Acute Division -Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A16	New: Return Ratio (excluding obstetrics, warfarin and haematology clinics)
1b	KPI Short Title	OPD Ratio
2	KPI Description	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. This is 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
3a	Indicator Classification	**National Scorecard Quadrant** a) Quality and Safety
4	KPI Target	1:2
4a	Target Trajectory	
4b	Volume metrics	
5	KPI Calculation	Number of new patients and number of review (return) patients seen in hospital clinic expressed as a ratio. Exclude obstetrics patients and haematology/warfarin, then calculate new to review ratio
6	Data Sources	Hospitals
6a	Data sign off	Acute Business Information Unit
6b	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	Monthly
8	Tracer Conditions (clinical metrics only)	As per description no. 2 above
9	Minimum Data Set (MDS)	BIU- Acute OPD Template
10	International Comparison	No OPD measure of performance internationally due to different structures of health service delivery.
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile, Other
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division -ABF (HIPE) - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A38**	Hospital Inpatient Enquiry (HIPE) completeness – Prior month: % of cases entered into HIPE
1b	**KPI Short Title**	HIPE Completeness
2	**KPI Description**	Percentage of all discharges from a prior month coded by the end of the following month by HIPE
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	100%
4a	**Target Trajectory**	Data is point in time
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 Sources**	HIPE and PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	Only accurate if all PAS downloads are made e.g. Dialysis
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	NA
9	**Minimum Data Set (MDS)**	HIPE and PAS data
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report, Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Inpatient & Day Case Waiting Times - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A152**	% of adults waiting <9 months for an elective procedure (inpatient)
1b	**KPI Short Title**	Adult IP WL <9 months
2	**KPI Description**	% of adults waiting <9 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 9 months for an IP procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	90%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	
6	**Data Sources**	Data Sourced from NTPF. Data taken from last day Wednesday of month and submitted to BIU
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Patient awaiting an inpatient procedure, waiting less than 9 months
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Inpatient & Day Case Waiting Times - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A153**	% of adults waiting <9 months for an elective procedure (day case)
1b	**KPI Short Title**	Adult DC WL <9 months
2	**KPI Description**	% of adults waiting <9 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 9 months for a day case procedure.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	90%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	
6	**Data Sources**	Data Sourced from NTPF. Data taken from last day Wednesday of month and submitted to BIU
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Patient awaiting a daycase procedure, waiting less than 9 months
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Inpatient & Day Case Waiting Times - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A154**	% of children waiting <9 months for an elective procedure (inpatient)
1b	**KPI Short Title**	Child IP WL <9 months
2	**KPI Description**	% of children waiting <9 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 9 months for an IP procedure. Waiting times for inpatient and outpatient services are standard measures internationally.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	90%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	
6	**Data Sources**	Data Sourced from NTPF. Data taken from last Wednesday 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 considered a child and anyone attending Adults only hospital will be classed as an adult
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	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 monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Inpatient & Day Case Waiting Times - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A155**	% of children waiting <9 months for an elective procedure (day case)
1b	**KPI Short Title**	Child DC WL <9 months
2	**KPI Description**	% of children waiting <9 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 9 months for a day case procedure.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	90%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	
6	**Data Sources**	Data Sourced from NTPF. Data taken from last Wednesday 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 considered a child and anyone attending Adults only hospital will be classed as an adult
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Outpatient Waiting Times - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A156**	% of people waiting <15 months for first access to OPD services
1b	**KPI Short Title**	OPD - WL <15 Months
2	**KPI Description**	% of people waiting less than 15 months to be seen in outpatient services
3	**KPI Rationale**	90% of patients should wait no more than 15 months for first access to outpatient services
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	90%
4a	**Target Trajectory**	Point in time
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 Sources**	Data Sourced from NTPF. Data taken from last day Wednesday of month and submitted to BIU
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	No. of patients waiting less than 15 months for first access to OPD services
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Inpatient Waiting list Chronologically Scheduled - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A146	% of routine elective procedures (inpatient) chronologically scheduled
1b	Additional Information	IP Scheduled
2	KPI Description	% of routine patients on IP waiting lists that are chronologically scheduled as reported by the Scheduled Care dashboard.
3	KPI Rationale	Patients who have been waiting for a routine procedure for an IP TCI date should not be scheduled ahead of a patient waiting for a shorter period of time.
3a	Indicator Classification	National Scorecard Quadrant a) Quality and Safety; b) Access;
4	KPI Target	85%
4a	Target Trajectory	95% by 2025
4b	Volume metrics	Volume metrics
5	KPI Calculation	For IP the Chronological Scheduling Rate is measured for each combination of hospital/specialty/procedure/consultant where clinical priority equals to "Routine Non-urgent" and wait category is not "Suspension". A patient is marked as scheduled chronologically if (a) they have a TCI date assigned and (b) they are in the top N longest waiters within their hospital/specialty/procedure/consultant combination, where their waiting time is based on the NTPF-derived [NumDays] field, and N is equal to the total number of patients within the same combination who do have a TCI date. The Chronological Scheduling Rate is then calculated by dividing the number of patients marked as chronologically scheduled by the total number of patients assessed who do have a TCI date.
6	Data Sources	SC Dashboard extraction from NTPF weekly CSV file
6a	Data sign off	TBD
6b	Data Quality Issues	Dependent on all hospitals signing a data sharing agreement.
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	All patients waiting for a routine IP TCI date.
9	Minimum Data Set (MDS)	NTPF IP current extracts
10	International Comparison	
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	Include any additional information relevant to the KPI
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Day Case Waiting list Chronologically Scheduled - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A147**	% of routine elective procedures (day case) chronologically scheduled
1b		DC Scheduled
2	**KPI Description**	% of routine patients on DC waiting lists that are chronologically scheduled as reported by the Scheduled Care dashboard.
3	**KPI Rationale**	Patients who have been waiting for a routine patient for an DC TCI date should not be scheduled ahead of a patient waiting for a shorter period of time.
3a	**Indicator Classification**	**National Scorecard Quadrant** a) Quality and Safety; b) Access;
4	**KPI Target**	85%
4a	**Target Trajectory**	95% by 2025
4b	**Volume metrics**	Volume metrics
5	**KPI Calculation**	For DC the Chronological Scheduling Rate is measured for each combination of hospital/specialty/procedure/consultant where clinical priority equals to "Routine Non-urgent" and wait category is not "Suspension". A patient is marked as scheduled chronologically if (a) they have a TCI date assigned and (b) they are in the top N longest waiters within their hospital/specialty/procedure/consultant combination, where their waiting time is based on the NTPF-derived [NumDays] field, and N is equal to the total number of patients within the same combination who do have a TCI date. The Chronological Scheduling Rate is then calculated by dividing the number of patients marked as chronologically scheduled by the total number of patients assessed who do have a TCI date.
6	**Data Sources**	SC Dashboard extraction from NTPF weekly CSV file
6a	**Data sign off**	TBD
6b	**Data Quality Issues**	Dependent on all hospitals signing a data sharing agreement.
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	NTPF /DC current extracts
10	**International Comparison**	
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	Include any additional information relevant to the KPI
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Day Case Waiting list Chronologically Scheduled - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title A148**	% of routine patients on Gastrointestinal (GI) waiting lists that are chronologically scheduled
1b		GI Sheduled
2	**KPI Description**	% of routine patients on GI waiting lists that are chronologically scheduled as reported by the Scheduled Care dashboard.
3	**KPI Rationale**	Patients who have been waiting for a routine procedure for an GI TCI date should not be scheduled ahead of a patient waiting
3a	**Indicator Classification**	**National Scorecard Quadrant** a) Quality and Safety; b) Access;
4	**KPI Target**	85% compliance
4a	**Target Trajectory**	95% by 2025
4b	**Volume metrics**	Volume metrics
5	**KPI Calculation**	For GI the Chronological Scheduling Rate is measured for each combination of hospital/specialty/procedure/consultant where clinical priority equals to “Routine Non-urgent” and wait category is not “Suspension”. A patient is marked as scheduled chronologically if (a) they have a TCI date assigned and (b) they are in the top N longest waiters within their hospital/specialty/procedure/consultant combination, where their waiting time is based on the NTPF-derived [NumDays] field, and N is equal to the total number of patients within the same combination who do have a TCI date. The Chronological Scheduling Rate is then calculated by dividing the number of patients marked as chronologically scheduled by the total number of patients assessed who do have a TCI date.
6	**Data Sources**	SC Dashboard extraction from NTPF weekly CSV file
6a	**Data sign off**	TBD
6b	**Data Quality Issues**	Dependent on all hospitals signing a data sharing agreement.
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	All patients waiting for a routine GI TCI date.
9	**Minimum Data Set (MDS)**	NTPF GI current extracts
10	**International Comparison**	
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	Include any additional information relevant to the KPI
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Day Case Waiting list Chronologically Scheduled - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title** **A149**	% of routine patients on OP waiting lists that are chronologically scheduled
1b		OPD Scheduled
2	**KPI Description**	% of routine patients on OP waiting lists that are chronologically scheduled as reported by the Scheduled Care dashboard.
3	**KPI Rationale**	Patients who have been waiting for a routine OP appointment date should not be scheduled ahead of a patient waiting for a
3a	**Indicator Classification**	**National Scorecard Quadrant** a) Quality and Safety; b) Access;
4	**KPI Target**	85%
4a	**Target Trajectory**	95% by 2025
4b	**Volume metrics**	Volume metrics
5	**KPI Calculation**	For OP the Chronological Scheduling Rate is measured for each combination of hospital/specialty/procedure/consultant where clinical priority equals to "Routine Non-urgent" and wait category is not "Suspension". A patient is marked as scheduled chronologically if (a) they have an appointment date assigned and (b) they are in the top N longest waiters within their hospital/specialty/procedure/consultant combination, where their waiting time is based on the NTPF-derived [NumDays] field, and N is equal to the total number of patients within the same combination who do have an appointment date. The Chronological Scheduling Rate is then calculated by dividing the number of patients marked as chronologically scheduled by the total number of patients assessed who do have a TCI date.
6	**Data Sources**	SC Dashboard extraction from NTPF weekly CSV file
6a	**Data sign off**	
6b	**Data Quality Issues**	Dependent on all hospitals signing a data sharing agreement.
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	All patients waiting for a routine OP appointment date.
9	**Minimum Data Set (MDS)**	NTPF GI current extracts
10	**International Comparison**	
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	Include any additional information relevant to the KPI
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Colonoscopy/Gastrointestinal Service - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A25**	% of people waiting <13 weeks following a referral for colonoscopy or OGD
1b	**KPI Short Title**	GI <13 weeks
2	**KPI Description**	% of people waiting less than 13 weeks for a colonoscopy or OGD
3	**KPI Rationale**	% of patients should wait no more than 13 weeks for a colonoscopy or OGD (including Day case and Inpatient intended management)
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	65%
4a	**Target Trajectory**	Point in time
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. The following ICD10 codes are used to identify the patients waiting **OGD (Upper)**: 11820-00 Panendoscopy via Camera Capsule, 30473-00 Panendoscopy to duodenum (If specialty not ENT), 30473-01 Panendoscopy to duodenum with biopsy (If specialty not ENT), 30473-02 Panendoscopy through artificial storma, 30473-03 Panendoscopy to duodenum (If specialty not ENT), 30473-04 Oesophagoscopy with biopsy, 30473-05 Panendoscopy to ileum (If specialty not ENT), 30473-07 Panendoscopy to deodenum with administration of tattooing agent, 30478-03 Panendoscopy to duodenum with laser coagulation, 30478-04 Panendoscopy to duodenum with excision of lesion, 30478-05 Percutaneous endoscopic jejunostom [PEJ], 30478-06 Endoscopic administration of agent into bleeding lesion of oesophagus, 30478-07 Endoscopic administration of agent into lesion of stomach or duodenum, 30478-08 Removal of gastrostomy tube, 30478-09 Endoscopic adminstration of agent into bleeding lesion of oesophagoastric junction, 30478-10 Oesophagoscopy with removal of foreign body, 30478-11 Oesophagoscopy with diathermy, 30478-12 Oesophagoscopy with heater probe coagulation, 30478-13 Oesophagoscopy with excision of lesion, 30478-19 Oesophagoscopy with other coagulation, 30478-21 Panendoscopy to ileum with other coagulation, 41819-00 Panendoscopy to duodenum (If specialty not ENT), 41819-02 Panendoscopy to duodenum (If specialty not ENT), 90771-00 Panendoscopy via Camera Capsule, 30688-00 ndoscopic Ultrasound **Colonoscopy (Lower)** 30473-06 Panendoscoy to ileum with biopsy, 30473-08 Panendoscopy to ileum with administration of tattooing agent, 30478-14 Panendoscopy to ileum with removal of foreign body, 30478-15 Panendoscopy to ileum with diathermy, 30478-16 Panendoscopy to ileum with heater probe coagulation, 30478-17 Panendoscopy to ileum with laser coagulation, 30478-18 Panendoscopy to ileum with excision of lesion, 30478-20 Panendoscopy to duodenum with other coagulation, 32084-00 Fibreoptic colonoscopy to caecum, 32084-01 Fibreoptic colonoscopy to caecum, 32084-02 Fibreoptic colonoscopy to hepatic flexure with Aministraton of tattoong agent, 32087-00 Fibreoptic conoloscopy to hepatic flexure, with polypectomy, 32090-00 Fibreoptic conoloscopy to caecum, 32090-01 Fibreoptic conoloscopy to caecum, with biopsy, 32090-02 Fibreoptic conoloscopy to caecum with administration of tattooing agent, 32093-00 Fibeoptic conoloscopy to caecum, with polypectomy
6	**Data Sources**	Data Sourced from: National Treatment Purchase Fund (NTPF)
6a	**Data sign off**	NTPF
6b	**Data Quality Issues**	NTPF
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	No of people waiting less than 13 weeks for a colonoscopy or OGD
9	**Minimum Data Set (MDS)**	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**	Monthly
12+A9	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, CHO
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is noted in the Service Plan 2024
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Grace O'Sullivan
		Email address: graceosullivan@rcpi.ie
		Telephone Number: 086 1409177
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision,***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Colonoscopy/Gastrointestinal Service - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A80**	No. of new people waiting > four weeks for access to an urgent colonoscopy
1b	**KPI Short Title**	Urgent colonoscopy greater than 4 weeks
2	**KPI Description**	Number of new people waiting greater than 4 weeks for access to an urgent colonscopy (an exam used to detect changes or abnormalities in the large intestine (colon) and rectum)
3	**KPI Rationale**	Access to an urgent colonscopy within 4 weeks
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	0
5	**KPI Calculation**	Count: Number of New patients waiting greater than 28 days for an Urgent Colonoscopy
6	**Data Sources**	Coverage 37 hospitals 100% 37/37 hospitals reporting
6a	**Data sign off**	Name: Acute Operations & Endoscopy Clinical Programme
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	As per description no. 2 above
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile, Other: give details: CompStat
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI is noted in the Service Plan
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Acute Operations & Endoscopy Clinical Programme
		Email address: for contact purposes : trish.king@hse.ie , graceosullivan@rcpi.ie
		Telephone Number: 0878175975/ 086 1409177
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01-7785222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division Colonoscopy/Gastrointestinal Service - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A157	% of people waiting <9 months for an elective procedure GI scope
1b	KPI Short Title	GI <9 months
2	KPI Description	% of people waiting <9 months for an elective procedure GI scope
3	KPI Rationale	95% of patients should wait no more than 9 months for a elective procedure GI scope
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	95%
4a	Target Trajectory	Point in time
5	KPI Calculation	Numerator: Number of patients waiting to be seen less than 9 months Denominator: Total number of patients waiting for an elective procedure GI scope. The following ICD10 codes are used to identify the patients waiting **OGD (Upper)**: 11820-00 Panendoscopy via Camera Capsule, 30473-00 Panendoscopy to duodenum (If specialty not ENT), 30473-01 Panendoscopy to duodenum with biopsy (If specialty not ENT), 30473-02 Panendoscopy through artificial storma, 30473-03 Panendoscopy to duodenum (If specialty not ENT), 30473-04 Oesophagoscopy with biopsy, 30473-05 Panendoscopy to ileum (If specialty not ENT), 30473-07 Panendoscopy to deodenum with administration of tattooing agent, 30478-03 Panendoscopy to duodenum with laser coagulation, 30478-04 Panendoscopy to duodenum with excision of lesion, 30478-05 Percutaneous endoscopic jejunostom [PEJ], 30478-06 Endoscopic administration of agent into bleeding lesion of oesophagus, 30478-07 Endoscopic administration of agent into lesion of stomach or duodenum, 30478-08 Removal of gastrostomy tube, 30478-09 Endoscopic adminstration of agent into bleeding lesion of oesophagoastric junction, 30478-10 Oesophagoscopy with removal of foreign body, 30478-11 Oesophagoscopy with diathermy, 30478-12 Oesophagoscopy with heater probe coagulation, 30478-13 Oesophagoscopy with excision of lesion, 30478-19 Oesophagoscopy with other coagulation, 30478-21 Panendoscopy to ileum with other coagulation, 41819-00 Panendoscopy to duodenum (If specialty not ENT), 41819-02 Panendoscopy to duodenum (If specialty not ENT), 90771-00 Panendoscopy via Camera Capsule, 30688-00 endoscopic Ultrasound **Colonoscopy (Lower)** 30473-06 Panendoscoy to ileum with biopsy, 30473-08 Panendoscopy to ileum with administration of tattooing agent, 30478-14 Panendoscopy to ileum with removal of foreign body, 30478-15 Panendoscopy to ileum with diathermy, 30478-16 Panendoscopy to ileum with heater probe coagulation, 30478-17 Panendoscopy to ileum with laser coagulation, 30478-18 Panendoscopy to ileum with excision of lesion, 30478-20 Panendoscopy to duodenum with other coagulation, 32084-00 Fibreoptic colonoscopy to caecum, 32084-01 Fibreoptic colonoscopy to caecum, 32084-02 Fibreoptic colonoscopy to hepatic flexure with Aministraton of tattoong agent, 32087-00 Fibreoptic conoloscopy to hepatic flexure, with polypectomy, 32090-00 Fibreoptic conoloscopy to caecum, 32090-01 Fibreoptic conoloscopy to caecum, with biopsy, 32090-02 Fibreoptic conoloscopy to caecum with administration of tattooing agent, 32093-00 Fibeoptic conoloscopy to caecum, with polypectomy
6	Data Sources	Data Sourced from: National Treatment Purchase Fund (NTPF)
6a	Data sign off	NTPF
6b	Data Quality Issues	NTPF
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	No of people waiting <9 months for an elective procedure GI scope
9	Minimum Data Set (MDS)	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	Monthly
12+A9	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, CHO
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI is noted in the Service Plan
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Acute Operations & Endoscopy Clinical Programme
		Email address: for contact purposes : trish.king@hse.ie , graceosullivan@rcpi.ie
		Telephone Number: 0878175975/ 086 1409177
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01-7785222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision,***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED - 6 hour - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A26	% of all attendees at ED who are discharged or admitted within six hours of registration
1b	KPI Short Title	ED - 6 hour
2	KPI Description	% of all Emergency Department (ED) patients who wait less than 6 hours. Total Emergency Department Time (TEDT) is measured from registration time 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.
3a	Indicator Classification	**National Scorecard Quadrant** a) Quality and Safety
4	KPI Target	70%
4a	Target Trajectory	N/A
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 Sources	ED System (PET)
6a	Data sign off	Name: Mary Flynn - EMP Programme Manager
6b	Data Quality Issues	
7	Data Collection Frequency	Daily
8	Tracer Conditions (clinical metrics only)	All attendances to ED
9	Minimum Data Set (MDS)	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	Daily
12	KPI Reporting Frequency	Monthly M
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National
15	KPI is reported in which reports?	MDR
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Mary Flynn - EMP Programme Manager
		Email address: emp@rcsi.ie / maryflynn@rcsi.ie
		Telephone Number : 087 2788545
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED - 9 hour - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A27	% of all attendees at ED who are discharged or admitted within nine hours of registration
1b	KPI Short Title	ED - 9 hour
2	KPI Description	% of all Emergency Department (ED) patients who wait less than 9 hours. Total Emergency Department Time (TEDT) is measured from registration time 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.
3a	Indicator Classification	National Scorecard Quadrant Quality and Safety
4	KPI Target	85%
4a	Target Trajectory	N/A
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 Sources	ED System (PET)
6a	Data sign off	Name: Mary Flynn - EMP Programme Manager
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	All attendances to ED
9	Minimum Data Set (MDS)	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

Acute Division - ED - 9 hour - Metadata 2024		
No	**Steps**	**Detail supporting KPI**
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
11	**KPI Monitoring**	Daily
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	Nationa, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile, Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED DNW - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A166**	% of ED patients who leave before completion of treatment
1b	**KPI Short Title**	ED DNW
2	**KPI Description**	% of Emergency Department (ED) patients who attend ED but leave before their treatment is completed.These patients are recorded as did not wait on hospital system or leave before treatment.
3	**KPI Rationale**	All patients attending ED have a right to treatment
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	<6.5%
4a	**Target Trajectory**	N/A
5	**KPI Calculation**	Numerator: number of patients that Did Not Wait Denominator: Total patients attending ED X100
6	**Data Sources**	Sourced from ED system (PET)
6a	**Data sign off**	Name: Mary Flynn - EMP Programme Manager
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	
10	**International Comparison**	
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile, Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Mary Flynn - EMP Programme Manager
		Email address: emp@rcsi.ie / maryflynn@rcsi.ie
		Telephone Number : 087 2788545
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED < 24 hours - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A29**	% of all attendees at ED who are in ED <24 hours
1b	**KPI Short Title**	ED < 24 hours
2	**KPI Description**	% of patients who attend Emergency Departments (ED) who are in ED less than 24 hours
3	**KPI Rationale**	a+C6:C11. A 24 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 24 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 less than 24 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 should not require longer than 24 hours care in an ED setting due to the complexity of their presenting problems. This is why a 100% compliance target has been set. i. An upper absolute limit of 24 hours is set to ensure that the 0% of patients who may not comply with the 24 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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	97%
4a	**Target Trajectory**	N/A
5	**KPI Calculation**	All attendances that have an experience time of less than 24 hours = sum (total patients - greater 24 hour patients)/ total patients
6	**Data Sources**	Sourced from ED system (PET)
6a	**Data sign off**	Name: Mary Flynn - EMP Programme Manager
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Daily
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	
10	**International Comparison**	
11	**KPI Monitoring**	Daily
12	**KPI Reporting Frequency**	Monthly M
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile, Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Mary Flynn - EMP Programme Manager
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		Telephone Number : 087 2788545
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED 75yrs+ 6 hour - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A32	% of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration
1b	KPI Short Title	ED - 75yrs+ - 6 hour
2	KPI Description	% of all Emergency Department (ED) patients who wait less than 6 hours whom are aged over 75 years and over. Total Emergency Department Time (TEDT) is measured from Registration time 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.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	95%
4a	Target Trajectory	N/A
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 Sources	ED System (PET)
6a	Data sign off	Name: Mary Flynn - EMP Programme Manager
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	All attendances to ED
9	Minimum Data Set (MDS)	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	Daily
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile, Other
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED 75yrs 9 hour - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A30	% of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration
1b	KPI Short Title	ED - 75yrs+ - 9 hour
2	KPI Description	% of all Emergency Department (ED) patients 75 years who wait less than 9 hours. Total Emergency Department Time (TEDT) is measured from Registration 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. This indicator sets an upper limit on the duration of ED patient care. However, a small minority of patients may require longer than 9 hours care in an ED setting due to the complexity of their presenting problems. 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. 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 9-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.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	99%
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 Sources	ED System (PET)
6a	Data sign off	Name: Mary Flynn - EMP Programme Manager
6b	Data Quality Issues	
7	Data Collection Frequency	Daily
8	Tracer Conditions (clinical metrics only)	All attendances to ED
9	Minimum Data Set (MDS)	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) KPI owner/lead for implementation Name: Ciara Hughes - EMP Programme Manager Email address: emp@rcsi.ie / ciarah@rcsi.ie Telephone Number : 087 7845571 Data support
11	KPI Monitoring	Daily
12	KPI Reporting Frequency	Monthly M
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - ED 75yrs < 24 hour - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A96	% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration
1b	KPI Short Title	ED - 75yrs+ < 24 hour
2	KPI Description	% of all Emergency Department (ED) patients 75 years who wait less than 24 hours. Total Emergency Department Time (TEDT) is measured from Registration time to ED Departure Time.
3	KPI Rationale	a. A 24 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 24 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 24 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 24 hours care in an ED setting due to the complexity of their presenting problems. 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 24-hour target time. 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 24-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.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	99%
4a	Target Trajectory	N/A
5	KPI Calculation	Numerator - All ED patients aged >75 years of age, who are admitted to a ward or discharged in less than 24 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 Sources	ED System (PET)
6a	Data sign off	Name: Mary Flynn - EMP Programme Manager
6b	Data Quality Issues	
7	Data Collection Frequency	Daily
8	Tracer Conditions (clinical metrics only)	All attendances to ED
9	Minimum Data Set (MDS)	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) KPI owner/lead for implementation Name: Ciara Hughes - EMP Programme Manager Email address: emp@rcsi.ie / ciarah@rcsi.ie Telephone Number : 087 7845571
11	KPI Monitoring	Daily
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile, Other
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - LOS - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A39	Average length of stay (ALOS) for all inpatient discharges excluding LOS over 30 days
1b	KPI Short Title	ALOS excl LOS >30 days
2	KPI Description	The average length of stay(ALOS) 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.
3a	Indicator Classification	National Scorecard Quadrant Access
4	KPI Target	≤4.8
5	KPI Calculation	Mean: Numerator: Total Inpatient Beddays (based on trimmed length of stay) for patients in the period Denominator: Total number of inpatient discharges for those in same period
6	Data Sources	Sourced from HIPE & Uncoded PAS data
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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.
9	Minimum Data Set (MDS)	HIPE: Admission Date, Discharge Date, LOS
10	International Comparison	Average Length of Stay, broken down by clinical condition, is a recognised international metric (GB, CAN, AUS, ECHI)
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Medical - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA11	Medical patient average length of stay
1b	KPI Short Title	Medical ALOS
2	KPI Description	The mean length of stay for patients admitted to the medical specialties as outlined in tracer conditions
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.
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	≤7.0
4a	Target Trajectory	Target will be site specific (CHI 4.6, DM 9.0, IE 7.0, RCSI 7.7, Saolta 6.7, SSW 7.0, UL 5.4) RHA HSE Dublin & Midlands 9.0, HSE Dublin & North East 7.7,HSE Dublin & South East 7.0, HSE Mid West 5.4, HSE West & North West 6.7
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 Sources	HIPE & Uncoded PAS data
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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 This includes all emergency admission and elective stay patients for the above mentioned specialties and excludes elective daycase, maternity and new born admissions Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple Street, CHI Tallaght and Louth
9	Minimum Data Set (MDS)	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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Medical - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA1	% of medical patients who are discharged or admitted from Acute Medical Assessment Unit (AMAU) within six hours AMAU registration
1b	KPI Short Title	AMAU within 6 hours
2	KPI Description	This measures the percentage of all new medical patients attending the Acute Medical Assesment Units (AMAU)/ Medical Assesment Units (MAU) who are admitted to a ward 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.
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	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 & do not go via ED) **Denominator** – All new patients attending an AMAU/AMU*
6	Data Sources	ED/AMU system
6a	Data sign off	
6b	Data Quality Issues	
7	Data Collection Frequency	Daily
8	Tracer Conditions (clinical	All patients referred to an AMAU/MAU*.
9	Minimum Data Set (MDS)	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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Medical - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number CPA31**	% of all medical admissions via AMAU
1b	**KPI Short Title**	% of all medical adm via AMAU
2	**KPI Description**	The percentage of total medical admissions to the hospital which are admitted via the Acute Medicine Assessment Unit (AMAU)or Medical Assessment Unit (MAU).
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	45%
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 Sources**	HIPE and uncoded PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	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) Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple Street, CHI Tallaght, Louth, South Infirmary and St Michael
9	**Minimum Data Set (MDS)**	HIPE: Specialty, Admission Ward, Admission Date, Discharge Date, LOS, Age, Admission Type, Discharge Code
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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report, Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	This KPI was moved to NSP in 2017 was in DOP in 2016.
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

AMP Appendix 1

HIPE Hospital Number	Hospital Name	MAU Ward Name	ssward
3	St. Columcille's Hospital	0708	
4	Naas General Hospital	0098	
5	Mater Misericordiae University Hospital	MELS	RAPH
7	St. Vincent's University Hospital	AMAU	AMU
7	St. Vincent's University Hospital	STJOHN	STJOHN
22	Connolly Hospital	JCM021	
41	Tallaght University Hospital		AM
100	UH Waterford	AMU5	AMU
101	St. Luke's General Hospital Kilkenny	MAU	
103	Wexford General Hospital	MAU	
105	South Tipperary General Hospital	AMAU	
202	Bantry General Hospital	BGHMAU	
203	Mercy University Hospital	AMAU	
207	Mallow General Hospital	MAU	
235	Cork University Hospital	AMAU	AMU
236	UH Kerry	AMAU	
303	UH Limerick	AMU	
305	St. John's Hospital Limerick	MAU	
307	Ennis Hospital	MAU	
308	Nenagh Hospital	0403	
401	Roscommon University Hospital	MAU	
403	Portiuncula	AMAU	
404	Galway University Hospitals	MAUTAR	SSUTIR
405	Mayo University Hospital	MAU	
501	MRH Tullamore	AMAU	
503	MRH Mullingar	MAU	
506	Portlaoise	AMAU	
601	Letterkenny University Hospital	AMAU	SST
602	Sligo University Hospital	MAU	SMSS
701	Our Lady of Lourdes Hospital	MAU	SSUMED
701	Our Lady of Lourdes Hospital	AMAU	SSUMED
702	Cavan General Hospital	MAU	SSU
702	Cavan General Hospital	AMAU	SSU
705	Our Lady's Hospital Navan	MAU	

Acute Division - Medical - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA53	% of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge
1b	KPI Short Title	Emergency Re-Admissions - Medical
2	KPI Description	Percentage of emergency re-admissions for acute medical conditions to the same hospital within 30 days of discharge
3	KPI Rationale	
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	≤11.1%
5	KPI Calculation	Numerator: (Number of medical inpatient discharges in the denominator period which resulted in an emergency readmission to the same hospital within 30 days)*100 Denominator: Number of medical inpatient discharges (elective and emergency) in the denominator period (denominator period is set 30 days in arrears) Example: April 2016 Numerator: (Number of medical inpatient discharges in the denominator period which were readmitted as an emergency within 30 days of a previous discharge i.e. an emergency readmission occurring between 02MAR2016 and 30APR2016 inclusive)*100 Denominator: : Number of medical inpatient discharges in the denominator period (denominator period is set 30 days in arrears i.e. medical inpatients discharged between 02MAR2016 and 31MAR2016 inclusive) Medical inpatient excludes elective daycase, maternity and new born admissions
6	Data Sources	HIPE and uncoded PAS data
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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 - Emergency readmissions have an Admission Type of 4 or 5 - Death are excluded from the denominator (Discharge code=6 or 7) Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple Street, CHI Tallaght, Louth and South Infirmary
9	Minimum Data Set (MDS)	HIPE: Specialty, Admission Date, Discharge Date, LOS, Age, Admission Type, Discharge Code
10	International Comparison	
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	This KPI was moved to NSP in 2017 was in DOP in 2016.
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Surgery - Metadata 2024 Surg El LOS

No	Steps	Detail supporting KPI
1	KPI title & Number CPA59	Surgical Elective Inpatient average length of stay
1b	KPI Short Title	Surg El LOS
2	KPI Description	A specified individual hospital target for Elective inpatient average length of hospital stay for surgical inpatients (excluding elective day cases). A surgical inpatient is a patient who 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	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 Clinical system can be used by individual clinicians, specialty teams, hospitals, hospital groups, Regional Health Areas and nationally to compare their performance against top quartile AvLOS for other clinicals performing similar procedures and or treating patients with similar diagnoses and age band mix for the elective inpatient flow stream. Reducing length of stay to optimum levels improves the patient pathway and experience, by reducing pre-operative and discharge delays. It also allows for better use of resources and improved access for patients awaiting surgical care.
3a	Indicator Classification	National Scorecard Quadrant Access
4	KPI Target	≤5.0
4a	Target Trajectory	Target will be site specific (CHI 4.3, DM 6.1, IEHG 4.2, RCSI 4.3, Saolta 5.3, UL 3.8) RHA (HSE Dublin & Midlands 5.2, HSE Dublin & North East 4.4, HSE Dublin & South East 3.8, HSE Mid West 3.8, HSE West & North West 5.3)
5	KPI Calculation	The length of stay of all surgical inpatients divided by the numbers of surgical inpatients. Surgical inpatients are admitted by a surgical speicalty in surgical appendix II Inpatient has an admission type - Elective discharges have an admission type =1 or 2 (excluding elective day cases). Each elective stay case will have a length of stay based on the length of stay on their HIPE record or alternatively stated as the number of midnights spent in hospital. Numerator: sum of lengths of stay for each HIPE discharge record in scope Denominator: number of HIPE discharge records in scope
6	Data Sources	HIPE
6a	Data sign off	HPO
6b	Data Quality Issues	Will be dependant on accuracy 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 specialties
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Patients who are admitted to a specialty as listed in the surgery programme specialty list (Appendix II) and where Admission types is Elective Stay Excludes Bantry, Ennis, Nenagh, Monaghan, Coombe, Cork Mat, Holles st., Limerick Mat, Rotunda. St Luke's Rathgar, Louth, Mallow & St Colmcilles.
9	Minimum Data Set (MDS)	- 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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/publications/
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Surgery - Metadata 2024 Surg El LOS

No	Steps	Detail supporting KPI
1	KPI title & Number CPA60	Surgical Emergency Inpatient average length of stay
1b	KPI Short Title	Surg Em LOS
2	KPI Description	A specified individual hospital target for average length of hospital stay for emergency surgical inpatients (admission type 4 or 5). A surgical inpatient is a patient who 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	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 Clinical system can be used by individual clinicians, specialty teams, hospitals, hospital groups, Regional Health Areas and nationally to compare their performance against top quartile AvLOS for other clinicals performing similar procedures and or treating patients with similar diagnoses and age band mix in the Emergency flow pathway. Reducing length of stay to optimum levels improves the patient pathway and experience, by reducing pre-operative and discharge delays. It also allows for better use of resources and improved access for patients awaiting surgical care.
3a	Indicator Classification	National Scorecard Quadrant Access
4	KPI Target	≤6.0
4a	Target Trajectory	Target will be site specific CHI 3.4, DM 6.4, IE 6.2, RCSI 5.9, Saolta 5.8, SSW 5.8, UL 5.3) RHA (HSE Dublin & Midlands 5.6, HSE Dublin & North East 6.1, HSE Dublin & South East 6.5, HSE Mid West 5.3, HSE South West 6.9, HSE West & North West 5.8)
5	KPI Calculation	The length of stay of all surgical inpatients divided by the numbers of surgical inpatients. Surgical inpatients are admitted by a surgical speicalty in surgical appendix II Inpatient has an admission type - Emergency discharges have an admission type = 4 or 5. Each emergency same day discharges will be calculated as having 0.5 days in hospital. Each emergency stay case will have a length of stay based on the length of stay on their HIPE record or alternatively stated as the number of midnights spent in hospital. Numerator: sum of lengths of stay for each HIPE discharge record in scope Denominator: number of HIPE discharge records in scope
6	Data Sources	HIPE
6a	Data sign off	HPO
6b	Data Quality Issues	Will be dependant on accuracy 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 specialties
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Patients who are admitted to a specialty as listed in the surgery programme specialty list (Appendix II) and where Admission types is Emergency stay or Emergecny same day Excludes Bantry, Ennis, Nenagh, Monaghan, Roscommon, Coombe, Cork Mat, Holles st., Limerick Mat, Rotunda. St Luke's Rathgar, St Josephs Raheny, Louth, Cappagh, Kilkreene, Mallow, Navan, St. Colmcilles, St John's, St Michaels
9	Minimum Data Set (MDS)	- 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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/publications/
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: National Director Acute Operations
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Surgery - Metadata 2024 Surgical DOSA

No	Steps	Detail supporting KPI
1	**KPI title & Number CPA27**	% of elective surgical inpatients who had principal procedure conducted on day of admission
1b	**KPI Short Title**	Surgical DOSA
2	**KPI Description**	The percentage of inpatients having elective surgical procedures conducted on the day of admission compared to the total number of all elective surgical inpatients who have surgery. This 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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	82.4%
4a	**Target Trajectory**	Target will be site specific (DM 76.4%, IE 90.3%, RCSI 75.8%, Saolta 72.4%, SSW 82.5%, UL 91.6%) RHA HSE Dublin & North East 84.8%, HSE Dublin & Midlands 87.8%, HSE Dublin & South East 78.8%, HSE Mid West 91.7%, HSE West & North West 70.3%
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 Sources**	HIPE
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	Will be dependant on accuracy 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 specialties
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Numerator - number of elective inpatient surgical discharges with a primary surgical procedure on date of admission = (Patients who had a Principal procedure in Appendix I and Patients who had a Surical Specialty in Appendix II and date of principal procedure Equals date of admission) * 100 'Denominator - number of elective inpatient surgical discharges with a primary surgical procedure = (Patients who had a Principal procedure in Appendix I and Patients who had a Surical Specialty in Appendix II) - Inpatients only (ie. stay in hospital one or more nights) - Elective discharges have an admission type =1 or 2 Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple Street, CHI Tallaght, Coombe, Cork Mat, Holles st., Limerick Mat, Rotunda, St Columcilles, St Luke's Rathgar, Bantry, Ennis, Nenagh, Monaghan, St Josephs Raheny and Roscommon
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report, Performance Report/Profile, Other: CompStat & SDU/ Surgery Programme/ Anaesthesia Programme reports.
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
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 1,021 commonly performed surgical procedures (Appendix I)as their primary procedure on the date of admission and who were surgically admitted (had a specialty from Appendix II). Total number of elective inpatients who have their primary surgical procedure includes All elective inpatient's who have one of the 1,021 commonly performed surgical procedures (Appendix I)as their primary procedure and who were surgically admitted (had a specialty from Appendix II).
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Surgery - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA28	% day case rate for Elective Laparoscopic Cholecystectomy
1b	KPI Short Title	Lap Chole daycase rate
2	KPI Description	The percentage daycase rate of Elective Laparoscopic Cholecystectomy (Elective gall bladder surgery)
3	KPI Rationale	It is better for the patient and a more efficient use of limited hospital resources to perform appropriate procedures as daycases 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 daycase.
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	60% - National Target
4a	Target Trajectory	40% target for model 4 hospital (Beaumont, Cork UH, Galway UH, Limerick UK, Mater UH, St Vincent's UH, St James UH, Tallaght UH, Waterford UH). 65% target for all other surgery hospitals.
4b	Volume metrics	
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 Sources	HIPE
6a	Data sign off	HPO
6b	Data Quality Issues	Will be dependant on accuracy 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 specialties
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Primary Procedure = 3044500 (ICD-10-AM/ACHI/ACS 30445-00 Laparoscopic cholecystectomy) For the numerator elective discharges have an admission type =1 or 2 Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple Street, CHI Tallaght, RVEEH, Monaghan, Cappagh, Coombe, Cork Mat, Holles st., Limerick Mat, Rotunda and St Luke's Rathgar
9	Minimum Data Set (MDS)	HIPE- Admission Date, Discharge Date, Admission Type, Specialty, Primary Procedure
10	International Comparison	Collected in UK and internationally.
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Performance Report/Profile, Other: CompStat
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	Note: Daycase rates should be assessed at individual hospital and hospital group level. Some hospital groups choose to conduct elective daycase 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 daycase surgery posed by patients with higher risk (eg. ASA 3 or higher). Appropriately qualified Surgical and Anaesthetic personnel will select patients for model 2 daycase activity and model 3 / 4 daycase activity in a pre-admission assessment process.

It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed

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Governance/sign off	***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
	Operational National Director: **National Director Acute Operations**

KPI's will be deemed 'active' until a formal request to change or remove is received

Acute Division - Hip Fracture Surgery - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A99**	% hip fracture surgery carried out within 48 hours of initial assessment (Hip fracture database)
1b	**KPI Short Title**	% Hip Fracture
2	**KPI Description**	From time of presentation to first ED to start of surgery recorded in exact hours and minutes as per the Irish Hip Fracture Database (Inclusive of all patients 0ver 60 with a primary or secondary diagnosis of a hip fracture as per HIPE Hip fracture: S72.0- S72.2 (includeing sub diagnoses)
3	**KPI Rationale**	To optimise the timing to surgery for patients with hip fracture to ensure international best practice standards are met to ensure the best outcomes for patients in terms of morbidity, functional ability and mortality.
3a	**Indicator Classification**	National Scorecard Quadrant Quality and Safety
4	**KPI Target**	85%
5	**KPI Calculation**	Numerator: The number of inpatient discharges in the reporting period where emergency hip fracture surgery was carried out within 48 hours of first presentation to ED on patients aged 60)*100 Denominator: The number of inpatient discharges in the reporting period where an emergency hip fracture surgery was carried out for patients aged over 60.(From time of presentation to first ED to start of surgery recorded in exact hours and minutes as per the Irish Hip Fracture Database (Inclusive of all patients 0ver 60 with a primary or secondary diagnosis of a hip fracture as per HIPE Hip fracture: S72.0- S72.2 (includeing sub diagnoses)
6	**Data Sources**	HIPE/ Irish Hip Fracture Database (IHFD) 100% data completeness
6a	**Data sign off**	**Louise Brent NOCA**
6b	**Data Quality Issues**	Data quality issue: incomplete data or incorrect times or no times entered
7	**Data Collection Frequency**	Daily
8	**Tracer Conditions (clinical metrics only)**	Hip fracture: a principal or secondary diagnosis of S72.0- S72.2 (includeing sub diagnoses) who underwent surgery as per IHFD dataset Age >60
9	**Minimum Data Set (MDS)**	IHFD Date and time of admission, date and time of surgery as per IHFD dataset
10	**International Comparison**	National Hip Fracture Database, UK, NHFD 2009-2016 British orthopaedic Association and British Geriatrics Society. Blue Book 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 2009
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	By exception Quarterly in arrears Q-1Q
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile; MDR ; Other: CompStat
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	KPI noted in National Service Plan and IHFD National Report
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: National Director Acute Operations
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Surgery - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A45	% of surgical re-admissions to the same hospital within 30 days of discharge
1b	KPI Short Title	Emergency Re-Admissions - Surgical
2	KPI Description	The percentage of unplanned re- admission to the same hospital within 30 days post acute or elective, inpatient or day-case surgical admission to the same hospital
3	KPI Rationale	As hospitals are encouraged to reduce surgical length of stay, it is important that re admission rates are 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.
3a	Indicator Classification	National Scorecard Quadrant Quality and Safety
4	KPI Target	≤2%
4a	Target Trajectory	Target will be site specific with individual hospital target of 2.4% for hospitals with ED's and 0.24% for hospitals without ED's for surgery (CHI -, DM 2%, IE 2%, RCSI 2%, Saolta 2%, SSW 2%, UL 2%) RHA HSE Dublin & North East 2%, HSE Dublin & Midlands 2%, HSE Dublin & South East 2%, HSE Mid West 2%, HSE West & North West 2%
4b	Volume metrics	
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) Excludes Children's Health Ireland (CHG), CHI Crumlin, CHI Temple St, CHI Tallaght, St Luke's Rathgar, Coombe, Rotunda, Holles Street, Monaghan and Limerick Maternity
6	Data Sources	HIPE
6a	Data sign off	HPO
6b	Data Quality Issues	Will be dependant on accuracy 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 specialties
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Denominator - Surgical Discharges = (Patients who had a Specialty in Surgery 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 (MDS)	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	Monthly
12+A7	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Performance Report/Profile, Other: CompStat
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Telephone Number: 01 778 5222 / 01-402-2143 M: 087-124-0759
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: National Director Acute Operations
KPI's will be deemed 'active' until a formal request to change or remove is received		

Surgery 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	
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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

Surgery Appendix I - Surgical primary procedures

PrcNum	PrcDesc	PrcShrt
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
4269807	Phacoem of crystalline lens	OPHTHA
4273401	Capsulotomy of lens	OPHTHA
3252000	Endovenous interptn of veins	VASCUL
3250400	Interruption VV multiple tributaries	VASCUL
3760412	Fixation of testis bilateral	PAEDIA
3760410	Fixation of testis unilateral	PAEDIA
3760411	Laparoscopic fixation of testis bi	PAEDIA
3760409	Laparoscopic fixation of testis uni	PAEDIA
3722403	Endoscopic resection of prostate	UROLOG

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

Specialty	HIPE Specilty Description	SurgClasTyp
0600	Otolaryngology	Otolaryngology
0601	Paediatric ENT	Paediatric
1400	Neurosurgery	Neurosurgery
1402	Paediatric Neurosurgery	Paediatric
1700	Opthalmology	Opthalmology
1702	Neuro Opthalmic Surgery	
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
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

Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number CPA51**	Rate of new cases of hospital acquired Staphylococcus aureus bloodstream infection
1b	**KPI Short Title**	Hospital acquired S. aureus bloodstream infection/10,000 BDU
2	**KPI Description**	Rate of new cases of hospital acquired S. aureus bloodstream infection. S. aureus blood stream infection is reported when S. aureus is cultured from a blood culture taken from a patient who had been hospitalised within the reporting hospital for 48 hours or longer before blood culture was taken. The number of infections is divided by total BDU and multiplied by 10,000 to calculate a rate.
3	**KPI Rationale**	To monitor progress towards the goal of reducing the occurrence of hospital acquired *S. aureus* blood stream infection in acute hospitals. A high proportion of hospital acquired S. aureus blood stream infection is avoidable.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	<0.7/10,000 bed days used
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	**Numerator:** Number of cases of *S. aureus* blood stream infection as per description above. **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 month numerator/denominator*10,000
6	**Data Sources**	Source: Monthly data report to BIU from each acute hospitals
6a	**Data sign off**	Data should be approved for issue to BIU by Hospital Manager or CEO
6b	**Data Quality Issues**	Completeness:100% of all acute hospitals must participate Quality: Does not account for hospital-acquired S. aureus bloodstream infections that present after hospital discharge, or for healthcare-associated cases outside of acute hospital inpatient settings.
7	**Data Collection Frequency**	Monthly M
8	**Tracer Conditions (clinical metrics only)**	N/A
9	**Minimum Data Set (MDS)**	Monthly data report by Acute Hospitals to BIU
10	**International Comparison**	European Centre for Disease Control
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Acute Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile; MDR ; Other (Compstat)
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	KPI noted in National Service Plan 2024
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number CPA52**	Rate of new cases of hospital associated C. difficile infection
1b	**KPI Short Title**	Hospital associated new cases of C. difficile infection/ 10,000 BDU
2	**KPI Description**	Rate of new cases of hospital associated C. difficile infection (per month per 10 000 bed days) - as per the definition below Hospital associated new cases of CDI are reported if all of the following 3 criteria are met (1) Confirmed CDI case, (2) New CDI case and (3) Hospital - associated CDI: 1. Confirmed CDI case "The case definition for CDI is as follows: A patient two years or older, to whom one or more of the following criteria applies: - Diarrhoeal* stools or toxic megacolon, with either a positive laboratory assay for C. difficile toxin A (TcdA) and / or toxin B (TcdB) in stools or a toxin producing C. difficile organism detected in stool via culture or other means. - Pseudomembraneous colitis (PMC) revealed by lower gastrointestinal, endoscopy. - Colonic histopathology characteristic of C. difficile infection (with or without diarrhoea) on a specimen obtained during endoscopy, colectomy or autopsy. Diarrhoea is defined as three or more loose/watery bowel movements that take up the shape of their container (which are unusual or different for the patient) in a 24 hour period." 2. New CDI Case - A case of CDI is considered a new CDI case is if it first diagnosis of CDI Or if the patient had CDI diagnosed previously and this diagnosis if more than 8 weeks after a previous positive specimen 3. Hospital - associated CDI (healthcare associated CDI - this hospital) A CDI case with either Onset of symptoms at least 48 hours following admission to the reporting hospital or with onset of symptoms in the community within 4 weeks following discharge from the reporting hospital
3	**KPI Rationale**	To monitor progress towards the goal of reducing the occurrence of C. difficile infection in acute hospitals. A high proportion of hospital associated C. difficile is avoidable.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	<2/10,000 bed days used
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	Numerator: Number of cases of hospital associated CDI infection as per definition above. 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 reporting month numerator/denominator*10,000
6	**Data Sources**	Source: Monthly data report to BIU from each acute hospital
6a	**Data sign off**	Data should be approved for issue to BIU by Hospital Manager or CEO
6b	**Data Quality Issues**	Completeness:100% of all acute hospitals must participate Quality: Does include C. difficile infection cases with onset more than 4 weeks after acute hospital discharge
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	N/A
9	**Minimum Data Set (MDS)**	Monthly data report by Acute Hospitals to BIU
10	**International Comparison**	European Centre for Disease Control
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Acute Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile; MDR ; Other (compstat)
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	KPI noted in National Service Plan 2024
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Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A97**	% of acute hospitals implementing the requirements for screening of patients with Carbapenemase-producing Enterobacterales (CPE) guidelines
1b	**KPI Short Title**	% of acute hospitals implementing requirements for CPE Screening
2	**KPI Description**	The implementation of the screening of patients with Carbapenemase Producing Enterobacterales (CPE) guidelines as per the definition below will be reported to BIU by each hospital. The number of hospitals reporting compliance will be represented as a % of all acute hospitals.
3	**KPI Rationale**	Carbapenemase Producing Enterobacterales (CPE) are an emerging threat to human health, particularly in hospital settings. CPE are gram-negative bacteria that are carried in the gut and are resistant to most available antibiotics. The true impact and extent of this increasing threat cannot be fully estimated at present. However, CPE blood stream infection has been associated with death in up to half of all patients affected by it. The incidence on CPE can also result in significant financial cost to the health system and challenges to effective patient flow in health care delivery for scheduled and unscheduled care. Comprehensive screening for CPE is essential to track the incidence of CPE in Ireland.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	The no. of acute hospitals reporting implementation of the " Requirements for screening of patients with CPE" as per the definition below, divided by the total number of acute hospitals, multiplied by 100.
6	**Data Sources**	Source: Quarterly data report to BIU from each acute hospital
6a	**Data sign off**	Data should be approved for issue to BIU by Hospital Manager or CEO
6b	**Data Quality Issues**	Dependant on hospitals being in a position to track required information and report same quarterly to BIU
7	**Data Collection Frequency**	Weekly
8	**Tracer Conditions (clinical metrics only)**	N/A
9	**Minimum Data Set (MDS)**	BIU Reporting template for same
10	**International Comparison**	Not Known
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Quarterly Q
14	**KPI Reporting Aggregation**	National, Hospital Group, Acute Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile; MDR ; Other: DOP report
16	**Web link to published data**	None
17	**Additional Information**	KPI noted in National Service Plan 2024
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
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	Above policy considered implemented if hospital can state yes to all of the following criteria	
	V2.0 CPE Expert Group Guidance - Control of Transmission of CPE in Acute Hospital Setting (December 2019)*	
	Criteria no.	**Criteria**
	1	Have " Requirements for screening of patients with CPE" guidelines been circulated to appropriate staff in the hospital?
	2	Does the hospital have a process in place for identifying and testing patients requiring screening for CPE on admission in accordance with above CPE guidance*?
	3	Does the hospital have a process in place for identifying CPE contacts on re- admission?
	4	Does the Infection Prevention & Control/ Antimicrobial Stewardship team review the effectiveness of local policy, implementation of guidelines above and review associated data on a monthly basis?
	5	Is the information returned to BIU regarding implementation of this guideline reported to the hospital CEO or Senior Manager?
	XXXXX	[2] *A key challenge for implementation is the ability to identify these patients readily. Information regarding inpatient stay in any other hospital in the previous 12 months and residence in a long-term care facility should be recorded routinely by the admissions office and should, whenever possible, be easy to obtain from the patient administration system.*
		[3] *Screening of contacts who have left the acute hospital is generally not appropriate until/unless they are subsequently readmitted to an acute hospital.*
		[4] *Hospitals with Neonatal Intensive Care Units (NICUs) may choose not to screen infants admitted to the NICU directly after their birth but should screen infants who are transferred from another hospital.*
		[5] *In some circumstances, it may be appropriate to screen patients who have previously been hospitalised more than one year ago. One year is an arbitrary cut-off, and it is acknowledged that some hospitals had significant issues with CPE as far back as 2011.*

Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A98	% of acute hospitals implementing the national policy on restricted antimicrobial agents
1b	KPI Short Title	% of acute hospitals implementing policy on restricted antimicrobial agents
2	KPI Description	The implementation of the national policy on the restricted antimicrobial agents as per the definition below which will be reported to BIU by each hospital. The number of hospitals reporting positively will be represented as a % of all acute hospitals.
3	KPI Rationale	There is an increasing prevalence of antimicrobial resistant pathogens causing invasive infection in Ireland. In parallel with the increasing levels of antimicrobial resistance, there has been an upward trend in antimicrobial consumption in hospitals in recent years. Of particular concern is the increasing consumption of broad-spectrum antibiotics. The National Policy on Restricted Antimicrobial Agents (HSE) outlines the controls which should be in place at hospital level for the use certain antimicrobial agents. It is important to monitor the implementation of this policy nationally to improve practice and minimise antimicrobial resistance.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	100%
4a	Target Trajectory	Point in time
5	KPI Calculation	The no. of acute hospitals reporting implementation of the " National Policy on Restricted Antimicrobial Agents" as per the definition below, divided by the total number of acute hospitals, multiplied by 100.
6	Data Sources	Source: Quarterly data report to BIU from each acute hospital
6a	Data sign off	Data should be approved for issue to BIU by Hospital Manager or CEO
6b	Data Quality Issues	dependant on hospitals being in a position to track required information and report same quarterly to BIU
7	Data Collection Frequency	Quarterly
8	Tracer Conditions (clinical metrics only)	N/A
9	Minimum Data Set (MDS)	BIU Reporting template for same
10	International Comparison	Not Known
11	KPI Monitoring	Quarterly
12	KPI Reporting Frequency	Quarterly
13	KPI report period	Quarterly Q
14	KPI Reporting Aggregation	National, Hospital Group, Acute Hospital
15	KPI is reported in which reports?	Annual Report; Performance Report/Profile; MDR ; Other: DOP Report
16	Web link to published data	None
17	Additional Information	KPI noted in National Service Plan 2024

It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed

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Governance/sign off	***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
	Operational National Director: **National Director Acute Operations**

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Appendix 1: " National Policy on Restricted Antimicrobial Agents" - DEFINITION OF IMPLEMENTATION	
Above policy considered implemented if hospital can state yes to all of the following criteria	
CPE012	Is there a local Infection prevention and Control / Antimicrobial Surveillance(IPC/AMS) team in place in the hospital?
CPE013	Is there a local Infection prevention and Control / Antimicrobial Surveillance Committee in place in the hospital?
CPE014	Does the hospital have a list of restricted antimicrobials which is in accordance with the above mentioned policy?
CPE015	Does the hospital have a process in place to ensure pre authorisation by a consultant or SpR in Microbiology or Infectious diseases, of the carbapenem antibiotics on 24 hour 7 days per week basis?

Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA56	Rate of new hospital acquired COVID-19 cases in hospital inpatients
1b	KPI Short Title	Hospital acquired COVID-19 inpatients rate
2	KPI Description	The number of hospital acquired COVID-19 inpatient cases as a factor of Acute hospital bed days used.
3	KPI Rationale	In the context of COVID-19 pandemic preventing patients from aquiring COVID-19 in hospital is an important quality indicator and measuring the incidence facilitates management of associated risks and improvement strategies.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	N/A
4a	Target Trajectory	Point in time
5	KPI Calculation	**Numerator:** Number of cases of COVID-19 inpatient cases as per ECDC definition. **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 month numerator/denominator*10,000 ECDC Definition: Onset of clinical features of COVID-19 more than 7 days after admission should be regarded as hospital acquired COVID-19 Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting· Onset of clinical features of COVID-19 between days 3 and 6 after admission are considered hospital acquired cases of COVID-19 if epidemiologically linked to hospital exposure Onset of clinical features of COVID-19 on day 1 or 2 after admission are considered community acquired unless epidemiologically linked to hospital exposure during a recent hospital admission · If onset of clinical features cannot be defined, a case by case assessment is required taking account of the date of sampling relative to the date of admission, the ct value of the test result and epidemiological evidence of a link to hospital exposure. Exclusions: · Cases where there is a positive laboratory test in a person who was previously diagnosed with COVID-19 and where the clinical evaluation determines that the test does not represent evidence of current infection. Clinical evaluation should take into consideration the length of time between the previous diagnosis of COVID-19 and the current positive test as part of the assessment of current infection. People who have COVID-19 assessed as acquired in the community or in another institution should not be included In this context hospitals are now required to report the number of new patients with hospital acquired COVID-19 that conform to the definition above.
6	Data Sources	Source: Monthly data report to BIU from each acute hospital
6a	Data sign off	Data should be approved for issue to Acute BIU by Hospital Manager or CEO
6b	Data Quality Issues	Completeness:100% of all acute hospitals must participate. Changes over time to COVID-19 guidance for acute hospitals, including the ending of testing on admission and the focus on symptomatic testing only, have made it difficult for providers to determine whether a case was hospital or community acquired. These inconsistencies should be taken into consideration when evaluating trends over time. It should be noted that properties of the current variant is different from original definitions agreed when reporting was introduced, this impacts on data quality issues.
7	Data Collection Frequency	Monthly M
8	Tracer Conditions (clinical metrics only)	N/A
9	Minimum Data Set (MDS)	Acute BIU Hospital reports
10	International Comparison	Not Applicable
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Hospital Group,Acute Hospital
15	KPI is reported in which reports?	National Service Plan Performance Report/Profile; MDR ; Other (Compstat) HPSC reports
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	KPI noted in National Service Plan 2024
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Medication Safety - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A113	Rate of medication incidents as reported to NIMS per 1,000 beds
1b	KPI Short Title	NIMS
2	KPI Description	Reports to the NIMS system of an incident related to medication per 1000 in-patient bed days. An incident is defined as an unplanned, unexpected or uncontrolled occurrence, which causes (or has the potential to cause) injury, ill-health and/or damage, related to medication. An incident can be a harmful incident (adverse event), a no harm incident, a near miss, dangerous occurrence or complaint (State Claims Agency). This KPI relates to reported medication-related clinical incidents in acute services only. Where a patient is involved in the incident then the patient may be an inpatient, day case patient or outpatient or any other department patient while attending an acute hospital for services.
3	KPI Rationale	Medicines are the most common treatment used in healthcare and contribute to significant improvement in health when used appropriately. However, medicines can also be associated with adverse drug events (harm) and with medication errors. Reporting facilitates the identification of risk and opportunites for improvement. Improved reporting is a key recommendation of HIQA's overview report on Medication Safety Monitoring Programme in Public Acute Hospitals https://www.hiqa.ie/sites/default/files/2018-01/Medication-Safety-Overview-Report.pdf
3a	Indicator Classification	National Scorecard Quadrant Quality and Safety
4	KPI Target	3.0 per 1,000 bed days
5	KPI Calculation	Numerator: Total number of medication-related incidents as reported on NIMS NIMS: - Date of Incident: Reporting Month - Who Was Involved: Service User - Division: Acute Hospitals - Sub-Hazard Type: Medications Denominator: Total number of in-patient bed days Calculate rate by dividing the numerator by the denominator and multiplying by 1,000.
6	Data Sources	NIMS (National Incident Management System). Data quality depends on completeness and timeliness of reporting incidents and entry to NIMS. NIMS is an incident reporting system not an outcome reporting system
6a	Data sign off	
6b	Data Quality Issues	BIU provide bed days used each month as submitted by hospitals The denominator (bed days) does not reflect day case or outpatient activity and is therefore a proxy for inhospital activity. NIMS is unable to disaggregate inpatients from other patients types. Consequently, rates may be higher in some hospitals if out-patient or day case incidents are frequently reported. Dependant on timely reporting and data entry to NIMS.
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	
9	Minimum Data Set (MDS)	NIMS and BDU reported to BIU
10	International Comparison	NHS England hospitals reported 222,514 medication incidents from April 2019 to March 2020 [National Reporting and Learning System (UK). Quarterly Reports, available from https://www.england.nhs.uk/wp-content/uploads/2020/03/NAPSIR-commentary-Sept-2020-FINAL.pdf]. England's NHS had 141,000 beds in 2018/2019 [Kings Fund (Mar 2020). NHS hospital bed numbers: past, present, future] and up to 95% occupancy, giving just under 50 million bed days used per annum. In England, 4.5 medication incidents are reported per 1,000 bed days used. Observational studies and research evidence indicates medication error rates in the medicine use process far greater than those identified by incident reporting: • prescribing error rate in hospital, 7% of prescription items (Lewis PJ et al. Drug Safety 2009;32(5)379-89) • dispensing error rate in hospitals, 0.02 – 2.7% of dispensed medicines (James KL et al. Int J Phar Pract. 2009; 17:9-30) • medicine administration errors in hospital, 3 – 8%. (Kelly J et al. J Clin Nursing 2011.21, 13-14, 1806-1815)
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	M-2M
14	KPI Reporting Aggregation	National
15	KPI is reported in which reports?	Annual Report; Performance Report/Profile; Other: Compstat
16	Web link to published data	http://www.hse.ie/eng/services/publications/
17	Additional Information	Higher reporting rates provide the hospital with insight into some of its medication safety issues. Actions and improvement initiatives to reduce the risk of recurrence should result from analysis of incidents and trends. The mean rate of medication-related clinical incidents reported to NIMS was 2.6 per 1000 bed days in 2019 and 3.5 in 2020, with wide variation in reporting rates. Reporting rates in UK hospitals are higher, with a mean of 4.5 reports per 1000 bed days. Hospitals should ensure their rate of medication-related clinical incident reporting consistently exceeds 3 reports per 1000 bed days and aim to achieve a higher reporting rate reflective of a positive patient safety culture.
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Ciara Kirke, Clinical Lead Medication Safety Improvement Programme, Clinical Lead I National Medication Safety Programme Health Service Executive I National Quality and Patient Safety Directorate
		Email address: ciara.kirke@hse.ie
		Telephone Number: 087 2955048
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: National Director Acute Operations
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Irish National Early Warning System (INEWS) - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A114**	% of hospitals implementing INEWS in all clinical areas of acute hospitals (as per 2019 definition)
1b	**KPI Short Title**	% INEWS
2	**KPI Description**	% of Hospitals that confirm that they are implementing the Irish National Early Warning System (INEWS) for non pregnant adult patients as per definition in Appendix 1.
3	**KPI Rationale**	To monitor the implentation of INEWS. To improve the governance of the Irish National Early Warning System (INEWS) by the use of outcome data. To improve the recognition and response of deteriorating adult non-pregnant patients. To ensure adequate numbers of healthcare professionals are trained in the use of the INEWS
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	Numerator: The total number of hospitals who confirm that they are implementing INEWS for non pregnant adult (16 years and over) patients as per definition in Appendix 1 multipled by 100. Denominator: The total number of hospitals (currently 47)
6	**Data Sources**	Acute Hospitals
6a	**Data sign off**	Hospital CEO/GM
6b	**Data Quality Issues**	Not all Maternity Hospital/Units/Department will admit non-pregnant adult patients and not all Paediatric Hospitals/Units/Department will admit non-pregnant adult patients.
7	**Data Collection Frequency**	Quarterly
8	**Tracer Conditions (clinical metrics only)**	Cardiorespiratory arrest, unplanned admission/readmissions to ICU
9	**Minimum Data Set (MDS)**	INEWS Quarterly Report
10	**International Comparison**	NEWS1 (UK), NEWS2 (UK) https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Quarterly
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile, Other: give details:
16	**Web link to published data**	N/A
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Bláthnaid Connolly
		Email address: blathnaid.connolly2@hse.ie
		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

	Appendix 1 INEWS considered implementated if hospital can state yes to all of the following criteria for all adult (16 years and over) non-pregnant patients
1	Is there a local National Early Warning System (INEWS)/EWS Governance Group in place and meetings held on quarterly basis with reports, including the elements of this KPI, submitted to and reviewed by hospital CEO/GM/Clinical Director?
2	Is the percentage of nursing staff who have completed INEWS training measured, monitored and a plan in place to achieve a minimum of the target of 85% trained?
3	Is the percentage of medical staff who have completed INEWS training measured, monitored and a plan in place to achieve a minimum of the target of 85% trained?
4	Prior to Goverance Group quarterly meetings has there been an audit of hospital's recognition and response practices against key INEWS recommendations (audit of minimum 5 healthcare records quarterly) and reported to the Governance group?
5	Are plans underway to ensure that the aggregatted outcomes (total number of cardiorespiratory arrests, unplanned admissions to ICU and readmissions to ICU) are monitored, reviewed and managed at local level?
6	Have identified deficits/gaps been formulated into an improvement plan with key actions and timeframes identifed and reported on quarterly to CEO/GM/Clinical Director?

Appendix 2: INEWS Hospitals list.

Children's Health Ireland (CHI at Crumlin, CHI at Tallaght, CHI at Temple St)
Coombe Women and Infants University Hospital
MRH Portlaoise
MRH Tullamore
Naas General Hospital
St. James's Hospital
St. Luke's Radiation Oncology Network
Tallaght University Hospital
Cappagh National Orthopaedic Hospital
Mater Misericordiae University Hospital
MRH Mullingar
National Maternity Hospital
Our Lady's Hospital Navan
Royal Victoria Eye and Ear Hospital
St. Columcille's Hospital
St. Luke's General Hospital Kilkenny
St. Michael's Hospital
St. Vincent's University Hospital
Wexford General Hospital
Beaumont Hospital
Cavan General Hospital includes Monaghan General Hospital
Connolly Hospital
Louth County Hospital
Our Lady of Lourdes Hospital
Rotunda Hospital
Galway University Hospitals
Letterkenny University Hospital
Mayo University Hospital
Portiuncula University Hospital
Roscommon University Hospital
Sligo University Hospital
Bantry General Hospital
Cork University Hospital
Cork University Maternity Hospital
Lourdes Orthopaedic Hospital Kilcreene
Mallow General Hospital
Mercy University Hospital
South Infirmary Victoria University Hospital
South Tipperary General Hospital
UH Kerry
UH Waterford
Croom Orthopaedic Hospital
Ennis Hospital
Nenagh Hospital
St. John's Hospital Limerick
UH Limerick
UMH Limerick

Acute Division - Paediatric Early Warning System (PEWS) - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A56**	% of hospitals implementing Paediatric Early Warning System (PEWS)
1b	**KPI Short Title**	PEWS
2	**KPI Description**	The Irish Paediatric Early Warning System (PEWS) should be used in any inpatient setting where children are admitted and observations are routinely required, in accordance with NCG no.12 PEWS Recommendation 1 and as per Paediatric Model of Care: up to the eve of their 16th birthday unless in a planned transition of care up to the eve of their 18th birthday.
3	**KPI Rationale**	To monitor the implementation of PEWS
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	Numerator: The total number of hospitals in Ireland requiring PEWS where children are treated and PEWS should be implemented. Denominator: The total number of hospitals in Ireland confirming implementation of PEWS according to the definition attached. (31 hospitals to date, List attached)
6	**Data Sources**	Verified by hospital PEWS governance group chair as per definition attached and reported by hospital/hospital group to HSE BIU
6a	**Data sign off**	
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Quarterly
8	**Tracer Conditions (clinical metrics only)**	N/A
9	**Minimum Data Set (MDS)**	
10	**International Comparison**	N/A
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Quarterly
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	N/A
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name:
		Email Address:
		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Appendix 1 PEWS considered implementated if hopital can state yes to all of the following criteria	
Criteria no.	**Criteria**
1	Is there a local PEWS Governance Group in place and meetings on a quarterly basis?
2	Is there a named consultant lead for PEWS?
3	Is there a named nurse lead for PEWS?
4	Is there a PEWS training programme in place for nurses in the hospital?
5	Is there a PEWS training programme in place for doctors who may attend paediatric patients in the hospital?
6	Are all admitted children monitored using PEWS?
7	Is the national PEWS audit tool utilised at least monthly with a minimum of 5 charts in each relevant clinical area? (this data is taken from the hospital PEWS
8	Is there evidence that where a deficit/gap is identified through audit, appropriate quality improvement plans are recorded and actioned?
9	Is the minimum recommended dataset for clinical outcomes (NCG No. 12 section 1.13) being recorded at local level?
10	Has the data submitted in this report been verified / approved by the PEWS governance Chair as per definition attached ? Enter the name of the signatory in the

Appendix 2: PEWS List of Hospitals

Children's Health Ireland (CHI at Crumlin, CHI at Tallaght, CHI at Temple St)
MRH Portlaoise
MRH Tullamore
Cappagh National Orthopaedic Hospital
MRH Mullingar
Royal Victoria Eye and Ear Hospital
St. Luke's General Hospital Kilkenny
Wexford General Hospital
Beaumont Hospital
Cavan General Hospital includes Monaghan General Hospital
Our Lady of Lourdes Hospital
Galway University Hospitals
Letterkenny University Hospital
Mayo University Hospital
Portiuncula University Hospital
Roscommon University Hospital
Sligo University Hospital
Cork University Hospital
Mercy University Hospital
South Infirmary Victoria University Hospital
South Tipperary General Hospital
UH Kerry
UH Waterford
Croom Orthopaedic Hospital
Ennis Hospital
Nenagh Hospital
UH Limerick

Acute Division - HPSIR - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A62**	% of acute hospitals that have completed and published monthly hospital patient safety indicator reports
1b	**KPI Short Title**	Acute Hospital Safety Statements
2	**KPI Description**	The percentage of acute hospitals who have completed a monthly Hospital Patient Safety Indicator Report (HPSIR), discussed the HPSIR at hospital management meetings each month (verified by hospital General Manager/CEO signature), and published on hospital websites by the last day of the following month that it is reported on, i.e. January data is published on last day of March and reported in April.
3	**KPI Rationale**	The objective in publishing the HPSIR is to provide public assurance, by communicating with its patients, staff and wider public in an open and transparent manner, that important patient safety indicators are being monitored by hospital management on a continual basis. The HPSIR is not intended to be used for comparative purposes as the clinical acitivity, patient profile and complexity of each hospital can differ significantly.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
5	**KPI Calculation**	Numerator: Total number of acute hospitals who have completed and published the HPSIR on the last day of the following month that it is reported on (i.e. January data is published on last day of March) Denominator: Total number of acute hospitals Calculate percentage by dividing the numerator by the denominator and multiplying by 100.
6	**Data Sources**	BIU: Data taken from BIU MDR to populate the HPSIR for that particular month will not reflect further changes that may occur in later versions of the BIU MDR.
6a	**Data sign off**	
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	N/A
9	**Minimum Data Set (MDS)**	Number of HPSIRs completed, signed and published.
10	**International Comparison**	N/A
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	M-2M
14	**KPI Reporting Aggregation**	National; Region; Hospital Group; Hospital;
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/Hospital-Patient-Safety-Indicators-Reports/
17	**Additional Information**	KPI noted in National Service Plan 2024
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Margaret Brennan
		Email address:q qps.acuteoperations@hse.ie
		Telephone Number
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Hospital Services: Clinical Programmes - Stroke Care Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA19	% acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit
1b	KPI Short Title	Stroke Care - Acute or Combined Stroke Unit
2	KPI Description	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	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
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	90%
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 and excluding thrombectomy cases transferred back to referrring hospital on same day (DisWard: RAD/XBAY). 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 and excluding thrombectomy cases transferred back to referrring hospital on same day (DisWard: RAD/XBAY). This is expressed as a percentage
6	Data Sources	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.
6a	Data sign off	National Stroke Programme
6b	Data Quality Issues	Information is available for 24 hospitals who can provide this service. Dependent on the patient data being enetered on the Stroke Register/HIPE Portal and the variable Admitted to Stroke Unit YES/NO being recorded. Data not meeting these criteria should not be used.
7	Data Collection Frequency	Quarterly
8	Tracer Conditions (clinical metrics only)	Intracerebral Haemorrhage (ICD I61) Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	Minimum Data Set (MDS)	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 Sentinel Stroke National Audit Programme https://www.strokeaudit.org/Home.aspx
11	KPI Monitoring	Quarterly
12	KPI Reporting Frequency	Quarterly
13	KPI report period	Audit Data is annual taken in 'a point in time during current year' and will be reported to BIU Acute in Dec of reporting year e.g. May and will be reported in December. By exception Quarterly two quarters in arrears Q-2Q
14	KPI Reporting Aggregation	National; Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	KPI noted in National Service Plan
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Dr Ronan Collins, Consultant Stroke Physican, Clinical Lead National Stroke Programme
		Email address: ronan.collins@tuh.ie
		Telephone Number: 0863874938
		Data support
		Name:Joan McCormack
		Email Address: joanmccormack@noca.ie
		Telephone Number: 087 2115281
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Hospital Services: Clinical Programmes - Stroke Care Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA20	% of patients with confirmed acute ischaemic stroke who receive thrombolysis
1b	KPI Short Title	% of patients with confirmed acute ischaemic stroke who receive thrombolysis
2	KPI Description	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 response was made to 'Did the patient recieve IV 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. Hospitals who provide a thrombectomy service have a large number of cases transferred **back to** the referring hospital and it has been agreed that those who are immediately transferred back to a referring hospital are not included in their denominator for all three KPIs - therefore exclude DISWARD_RAD/XBAY Hospitals who provide a thrombectomy service have a large number of cases transferred **to** their hospital for thrombectomy and it has been agreed that those cases should not be included in their denominator for CPA20 thrombolysis - therefore exclude transfers to Beaumont Hospital and Cork University Hospital using ADM_SOURCE.
3	KPI Rationale	To monitor development of acute stroke services in accordance with the national stroke programme (national policy and national guidelines) To assess patient access to acute stroke care.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	12%
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 + NO response was made to 'Admitted to stroke unit' and excluding thrombectomy cases transferred back to referrring hospital on same day(DisWard RAD/XBAY) and excluding cases transferred to Beaumont Hospital and Cork University Hospital ('AdmSource) and a Yes response was made to did the patient recieve IV thrombolysis on HIPE Portal Dataset. Denominator = Total 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 response was made to Admitted to a Stroke Unit and excluding thrombectomy cases transferred back to referrring hospital on same day(DisWard RAD/XBAY)and excluding cases transferred to Beaumont Hospital and Cork University Hospital ('AdmSource) and YES/NO/Contraindicated/Blank response was made to did the patient recieve IV thrombolysis?
6	Data Sources	Data for numerator and denominator will be collected through the HIPE Portal/Stroke Regsister.
6a	Data sign off	National Stroke Programme
6b	Data Quality Issues	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. Information is available for 24 hospitals who can provide this service. This is dependent on the patient data being enetered on the Stroke Register/HIPE Portal and the variable Treated with Thrombolysis being recorded. Data not meeting these criteria should not be used.
7	Data Collection Frequency	Quarterly
8	Tracer Conditions (clinical metrics only)	Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	Minimum Data Set (MDS)	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 RESPONSE WAS SELECTED TO DID THE PATIENT RECIEVE IV 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 5 CONTRAINDICATED RESPONSE WAS MADE TO DID THE PATIENT RECIEVE IV THROMBOLYSIS
10	International Comparison	Yes, Royal College of Physicians Sentinel Stroke National Audit Programme https://www.strokeaudit.org/Home.aspx
11	KPI Monitoring	Quarterly
12	KPI Reporting Frequency	Quarterly
13	KPI report period	Audit Data is annual taken in 'a point in time during current year' and will be reported to BIU Acute in Dec of reporting year e.g. May and will be reported in December. By exception Quarterly two quarters in arrears Q-2Q

Acute Division - Hospital Services: Clinical Programmes - Stroke Care Metadata 2024		
No	**Steps**	**Detail supporting KPI**
14	**KPI Reporting Aggregation**	National; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	KPI noted in National Service Plan
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Dr Ronan Collins, Consultant Stroke Physican, Clinical Lead National Stroke Programme
		Email address: ronan.collins@tuh.ie
		Telephone Number: 0863874938
		Data support
		Name:Joan McCormack
		Email Address: joanmccormack@noca.ie
		Telephone Number: 087 2115281
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Hospital Services: Clinical Programmes - Stroke Care Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number CPA21**	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit
1b	**KPI Short Title**	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit
2	**KPI Description**	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**	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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	90%
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 and excluding thrombectomy cases transferred back to referrring hospital on same day (DisWard: RAD/XBAY). 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 and excluding thrombectomy cases transferred back to referrring hospital on same day (DisWard: RAD/XBAY). This is expressed as a percentage.
6	**Data Sources**	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
6a	**Data sign off**	National Stroke Programme
6b	**Data Quality Issues**	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. Information is available for 24 hospitals who can provide this service. This is dependent on the patient data being enetered on the Stroke Register/HIPE Portal and the variables Admitted to Stroke Unit,Date of Admission to Stroke Unit and Date of Discharge from Stroke Unit being recorded. Data not meeting these criteria should not be used.
7	**Data Collection Frequency**	Other – give details: Data entered onto Stroke Register/HIPE Portal on an ongoing basis at each hospital
8	**Tracer Conditions (clinical metrics only)**	Intracerebral Haemorrhage (ICD I61) Cerebral Infarction (Ischaemic Stroke) (ICD I63); Stroke, not spec as haemorrhage or infarction (ICD I64)
9	**Minimum Data Set (MDS)**	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 Sentinel Stroke National Audit Programme https://www.strokeaudit.org/Home.aspx
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Audit Data is annual taken in 'a point in time during current year' and will be reported to BIU Acute in Dec of reporting year e.g. May and will be reported in December. By exception Quarterly two quarters in arrears Q-2Q

Acute Division - Hospital Services: Clinical Programmes - Stroke Care Metadata 2024		
No	**Steps**	**Detail supporting KPI**
14	**KPI Reporting Aggregation**	National; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	KPI noted in National Service Plan
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Dr Ronan Collins, Consultant Stroke Physican, Clinical Lead National Stroke Programme
		Email address: ronan.collins@tuh.ie
		Telephone Number: 0863874938
		Data support
		Name:Joan McCormack
		Email Address: joanmccormack@noca.ie
		Telephone Number: 087 2115281
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Acute Coronary Syndrome - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA25	% ST-Elevation Myocardial Infarction (STEMI) patients (without contraindication to reperfusion therapy) who get Primary Percutaneous Coronary Intervention (PPCI)
1b	KPI Short Title	STEMI-PPCI
2	KPI Description	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).
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	95%
4a	Target Trajectory	Point in time
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 Sources	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.
6a	Data sign off	
6b	Data Quality Issues	Data is availabe for 8 out of a possible 9 hospitals for 2014/15 data. Data is dependant on correct data input . A comprehensive manual is available and the software has some validation features.
7	Data Collection Frequency	
8	Tracer Conditions (clinical metrics only)	STEMI = ICD 10 I21.0 – I21.3 (Interpreted from medical record by Heartbeat coillators)
9	Minimum Data Set (MDS)	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	Quarterly
12	KPI Reporting Frequency	Quarterly -1Q
13	KPI report period	Quarterly Q By exception Rolling 12 months Rolling example Q1 2023 (March 23) reports Q1 to Q4 2022, Q2 2023 (June 23) reports Q 2,3,4 2022 and Q1 2023
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Email address: joanmccormack@noca.ie
		Mobile: (353) 87 2115281
		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Acute Coronary Syndrome- Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number CPA26	% of reperfused STEMI patients (or left bundle branch block (LBBB)) who get timely PPCI
1b	KPI Short Title	STEMI: Timely PPCI
2	KPI Description	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.
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	80%
4a	Target Trajectory	Point in time
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 Sources	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
6a	Data sign off	
6b	Data Quality Issues	Data is availabe for 8 out of a possible 9 hospitals for 2014/15 data. Data is dependant on correct data input . A comprehensive manual is available and the software has some validation features.
7	Data Collection Frequency	
8	Tracer Conditions (clinical metrics only)	STEMI = ICD 10 I21.0 – I21.3 (Interpreted from medical record by Heartbeat coillators)
9	Minimum Data Set (MDS)	As set out in e-Heartbeat 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	Quarterly
12	KPI Reporting Frequency	Quarterly -1Q
13	KPI report period	Quarterly Q By exception Rolling 12 months Rolling example Q1 2021 (March 21) reports Q1 to Q4 2020, Q2 2021 (June 21) reports Q 2,3,4 2020 and Q1 2021
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	

It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed

Contact details	**KPI owner/lead for implementation**
	Email address: joanmccormack@noca.ie
	Mobile: (353) 87 2115281
	Telephone Number:
	Data support
	Name: Acute Business Information Unit
	Email address: AcuteBIU@hse.ie
	Telephone Number 01 778 5222
Governance/sign off	***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
	Operational National Director: **National Director Acute Operations**

KPI's will be deemed 'active' until a formal request to change or remove is received

Acute Division - Metadata 2024		
No	**Steps**	**Detail supporting KPI**
1	**KPI title & Number NCCP24**	% of new patients attending rapid access breast (urgent), lung and prostate clinics within recommended timeframe
1b	**KPI Short Title**	Access to cancer RACs
2	**KPI Description**	% of new patients attending rapid access breast, lung and prostate clinics in the cancer centres and appropriate satellite units within recommended timeframe.
3	**KPI Rationale**	Timely access to a specialist opinion is a key component of a quality cancer service
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	95%
4a	**Target Trajectory**	Constant
5	**KPI Calculation**	Numerator : The number of new patients attending rapid access breast, lung and prostate clinics within recommended timeframe. Denominator: the number of new patients attending rapid access breast, lung and prostate clinic
6	**Data Sources**	NCCP HealthAtlas Portal
6a	**Data sign off**	Name: Mr Ian Dawkins
6b	**Data Quality Issues**	None
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	Composite metric
10	**International Comparison**	Composite metric
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Annual Report, MDR
16	**Web link to published data**	
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
		Email address:
		Telephone Number: 01 8287100
		Data support
		Name: Mr Ian Dawkins
		Email Address: ian.dawkins@cancercontrol.ie
		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Cancer Services Symptomatic Breast Cancer Services - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number NCCP6	% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks)
1b	KPI Short Title	% non-urgent Breast <12 wks
2	KPI Description	% of attendances whose referrals were triaged as non-urgent by the cancer centre and adhered to the national standard of 12 weeks for non-urgent referrals (% offered an appointment that falls within 12 weeks).
3	KPI Rationale	Monitoring access and adherence to HIQA standards
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	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 Sources	Symptomatic breast database in the cancer centres 100% coverage
6a	Data sign off	Name: Mr Ian Dawkins
6b	Data Quality Issues	None
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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 (MDS)	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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Other, please specify - Cancer Centre
15	KPI is reported in which reports?	Performance Report/Profile, Other: give details: CompStat
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
		Email address:
		Telephone Number: 01 8287100
		Data support
		Name: Mr Ian Dawkins
		Email Address: ian.dawkins@cancercontrol.ie
		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Cancer Services Symptomatic Breast Cancer Services - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number NCCP8	% of new attendances to the rapid access clinic, triaged as urgent, that have a subsequent primary diagnosis of breast cancer
1b	KPI Short Title	Clinical Detection Rate Breast Cancer - % - Urgent - New
2	KPI Description	% of patients who were triaged as urgent that were subsequently diagnosed with a breast cancer
3	KPI Rationale	Monitoring adequacy of GP referral criteria and hospital triage process
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	>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 Sources	Symptomatic breast database in the cancer centres 100% coverage
6a	Data sign off	Name: Mr Ian Dawkins
6b	Data Quality Issues	None
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	
9	Minimum Data Set (MDS)	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	Monthly
12	KPI Reporting Frequency	Annually A
13	KPI report period	By exception Rolling 12 months Rolling 12M - (Jan to Dec 2015 reported in Jan 2016)
14	KPI Reporting Aggregation	National, Other, please specify - Cancer Centre
15	KPI is reported in which reports?	Annual Report, Performance Report/Profile, Other: give details: CompStat
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
		Email address:
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		Email Address: ian.dawkins@cancercontrol.ie
		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Cancer Services - Lung Cancer- Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number NCCP13**	% of new attendances to the rapid access clinic that have a subsequent primary diagnosis of lung cancer
1b	**KPI Short Title**	Clinical Detection Rate Lung Cancer - % - New
2	**KPI Description**	% 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
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	>25%
5	**KPI Calculation**	Numerator:The total number of patients that 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 Sources**	RALC database in the cancer centre 100% coverage
6a	**Data sign off**	Name: Mr Ian Dawkins
6b	**Data Quality Issues**	No data quality issues
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	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**	Monthly
12	**KPI Reporting Frequency**	Annually A
13	**KPI report period**	By exception Rolling 12 months Rolling 12M (e.g. Jan to Dec 2015 reported in Jan 2016)
14	**KPI Reporting Aggregation**	National
15	**KPI is reported in which reports?**	Performance Report/Profile, Other: give details: CompStat
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
		Email address:
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		Data support
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		Email Address: ian.dawkins@cancercontrol.ie
		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Cancer Services - Prostate Cancer- Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number NCCP19	% of new attendances to the rapid access clinic that have a subsequent primary diagnosis of prostate cancer
1b	KPI Short Title	Clinical Detection Rate Prostate Cancer - % - New
2	KPI Description	% 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
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	>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 Sources	Rapid access prostate clinic returns 100% coverage
6a	Data sign off	Name: Mr Ian Dawkins
6b	Data Quality Issues	None
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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 (MDS)	1. The date of attendance in the cancer centre. 2. The patient's diagnosis
10	International Comparison	No standard international metric available for rapid access prostate cancer clinics
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Annually A
13	KPI report period	By exception Rolling 12 months Rolling 12M (e.g. Jan to Dec 2015 reported in Jan 2016)
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15+A3	KPI is reported in which reports?	Performance Report/Profile, Other: give details: CompStat
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
		Email address:
		Telephone Number: 01 8287100
		Data support
		Name: Mr Ian Dawkins
		Email Address: ian.dawkins@cancercontrol.ie
		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Cancer Services - Radiotherapy- Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number NCCP22	% 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)
1b	KPI Short Title	% Radiotheraphy <15 days
2	KPI Description	% 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.
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	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 Sources	Electronic patient record 100% coverage
6a	Data sign off	Name: Mr Ian Dawkins
6b	Data Quality Issues	Some data definitions still being clarified
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Patients who completed radical treatment for all cancers (C00 * - C96*)
9	Minimum Data Set (MDS)	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	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	Monthly M
14	KPI Reporting Aggregation	National, Other - 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 Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Professor. Risteard O'Laoide, National Director, NCCP
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		Data support
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		Telephone Number: +353-87-095-3651
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Irish Maternity Early Warning System (IMEWS) - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A115**	% of maternity units / hospitals with full implementation of IMEWS (as per 2019 definition)
1b	**KPI Short Title**	IMEWS % Maternity
2	**KPI Description**	% of maternity units and/hospitals that verify that they are implementing Irish Maternity Early Warning System (IMEWS) as per Appendix 1 below.
3	**KPI Rationale**	To monitor and understand the implementation of IMEWS. Results will inform progress made and areas that may require support and improvement. IMEWS supports the detection of pregnant and postpartum women who require escalation of care.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	Numerator: Total number of Maternity Units/Hospitals who have confirmed that they are implementing IMEWS as per definition in Appendix 1 multipiled by 100 Denominator: Total number of Maternity Units/Hospitals in the HSE (currently 19) see Appendix 2 below.
6	**Data Sources**	Maternity Units and Maternity Hospitals report data to BIU via Hospital Groups
6a	**Data sign off**	Hospital CEO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Quarterly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	IMEWS Quarterly Report
10	**International Comparison**	
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Quarterly Q
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Killian Mc Grane National Programme Director of National Women & Infants Health Programme
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		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

	Appendix 1: IMEWS - DEFINITION OF IMPLEMENTATION 2019 for Maternity Units/Hospitals
	IMEWS considered implementated if each unit/hospital can state yes to all of the following criteria
1	Is there a local Governance Group in place and meetings held on a quarterly basis to review IMEWS **implementation and audit** data?
2	Is there a named local co-ordinator for IMEWS?
3	Is there a named local Consultant lead for IMEWS?
4	Are IMEWS training records maintained locally?
5	Is there an ongoing IMEWS clinically based training programme in place for relevant clinical staff in the hospital?
6	Excluding women in labour, **high dependency, recovery and critical care,** are all pregnant and postpartum women monitored using IMEWS?
7	Is the national IMEWS audit tool on **completion** utilised at least monthly with a minimum of 10 charts per **clinical area/ward** in your maternity hospital/unit?
8	Is the national IMEWS audit tool on esclation and response utilised at least quarterly with a minimum of 15 episodes per **clinical area/ward** for your maternity hospital/unit?
9	Is there evidence that if an issue is identified following audit, appropriate quality improvement plans are recorded and actioned?
10	Has the data submitted in this report been reviewed by the Chair of the Local Goverenance Group?

Appendix 2: IMEWS Maternity Unit/Hospitals list.

Coombe Women and Infants University Hospital
MRH Portlaoise
MRH Mullingar
National Maternity Hospital
St. Luke's General Hospital Kilkenny
Wexford General Hospital
Cavan General Hospital
Our Lady of Lourdes Hospital
Rotunda Hospital
Galway University Hospitals
Letterkenny University Hospital
Mayo University Hospital
Portiuncula University Hospital
Sligo University Hospital
Cork University Maternity Hospital
South Tipperary General Hospital
UH Kerry
UH Waterford
UMH Limerick

Acute Division - Irish Maternity Early Warning System (IMEWS) - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A116**	% of all hospitals implementing IMEWS (as per 2019 definition)
1b	**KPI Short Title**	IMEWS % hospitals
2	**KPI Description**	% of hospitals that verify that they are implementing Irish Maternity Early Warning System (IMEWS) for any pregnant or postpartum woman in Emergency Department (ED) or on a general ward as per Appendix 1 below.
3	**KPI Rationale**	To monitor and understand the implementation of IMEWS. Results will inform progress made and areas that may require support and improvement. IMEWS supports the detection of pregnant and postpartum women who require escalation of care.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	Numerator: Total number of hospitals who have confirmed that they are implementing IMEWS as per definition in Appendix 1 multipiled by 100 Denominator: Total number of hospitals with non-maternity beds in the HSE (currently 44) see Appendix 2 below
6	**Data Sources**	Hospitals report data to BIU via Hospital Groups
6a	**Data sign off**	Hospital CEO
6b	**Data Quality Issues**	Not all non-maternity hospitals will admit pregnant or postpartum women during the year
7	**Data Collection Frequency**	Quarterly
8	**Tracer Conditions (clinical metrics only)**	
9	**Minimum Data Set (MDS)**	IMEWS Quarterly Report
10	**International Comparison**	
11	**KPI Monitoring**	Quarterly
12	**KPI Reporting Frequency**	Quarterly
13	**KPI report period**	Quarterly Q
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Killian Mc Grane National Programme Director of National Women & Infants Health Programme
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		Data support
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

	Appendix 1 IMEWS considered implementated if hospital can state yes to all of the following criteria
1	Is there a local Governance Group in place and meetings held on a quarterly basis to review IMEWS **implementation and audit** data?
2	Is there a named local co-ordinator for IMEWS?
3	Is there a named local Consultant lead for IMEWS?
4	Are IMEWS training records maintained locally?
5	Excluding women in labour, **high dependency, recovery and critical care,** are all pregnant and postpartum women monitored using IMEWS?
6	Is the national IMEWS audit tool on completion and esclation utilised annually for up to10 charts for maternity patients in ED or on a General ward in a General Hospital?
7	Is there evidence that if an issue is identified following audit, appropriate quality improvement plans are recorded and actioned?
8	Has the data submitted in this report been reviewed by the Chair of the Local Goverenance Group?

Appendix 2: IMEWS Hospitals with Non-maternity beds list.

Children's Health Ireland (CHI at Crumlin, CHI at Tallaght, CHI at Temple St)
MRH Portlaoise
MRH Tullamore
Naas General Hospital
St. James's Hospital
St. Luke's Radiation Oncology Network
Tallaght University Hospital
Cappagh National Orthopaedic Hospital
Mater Misericordiae University Hospital
MRH Mullingar
Our Lady's Hospital Navan
Royal Victoria Eye and Ear Hospital
St. Columcille's Hospital
St. Luke's General Hospital Kilkenny
St. Michael's Hospital
St. Vincent's University Hospital
Wexford General Hospital
Beaumont Hospital
Cavan General Hospital includes Monaghan General Hospital
Connolly Hospital
Louth County Hospital
Our Lady of Lourdes Hospital
Galway University Hospitals
Letterkenny University Hospital
Mayo University Hospital
Portiuncula University Hospital
Roscommon University Hospital
Sligo University Hospital
Bantry General Hospital
Cork University Hospital
Lourdes Orthopaedic Hospital Kilcreene
Mallow General Hospital
Mercy University Hospital
South Infirmary Victoria University Hospital
South Tipperary General Hospital
UH Kerry
UH Waterford
Croom Orthopaedic Hospital
Ennis Hospital
Nenagh Hospital
St. John's Hospital Limerick
UH Limerick

Acute Division - Maternity Safety Statements - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A128**	% of maternity hospitals / units that have completed and published monthly Maternity Safety Statements
1b	**KPI Short Title**	MSS (a)
2	**KPI Description**	% the 19 maternity units which have completed and published safety statement (see attached template). 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. Acute Hospital Division/ Women & infants programme will submit data on rates of completion per count to BIU. Where a hospital is not fully completing all 17 metrics this should be reported as a non-submission. Only hospitals which have fully completed and published get reported in National Service Plan/ Management Data Report.
3	**KPI Rationale**	No. of statements, if completed, signed and published. No. of safety statements completed and published and signed and No. of Maternity units (19 in total)
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	100%
4a	**Target Trajectory**	Point in time
5	**KPI Calculation**	No of hospitals which have completed (as above)X 100, divided by No. of maternity Units
6	**Data Sources**	
6a	**Data sign off**	
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	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.
9	**Minimum Data Set (MDS)**	
10	**International Comparison**	No. HSE Leading international safety management tool for maternity services.
11	**KPI Monitoring**	
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly two months in arrears M-2M
14	**KPI Reporting Aggregation**	National, Hospital Group, Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Killian Mc Grane National Programme Director of National Women & Infants Health Programme
		Email address: kililan.mcgrane@hse.ie
		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Maternity Safety Statements - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A129	% of Hospital Groups that have discussed a quality and safety agenda with National Women and Infants Health Programme (NWIHP) on a bi / quarterly / monthly basis, in line with the frequency stipulated by NWIHP
1b	KPI Short Title	MSS
2	KPI Description	% the 19 maternity units which have discussed maternity safety statement (see attached template) 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) 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. Acute Hospital Division/ Women & infants programme will submit data on rates of completion per count to BIU. Where a hospital is not fully completing all 17 metrics this should be reported as a non-submission. Only hospitals which have fully completed and published get reported in National Service Plan/ Management Data Report.
3	KPI Rationale	No. of statements, if completed, signed and published. No. of safety statements completed and published and signed and No. of Maternity units (19 in total)
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	100%
4a	Target Trajectory	Point in time
5	KPI Calculation	No of hospitals which have completed (as above)X 100, divided by No. of maternity Units
6	Data Sources	
6a	Data sign off	
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	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.
9	Minimum Data Set (MDS)	
10	International Comparison	No. HSE Leading international safety management tool for maternity services.
11	KPI Monitoring	
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly two months in arrears M-2M
14	KPI Reporting Aggregation	National, Hospital Group, Hospital
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Killian Mc Grane National Programme Director of National Women & Infants Health Programme
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		Telephone Number:
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division -Sexual assault services (14yrs)- Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A130	% of patients seen by a forensic clinical examiner within 3 hours of a request to a Sexual Assault Treatment Unit (SATU) for a forensic clinical examination
1b	KPI Short Title	SATU
2	KPI Description	From the time a request is made to a Sexual Assault Treatment Unit for a Forensic Clinical Examination for all patients over the age of 14years old until the time the Forensic Clinical Examiner commenced the Forensic Clinical Examination (as recorded on the individual SATU patient documentation) is within a 3 hour timeframe.
3	KPI Rationale	To monitor the quality of the SATU resonse to a request for a Forensic Clinical Examination. To improve patient care and response time as an area of performance. This links with the National Database which collates anonymysed data on all SATU attendances.
3a	Indicator Classification	**National Scorecard Quadrant** Quality and Safety
4	KPI Target	90%
4a	Target Trajectory	N/A
4b	Volume metrics	
5	KPI Calculation	Numerator: Number of patients over the age of 14 years who were seen within the 3 hour time frame (when appropriate, eg presenting within timeframe for forensic examination). Denominator:Total number of patients over the age of 14 years attending for a Forensic Clinical Examination. (when appropriate, eg presenting within timeframe for forensic examination).
6	Data Sources	Individual SATU patient documentation Database
6a	Data sign off	Maeve Eogan, National Clinical Lead SATU
6b	Data Quality Issues	
7	Data Collection Frequency	Daily
8	Tracer Conditions (clinical metrics only)	6 SATU nationally
9	Minimum Data Set (MDS)	Request for Services Form - telephone log. Date and time of call Reason for call Reason for any delay SATU record: date and time the Forensi Clinical Examination commenced.
10	International Comparison	UK, USA, WHO
11	KPI Monitoring	Weekly
12	KPI Reporting Frequency	Quarterly
13	KPI report period	Quarterly
14	KPI Reporting Aggregation	National
15	KPI is reported in which reports?	Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Killian Mc Grane National Programme Director of National Women & Infants Health Programme
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		Name: Acute Business Information Unit
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director:
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A3	Inpatient
1b	KPI Short Title	IP Cases
2	KPI Description	An inpatient is a patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed.
3	KPI Rationale	
3a	Indicator Classification	National Scorecard Quadrant Access
4	KPI Target	639,021
4b	Volume metrics	
5	KPI Calculation	Number of Inpatient discharges
6	Data Sources	HIPE and uncoded PAS data
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Inpatients Only
9	Minimum Data Set (MDS)	HIPE: Discharge Date, Patient Type
10	International Comparison	N/A
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report; Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Email address: acuteoperations@hse.ie
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A5**	Day case (includes dialysis)
1b	**KPI Short Title**	DC (inclu dialysis)
2	**KPI Description**	Total number of daycase discharges. A day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day. Episodes of care that result in a birth/delivery are not included. Maternity Daycases are included which include the like of antenatal care etc
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	1,218,297
4b	**Volume metrics**	
5	**KPI Calculation**	Total number of daycase discharges
6	**Data Sources**	HIPE and uncoded PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Daycases Only
9	**Minimum Data Set (MDS)**	HIPE: Discharge Date, Patient Type
10	**International Comparison**	N/A
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Acute Operations
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number**	Total inpatient and day cases
	A7	
1b	**KPI Short Title**	Total IPDC Cases
2	**KPI Description**	The total number of inpatient and day case discharges. An inpatient is a patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed. A day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day.
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	1,857,318
4b	**Volume metrics**	
5	**KPI Calculation**	Total number Inpatient and Daycase discharges
6	**Data Sources**	HIPE, uncoded PAS data, HPO
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Inaptients and Daycases
9	**Minimum Data Set (MDS)**	HIPE: Discharge Date, Patient Type,HPO: weighted Units
10	**International Comparison**	N/A
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
		Name: Acute Operations
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A12**	Emergency inpatient discharges
1b	**KPI Short Title**	Emergency IP discharges
2	**KPI Description**	Total number of emergency inpatient discharges. An emergency patient is a patient requires immediate care and treatment as a result of a severe, life threatening or potentially disabling condition. Generally, the patient is admitted through the Emergency Department.
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	453,209
4b	**Volume metrics**	
5	**KPI Calculation**	Total Number of Emergency Inpatient Discharges
6	**Data Sources**	HIPE and uncoded PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Admission Type equal to 4, 5 or 7 Inpatients Only
9	**Minimum Data Set (MDS)**	HIPE: Discharge Date, Patient Type, Admission Type
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A13**	Elective inpatient discharges
1b	**KPI Short Title**	Elective IP Discharges
2	**KPI Description**	Total Number of elective inpatient discharges. An elective inpatient is one where the patient's condition permits adequate time to schedule the availability of suitable services. An elective admission may be delayed without substantial risk to the health of the individual.
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	86,924
4b	**Volume metrics**	
5	**KPI Calculation**	Total Number of elective inpatient discharges
6	**Data Sources**	HIPE and uncoded PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Admission Type equal to 1 or 2 Inpatients Only
9	**Minimum Data Set (MDS)**	HIPE: Discharge Date, Patient Type, Admission Type
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A14	Maternity inpatient discharges
1b	KPI Short Title	Maternity IP Discharges
2	KPI Description	Total number of Maternity Inpatient Discharges. A materinty inpatient is a patient is admitted related to their obstetrical experience. (From conception to 6 weeks post delivery).
3	KPI Rationale	
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	98,888
4b	Volume metrics	
5	KPI Calculation	Total number of Maternity Inpatient Discharges
6	Data Sources	HIPE
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Admission Type equal to 6 Inpatients Only
9	Minimum Data Set (MDS)	HIPE: Discharge Date, Patient Type, Admission Type
10	International Comparison	NA
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report; Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity ≥ 75 years - Metadata 2024

No	Steps	Detail supporting KPI
1	KPI title & Number A103	Inpatient discharges ≥75 years
1b	KPI Short Title	IPCases ≥75 years
2	KPI Description	Number of Inpatient discharges ≥ 75 years. An inpatient is a patient admitted to hospital for treatment or investigation and is scheduled to stay in a designated inpatient bed.
3	KPI Rationale	
3a	Indicator Classification	**National Scorecard Quadrant** Access
4	KPI Target	142,003
4b	Volume metrics	
5	KPI Calculation	Total Number of Inpatient Discharges ≥ 75 years
6	Data Sources	HIPE and uncoded PAS data
6a	Data sign off	HPO
6b	Data Quality Issues	
7	Data Collection Frequency	Monthly
8	Tracer Conditions (clinical metrics only)	Age ≥ 75 years Inpatients Only
9	Minimum Data Set (MDS)	HIPE: Discharge Date, Patient Type, Age
10	International Comparison	NA
11	KPI Monitoring	Monthly
12	KPI Reporting Frequency	Monthly
13	KPI report period	By exception Monthly in arrears M-1M
14	KPI Reporting Aggregation	National, Hospital Group, RHA, Hospital
15	KPI is reported in which reports?	Annual Report; Performance Report/Profile
16	Web link to published data	http://www.hse.ie/eng/services/Publications
17	Additional Information	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Discharge Activity ≥ 75 years - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A104**	Day case discharges ≥75 years
1b	**KPI Short Title**	DC Cases ≥75 years
2	**KPI Description**	Total number of daycase discharges ≥ 75 years. A day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day.
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	236,388
4b	**Volume metrics**	
5	**KPI Calculation**	Total Number of Daycase discharges ≥ 75 years
6	**Data Sources**	HIPE and uncoded PAS data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Age ≥ 75 Years Daycases Only
9	**Minimum Data Set (MDS)**	HIPE: Discharge Date, Patient Type, Age
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Level GI - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A132**	Level of GI scope activity
1b	**KPI Short Title**	Level GI
2	**KPI Description**	Level of gastrointestinal scope (GI) day case discharges. A GI day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day for a gastrointestinal scope (procedure using a small camera to examine your upper digestive system (GI)).
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	114,286
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Total number of gastrointestinal daycase discharges
6	**Data Sources**	HIPE data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	NA
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	~Daycases only ~Version 8 Adjacent Diagnosis Related Group (ADRG) of G46 Complex Endoscopy or G47 Gastroscopy or G48 Colonoscopy
9	**Minimum Data Set (MDS)**	HIPE: Patient Type, ADRG
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	

It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed

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Governance/sign off	***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
	Operational National Director: **National Director Acute Operations**

KPI's will be deemed 'active' until a formal request to change or remove is received

Acute Division - Level Dialysis - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A133**	Level of dialysis activity
1b	**KPI Short Title**	Level dialysis
2	**KPI Description**	Level of dialysis daycase discharges. A dialysis day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day for dialysis (process in which your blood is filtered to remove waste products and excess fluid which build up because your kidneys are not working properly).
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	201,526
4b	**Volume metrics**	
5	**KPI Calculation**	Total number of Dialysis daycase discharges
6	**Data Sources**	HIPE data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	~Daycases only ~Version 8 Adjacent Diagnosis Related Group (ADRG) of L61 Haemodialysis
9	**Minimum Data Set (MDS)**	HIPE: Patient Type, ADRG
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Level Chemo - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A134**	Level of chemotherapy (R63Z) and other Neoplastic Dis, MINC (R62C)
1b	**KPI Short Title**	Level of Chemo and Radiotherapy
2	**KPI Description**	Level of Chemotherapy and Radiotherapy daycase discharges. A chemotherpay/radiotherapy day case is a patient who is admitted on an elective basis for care and/or treatment, who does not require the use of a hospital bed over night, and has been admitted and discharged as scheduled on the same day for Chemotherapy or Radiotherapy (treatment used to destroy cancer cells).
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	248,088
4b	**Volume metrics**	
5	**KPI Calculation**	Total number of Chemotherapy and Radiotherapy daycase discharges
6	**Data Sources**	HIPE data
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	~Daycases only ~Version 8 Diagnosis Related Group (DRG) of R62C Other Neoplastic Disorders, Minc or R63Z Chemotherapy
9	**Minimum Data Set (MDS)**	HIPE: Patient Type, DRG
10	**International Comparison**	NA
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	By exception Monthly in arrears M-1M
14	**KPI Reporting Aggregation**	National, Hospital Group, RHA, Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A164**	New ED attendances
1b	**KPI Short Title**	ED New
2	**KPI Description**	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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	1,350,913
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Count of Number of ED Attendances
6	**Data Sources**	ED System (PET)
6a	**Data sign off**	
6b	**Data Quality Issues**	Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Emergency Attendance
9	**Minimum Data Set (MDS)**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A165**	Return ED attendances
1b	**KPI Short Title**	ED Return
2	**KPI Description**	Total number of scheduled and unscheduled return attendances at the Emergency Department (ED) 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 returns up to and including 28-days: An unplanned Emergency Department attendance who returns with the same condition at the same department up to and including 28 days after 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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	112,963
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Count of Number of Return ED Attendances
6	**Data Sources**	ED System (PET)
6a	**Data sign off**	
6b	**Data Quality Issues**	Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	As per description no. 2 above
9	**Minimum Data Set (MDS)**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
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Acute Division - Metadata 2024		
No	**Steps**	**Detail supporting KPI**
1	**KPI title & Number** **A94**	Injury Unit attendances
1b	**KPI Short Title**	LIU
2	**KPI Description**	Total number of patients who present themselves to an Injury Unit. An Injury Unit provides care for non-life threatening or limb-threatening injuries, 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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	166,405
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Count of Other Presentations
6	**Data Sources**	Sourced from Hospitals systems
6a	**Data sign off**	
6b	**Data Quality Issues**	Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical**	Emergency Presentation other than New or Return
9	**Minimum Data Set (MDS)**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	Region; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A95**	Other Emergency Presentations
1b	**KPI Short Title**	Other EP
2	**KPI Description**	Total number of patients who present themselves to hospital as emergency other than New or Return at an Emergency Department. They include Paediatric Assessment Unit (PAU's) and Surgical Assessment Unit (SAU's), and emergency presentations direct to wards.
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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	49,073
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Count of Other Presentations
6	**Data Sources**	Sourced from Hospitals systems
6a	**Data sign off**	
6b	**Data Quality Issues**	Reporting all acute hospitals with recognised Emergency Departments
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Emergency Presentation other than New or Return
9	**Minimum Data Set (MDS)**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024		
No	**Steps**	**Detail supporting KPI**
1	**KPI title & Number A17**	Total no. of births
1b	**KPI Short Title**	Births
2	**KPI Description**	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.
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	54,589
4a	**Target Trajectory**	
4b	**Volume metrics**	
5	**KPI Calculation**	Count: Number of Live Births + Number of Still Births
6	**Data Sources**	Sourced from Hospitals PAS systems
6a	**Data sign off**	Name: Acute Business Information Unit
6b	**Data Quality Issues**	19/19 hospitals reporting
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	Total number of live births and still births greater than or equal to 500grms.
9	**Minimum Data Set (MDS)**	BIU – Acute MDR
10	**International Comparison**	Yes
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
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Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number** **A15**	No. of new and return outpatient attendances
1b	**KPI Short Title**	OPD New + Return
2	**KPI Description**	This metric includes the total number of both new and return outpatient attendances (OPD). 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.
3	**KPI Rationale**	The monitoring of outpatient attendance levels
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	3,758,139
4a	**Target Trajectory**	Monthly profile
5	**KPI Calculation**	Count. Total New + Return Outpatient attendances
6	**Data Sources**	Sourced from Hospitals PAS systems
6a	**Data sign off**	Name: OSPIP
6b	**Data Quality Issues**	All acute hospitals reporting
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical**	Qualifies as an outpatient attendance
9	**Minimum Data Set (MDS)**	BIU - Acute OPD Template (Excludes NTPF Activity)
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile; Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A136**	No. of new outpatient attendances
1b	**KPI Short Title**	OPD New
2	**KPI Description**	This metric includes the total number of new attendances. New attendance = A first new attendances at a consultant led Outpatient clinic
3	**KPI Rationale**	
3a	**Indicator Classification**	**National Scorecard Quadrant** Access
4	**KPI Target**	1,056,535
4a	**Target Trajectory**	Monthly profile
5	**KPI Calculation**	Count. Total New Outpatient attendances
6	**Data Sources**	Sourced from Hospitals PAS systems
6a	**Data sign off**	Name: Acute Operations
6b	**Data Quality Issues**	All acute hospitals reporting
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical**	Qualifies as a new outpatient attendance
9	**Minimum Data Set (MDS)**	BIU - Acute OPD Template (Excludes NTPF Activity)
10	**International Comparison**	No OPD measure of performance internationally due to different structures of health service delivery.
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile; Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Telephone Number
		Data support
		Name: Acute Business Information Unit
		Email address: AcuteBIU@hse.ie
		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A48**	No. of acute bed days lost through delayed transfers of care
1b	**KPI Short Title**	DTOC - Bed Days
2	**KPI Description**	This metric looks at the number of acute bed days lost due to delayed transfers of care. Delayed transfer of care: 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 transfer of care grouped under Type A -Home support service, Type B - Residential Care support Type C - Access to Rehabilitation Type D - Complex Clinical needs Type E - Homelessness/Housing support/Adjustment Type F - legal Complexity/ Ward of court Type G - Non compliance /Co-operation with process Type H - COVID-19 related queries The name Delayed Discharges has changed to Delayed Transfer of Care as of 18/12/2019
3	**KPI Rationale**	Delayed transfer of care is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	≤127,750
4a	**Target Trajectory**	N/A
5	**KPI Calculation**	Count of bed days lost to patients who are Delayed transfer of care
6	**Data Sources**	National Delayed transfer of care database to BIU Acute
6a	**Data sign off**	Name: Unscheduled Care Lead
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Daily
8	**Tracer Conditions (clinical metrics only)**	Bed days lost
9	**Minimum Data Set (MDS)**	Categorisation of delayed transfer of care grouped under Type A -Home support service, Type B - Residential Care support Type C - Access to Rehabilitation Type D - Complex Clinical needs Type E - Homelessness/Housing support/Adjustment Type F - legal Complexity/ Ward of court Type G - Non compliance /Co-operation with process Type H - COVID-19 related queries
10	**International Comparison**	Yes, similar information gathered in other countries
11	**KPI Monitoring**	Daily
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Performance Report/Profile
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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		Email address: acutehospitals@hse.ie
		Telephone Number
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		Telephone Number 01 778 5222
Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A49**	No. of beds subject to delayed transfers of care
1b	**KPI Short Title**	DTOC - Beds
2	**KPI Description**	This metric looks at the number of beds subject to delayed transfer of care. Delayed transfer of care: 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 transfer of care grouped under Type A -Home support service, Type B - Residential Care support Type C - Access to Rehabilitation Type D - Complex Clinical needs Type E - Homelessness/Housing support/Adjustment Type F - legal Complexity/ Ward of court Type G - Non compliance /Co-operation with process Type H - COVID-19 related queries The name Delayed Discharges has changed to Delayed Transfer of Care as of 18/12/2019
3	**KPI Rationale**	Delayed transfer of care is used in assessment of quality of care, costs and efficiency and is used for health planning purposes.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	≤350
4a	**Target Trajectory**	N/A
5	**KPI Calculation**	Count of bed in use to patients who are Delayed transfer of care at one point in time.
6	**Data Sources**	National Delayed transfer of care database to BIU Acute
6a	**Data sign off**	Name: Unscheduled Care Lead
6b	**Data Quality Issues**	
7	**Data Collection Frequency**	Daily
8	**Tracer Conditions (clinical metrics only)**	Bed subject to delayed transfer of care
9	**Minimum Data Set (MDS)**	Categorisation of Delayed transfer of care grouped under Type A -Home support service, Type B - Residential Care support Type C - Access to Rehabilitation Type D - Complex Clinical needs Type E - Homelessness/Housing support/Adjustment Type F - legal Complexity/ Ward of court Type G - Non compliance /Co-operation with process Type H - COVID-19 related queries
10	**International Comparison**	Yes, similar information gathered in other countries
11	**KPI Monitoring**	Daily
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	Other
16	**Web link to published data**	http://www.hse.ie/eng/services/Publications
17	**Additional Information**	
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
Contact details		**KPI owner/lead for implementation**
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Healthcare Associated Infections - Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A105**	No. of new cases of CPE
1b	**KPI Short Title**	No. of new cases of CPE
2	**KPI Description**	No. of new cases of CPE (Carbapenemase Producing Enterobacterales) reported in swabs/ faeces or other samples by acute hospitals. The CPE is not necessarily attributable to the hospital that detects it.
3	**KPI Rationale**	Carbapenemase Producing Enterobacterales (CPE) are an emerging threat to human health, particularly in hospital settings. CPE are gram-negative bacteria that are carried in the gut and are resistant to most available antibiotics. The true impact and extent of this increasing threat cannot be fully estimated at present. However, CPE blood stream infection has been associated with death in up to half of all patients affected by it. The incidence of CPE can also result in significant financial cost to the health system and challenges to effective patient flow in health care delivery for scheduled and unscheduled care. Tracking of incidences of CPE is key to accurate assessment of the situation in Ireland.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	N/A
5	**KPI Calculation**	CPE002 (Number of patients confirmed with newly detected CPE from rectal swabs/ faeces) plus CPE 003 (Number of patients confirmed with newly detected CPE from any other site)
6	**Data Sources**	Source: Monthly data report to BIU from each acute hospital
6a	**Data sign off**	Data should be approved for issue to BIU by Hospital Manager or CEO
6b	**Data Quality Issues**	Dependant on accurate reporting from Hospitals. To avoid duplication confirmed CPE should be counted once only and for the purpose of this return it should be associated with the month during which a rapid confirmation assay positive result performed either in house or at reference laboratory becomes available to the Infection Prevention Control team at the hospital making the return. (For example if a patient has a CPE detected from a rectal swab in January and again in February from any site (rectal/other), the patient is counted once only in January, with all subsequent CPE isolates, from this patient to be excluded)
7	**Data Collection Frequency**	Monthly M
8	**Tracer Conditions (clinical metrics only)**	see above No. 5
9	**Minimum Data Set (MDS)**	BIU Reporting template for same
10	**International Comparison**	A number of other countries track incidence of CPE using various systems e.g. UK and Israel.
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly M
14	**KPI Reporting Aggregation**	National, Hospital Group, Acute Hospital
15	**KPI is reported in which reports?**	Annual Report; Performance Report/Profile, MDR
16	**Web link to published data**	CPE in HSE Acute Hospitals in Ireland Monthly Report available on www.HPSC.ie and www.hse.ie
17	**Additional Information**	KPI noted in National Service Plan 2024
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Gove rnanc		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		

Acute Division - Venous Thromboembolism Metadata 2024

No	Steps	Detail supporting KPI
1	**KPI title & Number A140**	Rate of defined and suspected venous thromboembolism (VTE, blood clots) associated with hospitalisation
1b	**KPI Short Title**	VTE associated with hospitalisation
2	**KPI Description**	The rate, per 1,000 inpatient discharges, with length of stay of 2 or more days, of VTE occurring during hospitalisation
3	**KPI Rationale**	VTE (venous thromboembolism, blood clots) comprises deep vein thrombosis (DVT) and pulmonary embolism (PE). 9% of all deaths are VTE-related and recurrence affects 30% of survivors, in addition to post-thrombotic complications. 63% of all VTE is hospital-acquired (1), occurring during or in the 90 days after hospitalisation. Irish HIPE data shows that over 6,000 adult medical or surgical in-patients had a VTE resulting in hospital admission(primary diagnosis) or occurring during hospitalisation (additional diagnosis) in 2018 (2). An average of 270 inpatients per month in 2018 were reported as having an additional diagnosis of VTE or readmission within 90 days with VTE (2). Venous thromboembolism (VTE, blood clots) accounts for 0.4-3.8% of public hospital budget spend in 28 European Union countries (3). 70% of healthcare-associated VTE is potentially preventable with appropriate VTE prophylaxis (4). The OECD rated VTE prevention protocols as the patient safety intervention with the most favourable impact/cost ratio (5). The HSE Quality Improvement Division led the national Preventing VTE in Hospitals Improvement Collaborative from September 2016-2017. Median appropriateness of prophylaxis at 24 hours increased from a median of 61% to 81% in the 27 participating hospitals. This KPI will provide hospitals with a measure of their rate of VTE occurring during and after hospitalisation and act as a driver to improve prevention of VTE.
3a	**Indicator Classification**	**National Scorecard Quadrant** Quality and Safety
4	**KPI Target**	N/A
4a	**Target Trajectory**	N/A
4b	**Volume metrics**	These data are collected and coded as part of the HIPE process and collated by the HPO. Data includes all patients who are coded as having a diagnosis of VTE in "Dx 2-99", as this remains currently the most sensitive method to capture cases of true hospital-associated VTE (HA-VTE). It is recognized that additional cases of VTE that are not HA-VTE may be included using this methodology.
5	**KPI Calculation**	Numerator: ((Number of adult in-patient discharges with a length of stay of 2 or more days with an additional diagnosis of VTE^) *1000. Denominator: Number of adult in-patient discharges with a length of stay of 2 or more days in the index month.
6	**Data Sources**	HIPE Data Set
6a	**Data sign off**	HPO
6b	**Data Quality Issues**	Data is part of the routine data collected as part of the HIPE dataset. No quality issues specific to these criteria are known.
7	**Data Collection Frequency**	Monthly
8	**Tracer Conditions (clinical metrics only)**	**1. Numerator Part 1 - The number of adult in-patient discharges with an additional diagnosis of VTE^** *a. Any additional HIPE diagnosis of VTE (see list below^) NOT a primary HIPE diagnosis i.e. any diagnosis of VTE in the 29 additional HIPE diagnoses* *b. Inpatient only c. Length of stay of 2 or more days i.e. excludes discharges with 0 or 1 overnight stays d. Aged 16 or over e. Non-Maternity admission type i.e. Elective or Emergency only* f. Maternity and paediatric hospitals are excluded 2. **Denominator** *a. Inpatient only b. Length of stay of 2 or more days i.e. excludes discharges with 0 or 1 overnight stays* *c. Aged 16 or over d. Non-Maternity admission type i.e. Elective or Emergency only e. Maternity and paediatric hospitals are excluded* ^ Venous thromboembolism (VTE) encompasses both pulmonary embolism and deep venous thrombosis, defined by the following ICD-10-AM Diagnosis Codes in any of the following additional diagnosis codes: I26.0 Pulmonary embolism with mention of acute cor pulmonale; I26.9 Pulmonary embolism without mention of acute cor pulmonale; I80.1 Phlebitis and thrombophlebitis of femoral vein; I80.2 Phlebitis and thrombophlebitis of other deep vessels of lower extremities; I80.3 Phlebitis and thrombophlebitis of lower extremities, unspecified; I80.8 Phlebitis and thrombophlebitis of other sites; I80.9 Phlebitis and thrombophlebitis of unspecified site; I82.22 Embolism and thrombosis of vena cava; I82.8 Embolism and thrombosis of other specified veins; I82.9 Embolism and thrombosis of unspecified vein; O08.2 Embolism following abortion and ectopic and molar pregnancy; O88.2 Obstetric blood clot embolism Note codes validated against Lester (Heart 2013), Roberts (Chest 2013) and Stubbs (Int Med J 2018)
9	**Minimum Data Set (MDS)**	HIPE Data Set
10	**International Comparison**	The rate of healthcare-associated VTE is commonly referred to in the literature. Although the exact rates measured are not an exact match for those measured by our KPI, the rates quoted include Assareh, Australia: 11.45 / 1000 discharges; Stubbs, Australia: 9.7/1000 admissions (including all post-discharge HA-VTE); Rowswell, UK: 2 /1000 reducing to 1.4 / 1000; Rohit Bhalla, US, 6.5 /1000 reducing to 4.2 per 1000; Amin Alpesh et al, US, 7-16/ 1000. AHRQ recommends a HA-VTE measure and % appropriate prophylaxis as key metrics when endeavouring to reduce VTE. Potentially preventable healthcare associated VTE rate is collected in the US as a National Hospital In-patient Quality Measure (VTE-6). Each case identified as a HA-VTE as an additional diagnosis not present on admission is reviewed and categorised as preventable if the patient received no thromboprophylaxis up to that point. This is reported as % of HA-VTE patients who did not receive thromboprophylaxis.
11	**KPI Monitoring**	Monthly
12	**KPI Reporting Frequency**	Monthly
13	**KPI report period**	Monthly 1 month in arrears -Jan data reported in March
14	**KPI Reporting Aggregation**	National; Hospital Group; Hospital
15	**KPI is reported in which reports?**	MDR, Performance Report/Profile and VTE trend Report
16	**Web link to published data**	Not applicable
17	**Additional Information**	REFERENCES 1. HSE analysis of HIPE data, 2018 (unpublished) 2. Barco. Thromb Haemost 2016 Apr;115(4):800-8 3. Geerts et al. Chest 2001 Jan;119(1 Suppl):132S-175S 4. OECD The Economics of Patient Safety 2017
It is policy to include data in Open Data publication. Please indicate if there is an exceptional reason for this to be delayed		
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Governance/sign off		***This sign off is the governance at Divisional level in respect of management of the KPI including data provision, validation, and use in performance management***
		Operational National Director: **National Director Acute Operations**
KPI's will be deemed 'active' until a formal request to change or remove is received		