of patients hat attended the lung rapid access clinic (during the reporting month) who were subsequently diagnosed with a lung cancer. Denominator:The number of patients that attended the lung rapid access clinic (during the reporting month) Percentage calculation undertaken by NCCP.
6	**Data Source** **Data Completeness** **Data Quality Issues**	RALC database in the cancer centre 100% coverage No data quality issues
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		☐Daily ☐Weekly ☑Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐ Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	1. The date of attendance in the cancer centre. 2. The patient's diagnosis
10	**International Comparison**	No equivalent international studies available
11	**KPI Monitoring**	KPI will be monitored :
		KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Quarterly Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ☐Quarterly ☑Rolling 12 months (previous 12 month period) (e.g. Jan to Dec 2015 reported in Jan 2016)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐Regional ☐ LHO Area þHospital Group ☐ County ☐ Institution ☐ Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☐ Corporate Plan Report ☑Performance Report (NSP/CBP) ☑CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in National Service Plan 2016.
Contact details for Data Manager /Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Prostate Cancer	
1	KPI Title	Number of centres providing surgical services for prostate cancers
2	KPI Description NCCP14	Number of centres providing primary surgery for prostate cancer.
3	KPI Rationale	Monitoring service development and centralisation
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑Person Centred Care ☑ Effective Care
		Safe Care☑ Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	DOP 2016 :7
5	KPI Calculation	Number of centres providing primary surgical treatment
6	Data Source	Cancer Centre
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Men with prostate cancer (C61*) who require primary surgical treatment (radical prostatectomy) for treatment of their disease
9	Minimum Data Set	Number of centres providing primary surgical treatment for prostate cancer
10	International Comparison	No
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution Other – give details:
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the HSE Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/RapidAccessGuide.pdf KPI noted in Divisional Operational Plan
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Prostate Cancer	
1	**KPI Title**	No. of patients attending the rapid access clinic in the cancer centres
2	**KPI Description NCCP15**	Total number of new, return attendances to the rapid access prostate clinic
3	**KPI Rationale**	Attendance figures will monitor activity rates at these new clinics and support evaluation of the effectiveness of the referrals process
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑Person Centred Care ☑ Effective Care
		Safe Care☑ Better Health and Wellbeing ☐Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	**KPI Target**	NSP 2016: 2,600
5	**KPI Calculation**	A sum of the number of new and return attendances at a prostate cancer rapid access clinic between the first and the last date inclusive of any given month. Calculation undertaken by the cancer centre.
6	**Data Source**	Rapid access prostate clinic returns
	Data Completeness	100% coverage
	Data Quality Issues	None
7	**Data Collection Frequency**	☐Daily ☐Weekly ☑ Monthly Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	**Tracer Conditions**	All patients referred to the rapid access prostate clinic who adhere to the criteria for referral as defined by the National Prostate Cancer GP Referral Guidelines, NCCP.1 New attendance is defined as an attendance by a patient who has not been investigated at least once previously as an outpatient at a prostate cancer rapid access clinic with the same condition/complaint within the previous 18 months and has not been treated previously for prostate cancer in the cancer centre at any time. Return attendance is defined as an attendance by a patient who has been seen at least once previously as an outpatient at a prostate cancer rapid access clinic with the same condition/complaint within the previous 18 months.
9	**Minimum Data Set**	1. The date of new patient attendance at the rapid access prostate clinic 2. The date of return patient attendance at the rapid access prostate clinic
10	**International Comparison**	No
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	❑Daily ❑Weekly ❑Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Quarterly ☑ Monthly in arreas (June data reported in July) ☐Rolling 12 months (previous 12 month period)
14	**KPI Reporting Aggregation**	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer centre
15	**KPI is reported in which reports ?**	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	**Web link to data**	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	**Additional Information**	As reported in the Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/ProstateCancerReferralGuide.pdf KPI noted in National Service Plan 2016.
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	National Cancer Control - Prostate Cancer	
1	KPI Title	Number of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre.
2	KPI Description NCCP16	Number of patients seen or offered an appointment in a prostate rapid access clinic to be seen within 20 working days of referral from a GP.
3	KPI Rationale	This is in accordance with clinical guidelines on access to diagnosis with the ultimate aim of best outcome for the patient.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑Effective Care
		Safe Care ☑ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	DOP 2016 : 2,340
5	KPI Calculation	Numerator:the number of patients who attended or were offered an appointment to attend (in the reporting period) a rapid access prostate clinic within 20 working days of the date of receipt of referral letter in the cancer centre. Denominator: the number of patients who attended a rapid access prostate clinic during the reporting month
6	Data Source	Rapid access prostate clinic returns from cancer centres.
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑ Monthly Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	All patients referred to the rapid access prostate clinic who adhere to the criteria for referral as defined by the National Prostate Cancer GP Referral Guidelines, NCCP1
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The date of the first appointment offered to the patient 3. The date of attendance at the rapid access prostate clinic
10	International Comparison	No standard international metric available for rapid access prostate cancer clinics
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐ Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/ProstateCancerReferralGuide.pdf KPI noted in Divisional Operational Plan
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Prostate Cancer	
1	KPI Title	Percentage of patients attending the prostate rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre.
2	KPI Description NCCP17	Percentage of patients seen or offered an appointment in a prostate rapid access clinic to be seen within 20 working days of referral from a GP.
3	KPI Rationale	This is in accordance with clinical guidelines on access to diagnosis with the ultimate aim of best outcome for the patient.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☐Effective Care
		Safe Care ☑ Better Health and Wellbeing ☐ Use of Information☐
		Workforce☐Use of Resources☐Governance, Leadership and Management ☐
4	KPI Target	NSP 2016: 90%
5	KPI Calculation	Numerator: the number of patients who attended or were offered an appointment to attend (in the reporting period) a rapid access prostate clinic within 20 working days of the date of receipt of referral letter in the cancer centre. Denominator: total number of patients who attended a rapid access prostate clinic during the reporting period.
6	Data Source	Rapid access prostate clinic returns from cancer centres.
	Data Completeness	100% coverage
	Data Quality Issues	None
7	Data Collection Frequency	☐Daily ☐Weekly ☑ Monthly Quarterly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	All patients referred to the rapid access prostate clinic who adhere to the criteria for referral as defined by the National Prostate Cancer GP Referral Guidelines, NCCP1
9	Minimum Data Set	1. The date of receipt of the referral letter in the cancer centre. 2. The date of the first appointment offered to the patient 3. The date of attendance at the rapid access prostate clinic
10	International Comparison	No standard international metric available for rapid access prostate cancer clinics
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly ☑ Monthly ☐Quarterly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: Cancer Centre
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☑CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	As reported in the Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/ProstateCancerReferralGuide.pdf KPI noted in National Service Plan 2016.
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National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Prostate Cancer	
1	KPI title	Clinic cancer detection rate: No. of new attendances to clinic that have a subsequent diagnosis of a prostate cancer
2	KPI Description NCCP18	The number of patients who attended the rapid access prostate clinic and were subsequently diagnosed with a prostate cancer
3	KPI Rationale	Monitoring adequacy of GP referral criteria and hospital triage process
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	DOP 2016: >780
5	KPI Calculation	Numerator: The total number of patients hat attended the prostate rapid access clinic (during the reporting month) who were subsequently diagnosed with a primary prostate cancer. Denominator:The number of patients that attended the prostate rapid access clinic (during the reporting month) Percentage calculation undertaken by NCCP.
6	Data Source	RAPC database in the cancer centre 100% coverage No data quality issues
	Data Completeness	
	Data Quality Issues	
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected:
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	1. The date of attendance in the cancer centre. 2. The patient's diagnosis
10	International Comparison	No equivalent international studies available
11	KPI Monitoring	KPI will be monitored :
		❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly ☑Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies
		❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity)
		☐Monthly in arrears (June data reported in July)
		☐Quarterly in arrears (quarter 1 data reported in quarter 2)
		☑Rolling 12 months (previous 12 month period) (e.g. Jan to Dec 2015 reported in Jan 2016)
		❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location:
		☑ National ❑ Regional ☑Hospital Group ☐ Hospital ☐ CHO ☐ ISA ☐ LHO
		❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported:
		☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	As reported in the Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/ProstateCancerReferralGuide.pdf KPI noted in Divisional Operational Plan
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	National Cancer Control - Prostate Cancer	
1	KPI title	Clinic cancer detection rate: % of new attendances to clinic that have a subsequent diagnosis of a prostate cancer
2	KPI Description NCCP19	% of patients who attended the rapid access prostate clinic and were subsequently diagnosed with a prostate cancer
3	KPI Rationale	Monitoring adequacy of GP referral criteria and hospital triage process
	Indicator Classification	Please tick Indicator Classification this indicator applies to:
	(National Standards for Safer Better HealthCare)	☑ Person Centred Care ☑Effective Care ☑ Safe Care
		❑ Better Health and Wellbeing ☑ Use of Information ❑ Workforce
		☑ Use of Resources ❑ Governance, Leadership and Management
4	KPI Target	NSP 2016 :> 30%
5	KPI Calculation	Numerator:The number of patients that attended the prostate rapid access clinic (during the reporting month) Denominator:The total number of patients hat attended the prostate rapid access clinic (during the reporting month) who were subsequently diagnosed with a pirmary prostate cancer. Percentage calculation undertaken by NCCP.
6	Data Source Data Completeness Data Quality Issues	RAPC database in the cancer centre 100% coverage No data quality issues
7	Data Collection Frequency	Indicate how often the data to support the KPI will be collected: ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
8	Tracer Conditions	
9	Minimum Data Set	1. The date of attendance in the cancer centre. 2. The patient's diagnosis
10	International Comparison	No equivalent international studies available
11	KPI Monitoring	KPI will be monitored : ❑Daily ❑Weekly ☑ Monthly ❑Quarterly ❑Bi-annually ❑Annually ❑Other – give details: Please indicate who is responsible at a local level for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	Indicate how often the KPI will be reported: ❑Daily ❑Weekly Monthly ☑Quarterly ❑Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	Indicate the period to which the data applies ❑ Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☐Monthly in arrears (June data reported in July) ☐Quarterly in arrears (quarter 1 data reported in quarter 2) ☑Rolling 12 months (previous 12 month period) (e.g. Jan to Dec 2015 reported in Jan 2016) ❑ Other – give details:
14	KPI Reporting Aggregation	Indicate the level of aggregation – for example over a geographical location: ☑ National ❑ Regional ☑Hospital Group ☐ Hospital ☐ CHO ☐ ISA ☐ LHO ❑ County ❑ Institution Other – give details:
15	KPI is reported in which reports?	Indicate where the KPI will be reported: ☑ Performance Report (NSP) ☑CompStat ❑Other – give details:
16	Web link to data	
17	Additional Information	As reported in the Performance Report. 1http://www.hse.ie/eng/services/Find_a_Service/HospsCancer/dooradoyle/MWCC/ProstateCancerReferralGuide.pdf KPI noted in National Service Plan 2016.
Contact details for Data Manager /Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Radiotherapy	
1	KPI Title	No. of Patients who completed radical radiotherapy treatment (pallative care patients not included)
2	KPI Description NCCP20	No. of Patients who completed radical radiotherapy treatment (pallative care patients not included)
3	KPI Rationale	Monitors efficiency of the radiotherapy planning processes.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑Effective Care
		☑Safe Care Better Health and Wellbeing ☐Use of Information
		Workforce☐ Use of Resources Governance, Leadership and Management ☐
4	KPI Target	DOP 2016: 4,900
5	KPI Calculation	A sum of the total number of patients who completed radical radiotherapy in the reporting month
6	Data Source Data Completeness Data Quality Issues	Electronic patient record 100% coverage
7	Data Collection Frequency	☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Patients who completed radical treatment for all cancers (C00 * - C96*)
9	Minimum Data Set	1. Diagnosis 2. Date of ready to treat 3. Date of start of treatment 4. Date of completion of treatment
10	International Comparison	Yes - This benchmark is in line with British Columbia Guidelines & ahead of standards in the UK.https://www.wp.dh.gov.uk/publications/files/2012/11/Radiotherapy-Services-in-England-2012.pdf
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: By HSE radiotherapy facilities (SLRON, CUH & UCHG) and that for public patients treated under an SLA in private sector facilities in private facilities
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☑CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	KPI noted in Divisional Operational Plan
Contact details for Data Manager / Specialist Lead		Dr. Deirdre Murray, NCCP Tel: 021 4927601 Email: DeirdreE.Murray@hse.ie
National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Radiotherapy	
1	KPI Title	No. of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)
2	KPI Description NCCP21	Number of patients undergoing radical treatment for any cancer diagnosis who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist. This exculdes patients referred for palliative treatment.
3	KPI Rationale	Monitors efficiency of the radiotherapy planning processes.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑Effective Care
		☑Safe Care Better Health and Wellbeing ☐Use of Information
		Workforce☐ Use of Resources Governance, Leadership and Management ☐
4	KPI Target	DOP 2016: 4,410
5	KPI Calculation	Numerator: Number of patients refrered for radiotherapy whose radiotherapy treatment commenced within 15 days of being deemed ready to treat within the reporting period. Denominator: Total number of patients deemed ready to treat referred for radiotherapy
6	Data Source	Electronic patient record
	Data Completeness	100% coverage
	Data Quality Issues	
7	Data Collection Frequency	☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Patients who completed radical treatment for all cancers (C00 * - C96*)
9	Minimum Data Set	1. Diagnosis 2. Date of ready to treat 3. Date of start of treatment 4. Date of completion of treatment
10	International Comparison	Yes - This benchmark is in line with British Columbia Guidelines & ahead of standards in the UK.https://www.wp.dh.gov.uk/publications/files/2012/11/Radiotherapy-Services-in-England-2012.pdf
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: By HSE radiotherapy facilities (SLRON, CUH & UCHG) and that for public patients treated under an SLA in private sector facilities in private facilities
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	KPI noted in Divisional Operational Plan
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National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Radiotherapy	
1	KPI Title	% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)
2	KPI Description NCCP22	% of patients undergoing radical treatment for any cancer diagnosis who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist. This exculdes patients referred for palliative treatment.
3	KPI Rationale	Monitors efficiency of the radiotherapy planning processes.
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑Effective Care
		☑Safe Care ☑Better Health and Wellbeing ☐Use of Information
		Workforce☐ Use of Resources Governance, Leadership and Management ☐
4	KPI Target	DOP 2016: 90%
5	KPI Calculation	Numerator: Number of patients refrered for radiotherapy whose radiotherapy treatment commenced within 15 days of being deemed ready to treat within the reporting period. Denominator: Total number of patients deemed ready to treat referred for radiotherapy
6	Data Source	Electronic patient record
	Data Completeness	100% coverage
	Data Quality Issues	Some data definitions still being clarified
7	Data Collection Frequency	☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
8	Tracer Conditions	Patients who completed radical treatment for all cancers (C00 * - C96*)
9	Minimum Data Set	1. Diagnosis 2. Date of ready to treat 3. Date of start of treatment 4. Date of completion of treatment
10	International Comparison	Yes - This benchmark is in line with British Columbia Guidelines & ahead of standards in the UK.https://www.wp.dh.gov.uk/publications/files/2012/11/Radiotherapy-Services-in-England-2012.pdf
11	KPI Monitoring	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details: Please indicate who is responsible for monitoring this KPI:NCCP/Group CEO/Hospital Manager
12	KPI Reporting Frequency	❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	KPI report period	☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	KPI Reporting Aggregation	☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☑ Other – give details: By HSE radiotherapy facilities (SLRON, CUH & UCHG) and that for public patients treated under an SLA in private sector facilities in private facilities
15	KPI is reported in which reports ?	☑ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	Web link to data	http://www.hse.ie/eng/services/Publications/corporate/Performance_Reports_Monthly.html
17	Additional Information	KPI noted in National Service Plan 2016
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National Lead and Division		Dr. Jerome Coffey, National Director, NCCP Tel: 01 8287100

	National Cancer Control - Rectal	
1	**KPI title**	No. of centres providing services for rectal cancers
2	**KPI Description NCCP23**	No. of centres providing primary surgical treatment for rectal cancers
3	**KPI Rationale**	
	Indicator Classification	Please tick which Indicator Classification this indicator applies to, ideally choose one classification (in some cases you may need to choose two). ☑ Person Centred Care ☑Effective Care
	(National Standards for Safer Better HealthCare)	☑Safe Care Better Health and Wellbeing ☐Use of Information
		Workforce☐ Use of Resources Governance, Leadership and Management ☐
4	**KPI Target**	Target 2016: 8
5	**KPI Calculation**	No. of centres providing primary surgical treatment for rectal cancers
6	**Data Source**	100% coverage
	Data Completeness	
	Data Quality Issues	
7	**Data Collection Frequency**	Indicate how often the data to support the KPI will be collected:
		☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
8	**Tracer Conditions**	
9	**Minimum Data Set**	
10	**International**	
11	**KPI Monitoring**	KPI will be monitored on a (please indicate below) basis: ☐Daily ☐Weekly Quarterly ☑ Monthly ☐Bi-annually ☐Annually ☐Other – give details:
		Please indicate who is responsible at a local level for monitoring this KPI: NCCP/Group CEO/Hospital Manager
12	**KPI Reporting Frequency**	Indicate how often the KPI will be reported:
		❑Daily ❑Weekly Quarterly ☑ Monthly ☐Bi-annually ❑Annually ❑Other – give details:
13	**KPI report period**	Indicate the period to which the data applies
		☐Current (e.g. daily data reported on that same day of activity, monthly data reported within the same month of activity) ☑Monthly in arrears (June data reported in July) ☐Quarterly ☐Rolling 12 months (previous 12 month period)
14	**KPI Reporting Aggregation**	Indicate the level of aggregation – for example over a geographical location:
		☑ National ☐Regional ☐ LHO Area ☐Hospital ☐ County ☐ Institution ☐Other – give details:
15	**KPI is reported in which reports?**	Indicate where the KPI will be reported:
		☐ Performance Assurance Report (NSP) ☐CompStat ☐Other – give details:
16	**Web link to data**	
17	**Additional Information**	KPI noted in Divisional Operational Plan
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