Hospital Group

Operational Plan

2019

Contents

Introduction

RCSI Hospital Group established in 2015 comprises the following hospitals:
- Beaumont
- Connolly
- Cavan
- Monaghan
- Our Lady of Lourdes, Drogheda
- Louth County
- Rotunda

Academic Partner:
- Royal College Surgeons Ireland

RCSI Overall Statement of Vision and Key Strategic Objectives

Statement of RCSI Hospital Group Vision:
To provide world class care, exceptional clinical services with respect and compassion.

Key Strategic Objectives

Within the context of the patient being the core focus for all endeavours, the RCSI Hospital Group is pursuing 8 thematic objectives, each with related critical success factors necessary for successful advancement:

1. Improve Access Performance.
   - emergency care diagnosis, treatment and management.
   - elective care diagnosis, treatment and management.

2. Deliver relevant services that are planned and organised to meet designated population health needs, achieve desired health outcomes in a manner consistent with evidenced based best practise with particular focus on efficiency, effectiveness and quality. Recognising also the need for continuous improvement and innovation.

3. Do no preventable patient harm.

4. Deliver services equitably on the basis of need, governed by the principles of Fairness, Honesty, Respect and assigned Accountability.

5. Develop and generally advance an integrated delivery model.
   - a single delivery model across the 7 operational sites.
   - successful integration with Community Services, particularly with regard to Chronic Disease Management.
   - cognisant of the need to operate in a complex environment of vertical and lateral collaboration and the participation in service and academic health networks both nationally and internationally.

6. Fiscal Prudency with regard to resource utilisation and investment.

7. Develop Education and Research capacity and capability with designated academic partner in a manner that supports and generally enhances direct service delivery.

8. Ensure Staff enabled, supported, trained, developed and accountable.

Our Population

Population Health

The RCSI Hospital Group serves populations in five counties – North Dublin, Meath, Louth, Cavan and Monaghan. The area stretches from the north banks of the River Liffey in Dublin City Centre, north to the border with Northern Ireland, and west to the border with County Donegal. It comprises urban, rural and commuter belt areas, and covers approximately 6,817 square kilometres in total. There is considerable variation in population density from a low of 39 persons per square kilometre in Cavan to a high of 4,139 persons per square kilometre in north Dublin city.

Residents of neighbouring areas such as South Dublin and Kildare also access hospitals for secondary care and maternity services. Beaumont Hospital, which is the largest hospital in the group, in addition to providing emergency and acute Secondary Care services to the local community is also a designated Cancer Centre, the Regional Treatment Centre for Ear, Nose and Throat and Gastroenterology and also the National Referral Centre for Neurosurgery and Neurology, Renal Transplantation, and Cochlear Implantation - as such treating patients from all parts of the country.

The RCSI catchment area has experienced rapid population expansion in recent years, growing from approximately 640,000 in 2002 to 817,522 in 2011. This population growth is projected to continue, reaching almost 875,000 by 2021. Provisional preliminary data from Census 2016 suggests that the population in the catchment area has now reached approximately 864,000. The catchment covers a large area, including urban, rural and commuter areas, each presenting different challenges for service delivery.

The population in our catchment area is relatively young. Fingal has the youngest and fastest growing population in the Country. Per Census 2016 average age is 34.3 (3 years lower than the average) and the growth rate between 2011 and 2016 was 8 per cent more the twice that for the country as a whole. However while 10% of the population is aged 65 and over, compared with 11.7% nationally, some areas within the catchment include higher proportions of older people. In particular, in the area around Beaumont hospital (Dublin North Outer City), 15.4% of the population are aged 65 and over, while Cavan and Monaghan each have approximately 12% of the population aged 65+. While in the 5 counties (Fingal, Meath, Louth, Cavan and Monaghan) there were 5872 people over 85 and 21938 between 75 and 85 per Census 2016. Older people in the RCSI catchment area were less likely to be living alone, relative to other catchment areas. However, almost a third of older adults in Dublin City live alone, compared with less than a quarter in Meath and Fingal. Levels of deprivation in the area were low relative to other Hospital Group catchment areas, with 37% of the population living in areas which are classified in the top 3 deciles of deprivation. This compares with the most deprived catchment area, West/North West, where 49% of the population live in areas in the top 3 deciles of deprivation. However, there were sharp contrasts in deprivation across areas. In Louth, 68% of the population live in areas classified as being in the top 3 deciles of deprivation, compared with only 22% of the population in Fingal.

Levels of good or very good self-rated health among the total population, and older people, varied across the catchment, with better health reported in Fingal and Meath, and worse health in Dublin City, Louth and Monaghan.

GP provision is low in the RCSI catchment area, particularly in Meath, Cavan and Monaghan. This may lead to increased hospital activity which would be more appropriately carried out in a community setting and increased numbers of hospitalisations which could have been avoided with higher primary care provision.

A wide range of emergency, diagnostic, treatment and rehabilitation services are provided across these, supported by a workforce of 9,200WTE staff (December 2018 census). Our aim is to provide high quality and safe care underpinned by the development of a single effective corporate and clinical governance structure.

Reform and Transformation

Focus in developing operational plan has encompassed:
- Having patients at its centre.
- Being informed by the latest best practice.
- Striving to integrate all present services – insourcing and maximising usage of all available capacity with available capability.
- Development of appropriate patient pathways and clinical networks in and across hospitals in the Group.
- Promotion of integrated service provision with community services through working with the four CHOs associated with the population served by the RCSI Hospital group, by promoting a modernised and streamlined service model in line with Sláintecare. This can be delivered through outreach services, telemedicine, virtual health clinics, integrated assessment services and cross-sector working, which will all support independence and choice for patients.
- Ensuring alignment of service developments in both acute and community service areas where there is an opportunity to build upon existing pathways of care (e.g. frail intervention therapy teams and older persons' services) which provide the most gain for patient outcomes across community and acute services.
- Working with General Practitioners to avoid hospital admission, and support planned managed hospital discharge.

All underpinned by risk awareness (RCSI Corporate Risk Register), and a quality improvement focus in accordance with appropriate National Standards and Guidelines.

The Group will continue to seek to improve patient and staff health and wellbeing by continuing to implement RCSI Hospital Group Healthy Ireland plan 2017.

The Group will develop eHealth capability by working with the Office of the Chief Information Officer to implement;
- IPIMs (Intergrated Patient Management System) in Connolly Hospital. Connolly Hospital's current Patient Administration System (PAS) is no longer fit for purpose. Local Project Staffing required for iPMS implementation (staffing 12WTE).
- NiSRP (National integrated Staff Records Pay programme) in Connolly Hospital.
- E Rostering project in Connolly Hospital.
- Support national implementation of Maternal and Newborn Clinical Management System (MN-CMS) in Cavan General Hospital and Our Lady of Lourdes Hospital (staffing 6WTE).

Implementation of Q-Pulse will commence initially in Our Lady of Lourdes and Louth County Hospitals. Maximise effectiveness of present Q-pulse systems and continue implementation, across all hospitals in the Group. (project staffing 6WTE).

All hospitals in Group are operating at > 98% occupancy. The Group will seek to increase access to bed stock by reducing length of stay and increasing number of acute beds to reduce occupancy level.

The Group will seek to secure identification for Beaumont Hospital as Dublin Major Trauma Centre.

The Group will seek to ensure progression of capacity Capitol projects, which appropriately match patients needs specifically:

Beaumont Hospital	Emergency Department upgrade
Beaumont Hospital	Cystic Fibrosis unit
Beaumont Hospital	Neuro-interventional Radiology Suite Replacement
Rotunda Hospital	relocation to Connolly Hospital
Beaumont Hospital	additional acute bed capacity
Cavan Hospital	Phase 2 new Endoscopy unit, CSSD and Ward upgrade
Connolly Hospital	Laboratory expansion / replacement

The Group will continue to seek a Group CSSD wide solution, present proposal plans are based on Connolly Hospital site.

The Group will continue to implement lab modernisation in Beaumont and work with the national MEDLIS team to implement MEDLIS across the Acute Hospitals in the group.

The Group will commence adherence to:
- Compliance of European Falsified Medicines Directive 2016.
- Basic Safety Standards for Protection Against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations 2018 (S.I. No. 256 of 2018).

Quality and Safety

The established RCSI Hospital Group Quality and Safety Metrics which provide information on the quality and safety of services across the Group (appendix 1) will continue to be expanded. These metrics will be published on the RCSI Hospital Group Website. The Hospital specific Quality and Safety Metrics, will continue to be utilised by each Hospital to monitor and improve patient safety.

- Implementation of a Group Quality Management System (Q-pulse) in Our Lady of Lourdes Hospital and Louth County Hospitals. This system will,
  - Support the ongoing use of metrics at Hospital and Group Level.
  - Aid in standardizing policies, guidelines and processes.
  - Enable incident reporting at point of occurrence.
  - Assist in preparing the Hospital and Group for external monitoring and licensing.
  - Support audit.
  - Assist in collating staff training statistics.

- After Action Review is now being utilised by the RCSI Hospital Group as a mechanism of staff support following adverse events and incidents. In conjunction with our academic partner RCSI, training will be provided and evaluated throughout 2019.

- Develop capacity to listen and learn from patients, public and staff.
  - Bespoke complaints training will continue across the Hospital Group to support staff to address patient concerns. The number of patient complaints answered within 30 days will be continuously monitored and improvements sustained. A Re-audit of Patient Complaints across the Hospital Group is underway to assess the effectiveness of these interventions.
  - Support hospitals to implement Quality Improvement Plans developed in response to the 2018 National Patient Experience Survey (NPES) and support the roll out of the 2019 NPES in relevant RCSI Hospitals.
  - Continue staff training for Open Disclosure across all services.
  - Continue implementation of the Children First Act 2015 including mandatory training for staff as appropriate.

- Healthcare Acquired Infection (HCAI) / Anti-microbial Resistance (AMR).
  - Implementation of the national policy on restricted antimicrobial agents with a particular focus on antimicrobial stewardship and control measures for multi-resistant organisms, underpinned by the implementation of HIQA National Standards for the Prevention and Control of Healthcare Associated Infections.
  - Continue collation and publication of KPIs on HCAIs and their management.
  - Continue collation and monitoring of Sepsis Training Rates amongst relevant staff.
  - Implement the requirements for screening of patients with CPE guidelines, Assessing Evidence of Transmission and End of Transmission of Carbapenemase Producing Enterobacterales1 (CPE), 2018. Adherence to CPE criteria testing and associated infection control measures including use of screening volumes and appropriate accommodation of patients across all hospitals.
  - Progress microbiology consultant to support IPC / HCAI in Cavan and Monaghan Hospitals.

- Each hospital will continue to action recommendations from the HIQA review of nutrition and hydration in public acute and implement best practices in food and nutrition for patients in hospitals.

- Support the Hospitals in the Group to implement Influenza plan to manage all components including the uptake of the influenza vaccine amongst healthcare workers and at risk patients.

- Continue to support the implementation of the HIQA National Standards for Safer Better Healthcare (NSSBHC) in relation to Reusable Invasive Medical Devices (RIMD)

- Continue to implement the HIQA National Standards for Safer Better Healthcare (NSSBHC) in relation to on Medication Safety and promote increased reporting of medication incidences and errors.

- The RCSI Hospital Group will continue to implement the National Clinical Effectiveness Guidelines including:
  - Sepsis guidelines.
  - Early Warning Scores.
    - (NEWS, PEWS, iMEWS).
  - Clinical Handover.
    - Serious Reportable Events, Serious Incidents, Incident Reporting & Management.

Health and Social Care Delivery

RCSI Hospital Group will continue to deliver health and social care by:

- Promoting healthy lifestyle for patients and staff, reduce incidence of disease and support best management of chronic diseases such as diabetes, COPD and coronary heart disease through the phased implementation of hospital group Healthy Ireland plans (2017).
- Increase the number of hospital frontline staff trained in brief intervention and achieve MECC (Make Every Contact Count) Targets for 2019.
- Complete GNTH audit in August 2019 and introduce quality improvement plan by year end on all sites.
- Continue the development of linkages with community drugs and alcohol service.
- Support mothers of new-born babies to initiate and maintain breast feeding.
- Continue to support and encourage Staff to engage with initiatives and campaigns to improve their own health and wellbeing in the hospital workplace, including resilience training.

Unscheduled Care

- Improve access to unscheduled care through integrated action with community services and maximising present and allocated resources effectively, with the focus on:
    - Continuing to improve access to diagnostics, 2nd CT scanner in OLOL commissioning Q2 2019.
    - Improving clinical pathway implementation for admitted patients to ensure that variances in average length of stay, particularly for medical patients, are monitored and reduced where possible. Continue to implement specialty wards and appropriate bed designation.
    - Developing admission avoidance pathways, providing care closer to home and improving services for frail older persons within acute hospitals and in the community as part of care redesign. e.g. OPAT services, virtual clinics, Falls Clinics, Day Hospital Services and Outreach Services. Develop expert Orthogeriatric service in Connolly (staffing 3WTE).
    - Developing proposals for enhanced senior decision-making capacity in emergency medicine to deliver timely and appropriate assessment, streaming, treatment and care so that patients are seen and treated by the most appropriate clinician, at the right time and in the right place. (5th ED consultant BH) (Rapid Access ANPs Connolly Hospital, staffing2WTE).
- Increase bed capacity.
    - Open 2nd ward (opened January) and 3rd ward (opening Q3) in phase 2 extension in Our lady of Lourdes Hospital (OLOL), Drogheda.
- Enhance theatre capacity
    - Open 5 theatres in phase 2 extension of OLOL (opening Q4).
    - Open Hybrid Theatre, Beaumont Hospital.
    - Opening Theatre 12 with additional and further reconfiguration of existing emergency theatre capacity, Beaumont Hospital.
- Ensure protocols for rapid access to diagnostics and treatment.
    - Continued expansion of Beaumont Hospital's thrombectomy service for large vessel ischaemic stroke treated 247 patients.
    - Rapid access chest pain unit in Connolly to provide real time 'cardiology consults' for patients presenting with cardiac conditions (staffing 4WTE).
    - Stroke unit 24/7 Connolly Hospital (staffing 1WTE consultant).

- Progress implementation of integrated care pathways across all hospitals in collaboration with the Integrated Programme for Prevention and Management of Chronic Disease to support assessment +/- intervention / advice services for patients with chronic disease such as:
  - COPD
  - Asthma
  - heart failure
  - diabetes

- Work with General Practitioners to avoid hospital admission, and support planned managed hospital discharge. Improved GP direct diagnostics access. Promote use of e-referral and Healthlinks.

Delayed Discharges
During 2018 a monthly average of 3,778 bed days were inappropriately used for accommodation of patients whose acute treatment episode had been completed and were delayed waiting for either community home placement or home care package - annually this is the equivalent of necessary acute bed capacity for the treatment of 8017 elective inpatients (ALOS 7 days) - full access to this bed capacity would have enabled treatment of 86% of patients currently waiting for admission within the Hospital Group. Standardised process in place in all acute hospitals for managing delayed discharge protocols e.g. C-ZAR, Home Care package applications, and transition care placements. Each hospital continues to work with local community forum to make most efficient use of available resources achieving the best solution and support for each individual patient and family.

Handover of Ambulance Patients in EDs
Active management of handover of ambulance patients in ED and monitoring of same.

Scheduled Care

Implement waiting list action plans for patients in outpatient, day case and inpatient scheduled care areas with a particular focus on long waiting patients.

- Deliver active management of waiting lists for inpatient and day case procedures by monitoring operational and clinical governance structures including:
  - Monitor the number of patients who have had their surgery cancelled for non-clinical reasons and offered another surgery date within 28 days.
  - Continue to improve day of surgery rates and increase ambulatory services as clinically appropriate.
  - Monitor length of stay and opportunities for improvement using NQAIS.
  - Continued validation project for inpatient, day case and outpatient waiting lists.
  - Monitor and manage waiting list for CTs, MRIs and Ultrasounds.

- Enhance capacity in to promote a safe, quality scheduled care service.
  - Improve internal efficiencies and appropriate bed usage by striving to reduce average length of stay and improve access to diagnostics.
  - Maximise the move from inpatient to day case activity in line with clinical guidelines and international norms in. Focus on Basket of 24 procedures as identified in *National Elective Surgery Programme, Royal College of Surgeons in Ireland, Irish College of Anaesthetists and Health Service Executive, 2017.*
  - Implement the NTPF *National Inpatient, Day Case and Planned Procedure Waiting List Management Protocol.*
  - Continue to maximise capacity at level 2 hospitals as per *Securing the Future of Smaller Hospitals: A Framework for Development (2013).* Fully utilise day theatre capacity in Louth County increasing vascular surgery and ENT activity.
  - In Cavan Open additional theatre capacity for General Surgery. Utilise existing day care capacity for accommodation of inpatients 7 / 7.
  - Open Connolly new Radiology Intervention suite (staffing 4WTE)
  - Progress the development of care pathways in the outpatient, day case and inpatient areas.
  - Develop North East ENT service (staffing 2WTE consultants) utilising phase II OLOL theatre capacity and advance practice SLT (speech and language therapists) to target present waiting list.
  - Maximise theatre capacity in Beaumont and St Joseph's Hospitals ensuring all theatres open and further reconfiguration of existing emergency theatre capacity.
  - In St Joseph's Hospital, utilisation of existing day care capacity for accommodation of inpatients 7 / 7 and optimal utilisation of Minor Procedure Rooms.
  - Continue to improve day of surgery (DOSA) rates.
  - Continue to develop Vascular Surgery day care treatment service on the Louth County Hospital campus.

- Maximise RCSI Hospital Group insourcing initiative with particular focus on:
  - laparoscopic cholecystectomy.
  - varicose veins.
  - Cystectomy.

- Maximise all available OPD capacity, particularly physical capacity in Monaghan and Louth County Hospitals. Implement 'OMNI project' in Beaumont Hospital.

- Develop advanced practitioner-led clinics (e.g. increased use of physiotherapists, musculoskeletal clinic (1wte x 3 Connolly, OLOL and Cavan), clinical nurse specialists, advanced nurse practitioners, (speech and language therapist x 2, Beaumont and OLOL, etc.) in key specialties with the longest waiting lists, with a strong focus on delivering services closer to home.

- 13.8% of OPD bookings did not attend designated appointment (n = 21,587) in 2018, this value is equivalent to 38% of total number of patients currently waiting for appointment within the Hospital Group. Reduce DNAs by;
  - Validation exercises.
  - Partial booking processes.
  - Chronological scheduling.
  - Adherence to NTPF guidelines in relation to scheduling of patients for surgery.

- Physical capacity in Monaghan and Louth County Hospitals.
- Engage with patients through all means of communication, phone, text, email and post

Endoscopy

Continue RSCI Group insourcing programme for Endoscopy to support the achievement of national targets. Continue to maximise the capacity across the group with active management of referral processes and waiting lists. Promote the use of E-referral, utilize the team of CNM2 appointed to Endoscopy across the hospitals to initially manage triaging of referrals and promote the use of E-referral and evidence based protocols.

Specialist Services

- Secure identification for Beaumont Hospital as Dublin Major Trauma Centre
- Continue Laboratory modernisation programme in Beaumont Hospital, Support the roll-out of a Laboratory Information System in all other acute hospitals in group.
- Expansion of Laminectomy surgery on the St. Joseph's Hospital Raheny campus increasing the National Neurosurgery service capacity.
- Continue to increase the number of kidney transplants carried out in Beaumont from both deceased and living donors.
- Support the implementation of recommendations of the policy review on sexual assault treatment units, within available allocated resources.
- Continued development of National Hearing Implant and Research Centre.

Women and Children's Services

Continue implementation of *National Maternity Strategy 2016-2026 – Creating a Better Future Together*
Issues and Opportunities:

- Continue development of maternity and neonatal network within each Hospital Group.
- Secure the workforce and resources to implement termination of pregnancy service as legislated for from January 2019.
- Continue to implement national policy on use of transvaginal mesh, and patient follow-up.
- Continue to action issues identified by RCOG Review regarding Cervical Screening programme as appropriate to Hospital Group.
- Continue the Woman and Infant Serious Incident Management Forum, reviews cases, analysing themes, and sharing learning.
- Implement a phased plan for benign gynaecology in North East (plan).
- Continue to report Maternity/obstetric metric monthly in RCSI Group metric (see Appendix 1).
- Continue implementation of the midwifery workforce planning study (Birth-rate Plus 2016).
- Continue to develop the service to antenatal anomaly screening in all Maternity Units thus ensuring equitable access for all women attending ante-natal services in group and enabling local complex diagnosis with direct access to any specialist hospital care in the Rotunda hospital where required.
- Continue and develop the commitment to sharing capacity and expertise in order that Maternity patients receive the earliest possible and most appropriate treatment regardless of their geographic location.
- Rotunda Maternity Hospital capacity;
    - Progress Modular build for Theatre and Neonatal ICU.
    - Progress plans to relocate Rotunda to Connolly campus.
- Support national implementation of Maternal and Newborn Clinical Management System (MN-CMS) in Cavan and Our Lady of Lourdes. (Staffing 6WTE) and implementation of next Phase of the Maternal and New- born Clinical Management System at Rotunda Hospital.

Cancer Services

- Continue delivery of rapid access clinic for breast, lung and prostate cancers adhering to National targets.
- Work the NCCP to ensure best available cancer drug treatments are available, and support hospitals in meeting the continuing burden of drug costs and in implementing quality initiatives in cancer care.
- Support hospitals in meeting the continuing burden of drug costs and in securing reimbursement of cancer drugs from the Primary Care Reimbursement Service (PCRS).
- Roll out and implement the NCIS (National Cancer Information System), formerly the Medical Oncology Clinical Information System and the NCIS multi-disciplinary meeting module.
- Continue to develop cancer surgery designation.
    - Lung Cancer (Medical).
    - Urology.
    - Colo-rectal.
    - GI Upper.
    - Head and Neck.
    - Radiation Oncology.
- Secure identification, for Beaumont Hospital as a *'Comprehensive Cancer Centre'* (DOH 2017).

Financial Plan

Gross expenditure

The 2019 net financial allocation (excluding pensions) of €782.2m is €6.7m (0.8%) increase v outturn 2018. Incremental cost pressures and commitments include National pay awards and service developments in place to deliver existing services total €30m (as outlined below) and therefore a 2.4% deficit (circa €21m) is projected. Our financial cost containment plan is outlined below.

Cost pressures to deliver existing level of services and approved service developments are:
- National pay awards and increments - €16m.
- New approved service developments 2019 - €8.7m (table 1).
- Full year impact of 2018 service developments - €5.3m (table 2).

Income

The continuing fall-off in private patient income (€15m (18%) reduction since 2015) causes significant concerns. Without the previous accelerated targets in income budget the Group projects a breakeven position, assuming no further fall off due to PHI's action.

2018/19 Service Developments

The new 2019 service developments have a cost impact of €8.7m as follows. We assume full funding will be received.

Table 1: Service Developments 2019	
Description	Cost 2019 €,000
OLOL phase 2; 29 bed ward	3,910
Connolly additional bed capacity (20 beds)	1,751
TOP - cost submission €2.6m; notification from NWIHP - €1.45m	1,450
Monaghan 5 step down beds	364
Beaumont Living Donor consultant	222
Consultant Oncologist (NCCP)	188
Emergency Response System 1.5 CNM3	97
Falsified medicine directive - 8 pharmacy technicians	349
End of life coordinators - 1.5 wte grade 7	95
LW email 2.1.19 - 2 wte IT posts support programme	100
Endoscopy development 2019 OLOL - ANP, 2 x HCA, CO	202
Total cost 2019	**8,727**

In addition full year funding €5.3m for service developments commenced in 2018 required:

Table 2: Service Developments - Full year funding 2018 / 2019		
Description	Hospital	€'000
NWIHP 19 wte	Groupwide	1,132
CPE - med scientist and clerical officer & non pay	Groupwide	782
ANP x7 full year 2019 cost	Beau, Conn, OLOL	552
Skill mix phase one - 5 SN; 8.5 HCA	Beaumont	262
secondment of gastroenterologist HSE full year	Beaumont	225
Consultant geriatrician - Beaumont	Beaumont	177
Consultant Haematologist NCCP	Beaumont	176
secondments	Groupwide	176
Backfill National Lead Neurology	Beaumont	174
Consultant Gastroenterologist / endoscopy	OLOL	171
perinatal mental health	Rotunda	168
Lung/Prostate Services	Beaumont	159
Renal funding restored	Beaumont	100
CavMon 892/3 - Lab aides MEDLIS x 2	Cavan	96
NCHD for retrieval services Beaumont	Beaumont	85
NCHD for retrieval services Rotunda	Rotunda	85
Neonatologist Rotunda full year funding	Rotunda	79
Medical Oncology CNS - 1 WTE	Beaumont	65
NCCP skin CNS	Beaumont	65
CavMon 841 neonatal resus CNS NMPDU x 0.5	Cavan	63
Outpatients Antibiotic therapy (OPAT)	Cavan	58
Clinical Facilitator – Frail Elderly Patients	OLOL	58
Clinical Facilitator – Sepsis	OLOL	58
Nurse Clinicial Facilitator for ICU	OLOL	57
Critical care CNF	Cavan	57
CavMon 785 waiting list insourcing nurse	Cavan	53
U/s Dysplasia Hip Infants 0.5 Radiographer	OLOL	38
Hip dysplasia ultra sonographer / radiographer	Rotunda	38
CavMon 883 nurse NOCA post x 0.5	Cavan	26
Consultant Neurologist backfill	Beaumont	24
NRP Skills Co-ordinator 0.5 WTE	Cavan	23
		5,283

Caveats and assumptions

- Hepatitis C programme - no direction from the National Programme on treatment volumes.

- Concerns at the continuing fall off in private patient income reduced by 17% since 2015.

- Non pay budget is based on outturn 2018 and no allowance for activity, additional capacity or price increases.

- Requirement to discuss the accounting and cash funding for voluntary hospitals in the Group, and to find a mechanism to clear 2018 balance sheet deficits.

- Assumption that pension cost increases will be funded in line with Corporate Finance policy.

- Pension costs - Standard Fund Threshold Chargeable excess tax issue – potential liability €1.2m not included.

- No provision included for Corporate HR decisions in regard to IR disputes or job evaluation scheme.

- No provision for cost impact of new National HR instructions, agreements or circulars including Consultant Contract 2008 High Court Cases and recent nursing strike settlement.

- Under investment in capital infrastructure and addressing critical risks resulting from ageing medical equipment and physical infrastructure (Appendix 6).

Financial cost containment plan

The Group Cost Containment Plan (CCP) to deliver savings is outlined below. In view of the fixed nature of the cost base, increasing activity and ongoing non pay price inflation this will be extremely difficulty to deliver. In relation to all these measures we are committed to working with Corporate HSE and HBS to deliver and await detail of the implementation plans.

RCSI HOSPITAL GROUP FINANCIAL PLAN 2019	
	€'000
Agency conversion	2,655
Overtime	1,021
Sick leave reduction	124
Consultant pay	586
Pay total	**4,386**
National Procurement - Reduction in prices	1,500
Pharmacy generics and biosimilars	1,719
Lab tests insourcing	1,621
Radiology	257
Maintenance	192
Professional fees	90
Bad debt management - PHI retraction issue	2,800
Overheads - targeted reduction	1,336
Non pay total	**9,515**
NTPF income - cost neutral expenditure	900
Income maximisation	1,200
	2,100
Group CCP total	**16,000**

Workforce / HR

Workforce Plan

The RCSI Group recognises and acknowledges that staff are our most valuable resource and key to service delivery. Recruiting and retaining motivated and skilled staff is a high priority for the Group as specialist skill deficits put the delivery of services at risk. The RCSI Group will continue to actively recruit new staff using local, national and international approaches and continue to develop and progress workforce planning initiatives to support the delivery of quality and safe care.

The RCSI Group will focus on further reductions in the cost of, and reliance on, agency staff and overtime through the progression and implementation of such initiatives as redeployment, skill mix review, and changes in work practices. Significant change initiatives will be managed through the RCSI Hospital's Joint Union and Management Forum (JUMF).

RCSI Group continues our commitment to The Taskforce on Staffing and Skill Mix for Nursing. We are committed to the roll out of The Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland (2018) within allocated resources.

The RCSI Hospital Group are working in partnership with Hibernia College, Dublin who have received approval via Quality and Qualifications Ireland (QQI) for BSc Undergraduate Programme for General Nursing and they are currently awaiting approval from the Nursing and Midwifery Board of Ireland (NMBI). Hibernia College in 2018 submitted their paperwork for the BSc Undergraduate Programme for General Nursing to the Nursing and Midwifery Board of Ireland (NMBI) and Hibernia College and RCSI Hospital sites will also have site inspections/visits from the NMBI in 2019. The Department of Health in May 2017 wrote to Hibernia College.

Work Force Planning Considerations are a priority for the group with a focus on; initiatives that enable "employer of choice", recruitment practices, retention strategies, promotional strategies, career pathways and succession planning.

The Group Recruitment and Retention working group will continue to explore and implement initiatives to maximise the recruitment of new staff and to minimise staff turnover.

The RCSI Group absenteeism target remains at 3.5%. Management and staff will continue to focus on all measures to enhance the capacity to address and manage effectively absenteeism levels, support people managers in better managing the issue, while also supporting staff regain fitness to work and resume work in a positive and supporting environment.

The Group will continue to work collaboratively with all key stakeholders to work towards the achievement of full compliance with the EWTD. The Group will continue to actively engage with staff and will continuously seek to identify opportunities to involve more staff in planning and decision making. The Group Employment Control Process will continue in 2019. All new starters and replacement posts will be reviewed by the Group Employment Control Committee with decisions made on the basis of available pay budget, funding, service requirement and risk.

Ensuring that each Hospital is in compliance with the consultant public contract provisions, including that all Consultants work their prescribed ratio of public and private practice and work according to their contracted hours of attendance.

Roll out of our Corporate Induction commenced in January 2019 with a monthly programmed scheduled hereafter. Driven by the CEO and the senior management team, this incorporates all new starters from the previous month.

Organisational Development

Continue Future Leaders Programme with the latest intake of participants in the Future Leaders Programme commenced on 28th January 2019 incorporating the creation of a training and development programme. Development and implementation of an appropriately *"hands-on"* training programme for frontline supervisors and leaders.

Employee Engagement

Implement an employee value management programme giving consideration to employee Value Proposition and employee experience through RCSI/Hospital work cycle. Healthy workplace link to employee experience creates a supportive environment that protects and promotes the physical, mental and social wellbeing of staff.

Communications

Platform to be created that enables clear visibility of "what" RCSI Hospital Group is undertaking and how an individual can participate.

Appendices

Appendix 1: Quality Assurance Key Performance Metrics

RCSI HOSPITAL GROUP

QUALITY ASSURANCE PROGRAMME

KEY PERFORMANCE METRICS

www.rcsihospitals.ie

DECEMBER 2018

CHAPTER 1: INTRODUCTION

Measurement of quality to drive improvement is one of the hallmarks of a high performing healthcare system. The RCSI Hospital Group recognises the importance of a common relevant set of metrics and key performance indicators and their active usage in measuring, tracking and generally guiding performance in various dimensions of care across all clinical services. Their usage also helps identify where improvement is required and the impact of purposeful quality improvement initiatives when introduced.

The RCSI Hospital Group is committed to maximal transparency in relationship to performance measurement and in order to enable patients, relatives and the general public to see and understand current performance these metrics are now published on a cumulative basis on its web site (www.rcsihospitals.ie). Therefore focus of this Report is a statement of performance rather a description of actions to improve performance. All data presented is anonymous and necessary, patient confidentiality is and will be maintained at all times.

IAN CARTER
CHIEF EXECUTIVE
RCSI HOSPITAL GROUP

CHAPTER 2: INDICATORS SELECTED

2:1 SELECTION METHODOLOGY

The performance metrics are organised within 7 core dimensions:
- Access and Patient Flow
- Infection Control and Management
- Medication Management
- Maternity Services
- Patient Care and Treatment
- Patient and Family Experience
- Staff

For each performance metric considered:
- rationales for selection are identified and generally explained
- methodology for performance measurement in terms of numerator / denominator, frequency of data collection and data sources are articulated
- target performance values to be achieved are stated
- actual performance for each hospital site and overall performance for the RCSI HG are identified
- national performance values (where available) are provided for comparative purposes
- in certain instances due to either variance of services across the hospitals or because of particularly small incidence values, necessary caution in comparative analysis is identified
- an interpretive trend commentary is provided

2:2 KEY PERFORMANCE INDICATORS (UPDATED MONTHLY ON RCSI HOSPITAL GROUP WEBSITE)

TABLE 1: KEY PERFORMANCE INDICATORS [1]

DIMENSION		PERFORMANCE METRICS
Access + Patient Flow	3.1	ED Patient wait volume for admission
	3.2	ED Patient Experience Time (PET)
	3.3	OPD Waiting Time for New appointments
	3.4	Inpatient / Day Care Waiting Times
	3.5	Access to Symptomatic Breast Cancer Services
	3.6	Access to Rapid Access Clinic - Lung
	3.7	Access to Rapid Access Clinic - Prostate
	3.8	Urgent Colonoscopy Waiting Times
	3.9	Endoscopy Waiting Times
	3.10	Clients offered colonoscopy appointment date that occurs within 20 working days from when a client was deemed clinically suitable following pre-assessment/positive FIT
	3.11	Access to National Neurosurgical Unit
	3.12	Diagnostic Imaging waiting times
	3.13	% 'Did not Attend' of new OPD bookings
	3.14	Polyp Detection Rate
	3.15	Caecal Intubation Rate
	3.16	24 Day Case Procedures
	3.17	Scheduled Care Entry Recording
Infection Control and Management	4.1	S Aureus notification rate per 10,000 bed days used
	4.2	Rate of new cases of Hospital acquired Clostridium difficile infection
	4.3	Number of patients confirmed with newly detected CPE
	4.4	% compliance of Hospital staff with WHO's 5 moments of hand hygiene using national audit tool
	4.5	% Staff uptake of 'Flu' Vaccination
	4.6	Sepsis Training
Medication Management	5.1	Rate of Medication Management Error
Maternity Services	6.1	Clinical Activities
	6.2	Major Obstetric Events
	6.3	Delivery Metrics
	6.4	Competency Training
	6.5	Fetal Anomaly Scanning
Patient Care and Treatment	7.1	% of emergency Hip fractures surgeries undertaken within 48 hours of admission
	7.2	Serious Falls
	7.3	Development of Grade 3 or greater pressure sore (decubitus ulcer) in Hospital
	7.4	% of patients readmitted as an emergency within 28 days of discharge
	7.5	Number of patients identified as requiring Home Care Packages / access to Long term Care or Rehabilitation inappropriately remaining in acute beds
	7.6	Hospital Mortality for: - Acute Myocardial Infarction - Heart failure - Ischaemic Stroke - Haemorrhagic Stroke - Chronic obstructive pulmonary disease and bronchiectasis
	7.7	Thrombolysis in patients with confirmed acute ischaemic stroke
Patient and Family Experience	8.1	Patient satisfaction studies
	8.2	% of complaints responded to within 30 days
	8.3	Parliamentary Questions (PQs)
Staff	9.1	% Staff absenteeism
	9.2	% Staff Garda Vetting

Note[1] - *these statistics reflect the most recent activity within RCSI Hospital Group. Data presented is subject to revision. Caution should be used in making comparisons between hospitals due to different sizes and services provided.*

CHAPTER 3: DIMENSION: ACCESS AND PATIENT FLOW (A+PF)

3:1 ED PATIENT WAIT VOLUME FOR ADMISSION

Rationale for measurement

Overcrowding within ED negatively impacts on both dignity and privacy for patients and the ability of staff to deliver fully effective care / treatment. Related international studies have also demonstrated extended length of stay within overcrowded EDs leads to poorer clinical outcomes for concerned patients.

Measurement methodology and data sources
- data refers to the daily number of patients on trolleys in ED, at 8.00am daily, as recorded by the hospital (TrolleyGAR)
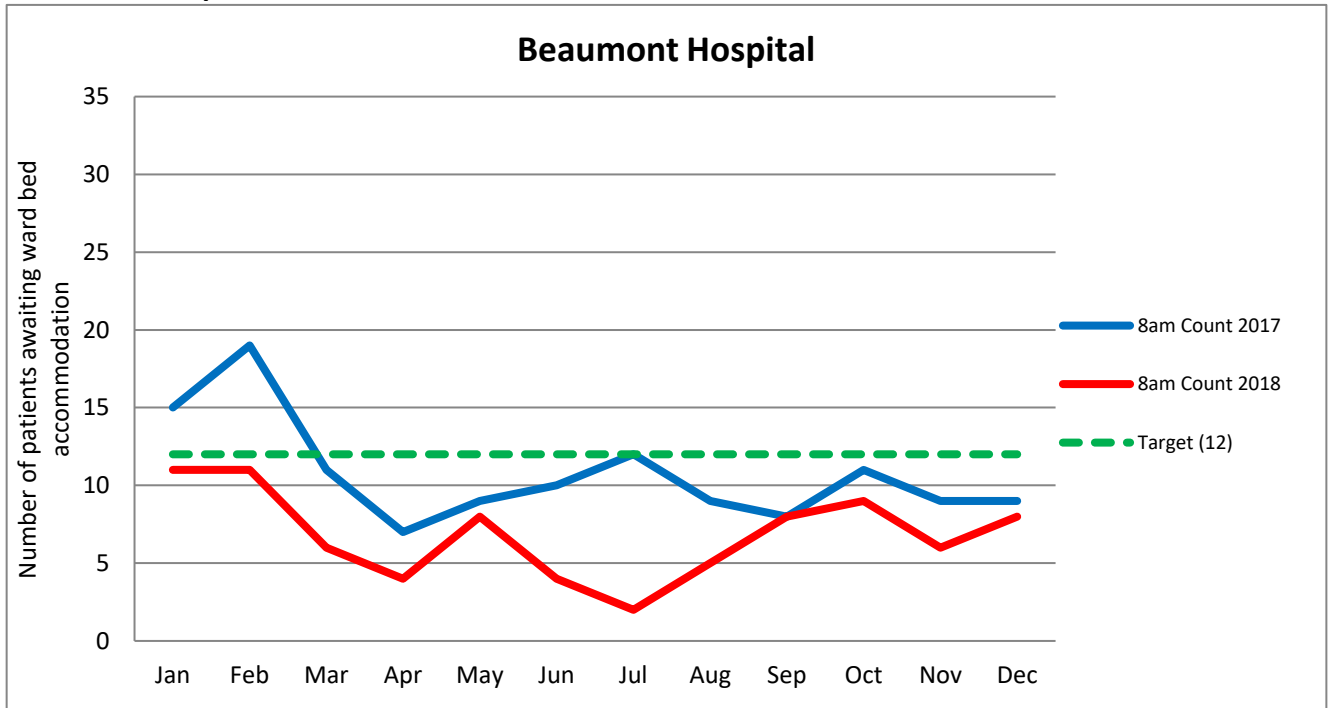- data set is provided by BIU - HSE

Target

The following daily targets were set by the HSE Acute Hospital Division:
- Beaumont Hospital: 12
- Cavan General Hospital: 8
- Connolly Hospital: 8
- Our Lady of Lourdes Hospital: 12
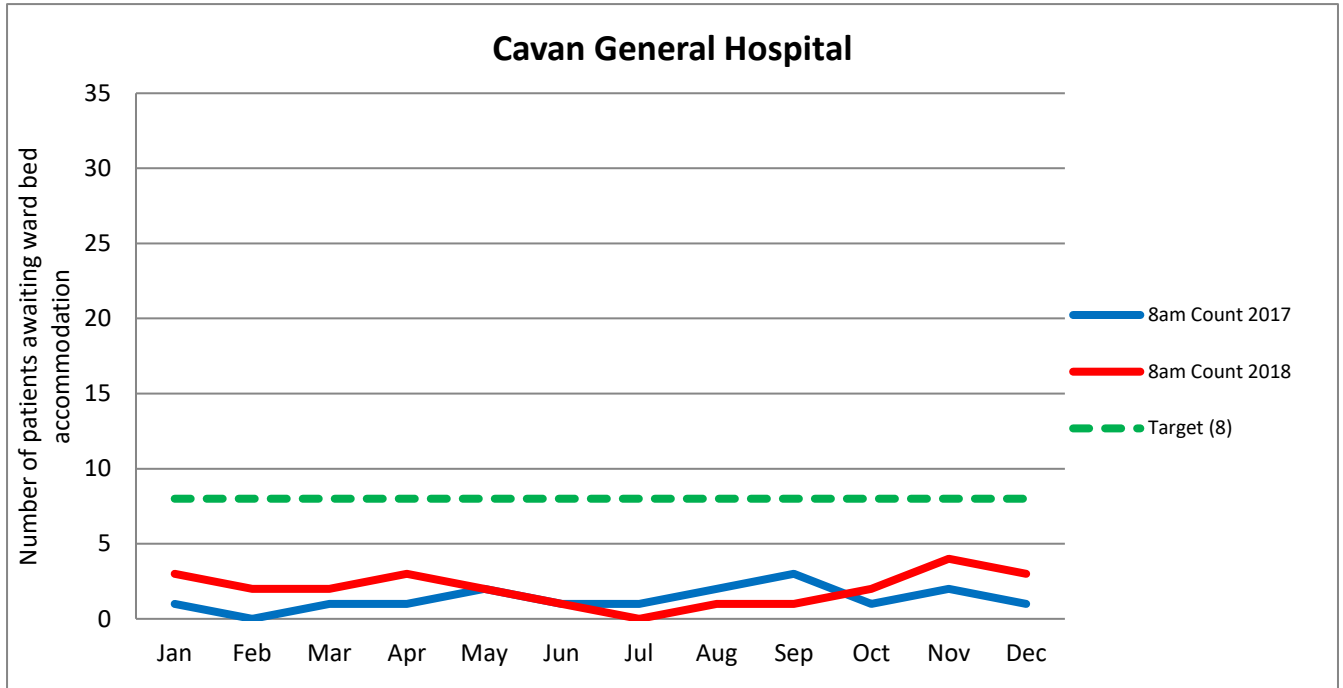- RCSI Hospital Group: 40

- National: 228
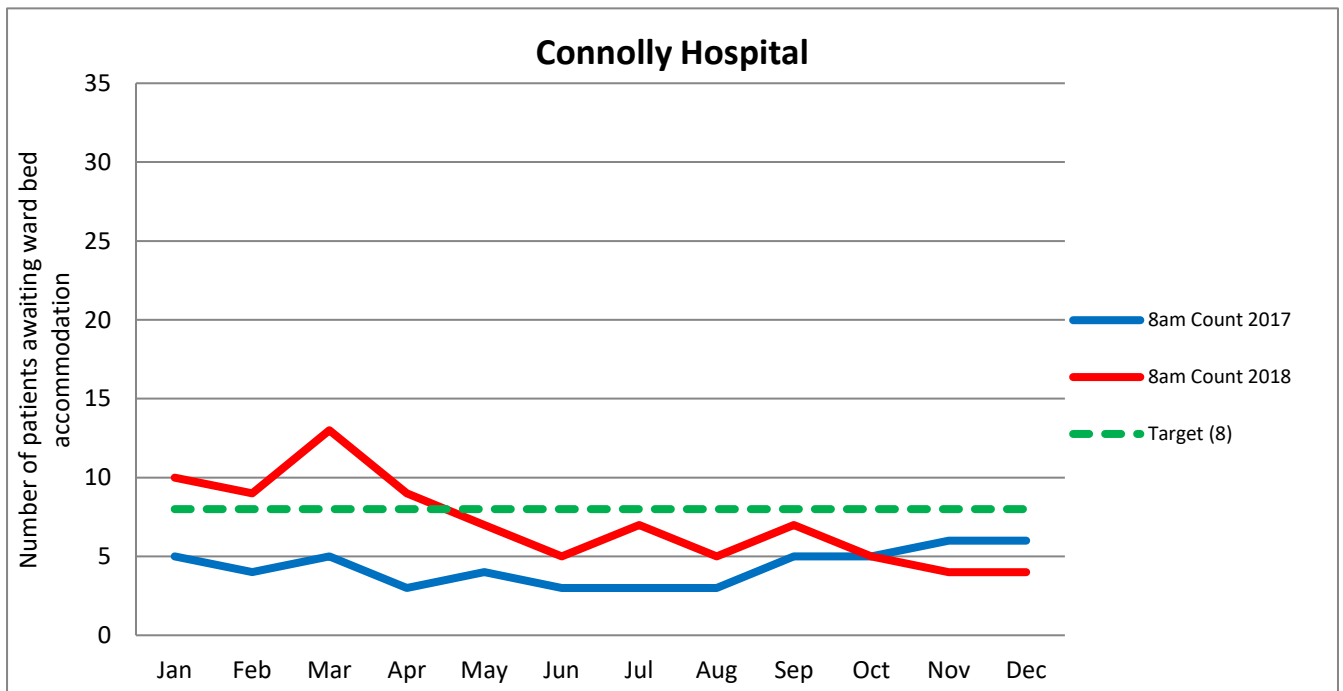
Performance

Beaumont Hospital

- 11% reduction in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count reduction 36% n=1398 Jan-Dec)**
- performance improvement commenced in July 2016 generally maintained during 2018 reporting period
- an average daily count value of **8** demonstrated for December 2018 (**Target 12 surpassed**)

Cavan General Hospital

- 200% increase in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count increase 25% n=134 Jan-Dec)**
- an average daily count of **3** demonstrated for December 2018 (**Target 8 surpassed**)

Connolly Hospital

- 33% reduction in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count increase 63% n=990 Jan-Dec)**
- an average daily count of **4** demonstrated for December 2018 (**Target 8 surpassed)**
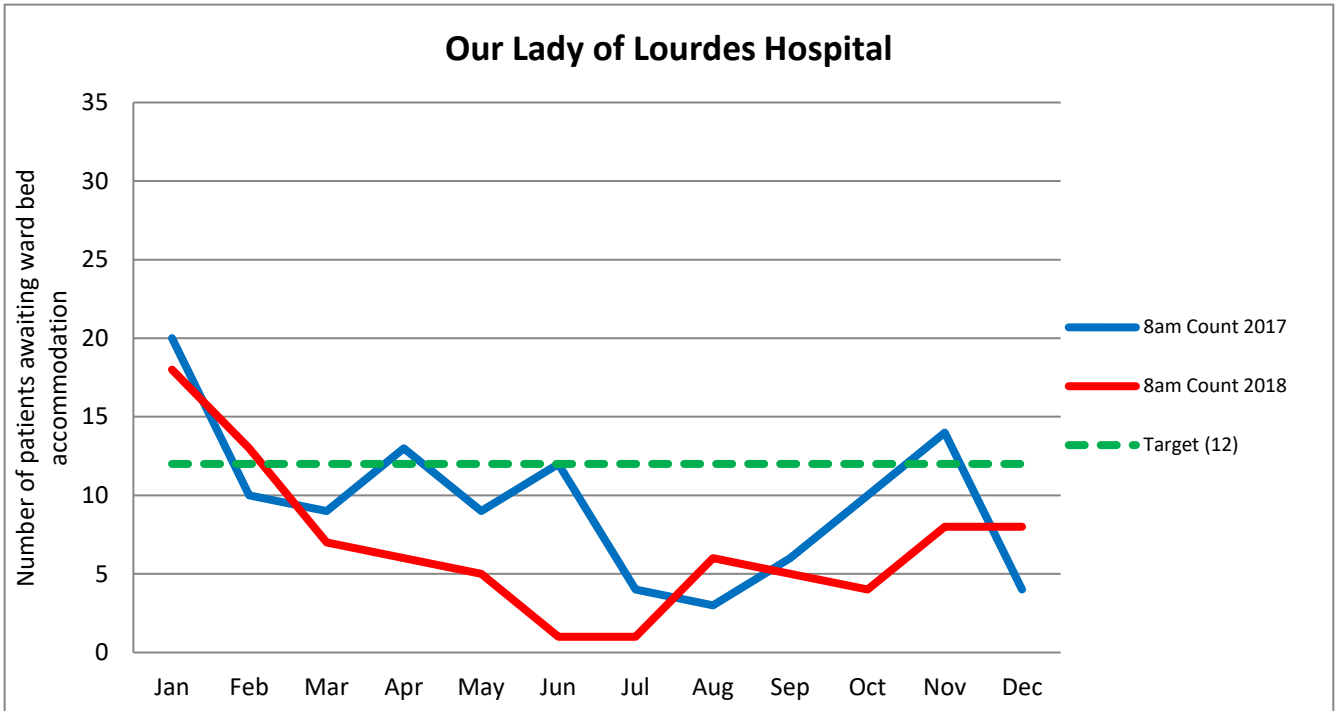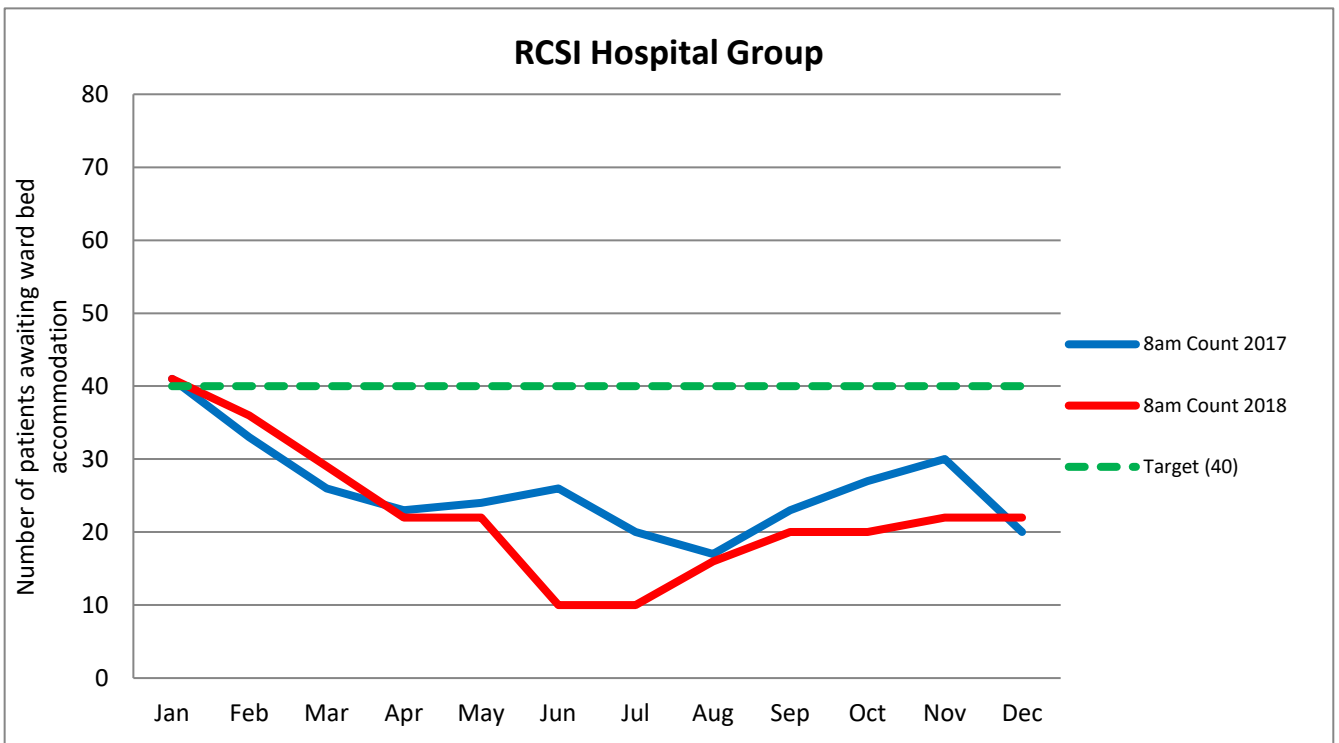
Our Lady of Lourdes Hospital, Drogheda

- 100% increase in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count reduction 29% n=1000 Jan-Dec)**
- an average daily count of **8** demonstrated for December 2018 (**Target 12 surpassed)**

RCSI Hospital Group

- 10% increase in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count reduction 13% n=1274 Jan-Dec)**
- an average daily count of **22** demonstrated for December 2018 (**Target 40 surpassed**)
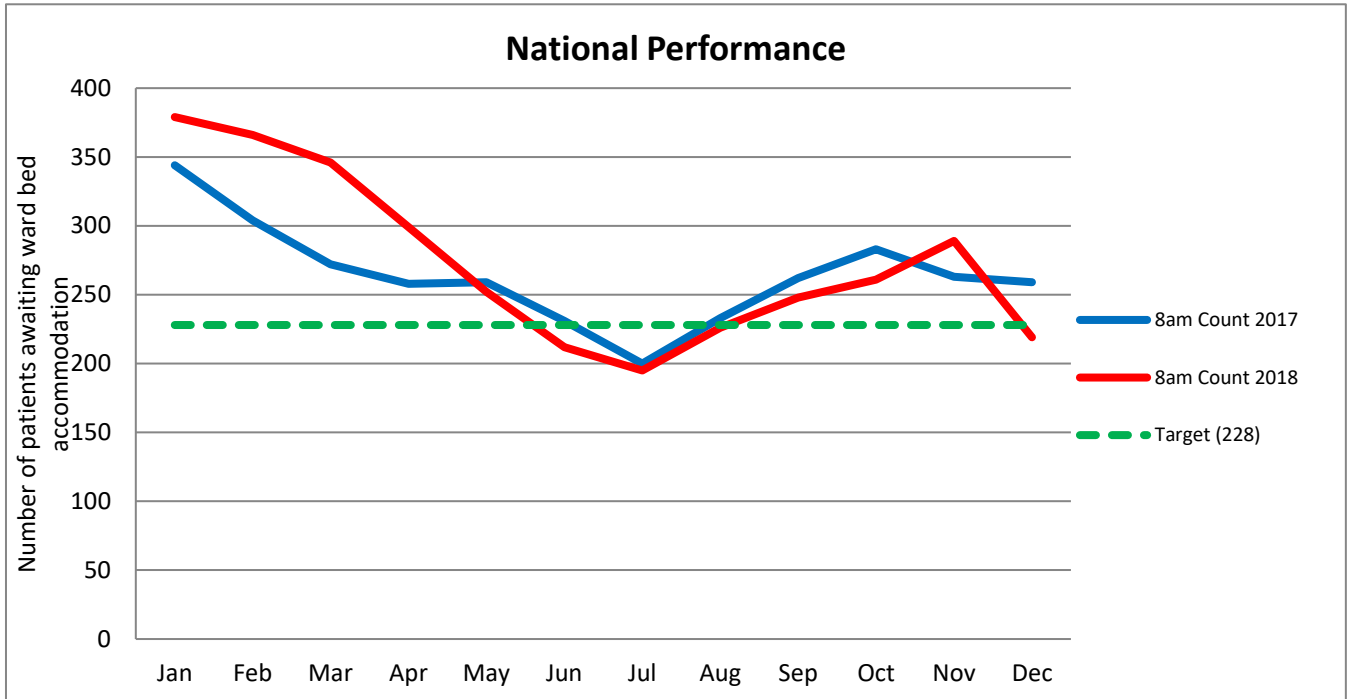
National Performance Comparator

- 15% reduction in average number of patients awaiting ward bed accommodation in ED 2018 / 2017 for December **(total count increase 4% n=3600 Jan-Dec)**
- an average daily count of **219** demonstrated for December 2018 (**Target 228 achieved)**

3:2 ED Patient Experience Time (PET)

3.2.1 Average time spent in ED admitted/non admitted
3.2.2 PET 9 hour compliance admitted/non admitted
3.2.3 PET > 24 hour breach

Rationale for measurement

International studies have demonstrated extended length of stay within overcrowded EDs leads to poorer clinical outcomes for patients.

Measurement methodology and data sources

- Data extract from hospital site patient administration system (PAS), extrapolated by HSE Business Intelligence Unit, measuring for all ED attendances the length of time spent in the Emergency Department.

3:2:1 Average time spent in ED – non admitted / admitted

Target

- 100% of patients admitted / discharged from ED within 24 hours

Performance

Beaumont Hospital

Beaumont - Average time spent in ED Admitted/Non-Admitted
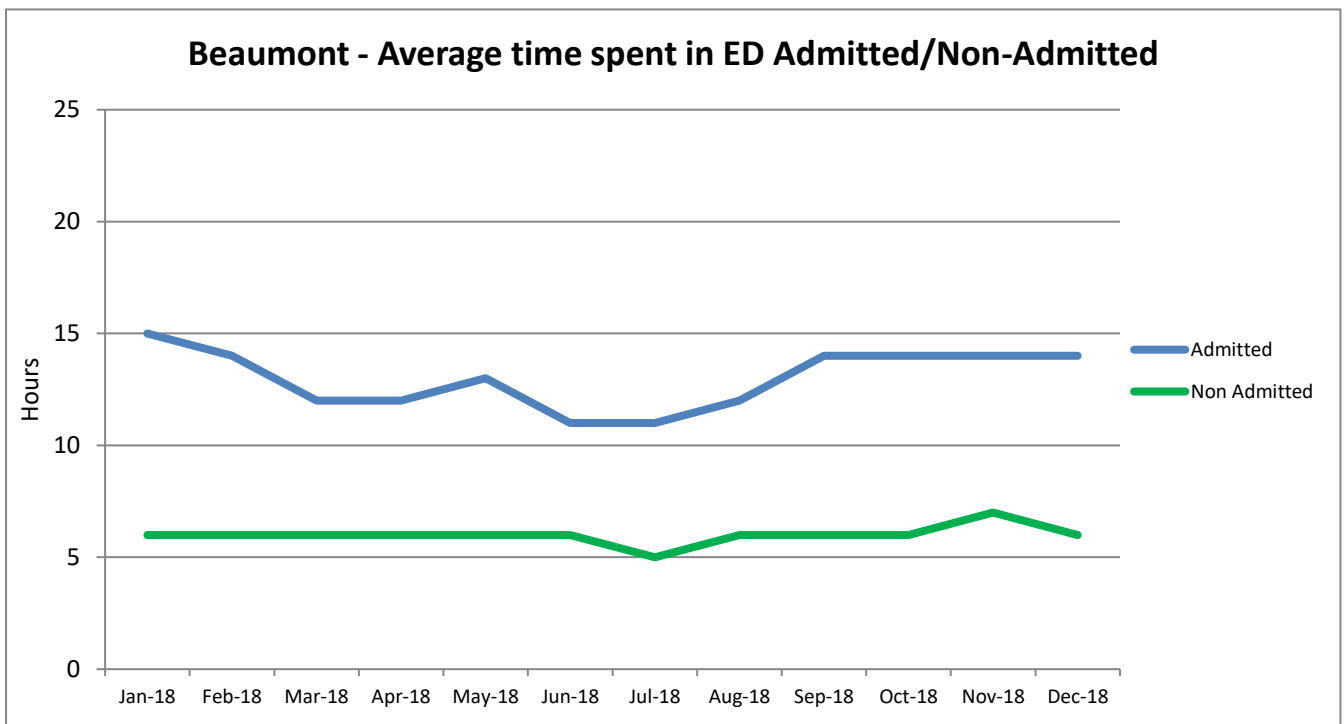
- the average time spent in ED for admitted patients has increased by 8% from reporting month 2017 **(13 hours)** to reporting month 2018 **(14 hours)**
- the average time spent in ED for non-admitted patients has remained constant from reporting month 2017 to reporting month 2018 **(6 hours)**

Cavan General Hospital
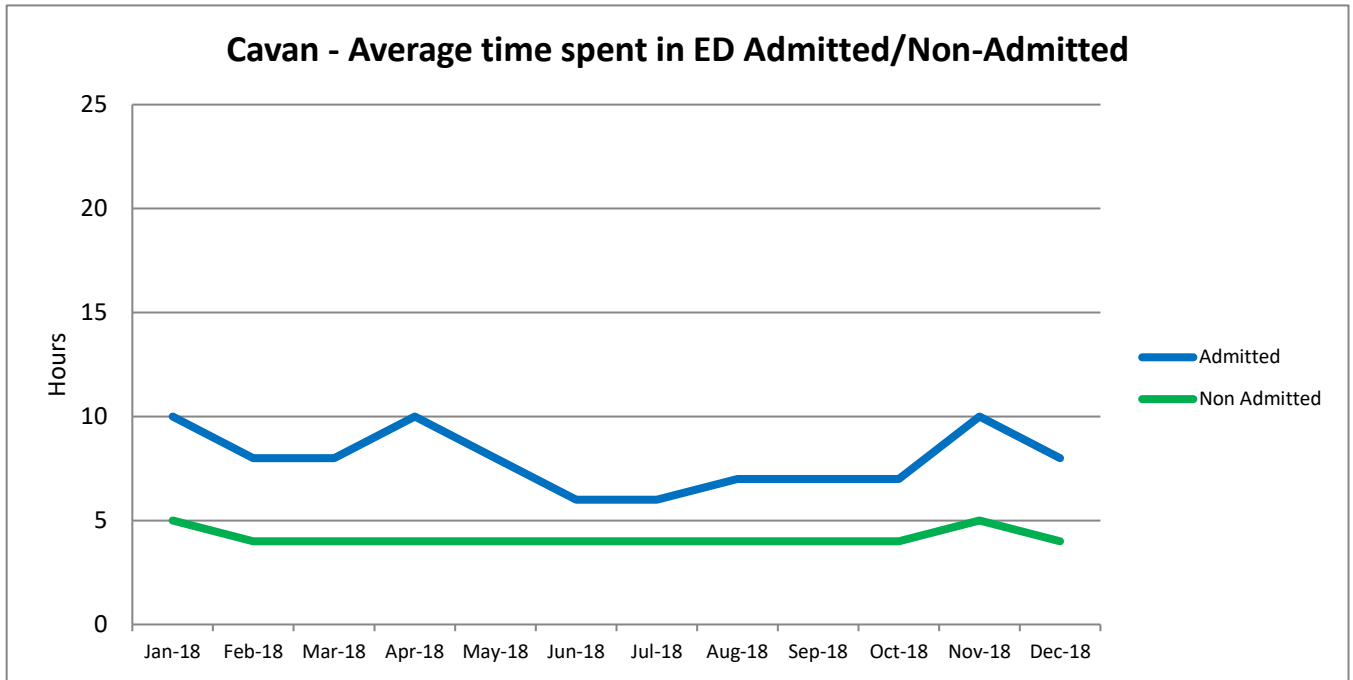
Cavan - Average time spent in ED Admitted/Non-Admitted

- the average time spent in ED for admitted patients has remained constant from reporting month 2017 to reporting month 2018 **(8 hours)**
- the average time spent in ED for non-admitted patients has remained constant from reporting month 2017 to reporting month 2018 **(4 hours)**

Connolly Hospital

Connolly - Average time spent in ED Admitted/Non-Admitted

- the average time spent in ED for admitted patients has reduced by 8% from reporting month 2017 **(12 hours)** to reporting month 2018 **(11 hours)**
- the average time spent in ED for non-admitted patients has remained constant from reporting month 2017 to reporting month 2018 **(6 hours)**

Our Lady of Lourdes Hospital, Drogheda

OLOL - Average time spent in ED Admitted/Non-Admitted
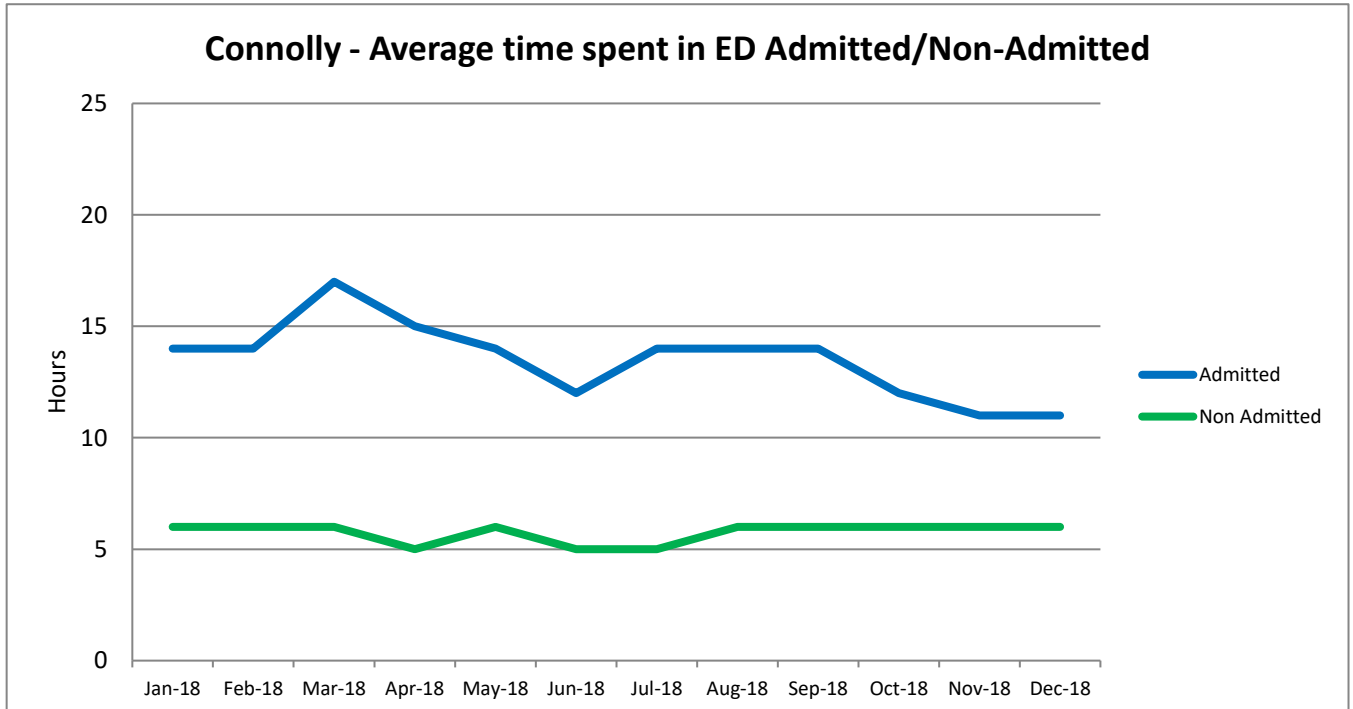
- the average time spent in ED for admitted patients has increased by 25% from reporting month 2017 **(8 hours)** to reporting month 2018 **(10 hours)**
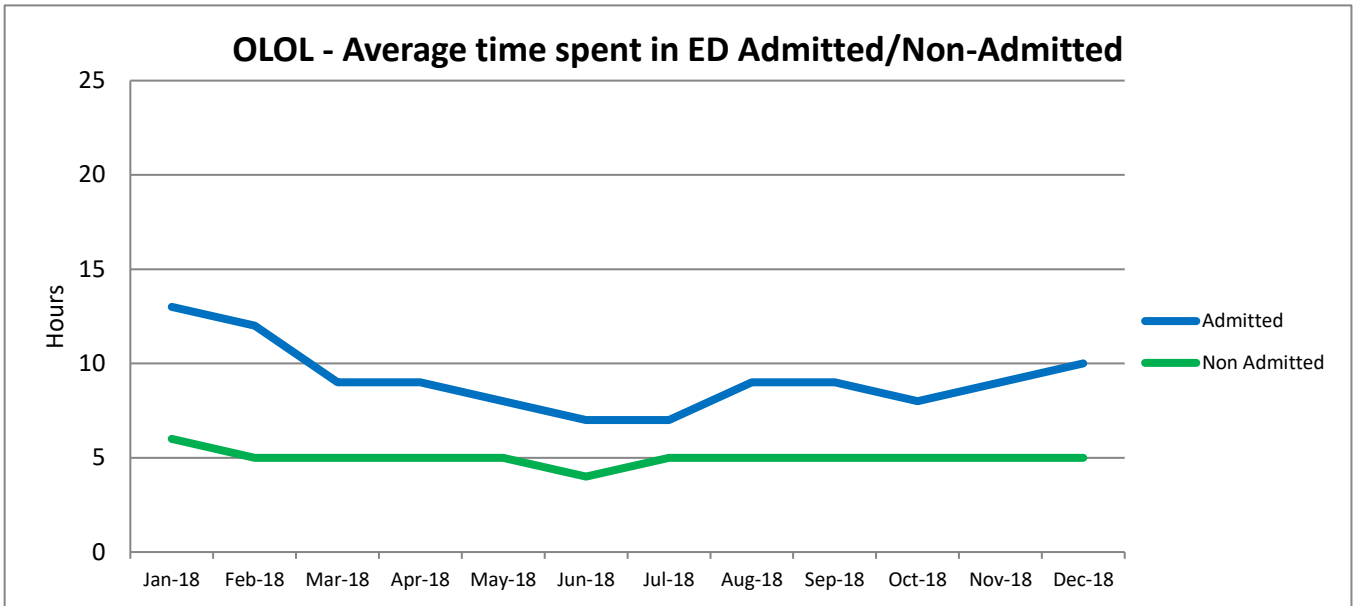- the average time spent in ED for non-admitted patients has remained constant from reporting month 2017 to reporting month 2018 **(5 hours)**

3:2:2 PET 9 HOUR COMPLIANCE ADMITTED AND NON-ADMITTED

Target
- 100% patients admitted or discharged or non-admitted from ED within 9 hours

Performance

Beaumont Hospital

Beaumont Hospital Emergency Department Patient Experience Time (9 Hours)
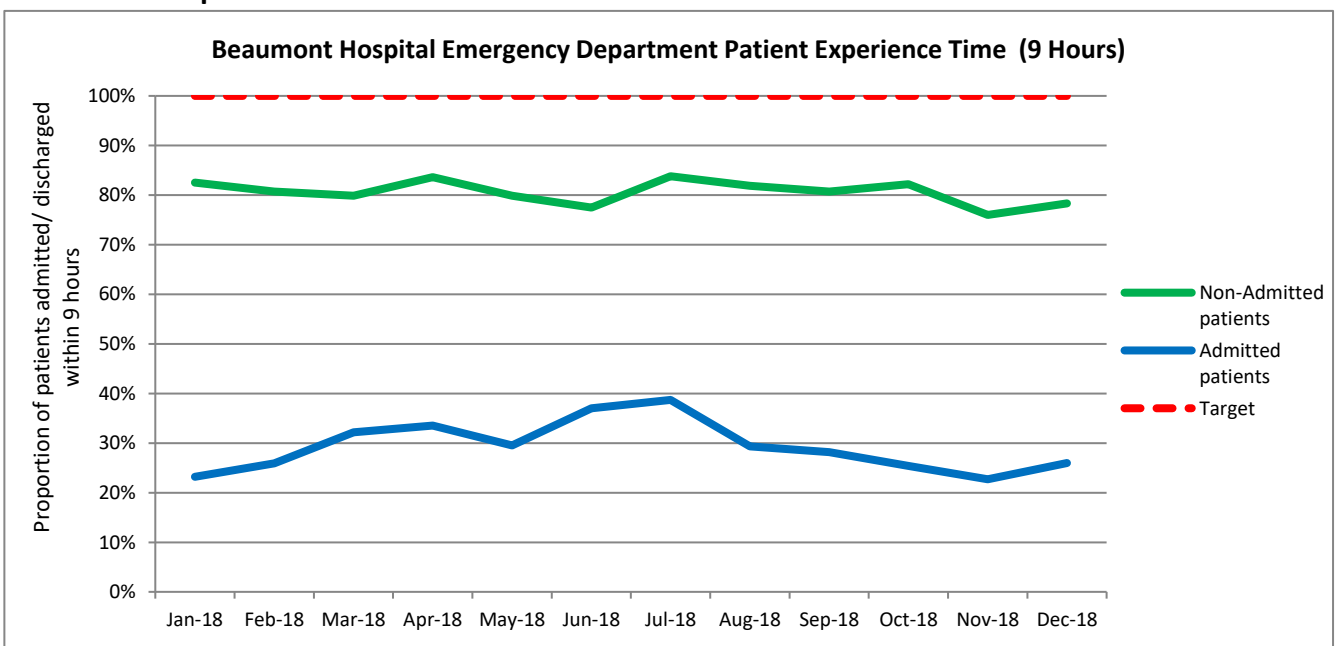
- December 2018 78.3% compliance with 9 hour non-admitted PET / 26.0% compliance with admitted PET

Appendix 1: Quality Assurance Key Performance Metrics

Cavan General Hospital

Cavan General Hospital Emergency Department Patient Experience Time (9 Hours)
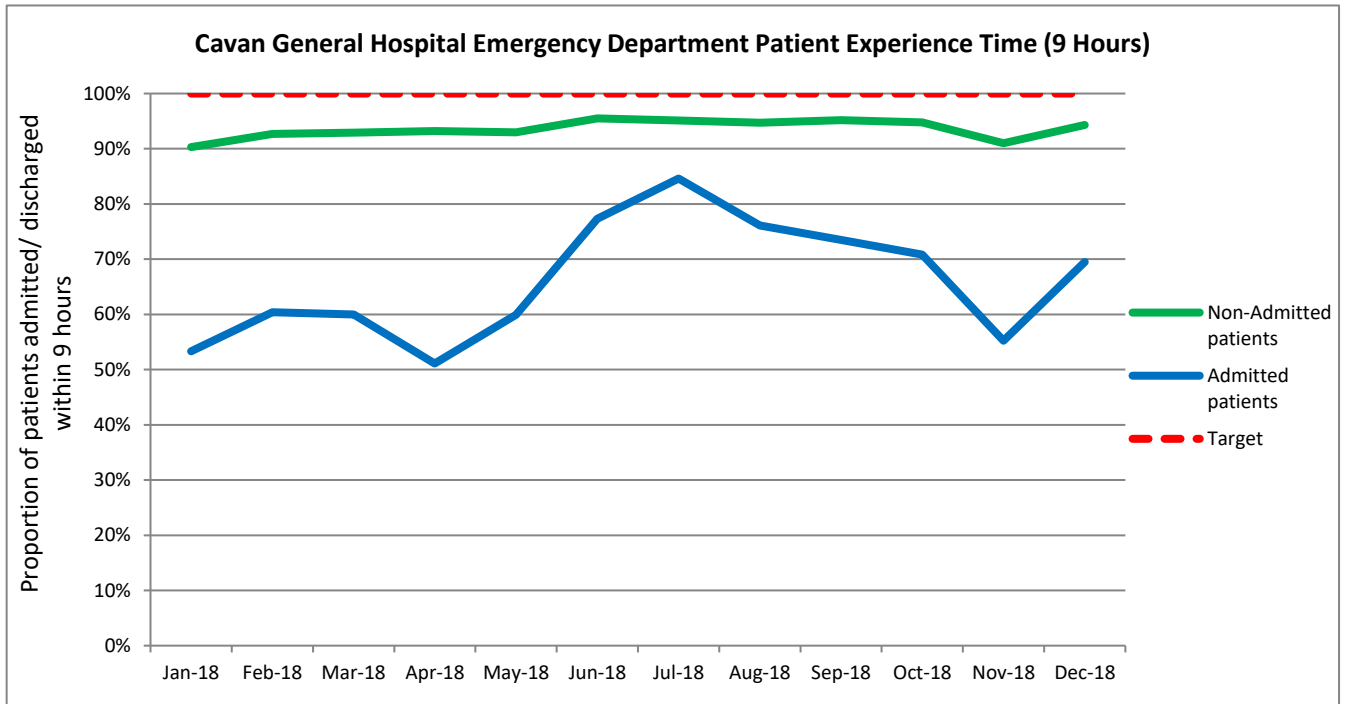
- December 2018 94.3% compliance with 9 hour non admitted PET / 69.5% compliance with admitted PET

Connolly Hospital

Connolly Hospital Emergency Department Patient Experience Time (9 Hours)
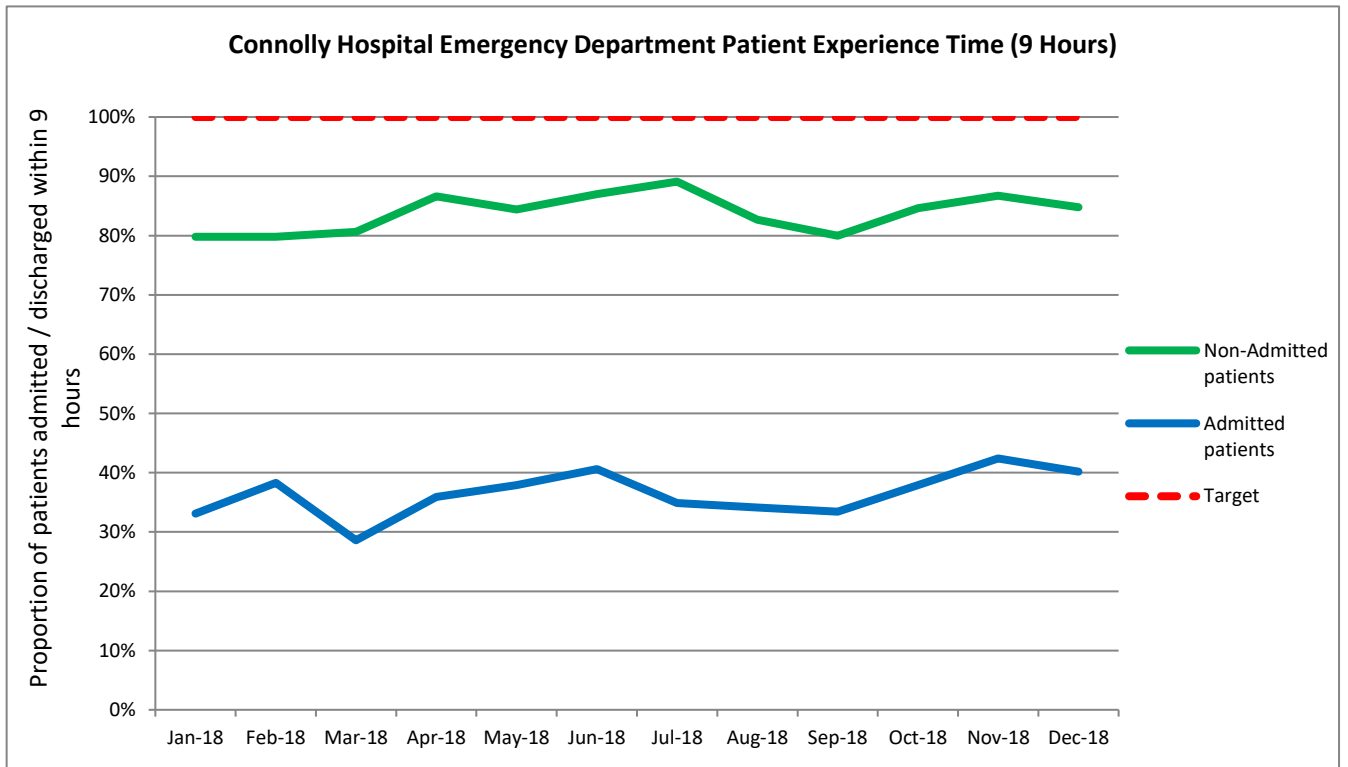
- December 2018 84.8% compliance with 9 hour non admitted PET / 40.2% compliance with admitted PET

Our Lady of Lourdes Hospital, Drogheda

Our Lady of Lourdes Hospital Emergency Department Patient Experience Time (9 Hours)
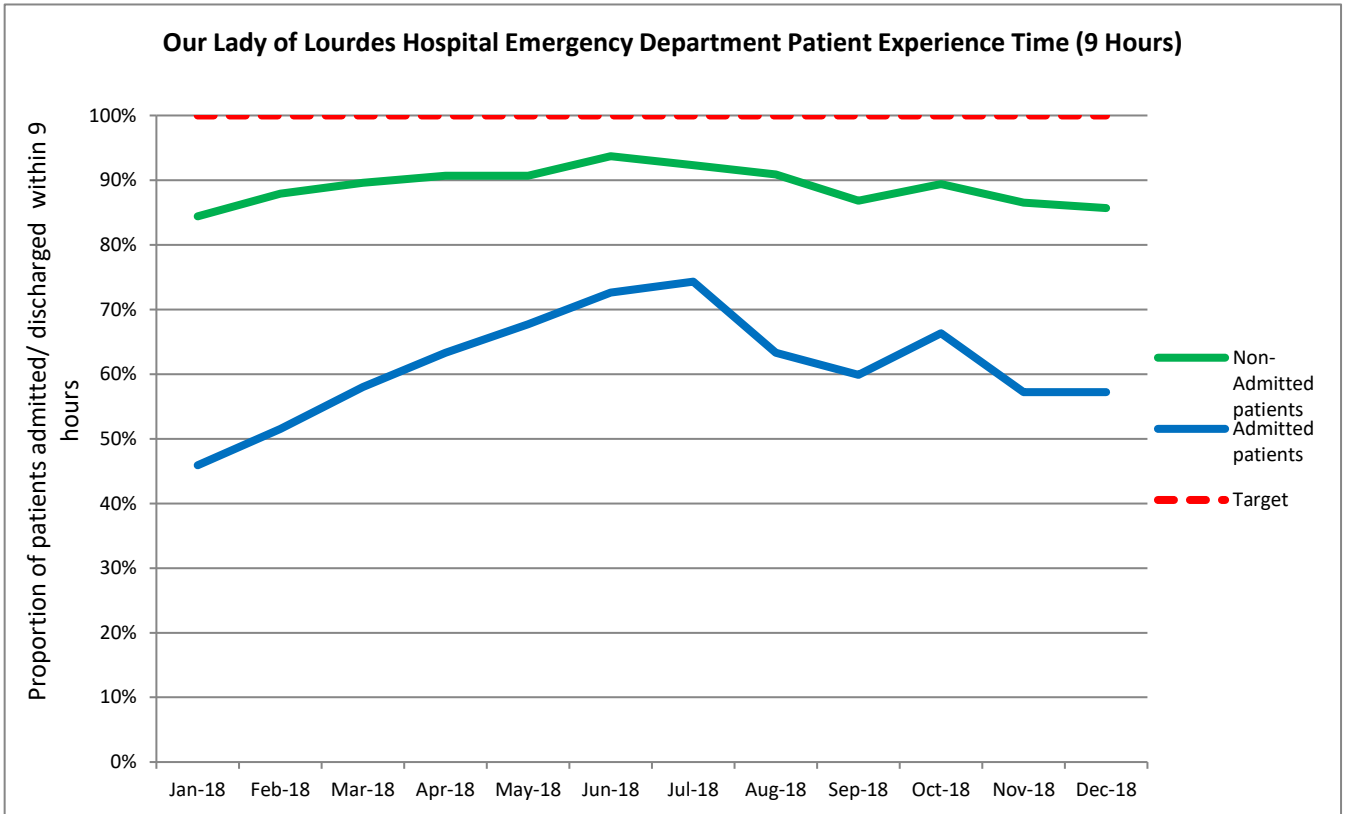
- December 2018 85.7% compliance with 9 hour non admitted PET / 57.2% compliance with admitted PET

RCSI Hospital Group

RCSI Hospital Group Emergency Department Patient Experience Time (9 hours)
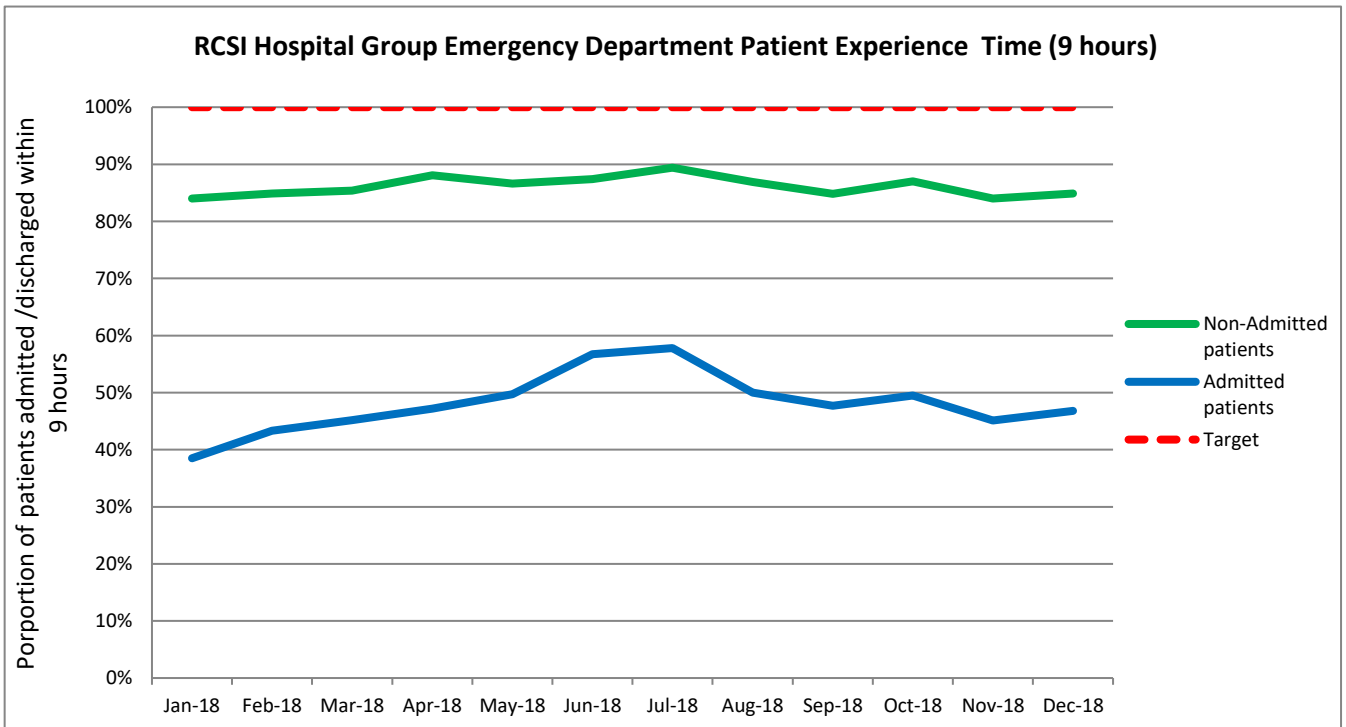
- December 2018 84.9% compliance with 9 hour non admitted PET / 46.8% compliance with admitted PET

National Performance Comparator

National Performance Emergency Department Patient Experience Time (Admitted & Non-Admitted - 9 Hours)
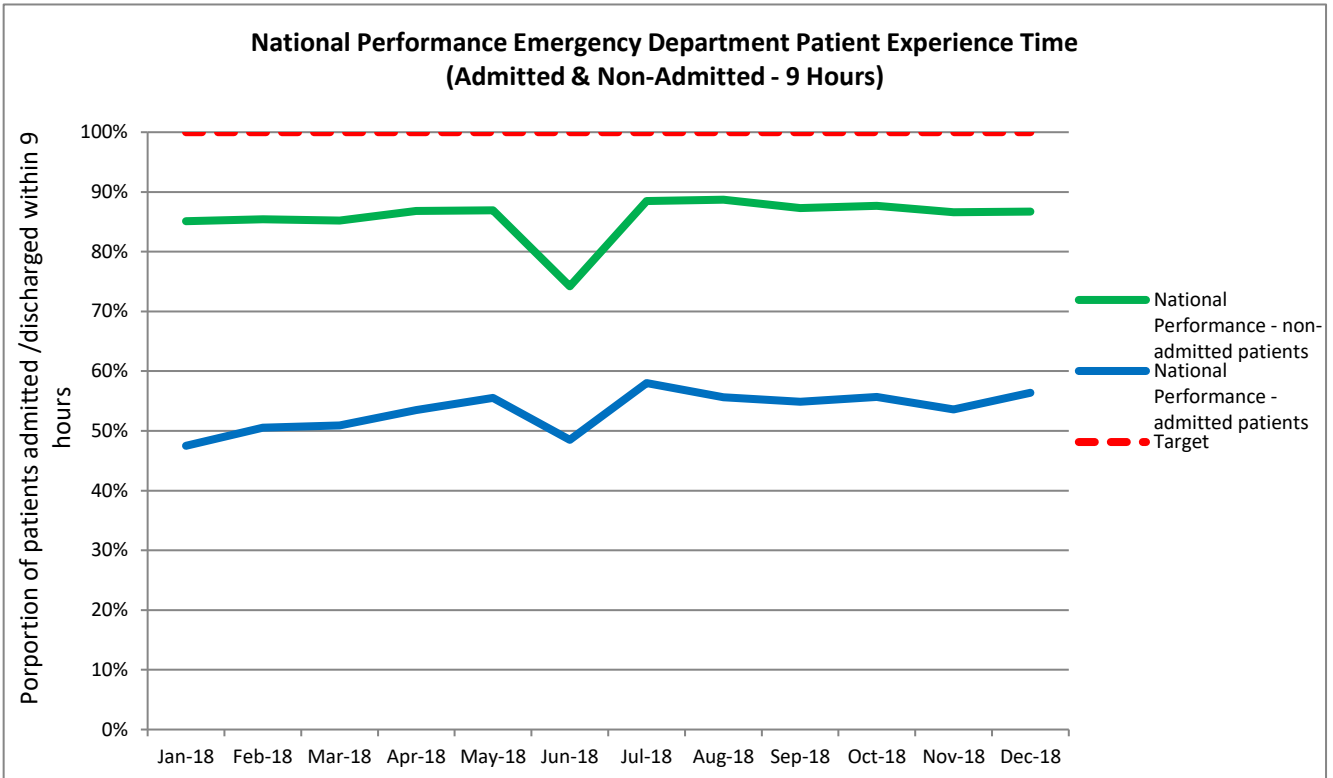
- December 2018 86.7% compliance with 9 hour non admitted PET / 56.4% compliance with admitted PET

3:2:3: PET >24 HOUR BREACHES FOR ADMITTED PATIENTS

Target:
- 100% of patients wait less than 24 hours in Emergency Department for ward bed accommodation

Performance

RCSI Hospital Group
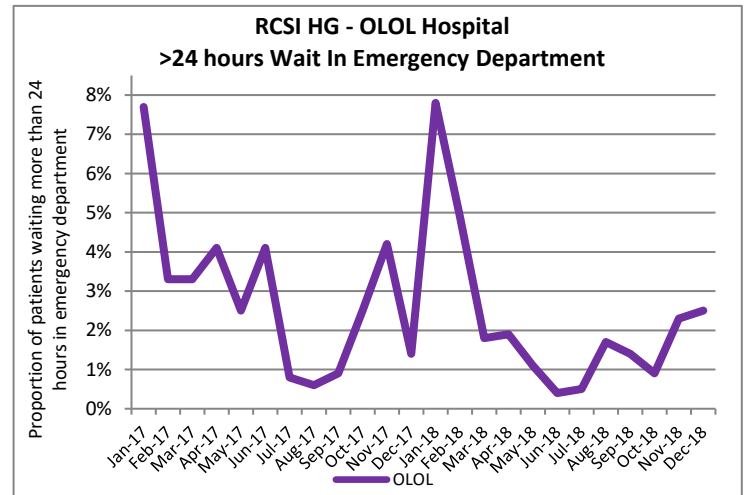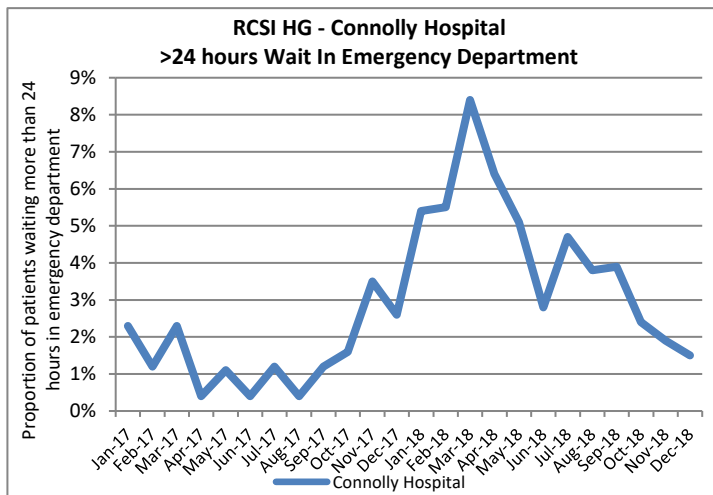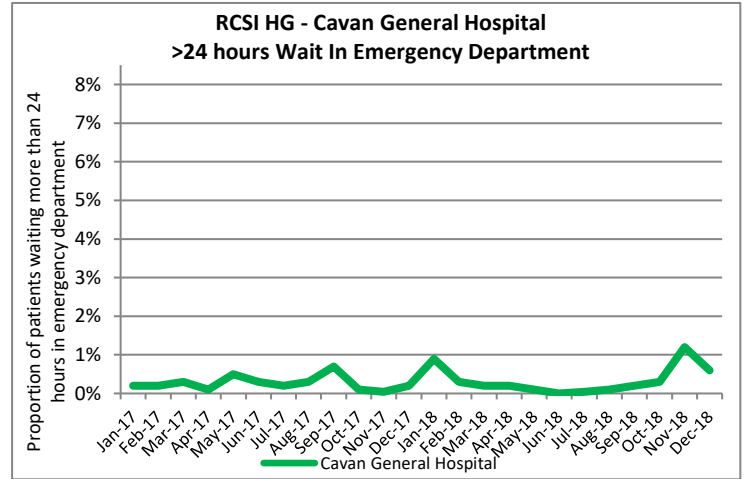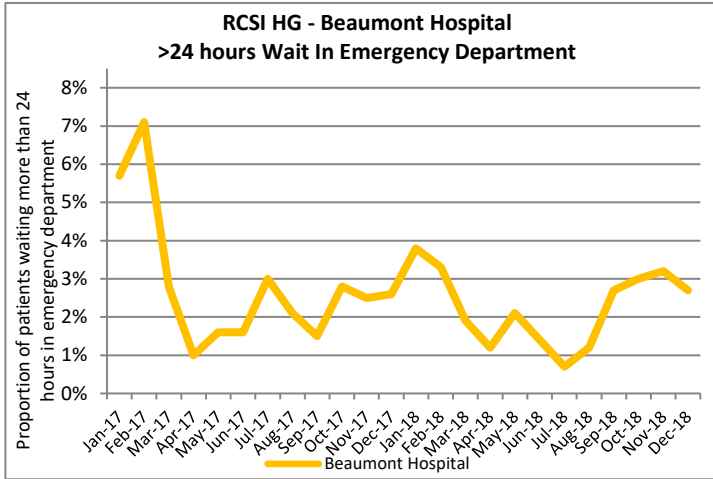
- Beaumont Hospital - Dec 2018 **2.7%** >24hours (2.6% Dec 2017) performance deterioration demonstrated
- Cavan Hospital - Dec 2018 **0.6%** >24hours (0.2% Dec 2017) performance deterioration demonstrated
- Connolly Hospital - Dec 2018 **1.5%** >24hours (2.6% Dec 2017) performance improvement demonstrated
- OLOL Hospital - Dec 2018 **2.5%** >24hours (1.4% Dec 2017) performance deterioration demonstrated
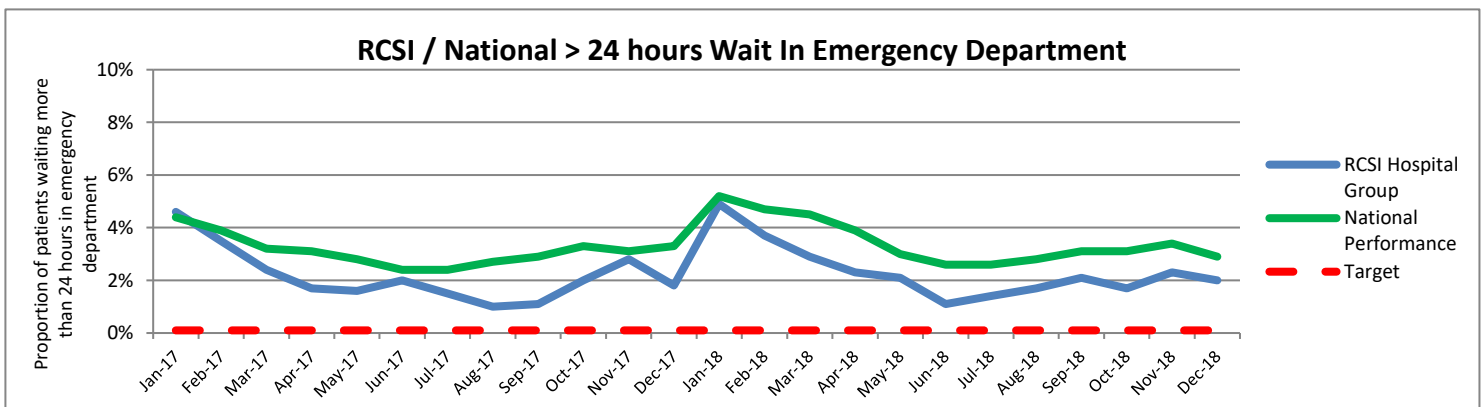
- RCSI HG - Dec 2018 **2.0%** > 24hours (1.8% Dec 2017)
- National - Dec 2018 **3.5%** > 24hours (3.3% Dec 2017)

3:3 OPD WAITING TIME FOR NEW APPOINTMENTS

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome for patients.

Measurement methodology and data source

- Compliance % with <52 weeks waiting time. Periodic local data extracts submitted to NTPF extrapolated for analysis and publication.

Target

- 100% patients waiting <52 weeks for new outpatient appointment

Performance

Beaumont Hospital
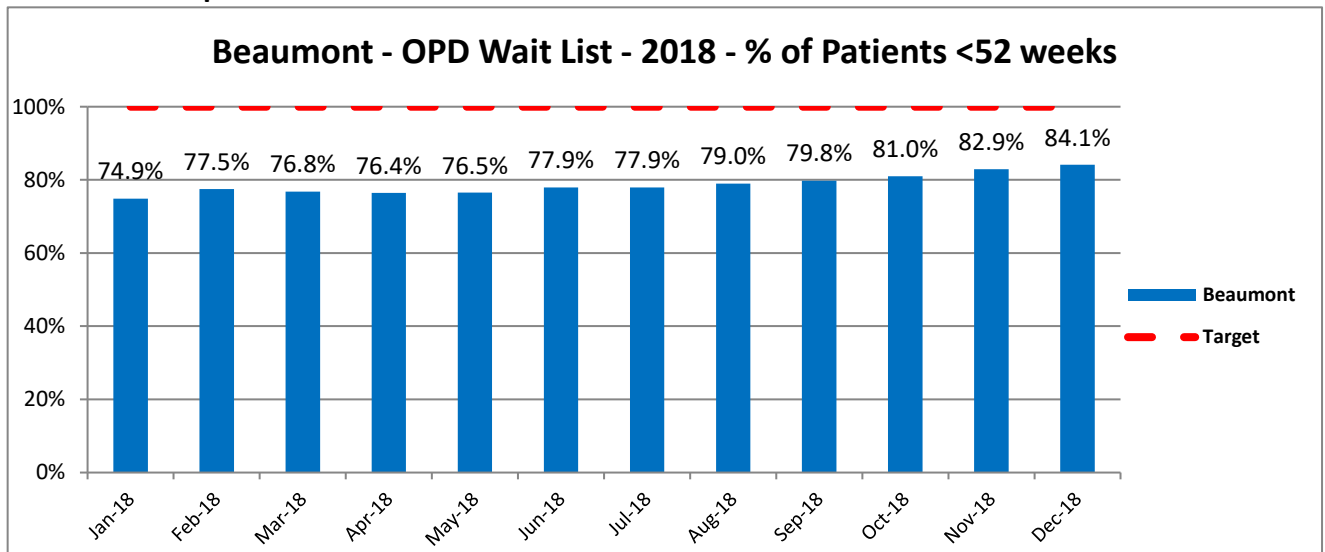
- % of patients waiting <52 weeks on OPD wait list 84.1% (2018)

Cavan General Hospital
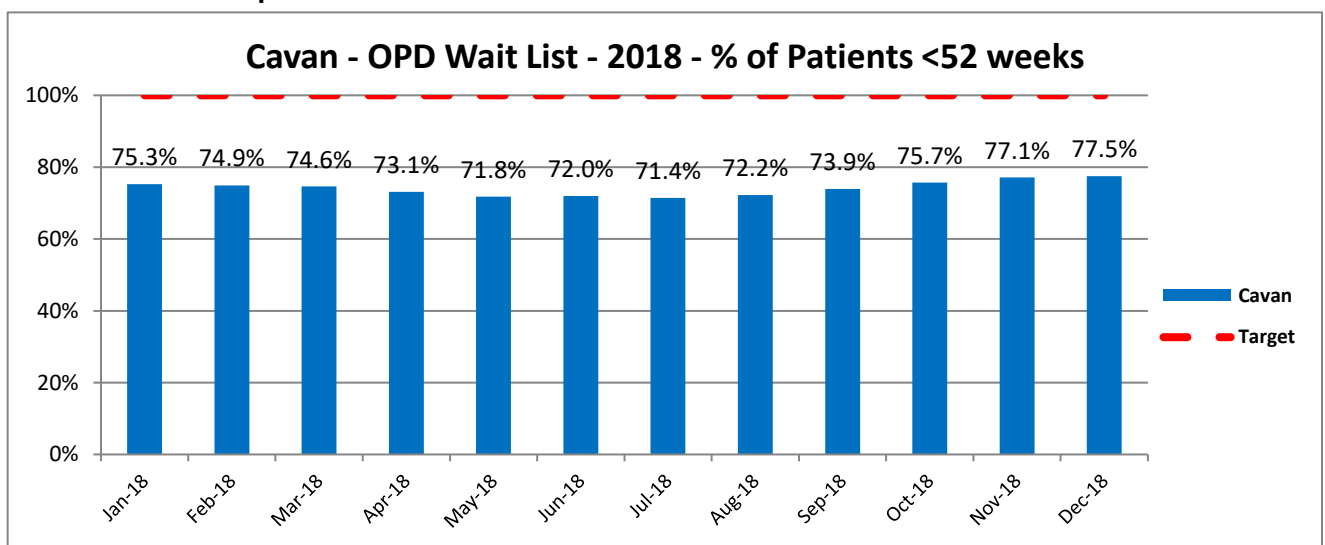
- % of patients waiting <52 weeks on OPD wait list 77.5% (2018)

Connolly Hospital

Connolly - OPD Wait List - 2018 - % of Patients <52 weeks
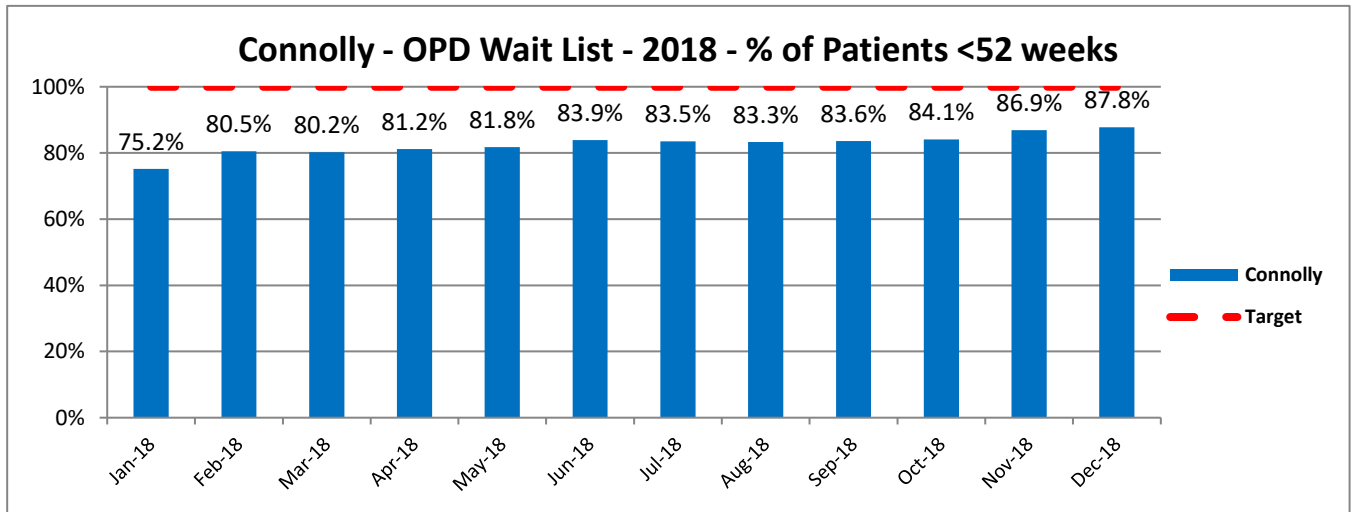
- % of patients waiting <52 weeks on OPD wait list 87.8% (2018)

OLOL Drogheda

OLOL - OPD Wait List - 2018 - % of Patients <52 weeks
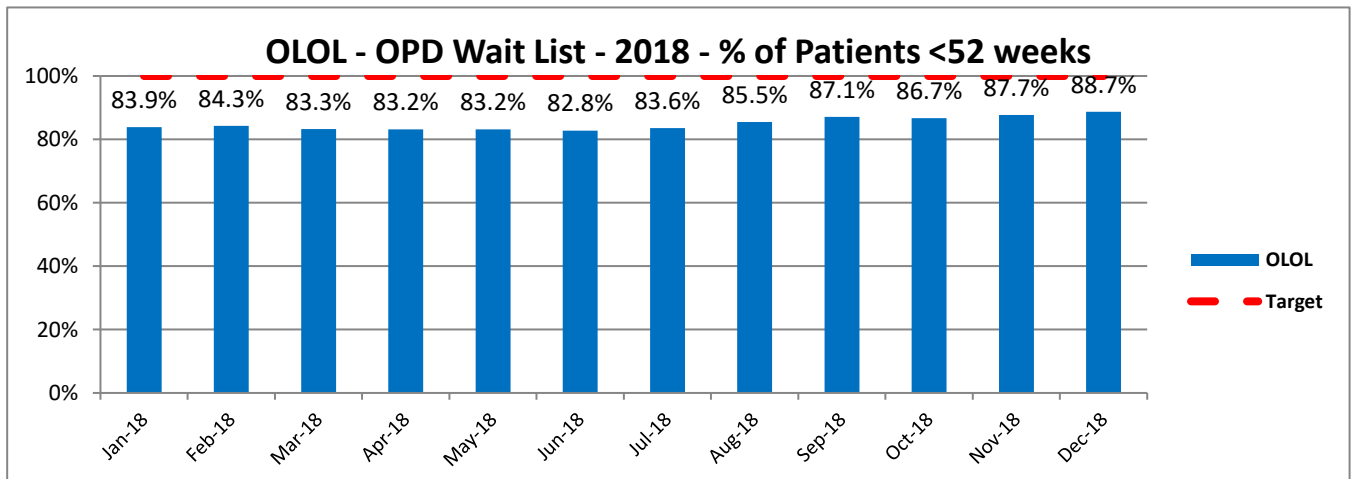
- % of patients waiting <52 weeks on OPD wait list 88.7% (2018)

Louth County Hospital

LCH - OPD Wait List - 2018 - % of Patients <52 weeks
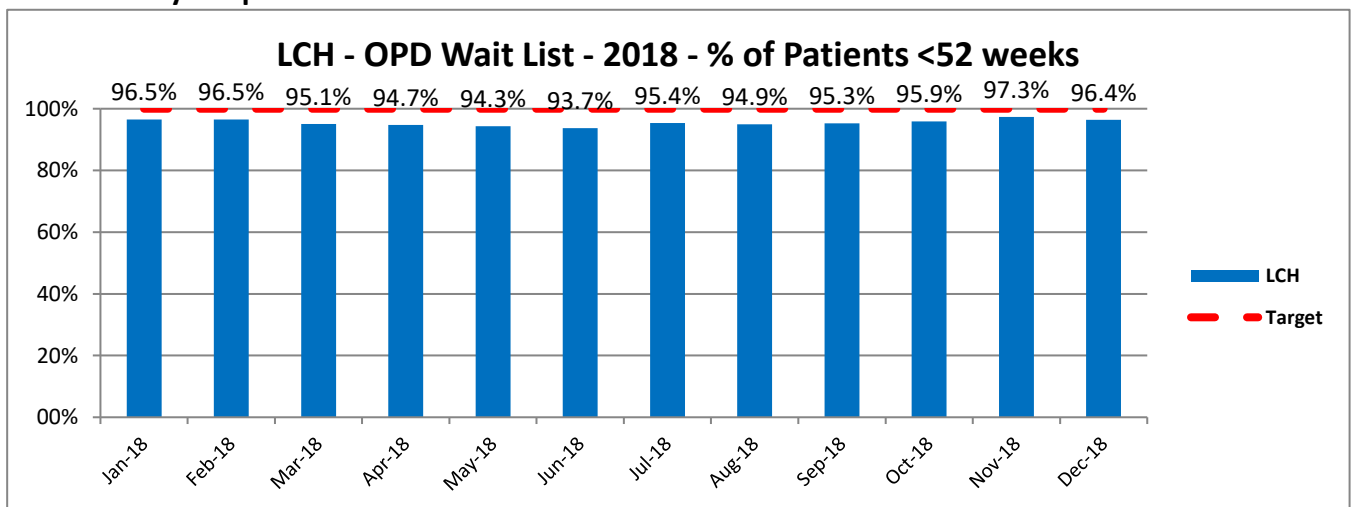
- % of patients waiting <52 weeks on OPD wait list 96.4% (2018)

Appendix 1: Quality Assurance Key Performance Metrics

Rotunda Hospital

Rotunda - OPD Wait List - 2018 - % of Patients <52 weeks

Values by month: Jan-18 93.5%, Feb-18 93.3%, Mar-18 91.4%, Apr-18 90.9%, May-18 83.0%, Jun-18 81.4%, Jul-18 87.0%, Aug-18 86.6%, Sep-18 88.0%, Oct-18 89.7%, Nov-18 90.6%, Dec-18 90.6%

Legend: Rotunda, Target
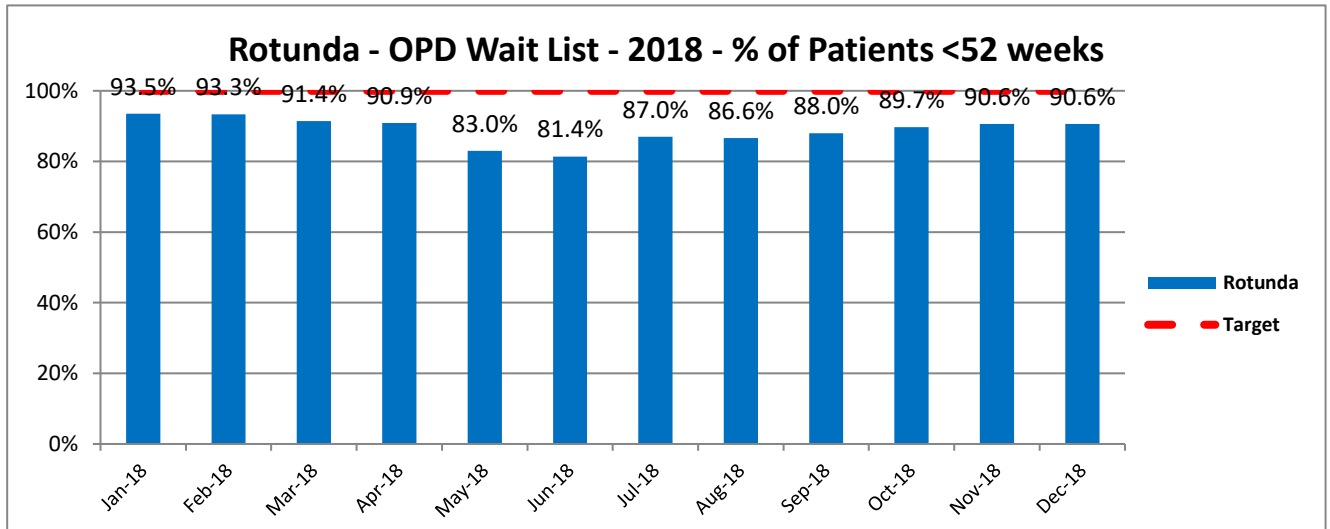
- % of patients waiting <52 weeks on OPD wait list 90.6% (2018)

RCSI Hospital Group

RCSI HG - OPD Wait List - 2018 - % of Patients <52 weeks

Values by month: Jan-18 78.7%, Feb-18 80.9%, Mar-18 80.2%, Apr-18 80.0%, May-18 79.2%, Jun-18 80.0%, Jul-18 80.2%, Aug-18 81.1%, Sep-18 82.1%, Oct-18 83.1%, Nov-18 84.7%, Dec-18 85.6%

Legend: Group, Target
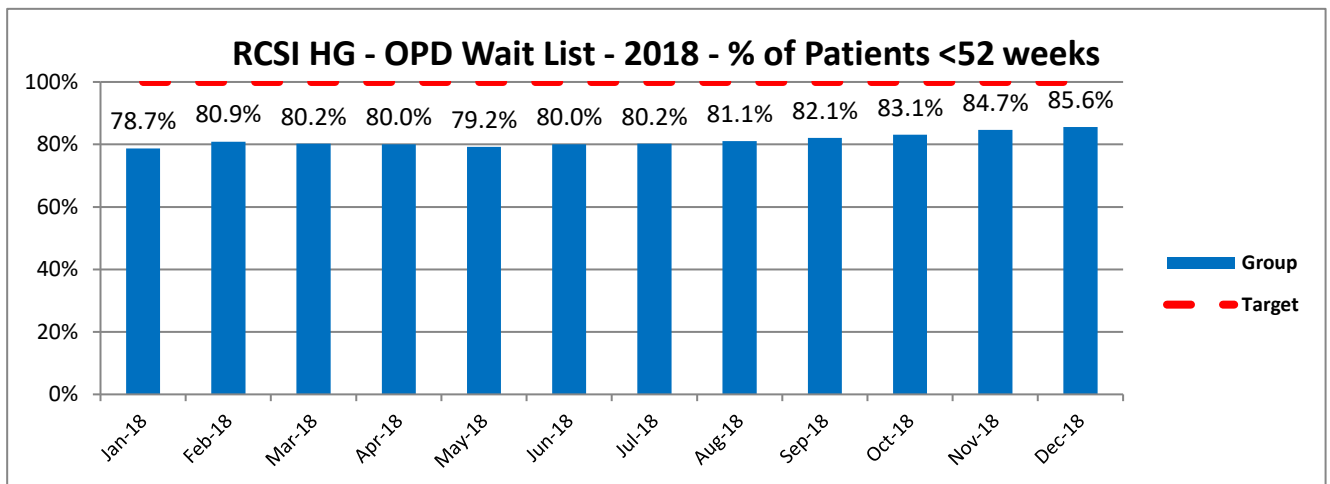
- % of patients waiting <52 weeks on OPD wait list 85.6% (2018) - overall RCSI demonstrating higher performance than national (**see Comparator Graph**)

National Performance Comparator

National - OPD Wait List - 2018 - % of Patients <52 weeks

Values by month: Jan-18 72.1%, Feb-18 71.7%, Mar-18 71.2%, Apr-18 71.3%, May-18 71.2%, Jun-18 71.0%, Jul-18 70.9%, Aug-18 71.2%, Sep-18 71.0%, Oct-18 70.7%, Nov-18 70.5%, Dec-18 70.4%

Legend: National Total, Target
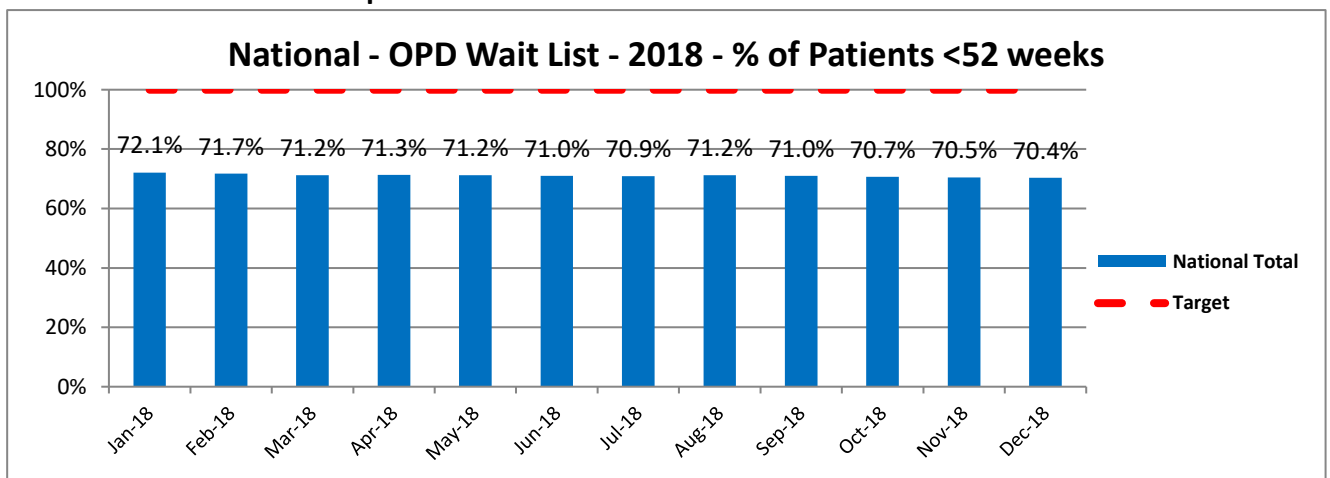
- % of patients waiting <52 weeks on OPD wait list 70.4% (2018)

3:4 INPATIENT / DAY CARE WAITING TIMES

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.

Measurement methodology and data source

Number of adult patients waiting < 8 months for admission / attendance. Periodic local data submission to NTFP extrapolated for analysis and publications excluding patients with '*to come in date*' (tci) **(NTPF - definition).**

Target

- 70% patients waiting <8 months for admission / attendance

Performance
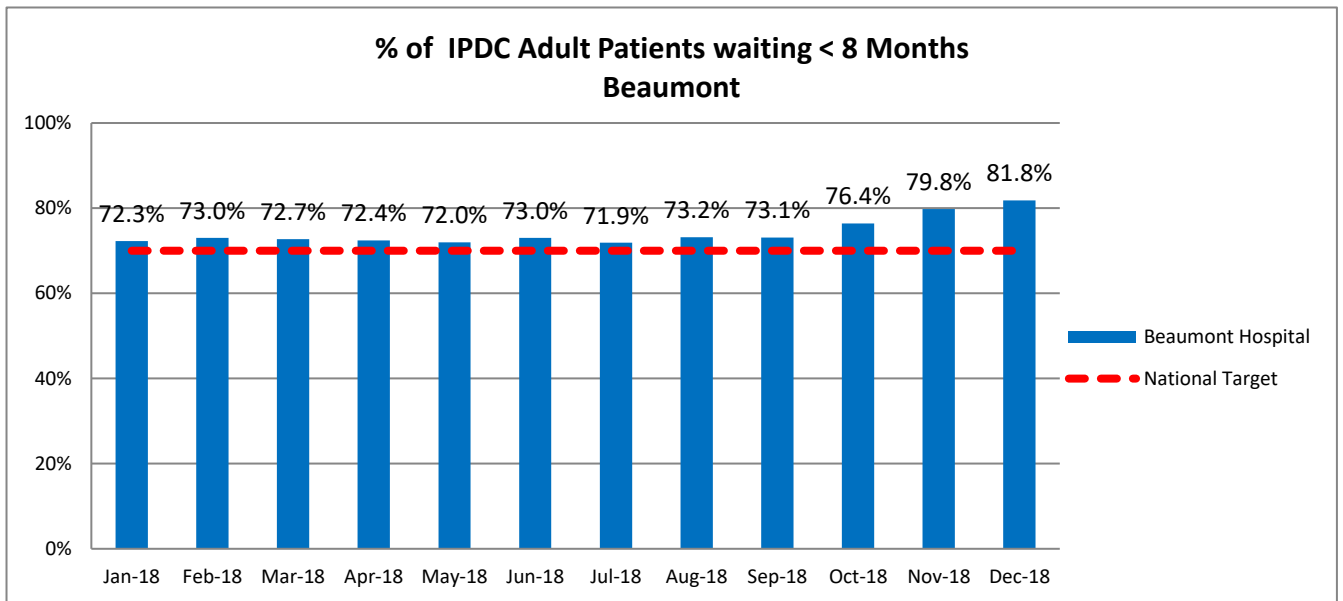
Beaumont Hospital

- Beaumont Hospital exceeded national target for 2018 monthly reporting period

Cavan General Hospital
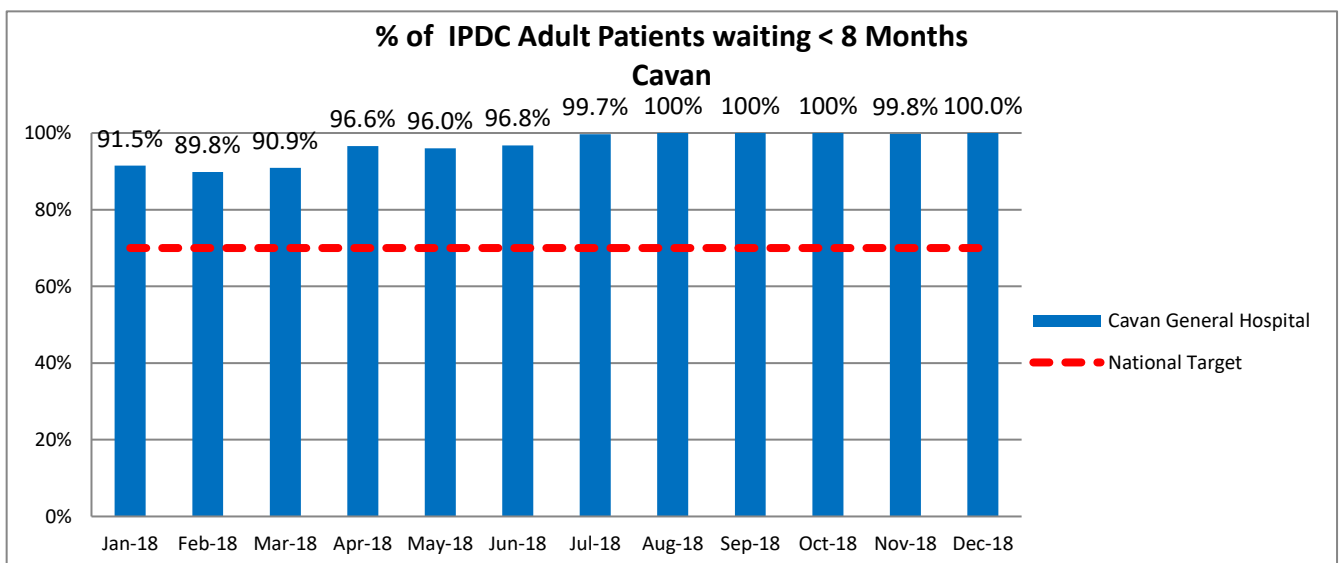
- Cavan General Hospital exceeded national target for 2018 monthly reporting period

Connolly Hospital

% of IPDC Adult Patients waiting < 8 Months Connolly
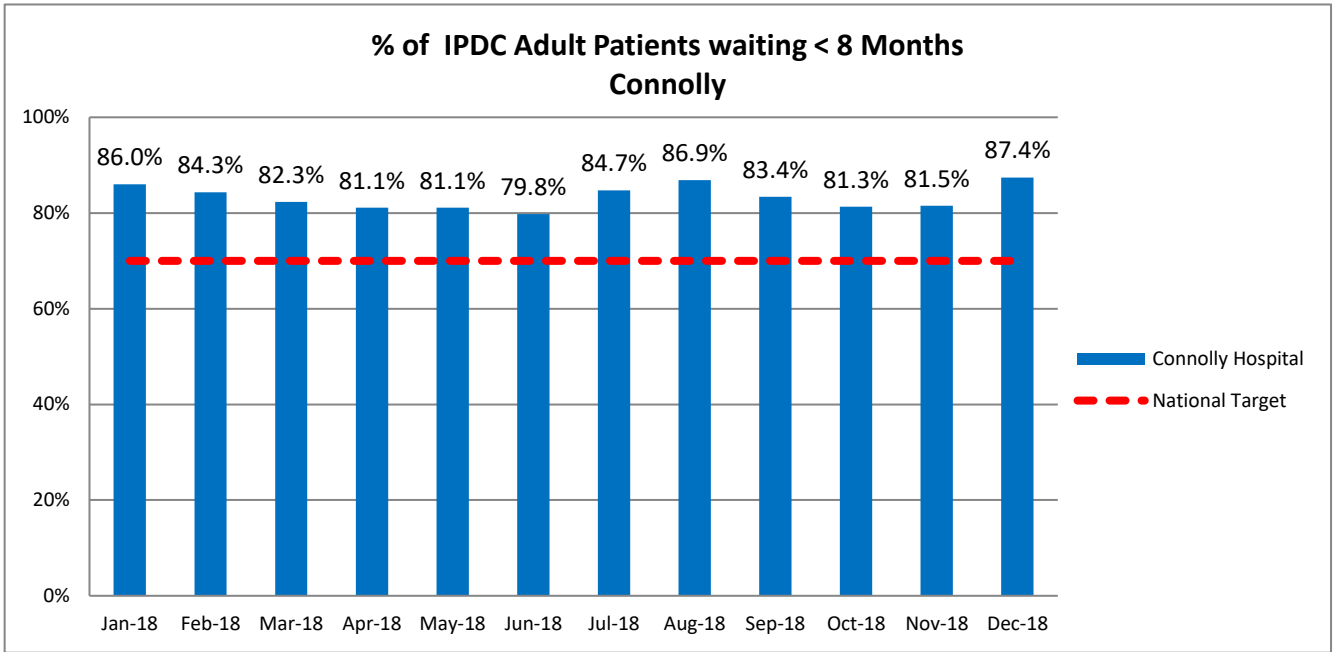
- Connolly Hospital exceeded national target for 2018 monthly reporting period

Our Lady of Lourdes Drogheda

% of IPDC Adult Patients waiting < 8 Months OLOL
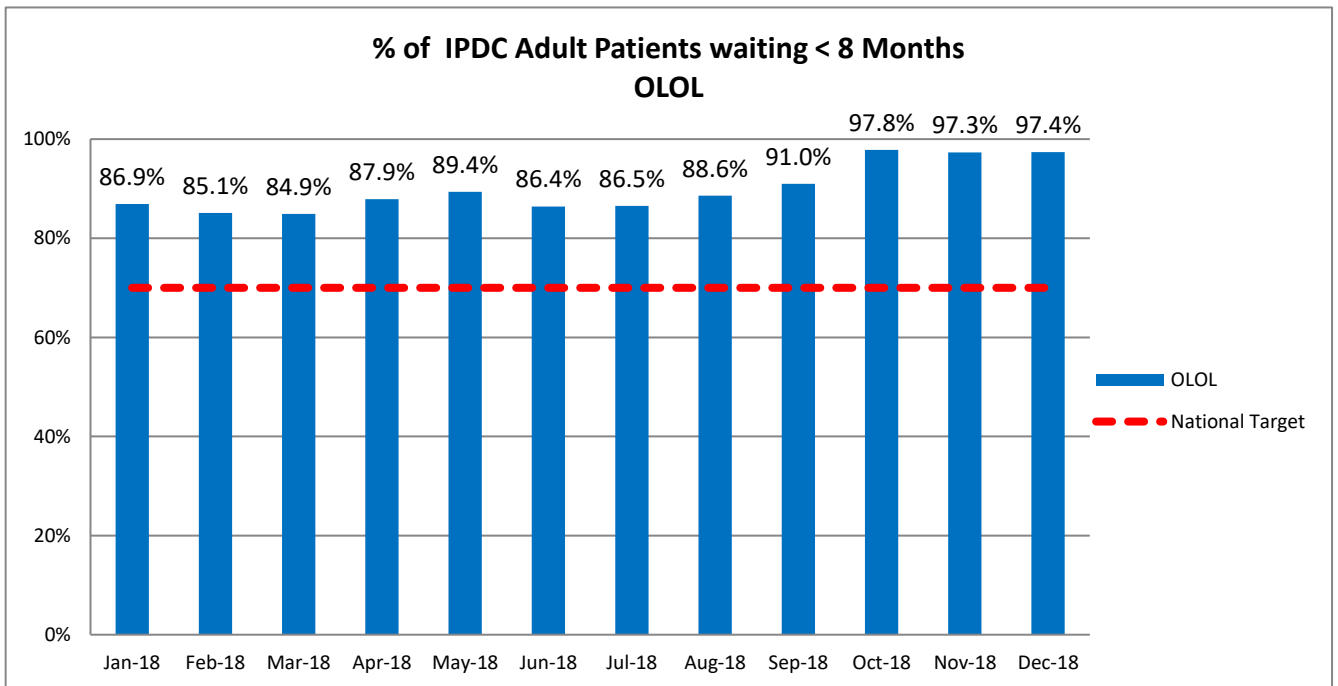
- Our Lady of Lourdes exceeded national target for 2018 monthly reporting period

Louth County Hospital

% of IPDC Adult Patients waiting < 8 Months
LCH
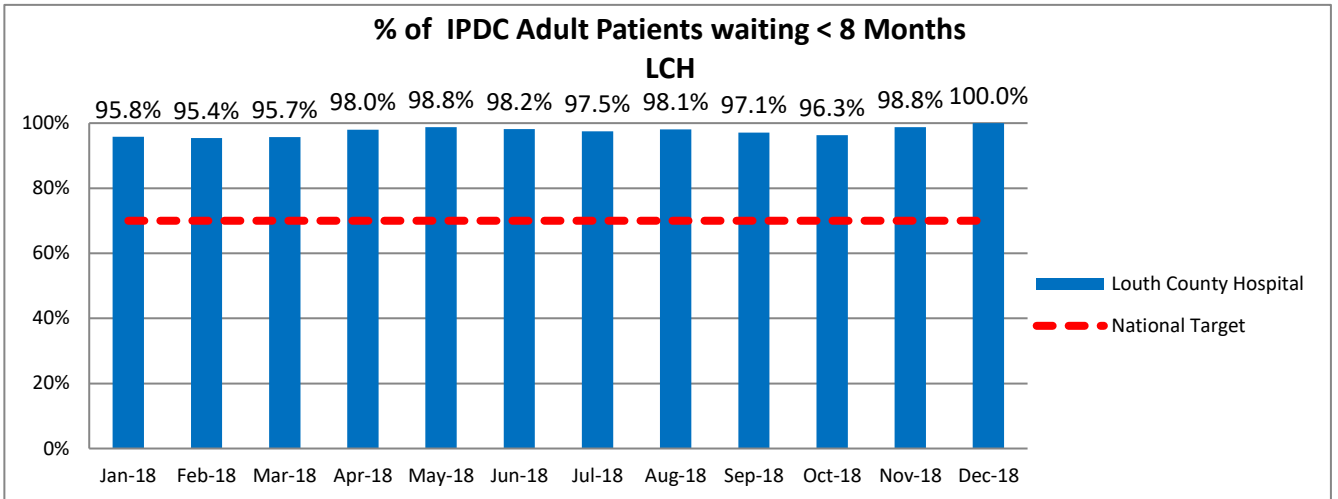
- Louth County Hospital exceeded national target for 2018 monthly reporting period

RCSI Hospital Group

% of IPDC Adult Patients waiting < 8 Months
RCSI HG
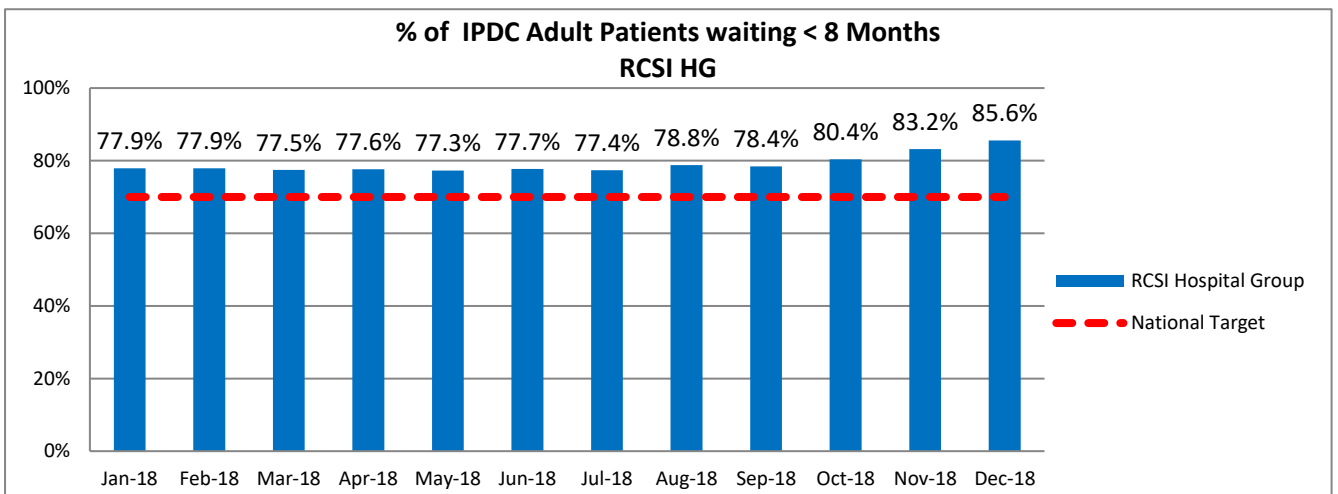
- RCSI HG exceeded national target for 2018 monthly reporting period

National Performance by Hospital Group Comparator

% of IPDC Adult Patients waiting < 8 Months
Nationally - December 2018
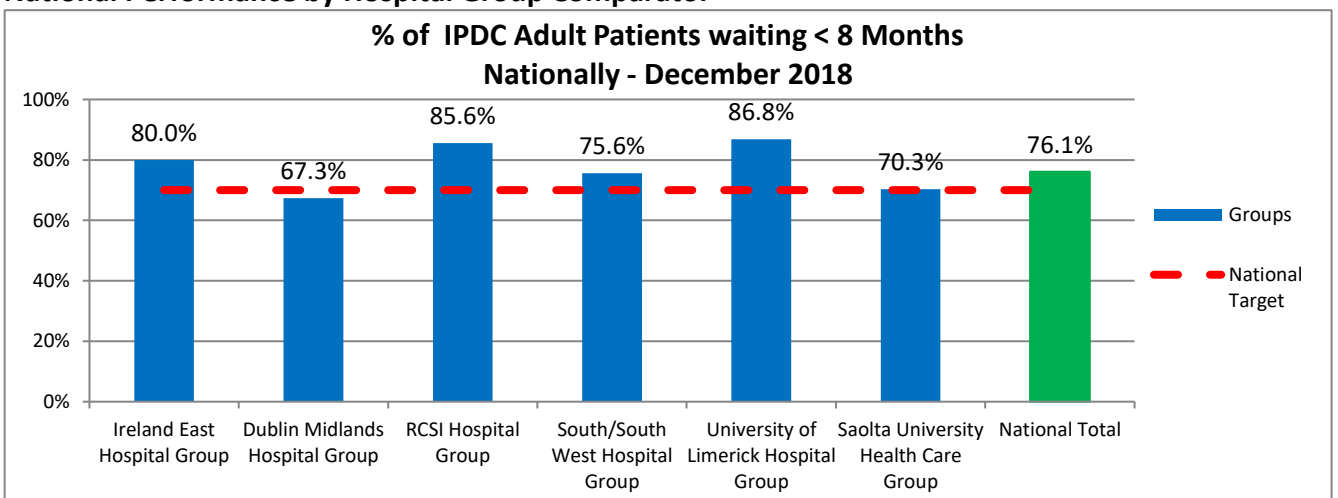
- 5 Hospital Groups achieving national target

3:5 ACCESS TO SYMPTOMATIC BREAST CANCER SERVICES

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.

Measurement methodology and data source

- periodic local data extracts submitted to the National Cancer Control Programme (NCCP), extrapolated for analysis and publication

Target

- 95% of attendances whose referral was triaged as urgent by the cancer centre and attended or were offered an appointment within 2 weeks

Performance

Beaumont Hospital

- Beaumont Hospital exceeded National Target set for 2018 reporting period (100%). National Performance (88.2%) did not achieve target.

3:6 RAPID ACCESS CLINIC - LUNG

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.

Measurement methodology and data source

- % of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre
- Periodic local data extracts submitted to NCCP, extrapolated for analysis and publication

Target:

- National Target Compliance is 95%

Performance

Beaumont Hospital
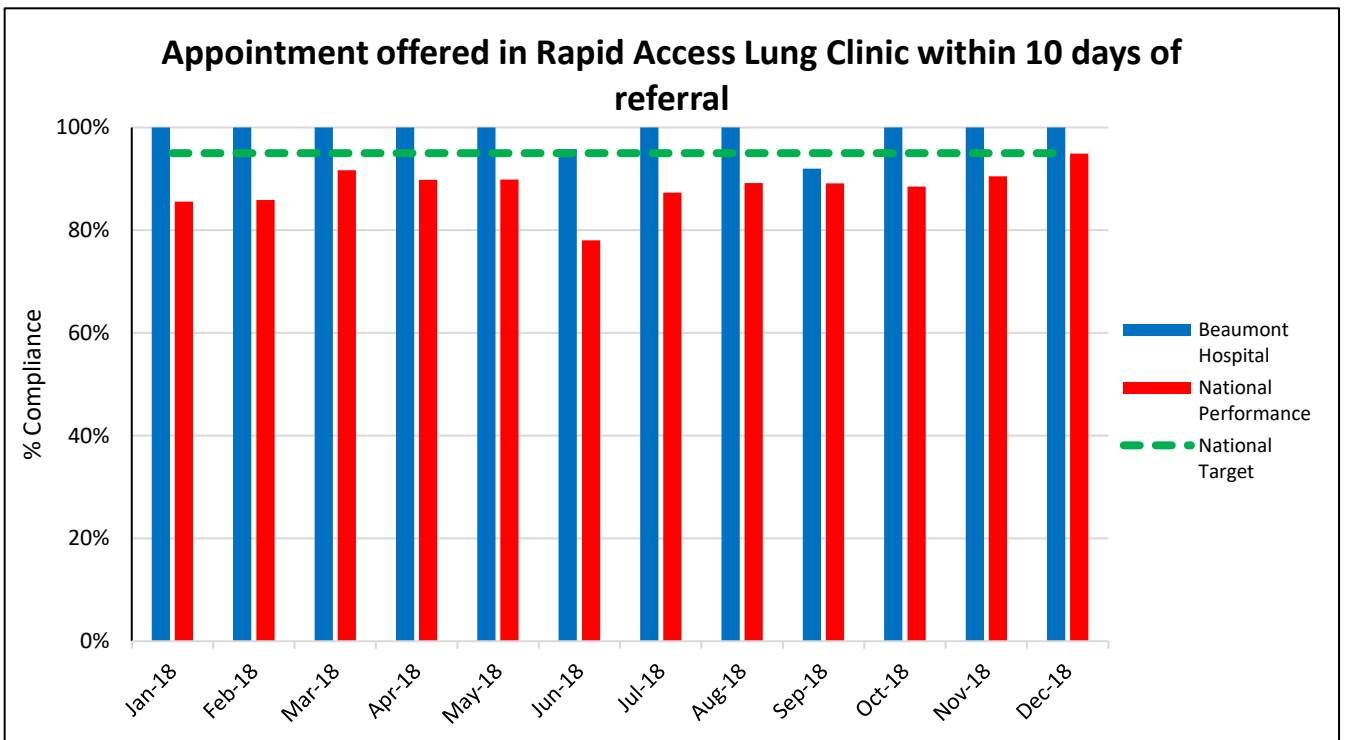
- Beaumont Hospital exceeded National Target set for 2018 reporting period (100%). National Performance (94.9%) did not achieve target

3:7 RAPID ACCESS CLINIC - PROSTATE

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.

Measurement methodology and data source

- % of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre
- Periodic local data extracts submitted to NCCP, extrapolated for analysis and publication

Target:

- 90% compliance

Performance
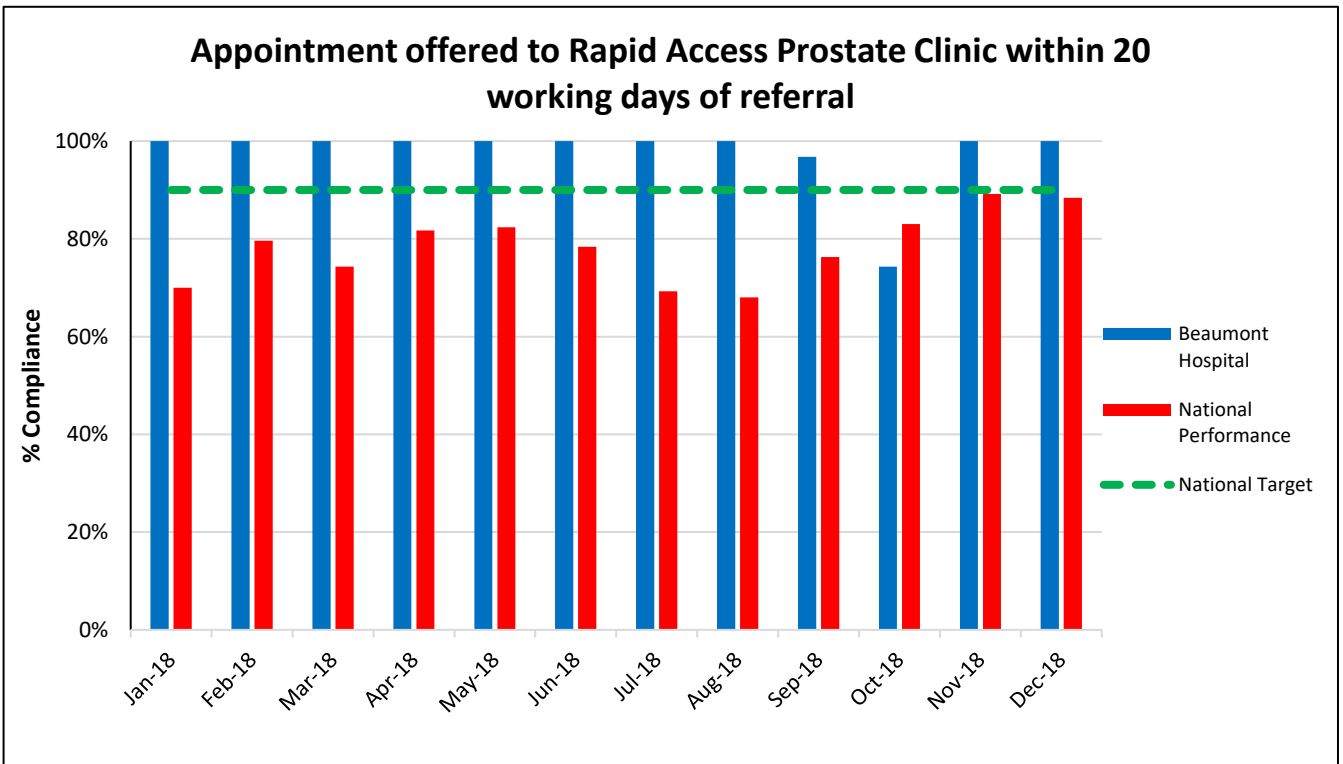
Beaumont Hospital

- Beaumont Hospital exceeded National Target set for 2018 reporting period (100%). National Performance (88.4%) did not achieve target.

3:8 ACCESS TO URGENT COLONOSCOPY WAITING TIMES

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome for patients.

Measurement methodology and data source

- Periodic local data extracts submitted to NTPF, extrapolated for analysis and publication

Target

- 100% of patients identified a requiring urgent colonoscopy undertaken / offered appointment within 28 days

Performance

RCSI Hospital Group
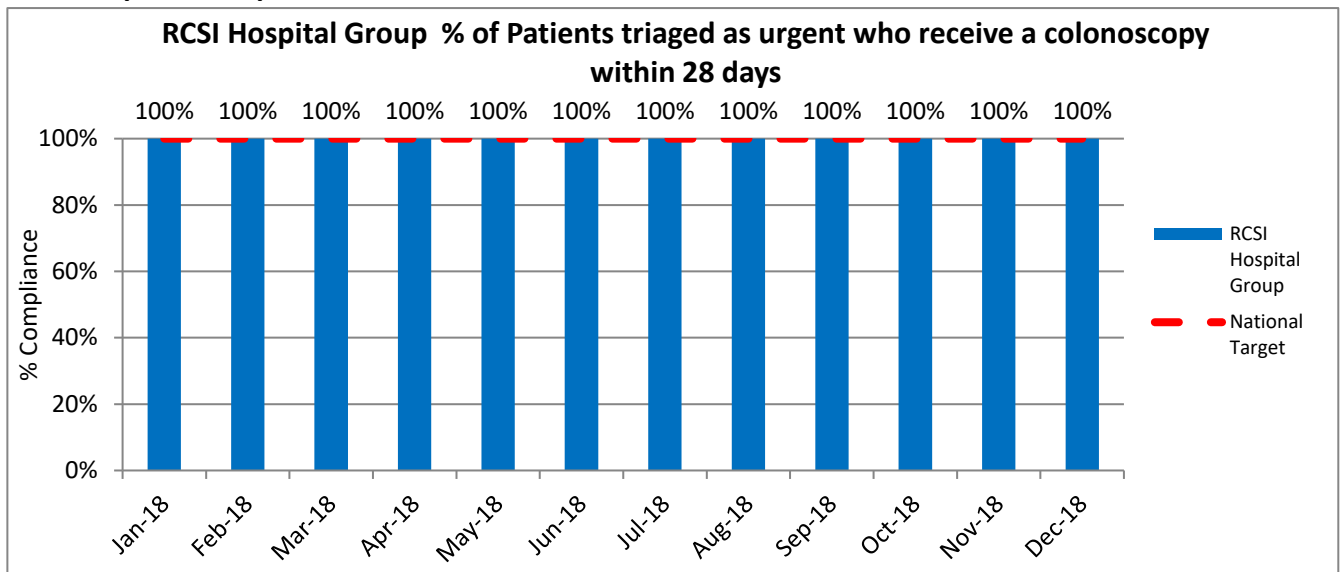
- 100% compliance within the RCSI Hospital Group for 2018 monthly reporting period and entire year

National Performance
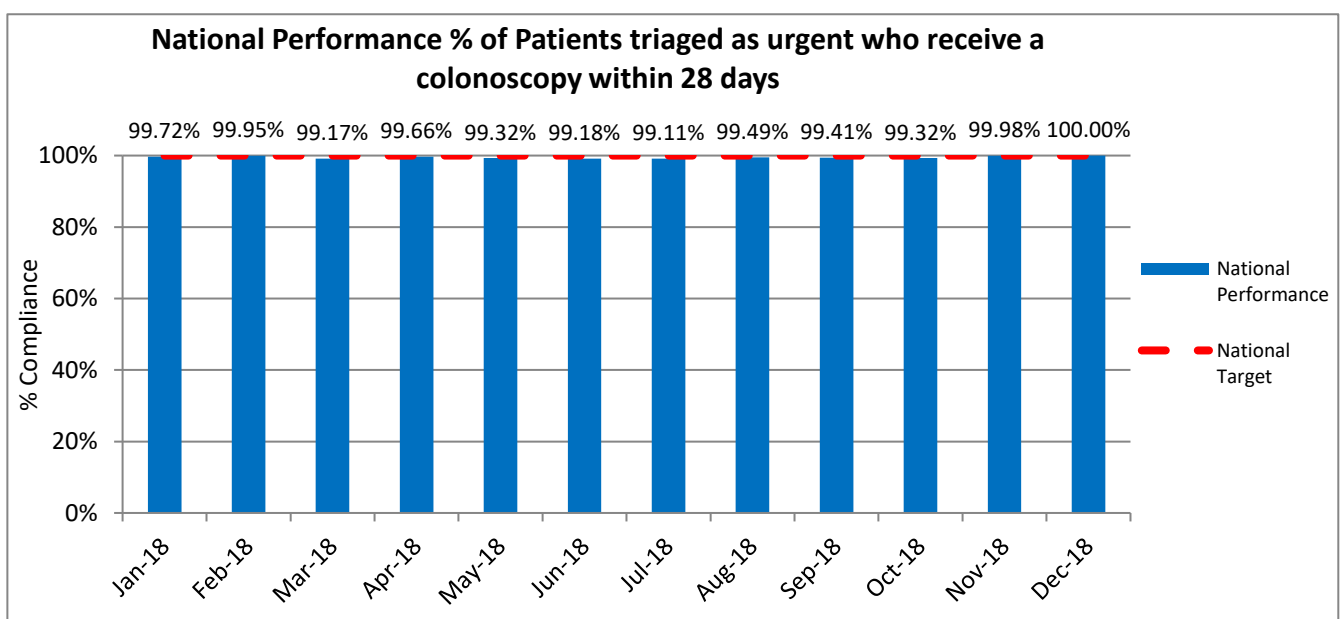
- 100% compliance nationally for 2018 monthly reporting period

3:9 GI ENDOSCOPY WAITING TIMES

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.
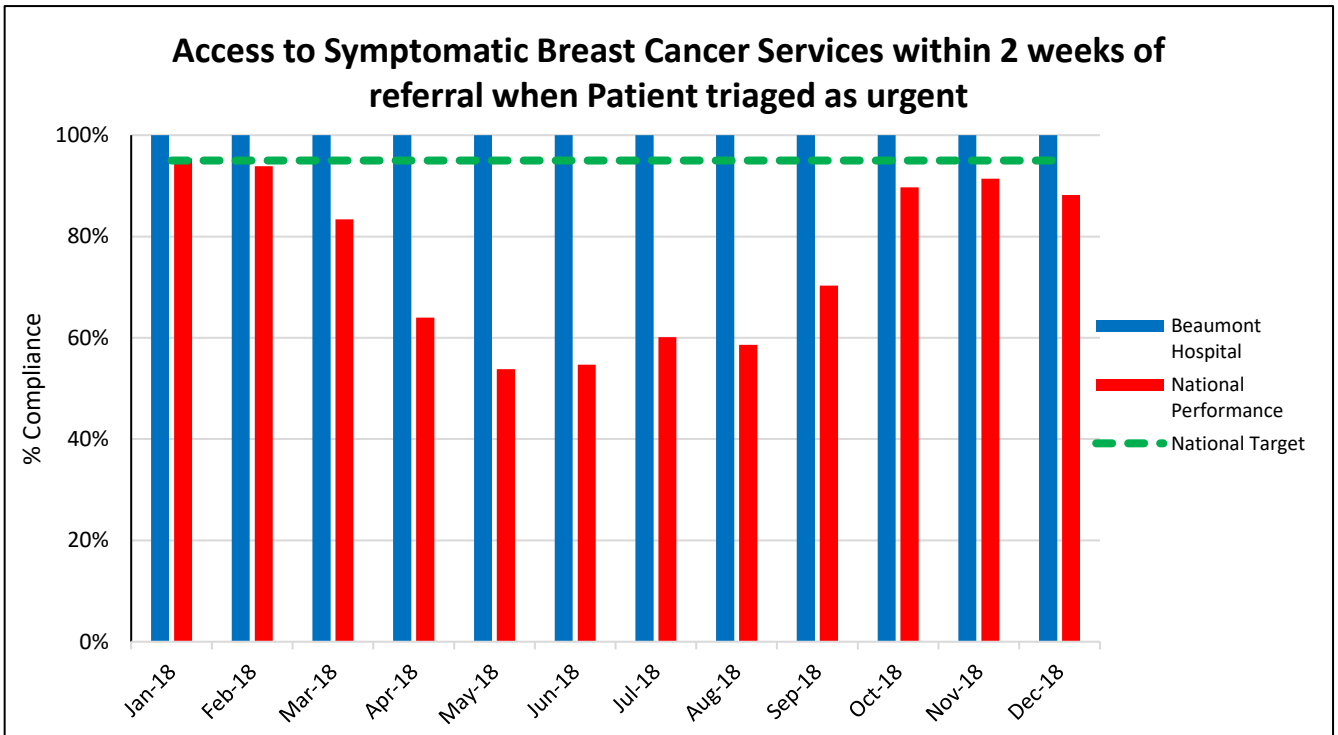
Measurement methodology and data sources

- Periodic local data extracts submitted to NTPF, extrapolated for analysis and publication

Target

- 70% of patients identified as requiring routine GI endoscopy undertaken or offered appointment within 13 weeks

Performance
Beaumont Hospital
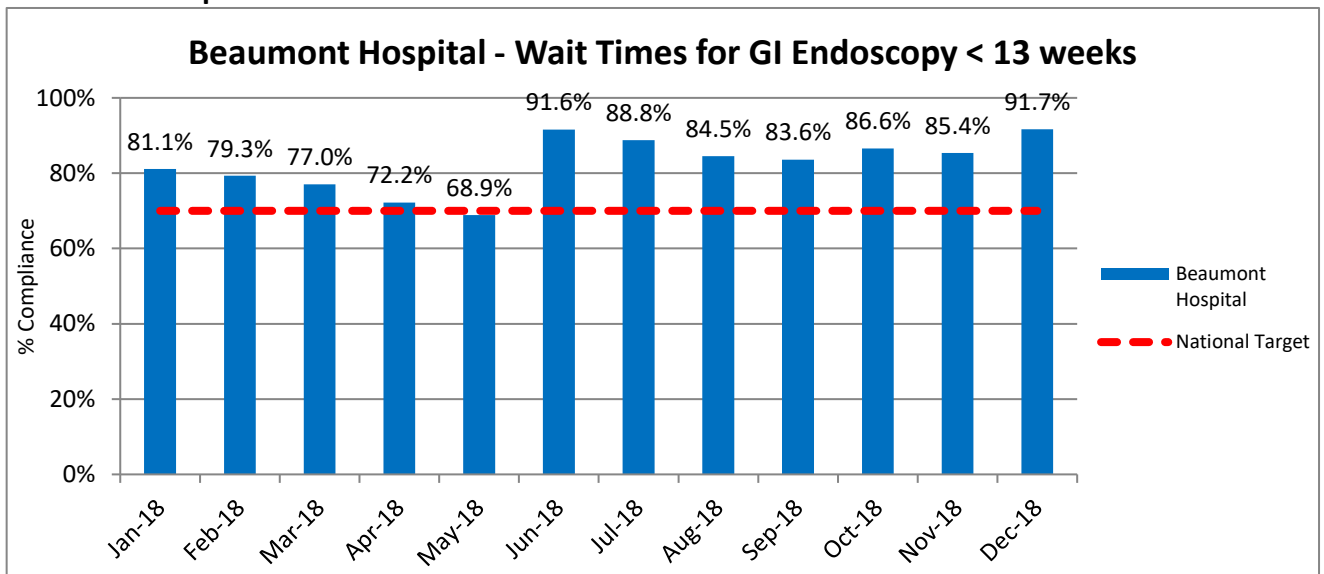
- Beaumont Hospital is currently exceeding this target for reporting period **(December 91.7% compliance)**

Cavan General Hospital
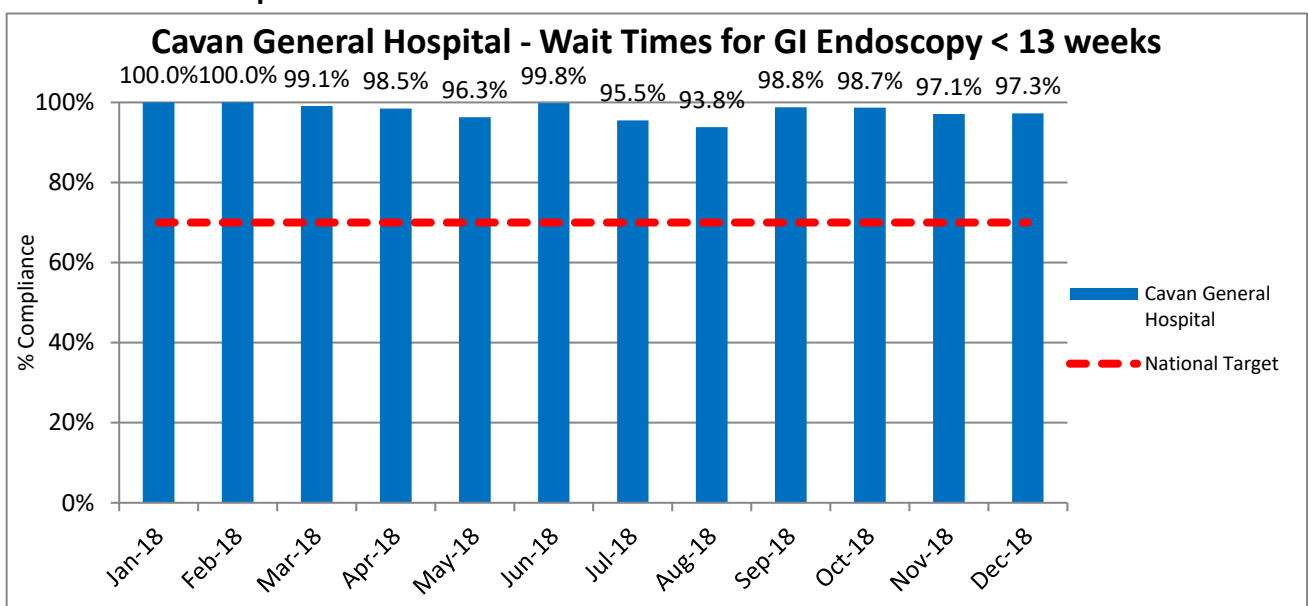
- Cavan General Hospital is currently exceeding this target for reporting period **(December 97.3% compliance)**

Connolly Hospital

Connolly Hospital - Wait Times for GI Endoscopy < 13 weeks

Bar chart showing % Compliance by month (Jan-18 to Dec-18) for Connolly Hospital with National Target line:
- Jan-18: 72.5%
- Feb-18: 71.9%
- Mar-18: 76.8%
- Apr-18: 76.5%
- May-18: 73.5%
- Jun-18: 75.6%
- Jul-18: 83.8%
- Aug-18: 86.1%
- Sep-18: 89.8%
- Oct-18: 99.5%
- Nov-18: 82.7%
- Dec-18: 87.6%

Legend: Connolly Hospital, National Target
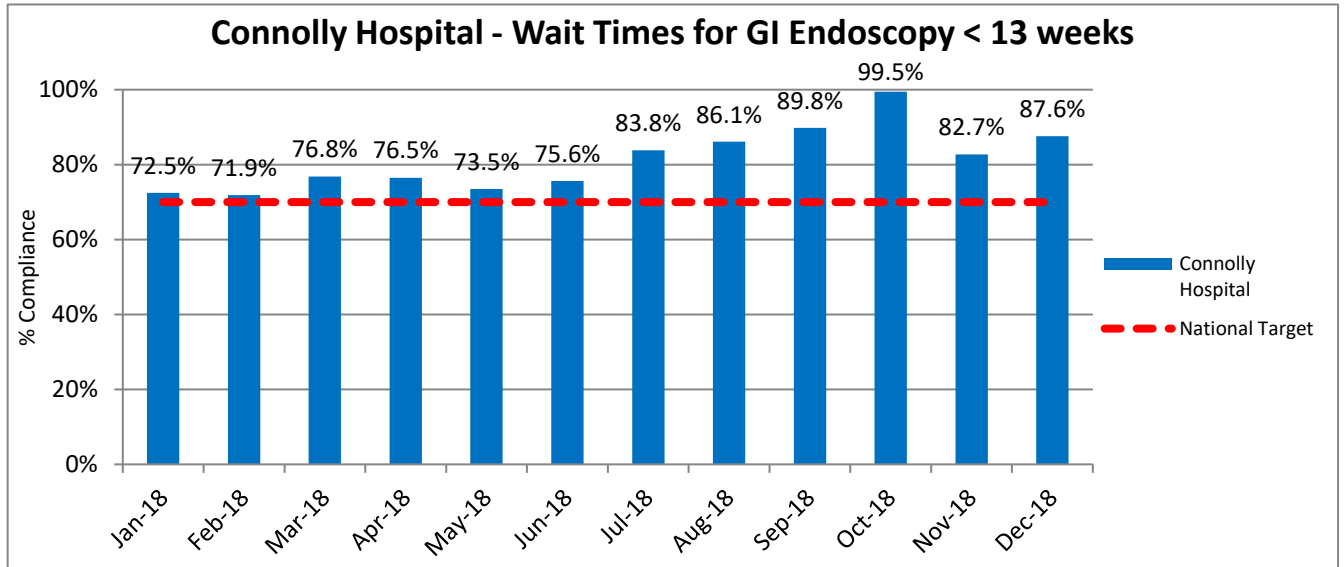
- Connolly Hospital is currently exceeding this target for reporting period **(December 87.6% compliance)**

Appendix 1: Quality Assurance Key Performance Metrics

Our Lady of Lourdes, Drogheda

OLOL Hospital - Wait Times for GI Endoscopy < 13 weeks

Month	OLOL
Jan-18	97.2%
Feb-18	100.0%
Mar-18	90.8%
Apr-18	97.2%
May-18	95.8%
Jun-18	89.7%
Jul-18	82.3%
Aug-18	71.6%
Sep-18	98.1%
Oct-18	94.2%
Nov-18	93.8%
Dec-18	100.0%
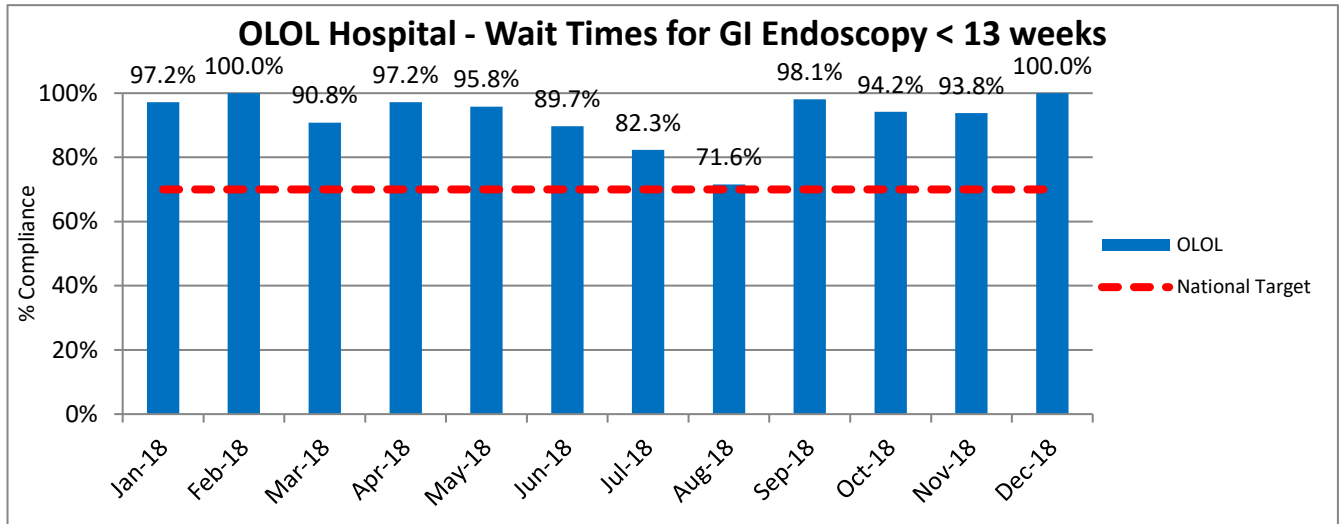
- Our Lady of Lourdes is currently exceeding this target for reporting period **(December 100% compliance)**

Louth County Hospital

Louth County Hospital - Wait Times for GI Endoscopy < 13 weeks

Month	Louth County
Jan-18	80.0%
Feb-18	81.8%
Mar-18	89.0%
Apr-18	89.0%
May-18	92.2%
Jun-18	97.7%
Jul-18	86.4%
Aug-18	87.7%
Sep-18	83.8%
Oct-18	85.0%
Nov-18	89.8%
Dec-18	91.6%
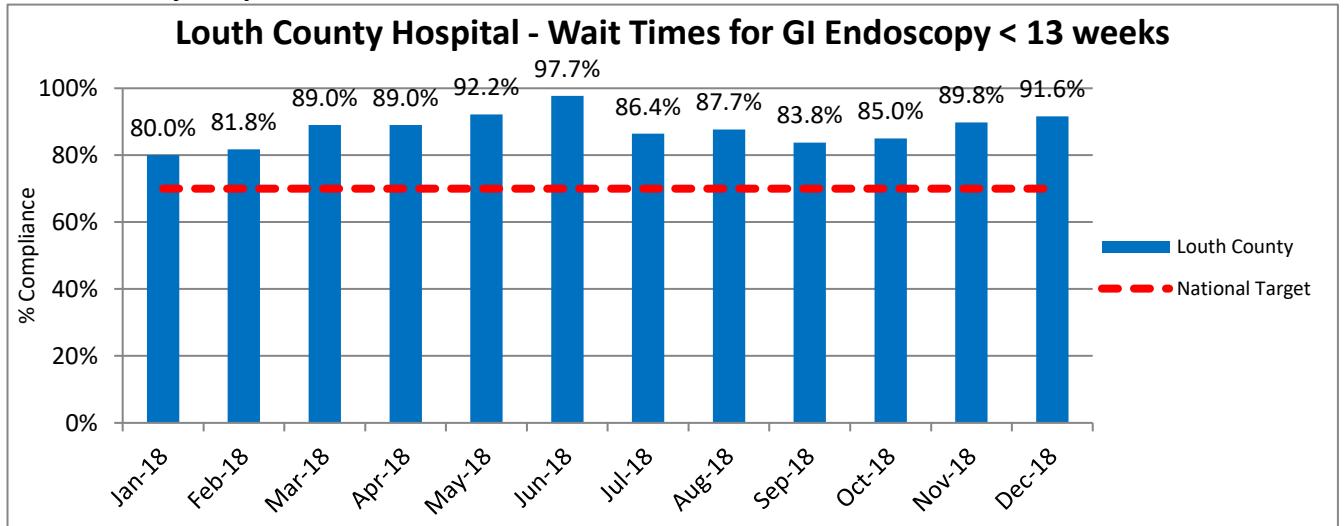
- Louth County Hospital is currently exceeding this target for reporting period **(December 91.6% compliance)**

RCSI Hospital Group

RCSI Hospital Group - Wait Times for GI Endoscopy < 13 weeks

Month	RCSI Hospital Group
Jan-18	81.5%
Feb-18	80.5%
Mar-18	82.3%
Apr-18	82.7%
May-18	80.3%
Jun-18	89.3%
Jul-18	87.1%
Aug-18	86.2%
Sep-18	88.9%
Oct-18	92.9%
Nov-18	87.6%
Dec-18	92.2%
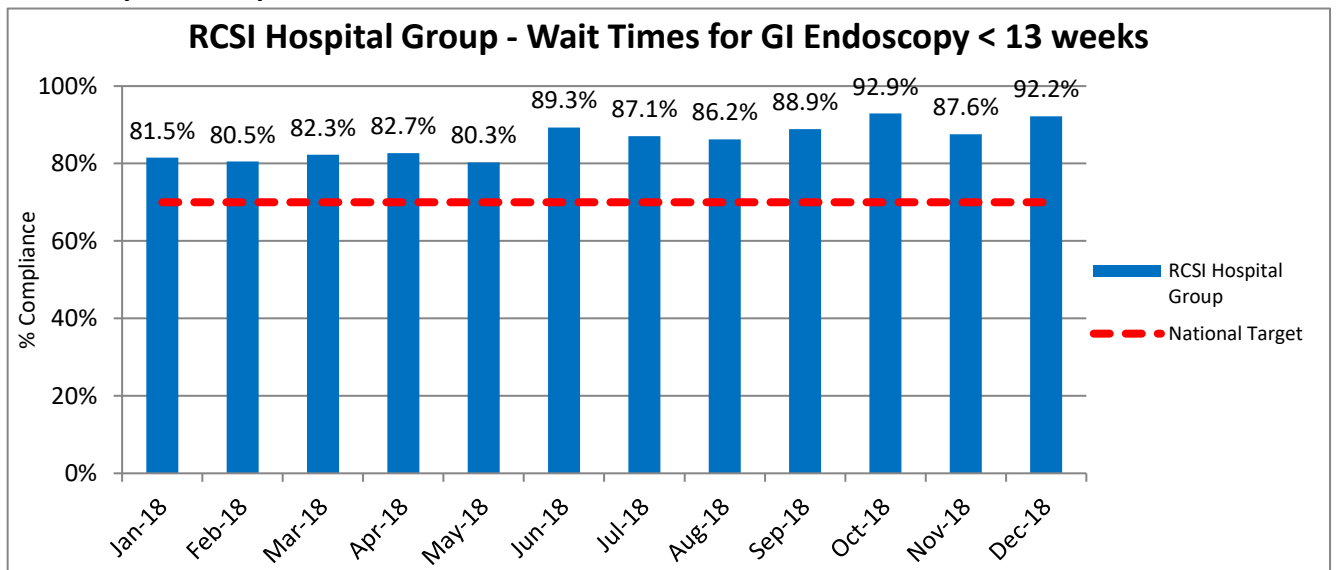
- RCSI Hospital Group is currently exceeding this target for reporting period **(December 92.2% compliance)**

Appendix 1: Quality Assurance Key Performance Metrics

National Performance Comparator

National Performance - Wait Times for GI Endoscopy < 13 weeks
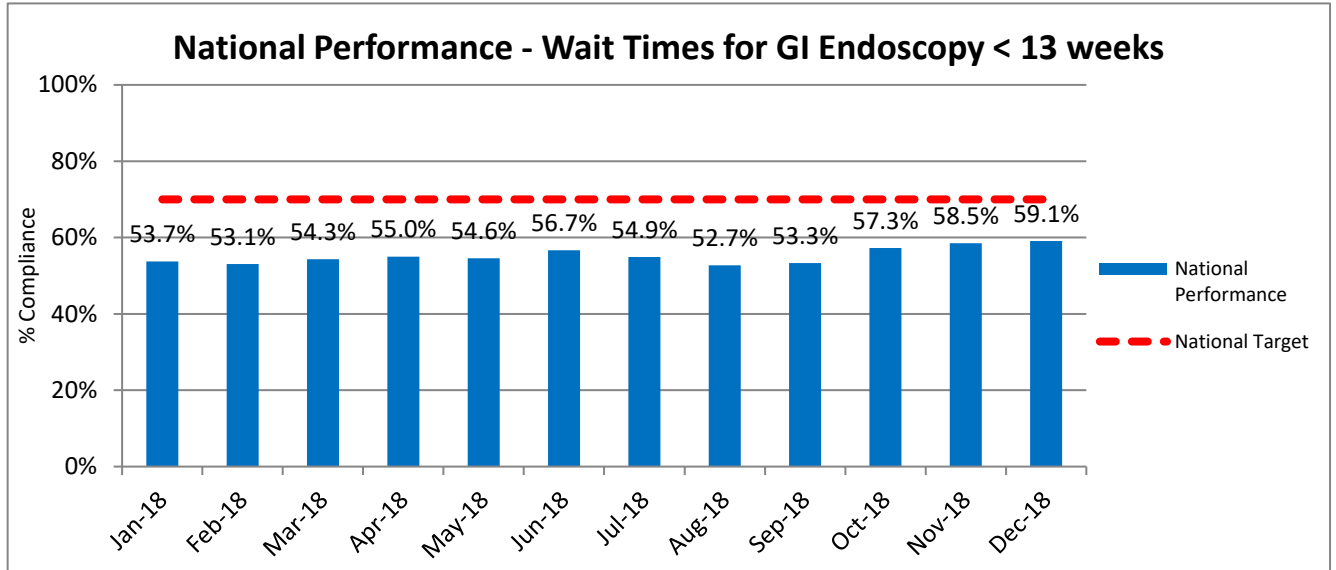
- Nationally this target is not being met for reporting period **(December 59.1% compliance)**

3:10 % CLIENTS OFFERED A COLONOSCOPY APPOINTMENT DATE THAT OCCURS WITHIN 20 WORKING DAYS FROM WHEN A CLIENT WAS DEEMED CLINICALLY SUITABLE FOLLOWING PRE-ASSESSMENT/POSITIVE FIT

Rationale for measurement

Significant delay in accessing hospital services delays diagnosis and any necessary treatment commencement with potential for less than optimal outcome.

Measurement methodology and data sources

- Monthly data provided by BowelScreen programme

Target

- Minimum standard target is ≥90% of clients offered a colonoscopy appointment that occurs within 20 working days from when a client was deemed clinically suitable following pre-assessment / notification of positive FIT

Performance
RCSI Hospital Group – Per Month
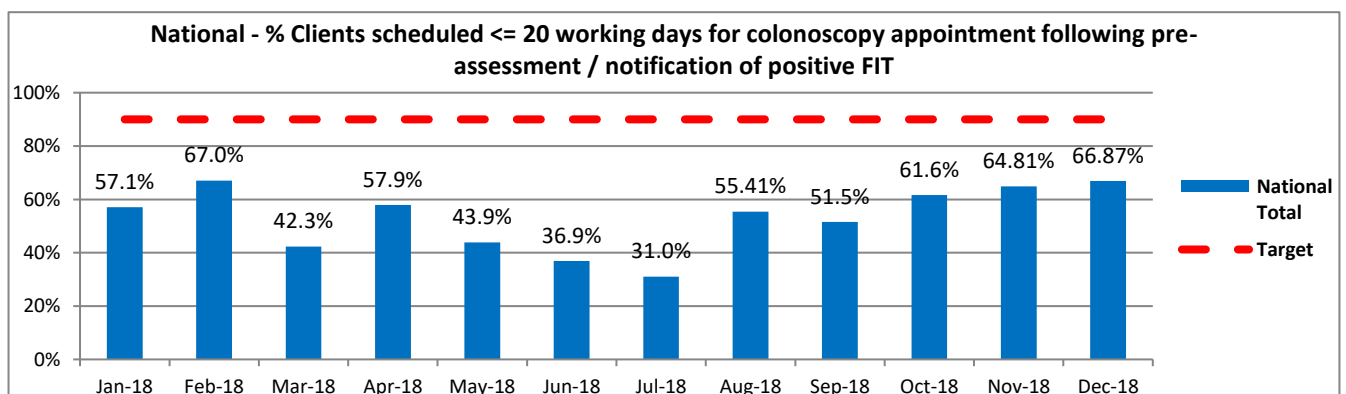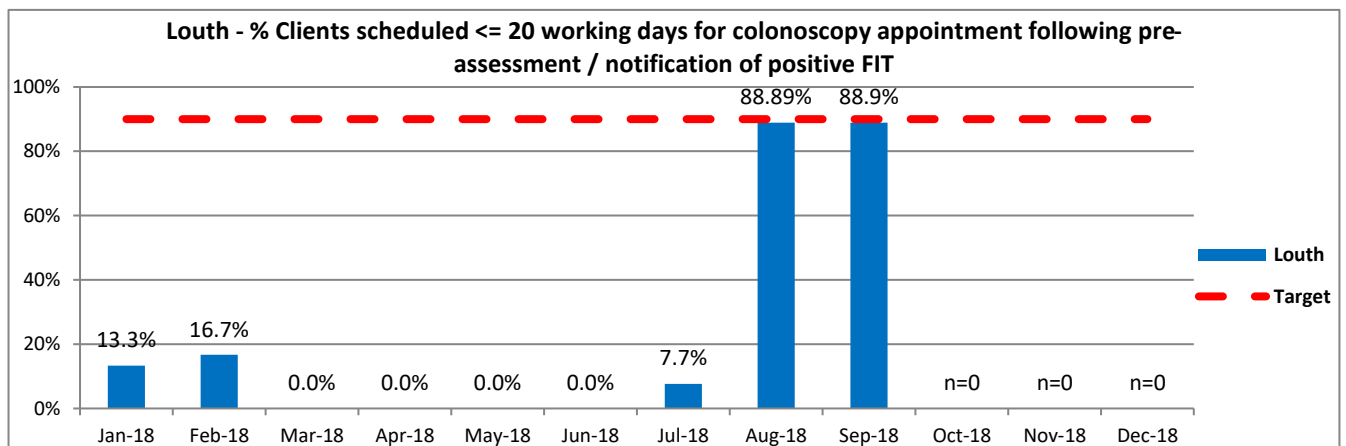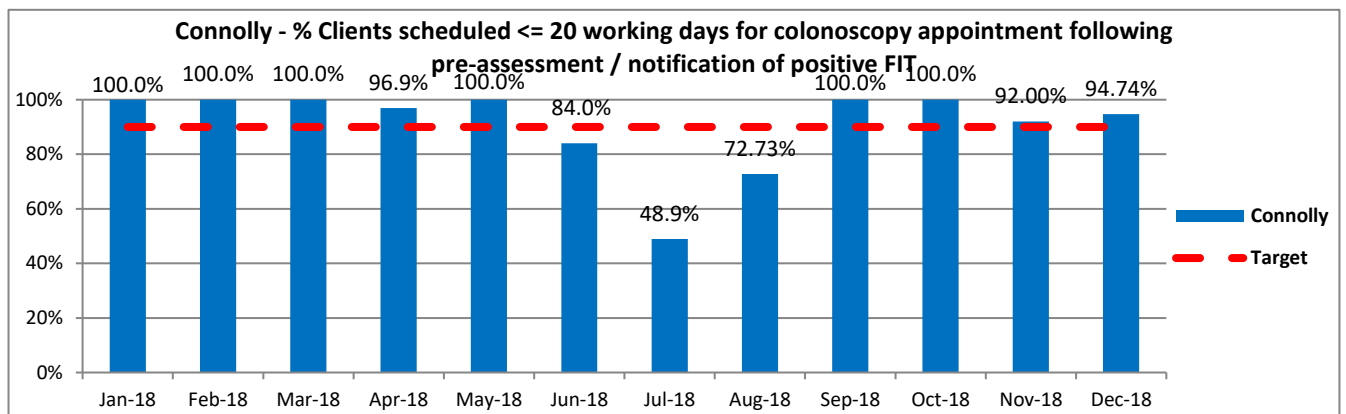
3:11 ACCESS TO NATIONAL NEUROSURGICAL UNIT

Rationale for measurement

Beaumont Hospital is the National Referral Centre for Neurosurgery in Ireland. Neurosurgery concerns the operative and non-operative management of patients with disorders of the central and peripheral nervous systems. The specialty developed initially through the treatment of cranial trauma and intracranial mass lesions. Subsequent advances in microsurgical techniques, non-invasive imaging, neuro-anaesthesia, intensive care, image-guided surgery, and the introduction of sophisticated radio-oncological and interventional treatments have substantially enhanced and widened the scope of effective neurosurgical treatment. Delay in access to Unit can result in delay in treatment commencing with potential for less than optimal outcome for patients.

Measurement methodology and data sources

- Beaumont is the National Neurosurgical Unit. Therefore data for Beaumont hospital only is represented.
- Periodic local data extracts submitted quarterly and retrospectively extrapolated for analysis and publication.

Targets

1 100% of patients triaged as Traumatic Brain Injury (TBI) admitted to Unit within 12 hours of acceptance.

2 90% of patients triaged as Grade I / II Sub-arachnoid Haemorrhage (SAH) admitted to Unit within 24 hours of acceptance.

3 90% of patients triaged as having a brain tumour are transferred to Unit within 5 working days / 7 calendar days of acceptance

Performance

RCSI Hospital Group
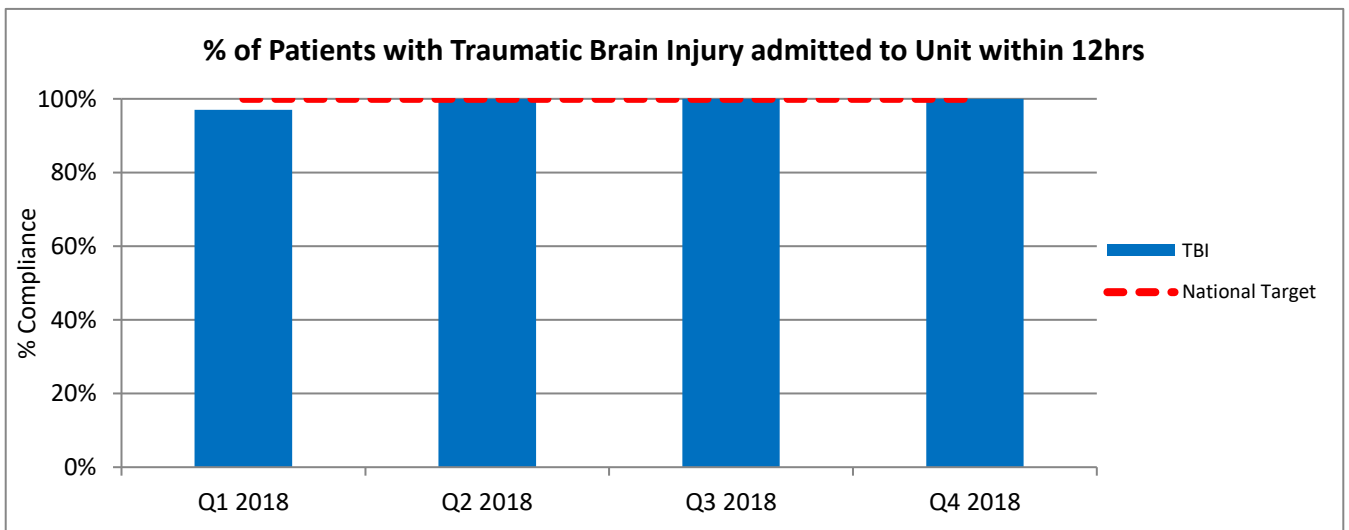
% of Patients with Traumatic Brain Injury admitted to Unit within 12hrs

- 100% compliance with target achieved (National target of 100%)

% of Patients with Sub-arachnoid Haemorrhage admitted to Unit within 24 hrs of acceptance

- 100% compliance with target achieved (National target of 90%)

% of Patients with Brain Tumour admitted to Unit within 5 working days of acceptance
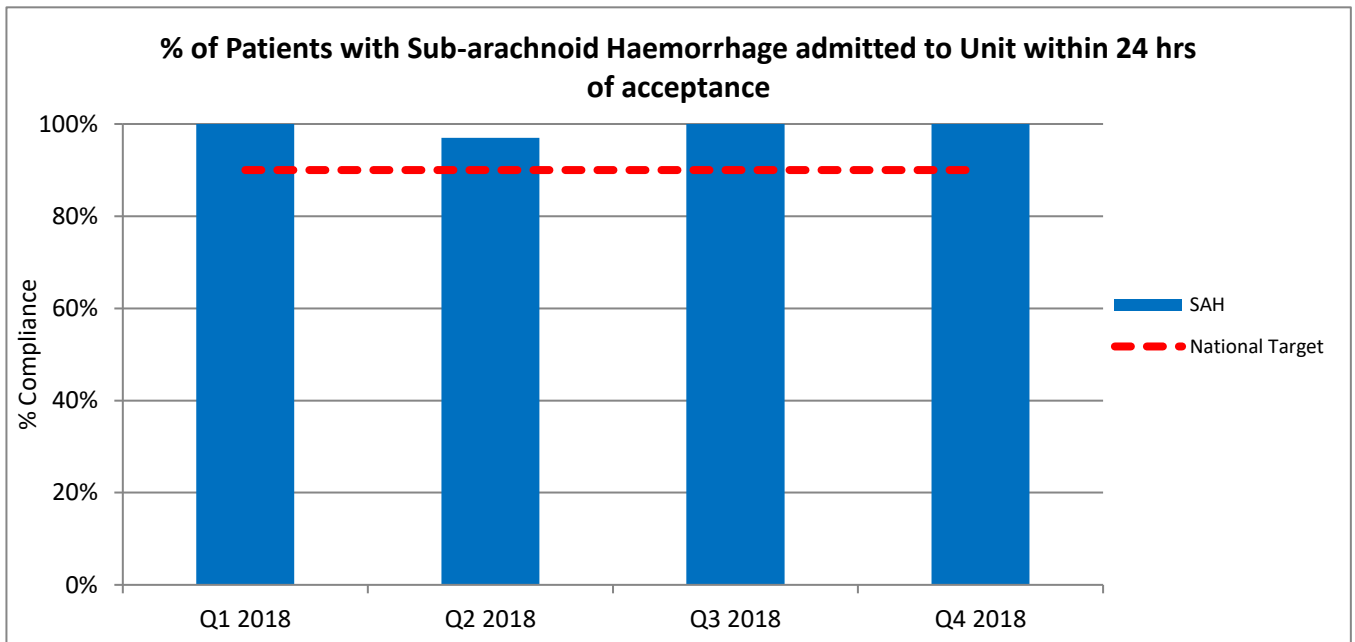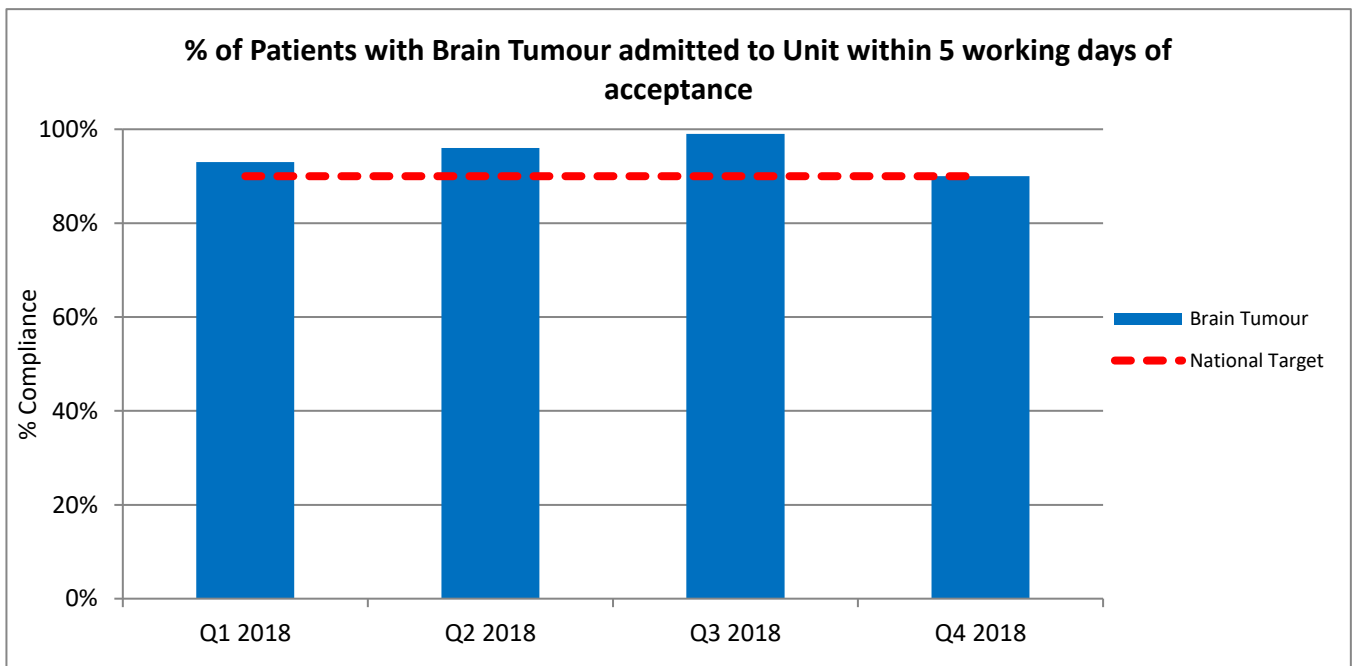
- 90% compliance with target achieved (National target of 90%)

3:12 DIAGNOSTIC IMAGING WAITING TIMES

Rationale for measurement

Significant delay in securing necessary diagnostic image report can delay primary diagnosis, treatment commencement or treatment review with potential for less than optimal outcome for patients.

Measurement methodology and data sources

- waiting time from diagnostic order identification and diagnostic being undertaken (either GP or Consultant)
- local site data sets extrapolated for analysis and publication, by definition excluding time staged diagnostic order requirements
- national data sets not available at time of report publication

Target

- Ultrasound < 3 months
- MRI < 6 months
- CT < 6 months

Performance

Beaumont Hospital

Beaumont Hospital - Ultrasound - 2018

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
100.00%	100.00%	100.00%	100.00%	100.00%	99.80%	99.69%	99.79%	100.00%	100.00%	100.00%	100.00%

Beaumont Hospital - MRI - 2018

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
94.60%	99.30%	93.50%	93.96%	98.96%	99.62%	99.93%	99.45%	99.86%	99.50%	99.87%	99.82%

Beaumont Hospital - CT - 2018

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
99.06%	98.49%	97.45%	99.45%	96.65%	97.61%	99.84%	97.68%	97.93%	98.15%	99.65%	99.68%

- US 100% waiting < 3 months - Beaumont achieved target
- MRI 99.82% waiting < 6 months - Beaumont did not achieve target
- CT 99.68% waiting < 6 months - Beaumont did not achieve target
- national performance currently not published

Appendix 1: Quality Assurance Key Performance Metrics

Connolly Hospital

Connolly Hospital - Ultrasound - 2018

% Compliance: Jan 48.45%, Feb 47.21%, Mar 47.39%, Apr 45.61%, May 43.53%, Jun 42.40%, Jul 41.10%, Aug 39.04%, Sep 31.56%, Oct 39.46%, Nov 41.25%, Dec 38.96% — % waiting < 3 months

Connolly Hospital - MRI - 2018

% Compliance: Jan 100.00%, Feb 100.00%, Mar 100.00%, Apr 100.00%, May 100.00%, Jun 100.00%, Jul 100.00%, Aug 100.00%, Sep 100.00%, Oct 100.00%, Nov 100.00%, Dec 100.00% — % waiting < 6 months

Connolly Hospital - CT - 2018

% Compliance: Jan 52.13%, Feb 53.87%, Mar 51.54%, Apr 53.09%, May 53.05%, Jun 54.93%, Jul 53.46%, Aug 54.93%, Sep 64.29%, Oct 63.98%, Nov 63.72%, Dec 65.24% — % waiting < 6 months

- US 38.96% waiting < 3 months - Connolly did not achieve target
- MRI 100% waiting < 6 months - Connolly achieved target
- CT 65.24% waiting < 6 months - Connolly did not achieve target
- national performance currently not published

Cavan Hospital

Cavan Hospital - Ultrasound - 2018

% Compliance: Jan 39.66%, Feb 51.18%, Mar 78.62%, Apr 94.17%, May 97.56%, Jun 98.38%, Jul 93.17%, Aug 100.00%, Sep 97.66%, Oct 100.00%, Nov 96.53%, Dec 100.00% — % waiting < 3 months

Cavan Hospital - MRI - 2018

% Compliance: Jan 88.64%, Feb 82.14%, Mar 74.62%, Apr 84.36%, May 79.90%, Jun 77.92%, Jul 77.55%, Aug 76.08%, Sep 80.57%, Oct 82.91%, Nov 93.32%, Dec 89.30% — % waiting < 6 months

Appendix 1: Quality Assurance Key Performance Metrics

Cavan Hospital - CT - 2018

Bar chart showing % Compliance (% waiting < 6 months) by month:
Jan 95.77%, Feb 96.00%, Mar 93.83%, Apr 95.62%, May 96.82%, Jun 95.82%, Jul 90.91%, Aug 86.73%, Sep 87.60%, Oct 86.17%, Nov 82.10%, Dec 73.47%

- US 100% waiting < 3 months - Cavan achieved target
- MRI 89.30% waiting < 6 months - Cavan did not achieve target
- CT 73.47% waiting < 6 months - Cavan did not achieve target
- national performance currently not published

OLOL Hospital

OLOL Hospital - Ultrasound - 2018

Bar chart showing % Compliance (% waiting < 3 months) by month:
Jan 42.15%, Feb 62.37%, Mar 72.72%, Apr 63.27%, May 61.90%, Jun 64.09%, Jul 58.20%, Aug 53.21%, Sep 56.47%, Oct 61.11%, Nov 61.09%, Dec 58.15%

OLOL Hospital - MRI - 2018

Bar chart showing % Compliance (% waiting < 6 months) by month:
Jan 76.66%, Feb 87.33%, Mar 97.07%, Apr 81.27%, May 81.04%, Jun 81.76%, Jul 79.42%, Aug 84.78%, Sep 79.40%, Oct 80.92%, Nov 81.05%, Dec 79.40%

OLOL Hospital - CT - 2018

Bar chart showing % Compliance (% waiting < 6 months) by month:
Jan 80.80%, Feb 94.17%, Mar 91.94%, Apr 89.77%, May 100.00%, Jun 93.81%, Jul 91.89%, Aug 91.22%, Sep 91.17%, Oct 91.84%, Nov 92.03%, Dec 92.35%

- US 58.15% waiting < 3 months - OLOL did not achieve target
- MRI 79.40% waiting < 6 months - OLOL did not achieve target
- CT 92.35% waiting < 6 months - OLOL did not achieve target (OLOL CT includes out-patients scanned in LCH under OLOL MRN)
- national performance currently not published

Louth County Hospital

LCH Hospital - Ultrasound - 2018
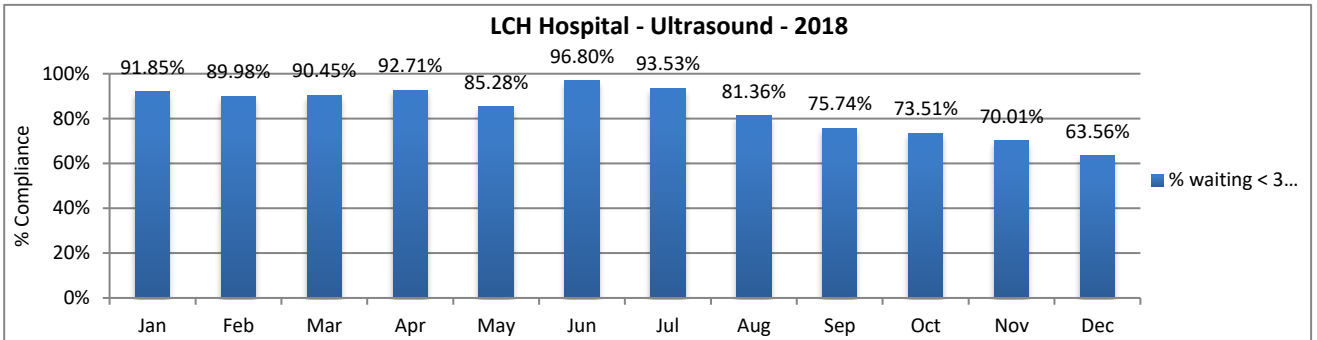
- US 63.56% waiting < 3 months - LCH did not achieve target
- national performance currently not published

RCSI Hospital Group

RCSI HG - Ultrasound - 2018

RCSI HG - MRI - 2018

RCSI HG - CT - 2018
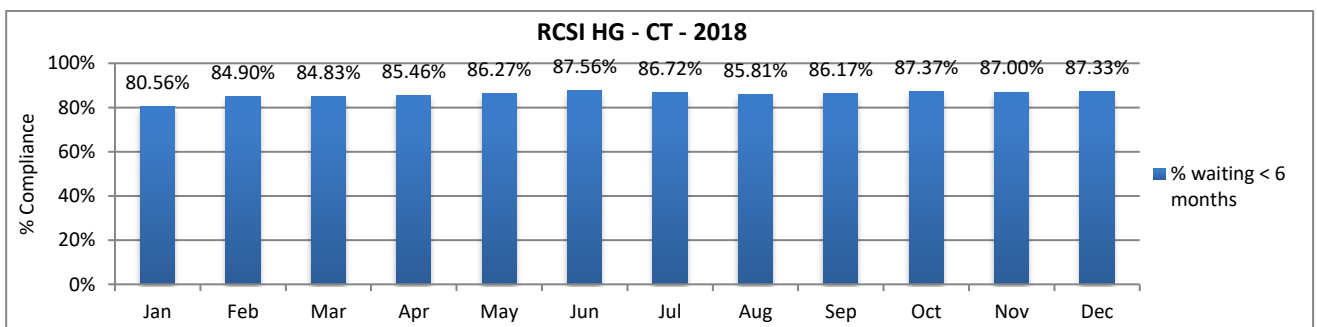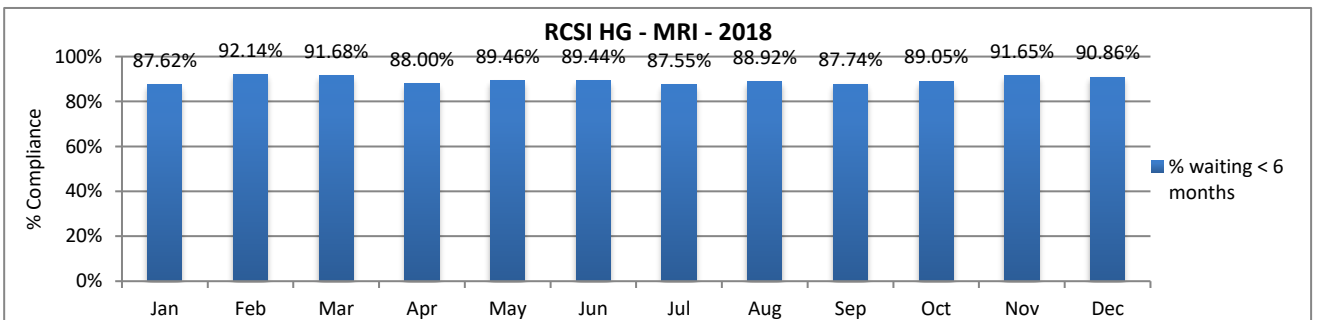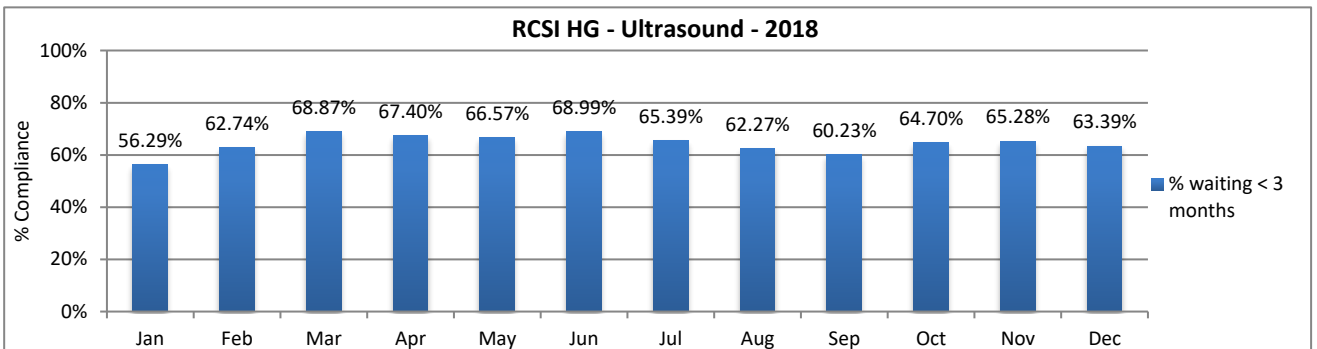
- US 63.39% waiting < 3 months - Group did not achieve target
- MRI 90.86% waiting < 6 months - Group did not achieve target
- CT 87.33% waiting < 6 months - Group did not achieve target
- national performance currently not published

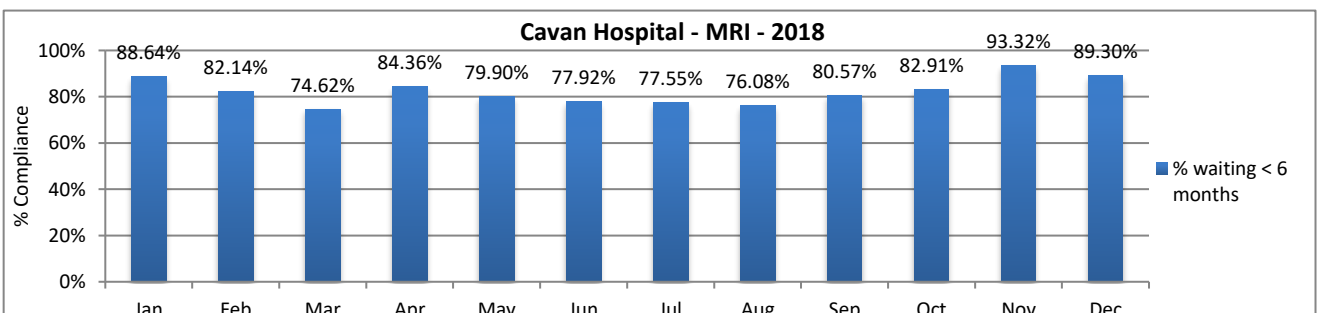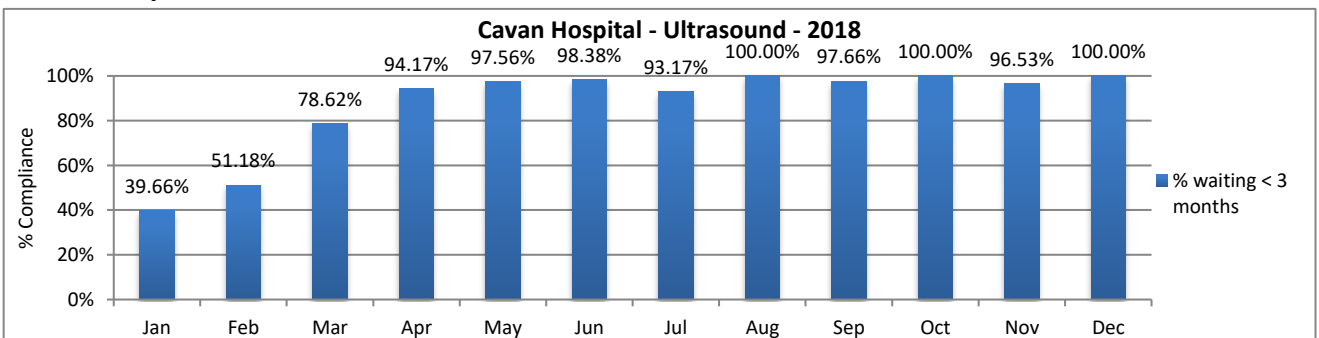## Rotunda Hospital (not included in Group total - only Gynae scans)

Diagnostic Modality	0-3 months	3-6 months	6-12 months	12+ months
Ultrasound (US)	74	39	27	0

- demonstrating
  - US 52.86% waiting < 3 months - Rotunda did not achieve target

3:13 Percent 'Did not Attend' (DNA) of total OPD bookings

Rationale for measurement

Non-attendance of new patients for OPD appointment negates the ability to diagnose and treat and generally wastes clinical time. This wasted clinical time significantly adds to wait times for other patients.

Measurement methodology and data sources

- periodic local data extracted and extrapolated for analysis and publication by HSE BIU
- source for national data provided by BIU OPD MDR

Target

- Less than 5% of new OPD bookings do not attend appointment

Performance
RCSI Hospital Group
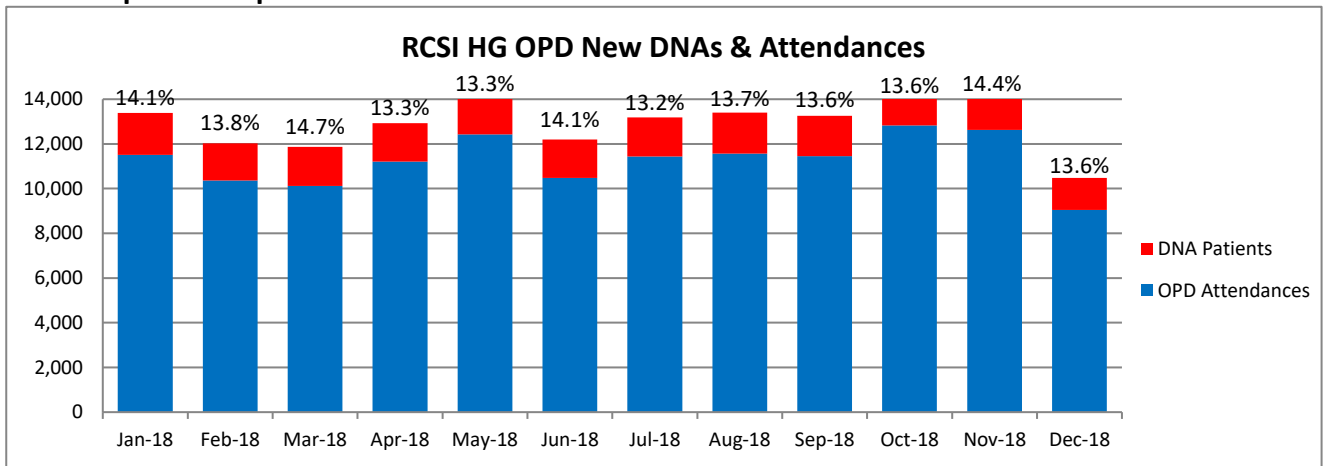
- cumulative for 2018 reporting period 13.8% of total new bookings (n=21587) did not attend (DNA) scheduled appointments / 2017 13.9% DNA (n=20532) - represents 5.1% increase
  - Beaumont 2018 14.4% DNA / 2017 14.3% DNA
  - Cavan 2018 9.3% DNA / 2017 9.4% DNA
  - Connolly 2018 16.7% DNA / 2017 17.3% DNA
  - OLOL 2018 10.7% DNA / 2017 10.9% DNA
  - Louth 2018 11.8% DNA / 2017 14.4% DNA
  - Rotunda 2018 15.7% DNA / 2017 15.5% DNA

National Performance Comparator
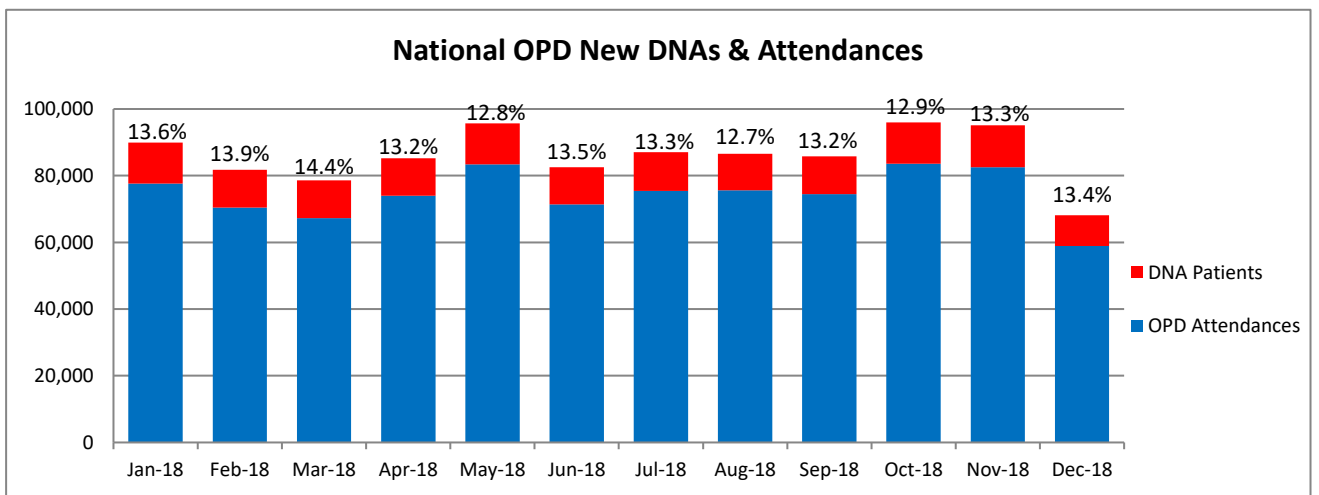
- during December reporting period 13.4% of total new bookings (n = 9,145) did not attend scheduled appointment

3:14 POLYP DETECTION RATE

Rationale for measurement

Internationally accepted guidelines on performance indicators for colonoscopy recommend monitoring of detection rates of suspicious lesions including polyps and adenomas.

Measurement methodology and data sources

The data is recorded at local hospital Endoscopy Units. It is subsequently reported into Conjoint Board in Ireland of the Royal College of Physicians and Royal College National Quality Improvement Programme in GI Endoscopy (EQI Programme) in collaboration with the National Cancer Control Programme.

Results are reported as *colonoscopies with polyp detected expressed as a % of total colonoscopies per endoscopist.*

Data Sources:
1. https://www.rcpi.ie/quality-improvement-programmes/gastrointestinal-endoscopy
2. National GI Endoscopy Quality Improvement Programme 2017-2018 Data Report, Conjoint Board in Ireland of the Royal College of Physicians and Royal College of Surgeons

Target

- 20% of all colonoscopies have a polyp(s) detected.

Performance
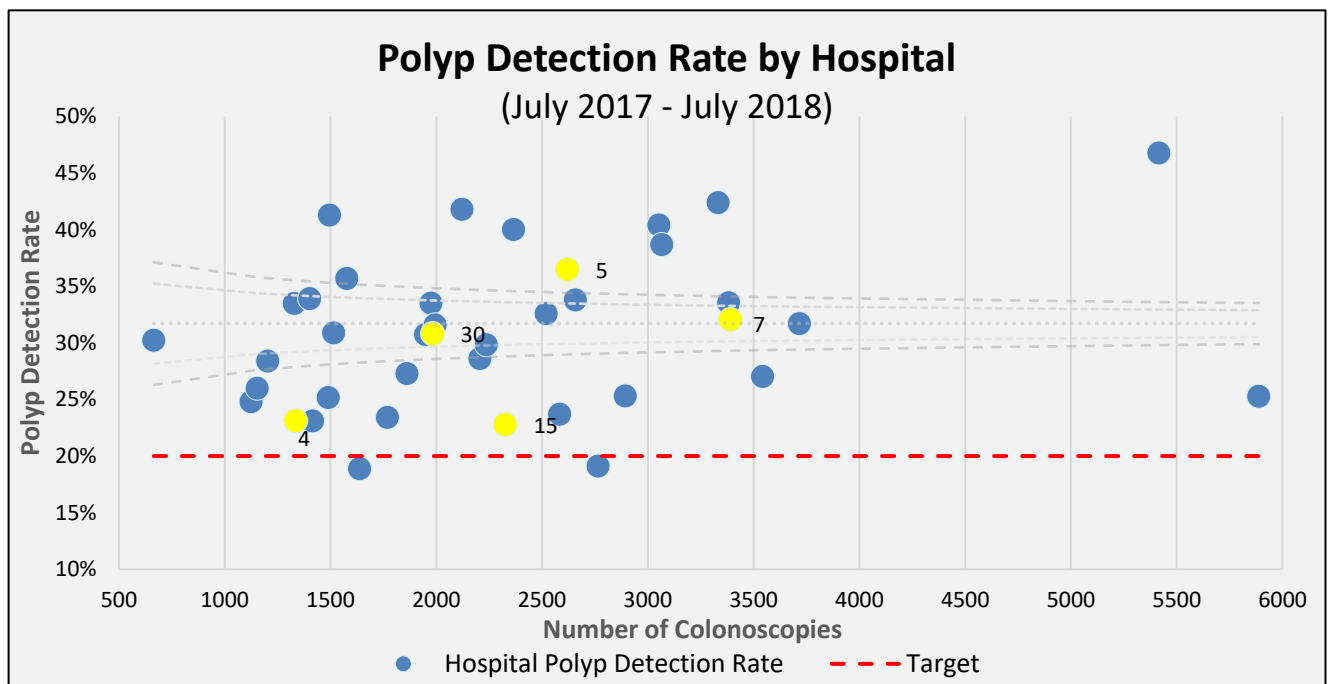
4 = Our Lady of Lourdes Hospital (23%)

5 = Connolly Hospital (37%)
7 = Beaumont Hospital (32%)
15 = Cavan General Hospital (23%)
30 = Louth County Hospital (31%)
- All hospitals in RCSI Hospital Group achieved target

3:15 CAECAL INTUBATION RATE

Rationale for measurement

Caecal intubation is defined as the passage of the tip of the colonoscope to a point proximal to the ileocecal valve so that the entire cecum is visualised. Caecal intubation rates (CIR) is a key quality indicator of colonoscopy. Caecal intubation can be expected to be difficult in 5%–15% of colonoscopies, but skilled colonoscopists should be able to apply techniques to overcome the difficulties in most of these instances and reach the cecum in ≥90% of all cases.

Measurement methodology and data sources

The data is recorded at local hospital Endoscopy Units. It is subsequently reported into Conjoint Board in Ireland of the Royal College of Physicians and Royal College National Quality Improvement Programme in GI Endoscopy (EQI Programme) in collaboration with the National Cancer Control Programme.

Results are reported as *number of colonoscopies where the terminal ileum/caecum/anastomosis has been reached as a % of total colonoscopies per endoscopist.*

Data Sources:

1. https://www.rcpi.ie/quality-improvement-programmes/gastrointestinal-endoscopy
2. National GI Endoscopy Quality Improvement Programme 2017-2018 Data Report, Conjoint Board in Ireland of the Royal College of Physicians and Royal College of Surgeons

Target

- 90% of all colonoscopy cases should reach the terminal ileum/caecum/anastomosis

Performance
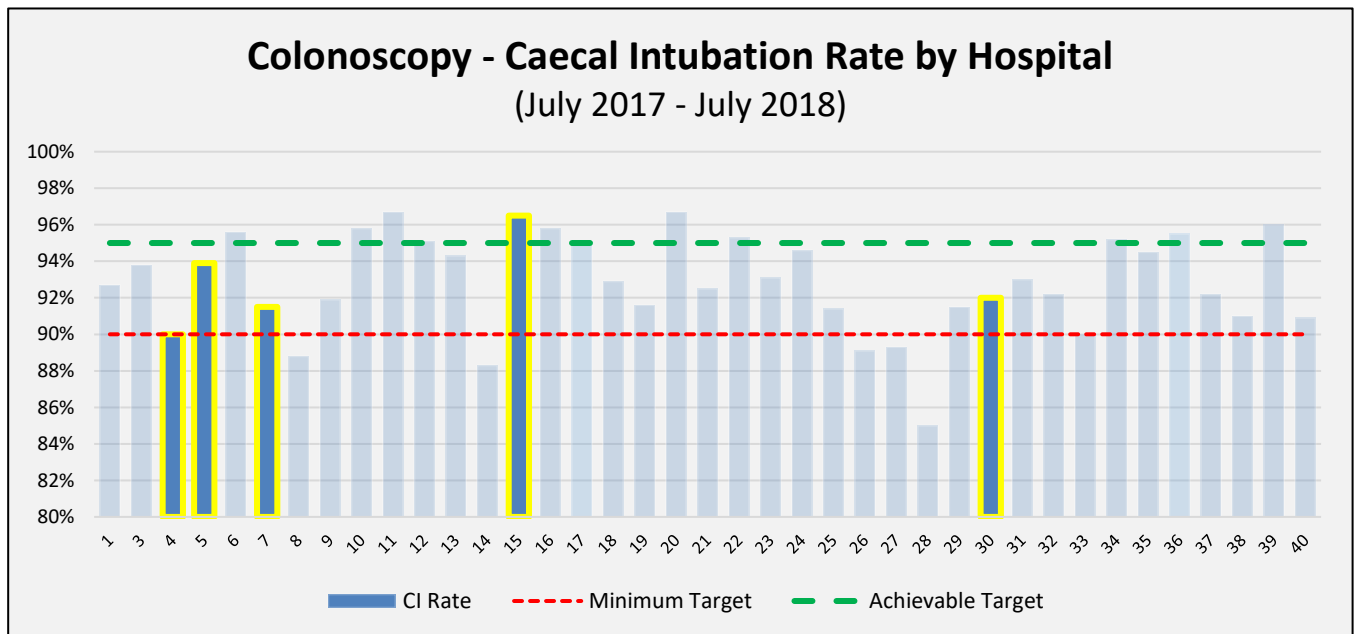
4 = Our Lady of Lourdes Hospital (90%)
5 = Connolly Hospital (94%)
7 = Beaumont Hospital (92%)
15 = Cavan General Hospital (97%)
30 = Louth County Hospital (92%)
- All hospitals in RCSI Hospital Group achieved target

Appendix 1: Quality Assurance Key Performance Metrics

3:16 24 DAY CASE PROCEDURES

Introduction

Elective day surgery is the admission of selected patients to hospital for a planned surgical procedure who return home on the same day. Elective day surgery benefits patients as they receive treatment that is suited to their needs and allows them to recover in their own home. In addition the risk of patients contracting a hospital acquired infection is reduced. Elective day case surgery releases inpatient beds for major cases, this improves throughput of patients and reduces waiting lists.

Rationale for measurement

75% of elective admissions on each of the 24 procedures identified can be carried out as day cases *(National Elective Surgery Programme, Royal College of Surgeons in Ireland, Irish College of Anaesthetists and Health Service Executive).*

(Orchidopexy, Circumcision, Inguinal Hernia Repair, Excision of Breast Lump, Anal Fissure Dilatation or Excision, Haemorrhoidectomy, Laparoscopic Cholecystectomy, Varicose Vein Stripping or Ligation, Transurethral Resection of Bladder Tumour (<2cm), Excision of Dupuytren's Contracture, Carpal Tunnel Decompression, Excision of Ganglion, Arthroscopy, Bunion Operations, Removal of Metal-ware, Extraction of Cataract with/without Implant, Correction of Squint, Myringotomy, Tonsillectomy, Sub Mucous Resection, Reduction of Nasal Fracture, Operation for Bat Ears, Dilatation and Curettage/Hysteroscopy, Laparoscopy).

Measurement methodology and data sources

Local Hospital HIPE Data extrapolated for analysis and publication and published on a quarterly basis.

Target

75% of elective admissions on each of the 24 procedures identified are carried out as a day case.

Performance

RCSI Group - Basket of 24 - Quarter 3 2018
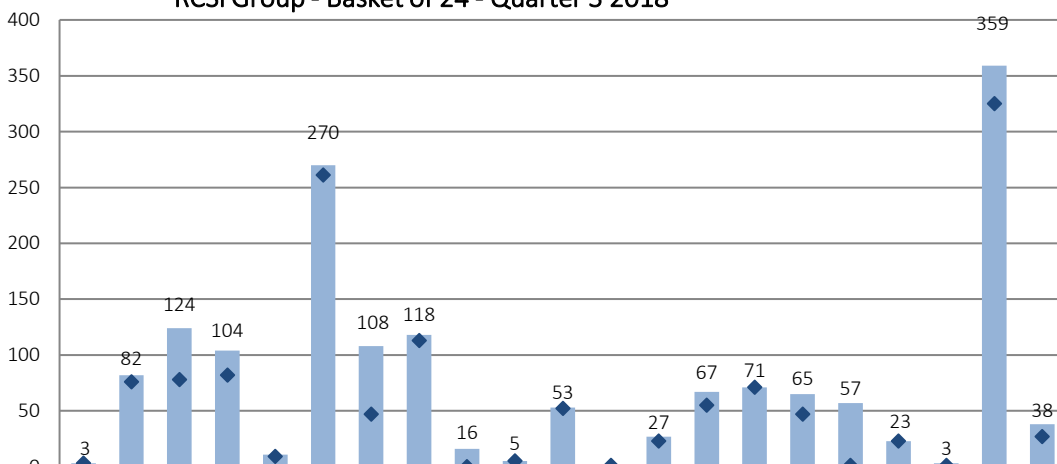
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Totals
TOTAL Admitted	3	82	124	104	11	270	108	118	16	5	53	1	27	67	71	65	57	23	3	359	38	1605
Performed as a Daycases	3	76	78	82	9	261	47	113	0	5	52	1	23	55	71	47	1	23	1	325	27	1300
Total % Performed as a Daycase	100%	93%	63%	79%	82%	97%	44%	96%	0%	100%	98%	100%	85%	82%	100%	72%	2%	100%	33%	91%	71%	**77%**

1	Orchidopexy	12	Excision of Ganglion
2	Circumcision	13	Arthroscopy
3	Inguinal Hernia Repair	14	Removal of Metal Ware
4	Excision of Breast Lump	15	Extraction of Cataract with/without Implant
5	Anal fissure dilation or Excision	16	Myringotomy
6	Haemorrhoidectomy	17	Tonsillectomy
7	Laparoscopic Cholecystectomy	18	Reduction of Nasal Fracture
8	Varicose Vein Stripping or Ligation	19	Operation for Bat Ears
9	Transurethral resection of Bladder Tumour <2cm	20	Dilation and Currettage / Hysteroscopy
10	Excision of Dupuytren's Contracture	21	Laparoscopy
11	Carpal Tunnel Decompression		

- 77% of procedure basket undertaken on a daycare basis - overall target achieved

3:17 SCHEDULED CARE ENTRY RECORDING

Rationale for measurement

Four key reasons may cause delay in patients receiving timely diagnosis and treatment and can also waste clinical treatment time:

- tardy recording of patient details onto scheduled care waiting list record (OPD / IP / DC)
- absence of advance patient notification in regard to intended scheduled care: OPD appointment / Day Care attendance / Inpatient admission date
- incomplete patient specific minimum data set record
- non-compliance with Hospital Group policies in regard to patients not being able to attend (CNA) scheduled OPD appointment / Day Care attendance / Inpatient admission date or patients who do not attend (DNA) scheduled OPD appointment / Day Care attendance / Inpatient admission (**see 3.12**)

Measurement methodology and data sources

- periodic sampling (taken on a monthly basis) of Hospital Group *'waiting list'* data sets to ascertain:
  - time period from receipt of GP referral letter / treatment requirement identification and waiting list record entry
  - advance patient notification in regard to intended scheduled care: OPD appointment / Day Care attendance / Inpatient admission date
  - completeness of patient specific minimum data set record: all hospital waiting list cards examined for inclusion of 25 items
  - for those patients identified as *'could not attend'* (CNA) i.e. sickness, leave, family commitments review of subsequent practises in terms of record keeping including patient waiting time
  - for those patients identified as '*did not attend'* (DNA) review of subsequent practices in terms of record keeping including patient waiting time

Target:

- > 95% of New OPD / Day Care / Inpatient record entries. Two measurements of compliance
  - WL record is updated within 3 working days of receipt of WL booking form
  - start date on WL record = Decision to Admit date
- > 95% of patients are directly notified in regard to intended scheduled care appointment / attendance
- > 95% compliance with sending acknowledgement letter (outpatients)
- > 85% compliance with completeness of patient specific minimum data set record
- > 90% compliance with DNA / CNA RCSI HG policies

Performance

% compliance recording of patient details onto scheduled care waiting list record

% compliance of recording of patient details onto scheduled care waiting list record ≤ 3 days

Beaumont Hospital	Cavan General Hospital	Connolly Hospital	Louth County Hospital	Our Lady of Lourdes Hospital	RCSI Hospital Group
70%	100%	100%	90%	100%	92%
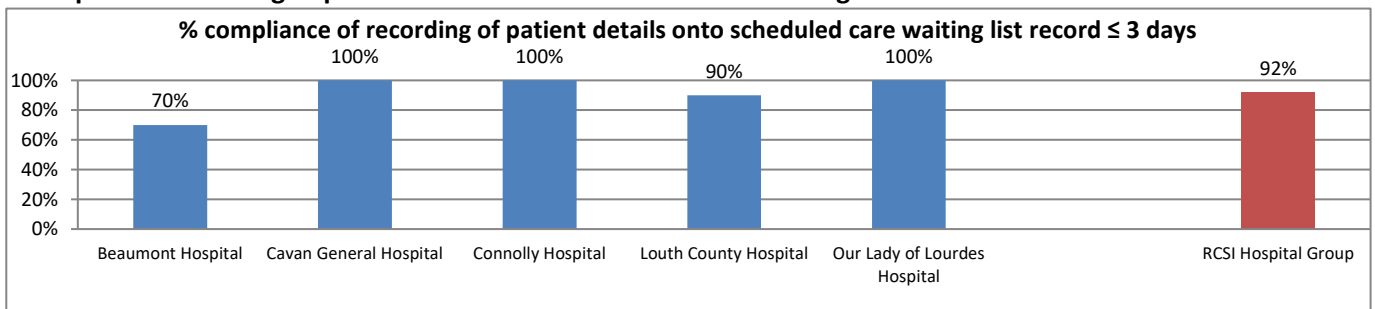
Note[1]: overall sample size n=100 patients (20 per hospital)

- during December overall sample group demonstrated 92% compliance with data entry requirements

% compliance of recording of patient details onto scheduled care waiting list (Start date = DTA)

Beaumont Hospital	Cavan General Hospital	Connolly Hospital	Louth County Hospital	Our Lady of Lourdes Hospital	RCSI Hospital Group
70%	95%	85%	100%	100%	90%
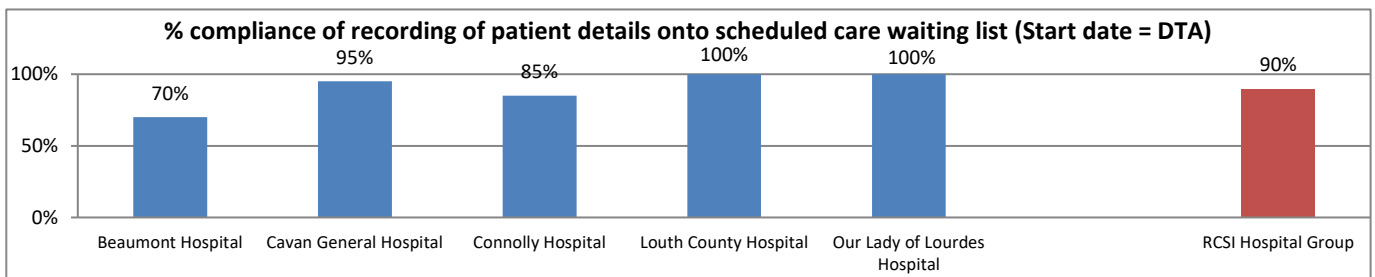
- during December overall sample group demonstrated 90% compliance with data entry requirements
- Connolly Hospital have rectified data capture to NTPF to correct field and now have a compliance rate of 85% compared to 0% in previous audits

Appendix 1: Quality Assurance Key Performance Metrics

% compliance with advance patient notification ≥ 14 days' notice

% compliance with advance patient notification ≥ 14 days notice

Hospital	Value
Beaumont Hospital	50%
Cavan General Hospital	85%
Connolly Hospital	100%
Louth County Hospital	100%
Our Lady of Lourdes Hospital	100%
RCSI Hospital Group	87%
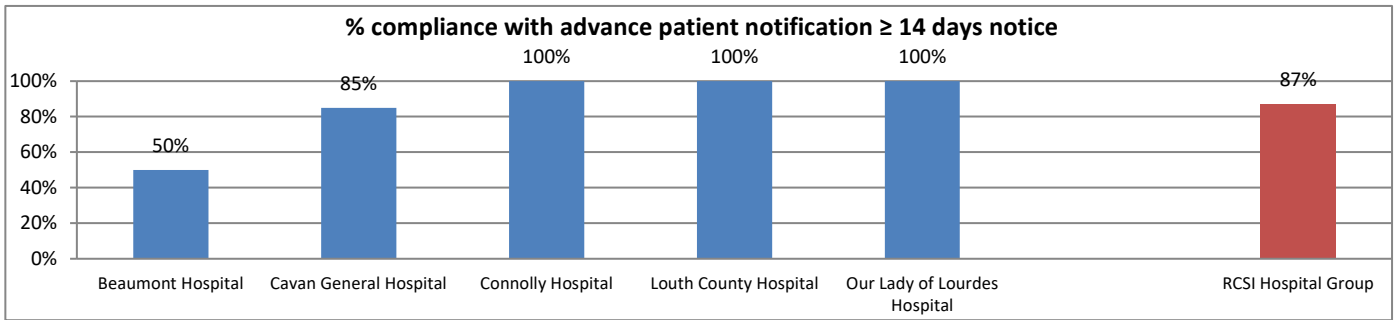
Note[2]: overall sample size n=100 patients (20 per hospital)
- during December overall sample group demonstrated 87% compliance with patient notification requirements (IP.DC)

% compliance of sending acknowledgement letter (Out Patients)

% compliance with acknowledgement notification of patient on OPD waiting list

Hospital	Value
Beaumont Hospital	95%
Cavan General Hospital	90%
Connolly Hospital	100%
Louth County Hospital	100%
Our Lady of Lourdes Hospital	95%
RCSI Hospital Group	96%

Note[3]: overall sample size n=100 patients (20 per hospital)
- during December overall sample group demonstrated 94% compliance with requirement to send acknowledgement letter

% compliance of patient specific minimum data set completeness on WL Record

% compliance of patient specific minimum data set completeness on WL Record

Hospital	Value
Beaumont Hospital	58%
Cavan General Hospital	66%
Connolly Hospital	86%
Louth County Hospital	75%
Our Lady of Lourdes Hospital	88%
RCSI Hospital Group	75%
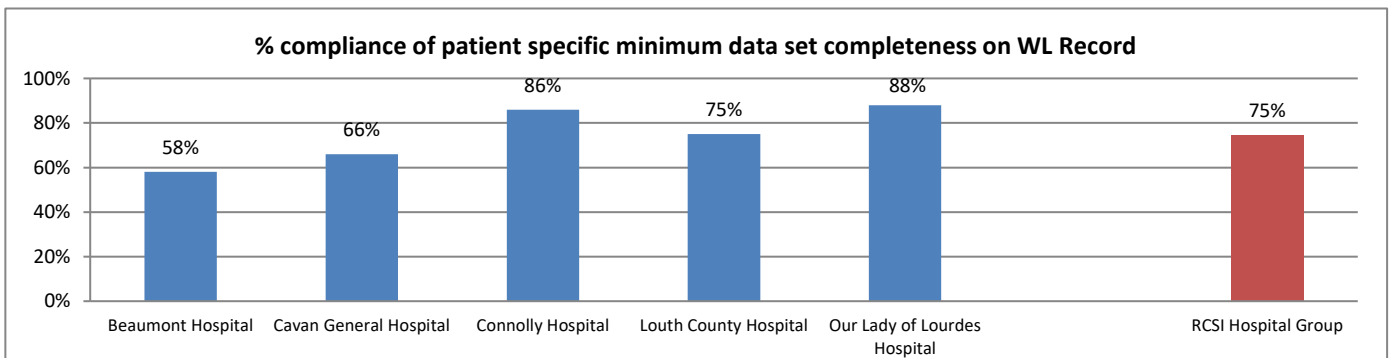
Note[4]: sample size n=250 data sets
- during December overall sample group demonstrated 75% compliance with completion of patient specific minimum data set

% compliance of DNA / CNA Policy compliance

% compliance of DNA / CNA Policy compliance
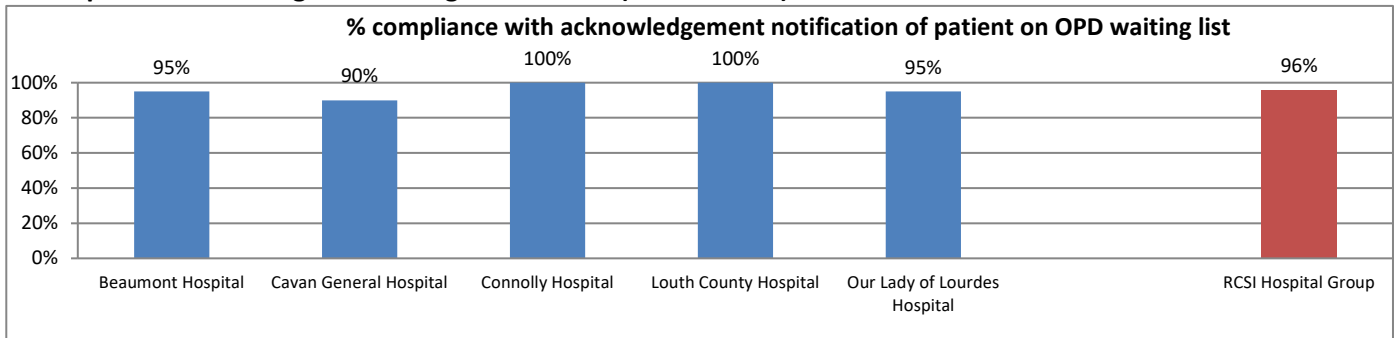
Hospital	DNA	CNA
Cavan General Hospital	85%	100%
Connolly Hospital	85%	100%
Louth County Hospital	90%	85%
Our Lady of Lourdes Hospital	100%	95%
RCSI Hospital Group	90%	95%
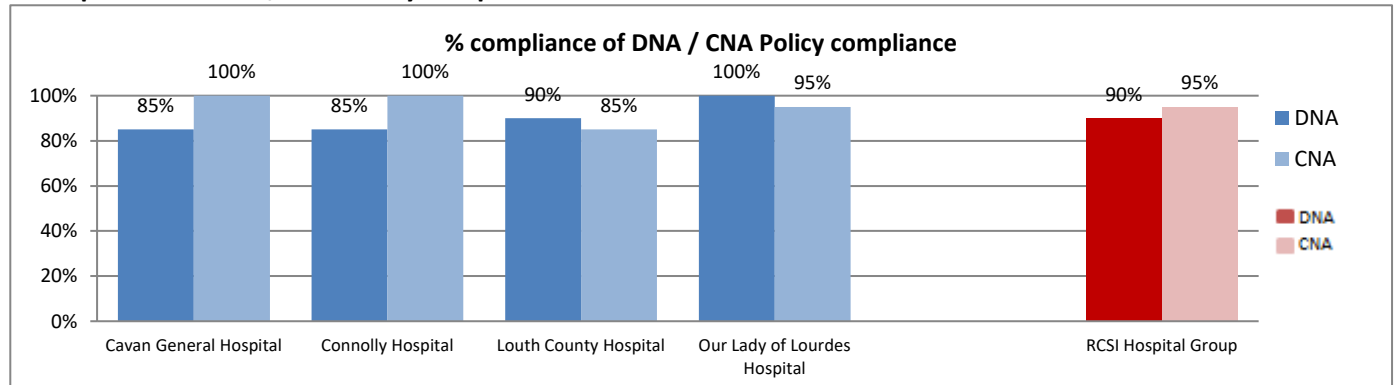
Note[5]: DNA policy: DNA patients are removed from waiting list   Note[6]: If patient cannot attend (CNA) their wait time clock restarts
Note[7]: Report sample size (n=200)
- during December overall sample group demonstrated 90%/95% compliance with DNA and CNA policies respectively
  - Beaumont DNA/CNA information unavailable on PTL as ICT project for mapping of codes is currently in process

CHAPTER 4: DIMENSION: INFECTION CONTROL AND MANAGEMENT

4:1 RATE OF NEW CASES OF HOSPITAL ACQUIRED STAPHYLOCOCCUS AUREUS BLOODSTREAM INFECTION

Rationale for measurement

Bloodstream infection with *S. aureus* (which includes MRSA bloodstream infection) occurring more than 48 hours after admission is likely to be hospital-acquired (i.e. the patient is unlikely to have come in with this infection – rather they may have got this infection in the hospital).

What is Staphylococcus aureus?

A bacteria that is commonly carried on the skin or in the nose, where it mostly causes no harm (= carriage or colonisation). Infection occurs when it manages to get through the skin or into other parts of the body where it can multiply and cause a person to become ill.

- It can cause a wide range of infections in hospitals – most commonly skin/wound infections.
- Bloodstream infection is one of the more serious infections and can cause significant morbidity and mortality (in addition to increased length of stay and more medications/procedures). As *S. aureus* is a skin bacteria - *when it gets into the bloodstream in hospital patients it is usually because of a break in skin. Therefore patients with IV lines (drips) and wounds and patients that have had recent procedures (surgery) are at risk if infection prevention and control precautions have not been applied consistently.*

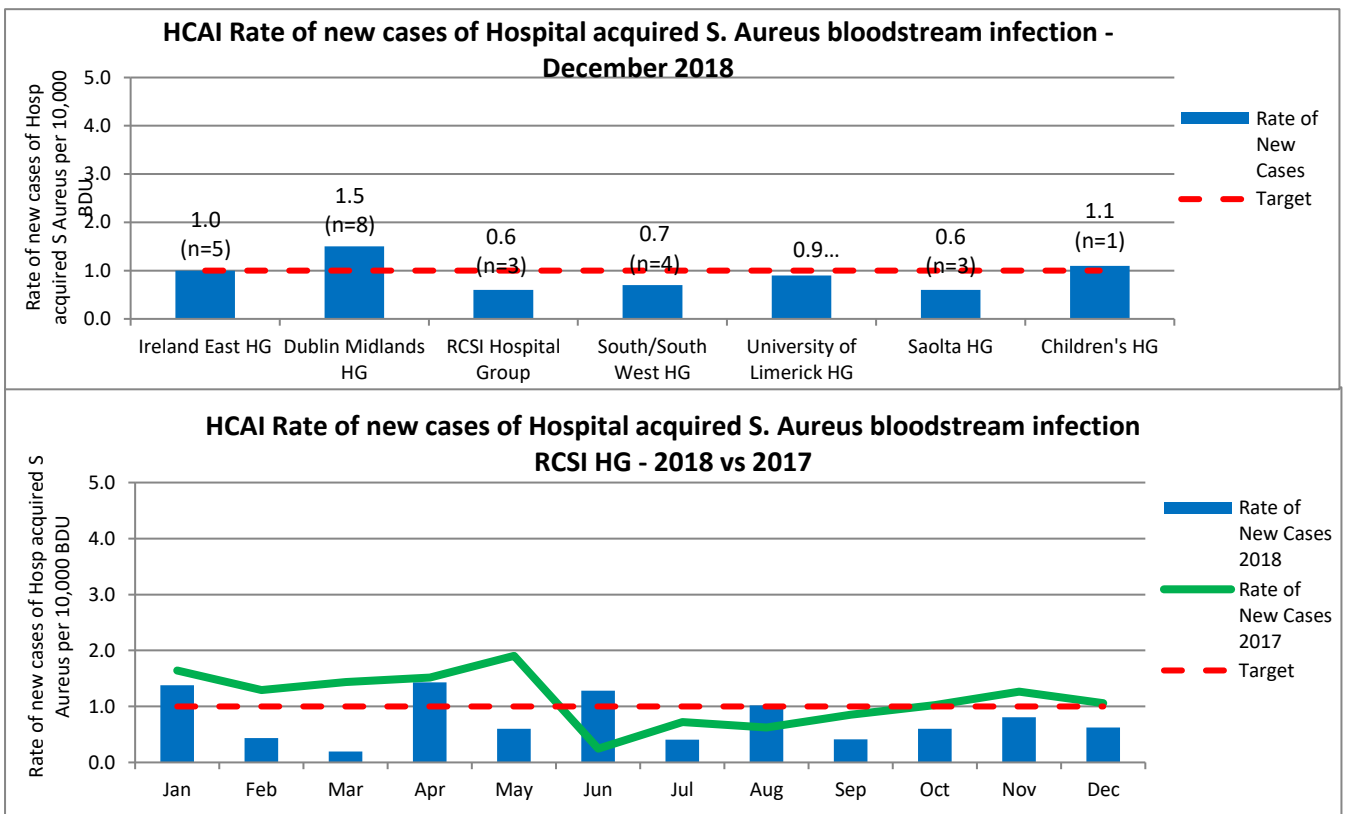**Measurement methodology and data sources**

- S Aureus notification rate per 10,000 bed days used (monthly)
- source for national data provided by BIU MDR

Target:

- <1 new cases per 10,000 Bed Days Used (BDU)

Performance

National - Hospital Group Comparator

- RCSI HG is achieving national performance target for reporting period of December 2018

4:2 RATE OF NEW CASES OF HOSPITAL ACQUIRED CLOSTRIDIUM (C. *DIFFICILE*) INFECTION

Rationale for measurement

Clostridium difficile (*C. difficile*) is a bacterium that can be found in the large bowel. A small proportion (less than 1 in 20) of the healthy adult population carry *C. difficile* and do not experience any symptoms. However sometimes when a person takes an antibiotic, some "good" bacteria die allowing *C. difficile* to multiply and this can lead to *C. difficile* infection (CDI), which affects the large bowel.

Symptoms of CDI include diarrhoea, stomach cramps, fever, nausea and loss of appetite. Most people get a mild illness and recover fully but in certain circumstances, patients can develop serious complications including colitis (inflammation of the bowel), which can be life threatening. Risk factors for developing infection include older age, antibiotic use, serious illness, immune-compromised state (weakened immunity), recent bowel surgery and long term hospitalisation or residence in other health care settings e.g. nursing homes (www.hpsc.ie/A-Z)

Control of *C. difficile* comprises antibiotic stewardship (only using antibiotics when required and using the right antibiotic for the infection in question) and good infection prevention and control practice, which means patients, their family members and hospital staff regularly washing their hands and appropriate cleaning and disinfection of equipment. CDI rates in hospitals are recognised and used internationally as a good measure of the quality and safety of a health care service.

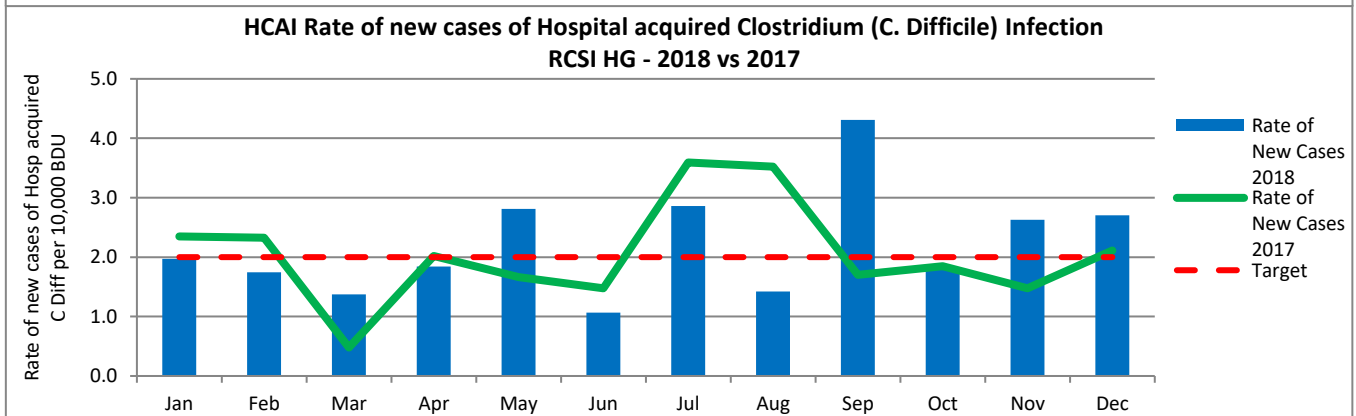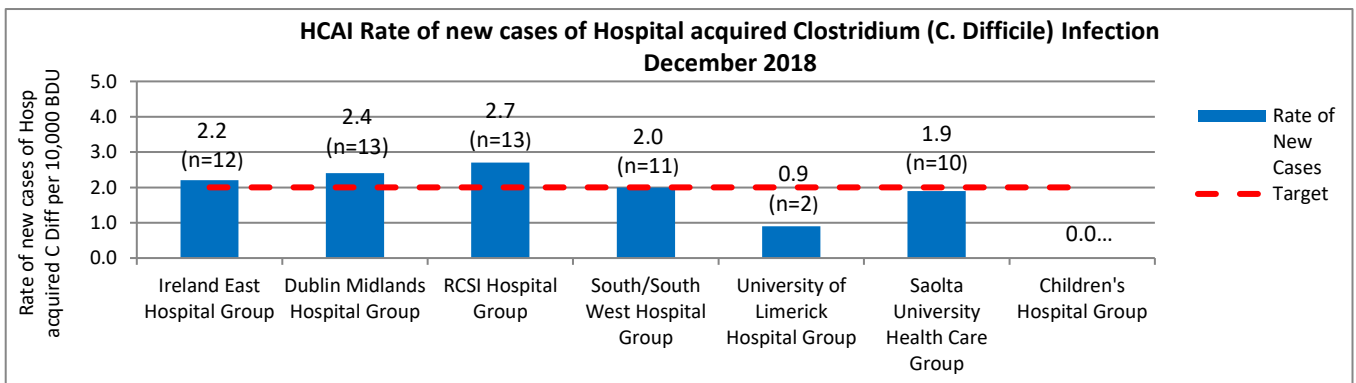### Measurement methodology and data sources

- Clostridium difficile – new cases of healthcare associated C. diff infection per 10,000 bed days (monthly)
- source for national data provided by BIU MDR

Target

- <2 per 10,000 bed days used

Performance
National – Hospital Group Comparator

- RCSI HG is not achieving national performance target for reporting period of December 2018

4.3 NUMBER OF PATIENTS CONFIRMED WITH NEWLY DETECTED CPE

Introduction

Carbapenemase-Producing Enterobacteriaceae (CPE) infections are most commonly seen in people with exposure to healthcare settings such as hospitals and long-term care facilities. In healthcare settings, CPE infections occur among sick patients who are receiving treatment for other conditions.
Patients carrying CPE either colonised or infected need to be identified and isolated to limit onward spread of this infection.

Rationale for measurement

All patients from the following cohorts will be swabbed on admission or transfer to establish whether they are colonised or infected with CPE

- All patients admitted from another healthcare organisation or nursing home. This includes patients who have been an inpatient in any healthcare facility in the last 12 months. Please note any healthcare facility includes the Hospital to which the patient is being readmitted.
- Any patient on admission to a critical care area (Intensive Care Units, High Dependency Units, Neonatal Intensive Care Units or Coronary Care Units) and weekly thereafter.
- All patients admitted to haematology and transplant wards on admission and weekly thereafter.
- All patients who have received Cancer Chemotherapy in the previous twelve months on admission.
- Patients who are receiving Renal Dialysis on their first dialysis and then periodically at periods of not less than six months whilst receiving dialysis. Every patient who has received dialysis in another healthcare organisation needs to be swabbed on return.
- All contacts of a patient identified as having CPE.

Measurement methodology and data sources

- *Carbapenemase-Producing Enterobacteriaceae* – cases of newly detected CPE per 10,000 bed days month
- RCSI CPE Report from Planning and Performance Section, Acute Hospital Division

Target

100% of patients from each of the cohorts identified will be swabbed for CPE.

Performance

Number of patients confirmed with newly detected CPE
December 2018

- 4 confirmed cases of newly detected CPE in RCSI Hospital Group

HCAI Rate of number of patients confirmed with newly detected CPE
RCSI HG - YTD 2018
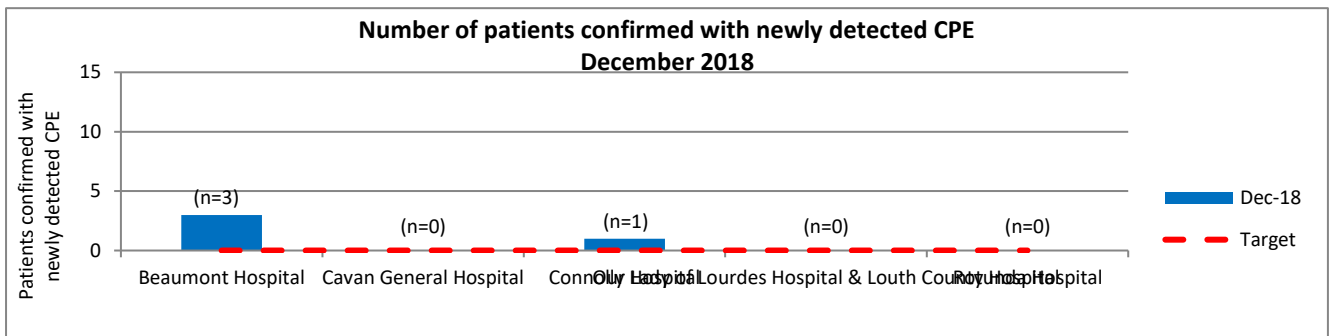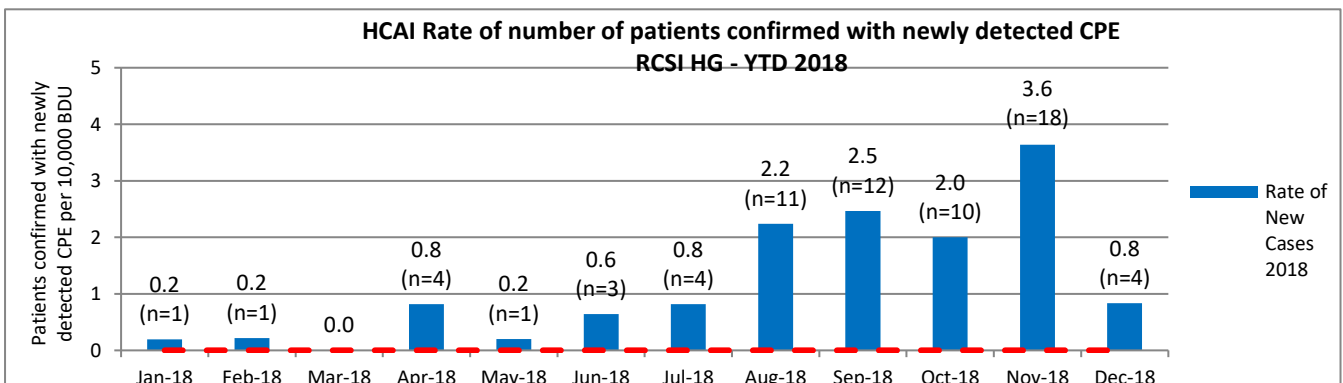
- 69 confirmed cases of newly detected CPE in RCSI Hospital Group in YTD 2018

4:4 PERCENT COMPLIANCE OF HOSPITAL STAFF WITH (WHO) 5 MOMENTS OF HAND HYGIENE USING NATIONAL AUDIT TOOL

Rationale for measurement

Improving healthcare workers hand hygiene compliance has been described by the WHO as a key measure to reduce healthcare-associated infections. Poor hand hygiene practice can result in an increased risk of cross infections from one person to another by hand contact. It is best practice of all staff working in the healthcare facility washing their hands frequently including **(1)** before touching a patient, **(2)** before clean/aseptic procedures, **(3)** after body fluid exposure/risk, **(4)** after touching a patient, **(5)** after touching patient surroundings (WHO, 5 moments).

Measurement methodology and data sources:

- The proportion of healthcare workers who comply with hand hygiene protocols. Source of data - report on Hand Hygiene Compliance in HSE Acute Hospitals. This is measured twice yearly. http://www.hpsc.ie/AZ/MicrobiologyAntimicrobialResistance/EuropeanSurveillanceofAntimicrobialConsumptionESAC/PublicMicroBReports/).

Target

- 90% HSE target proportion of healthcare workers who comply with hand hygiene protocols.

Performance

- Performance data set updated monthly with local hospital data.

Beaumont Hospital

Beaumont Hospital - % Compliance of staff with hand hygiene
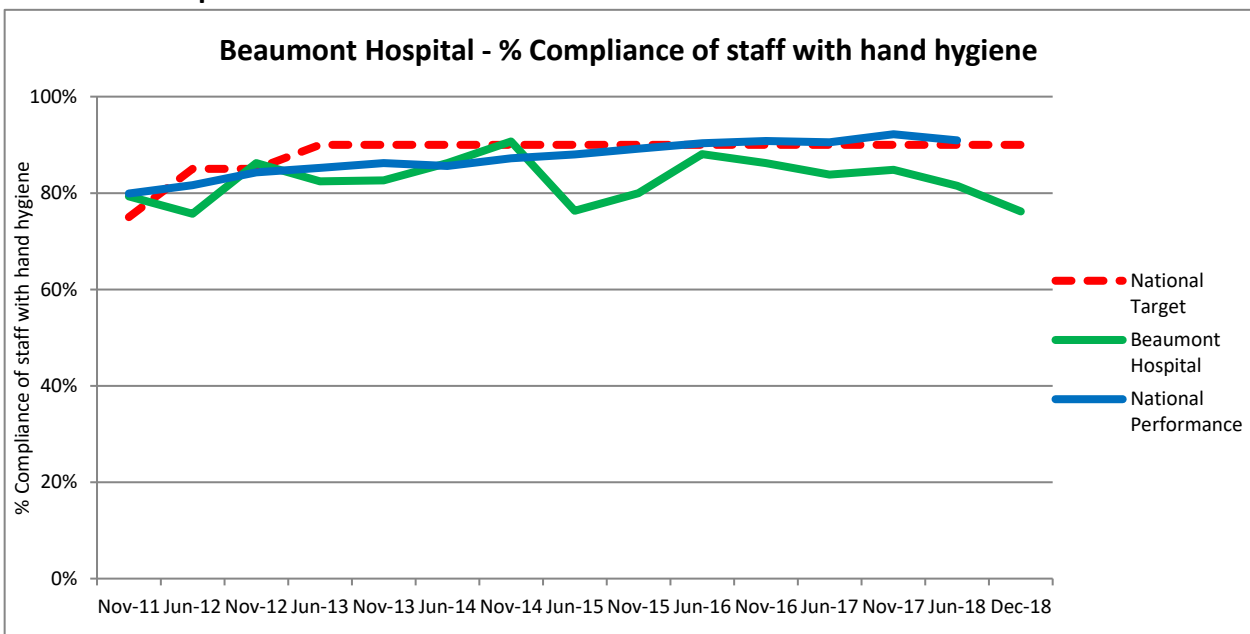
- Beaumont Hospital is not achieving target (December 2018 76%)
- national performance not available at time of publication

Cavan General Hospital
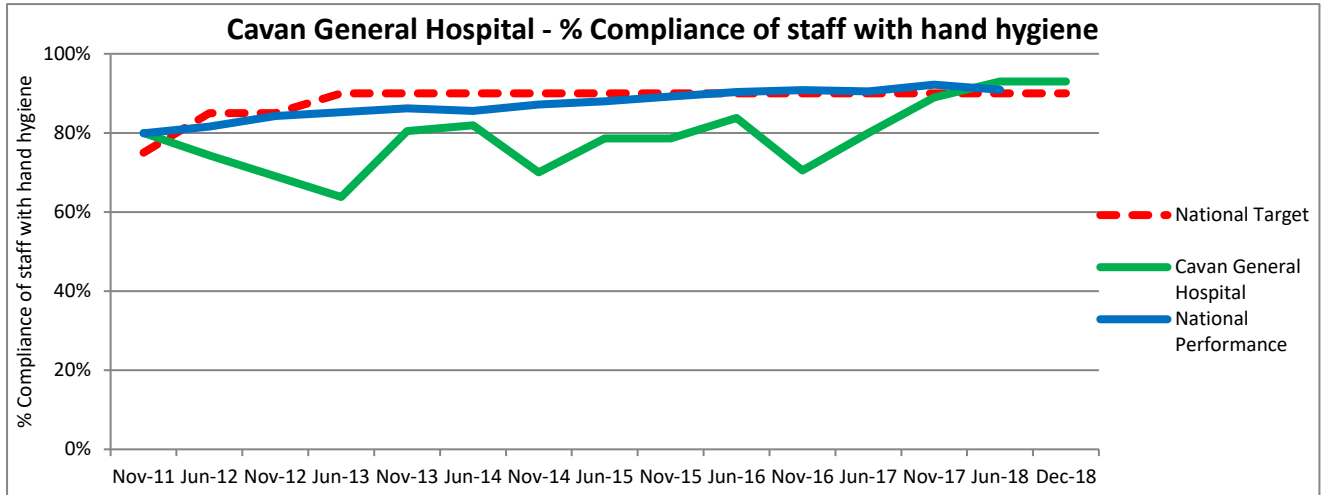
- Cavan General Hospital is achieving target (December 2018 93%)
- national performance not available at time of publication

Connolly Hospital
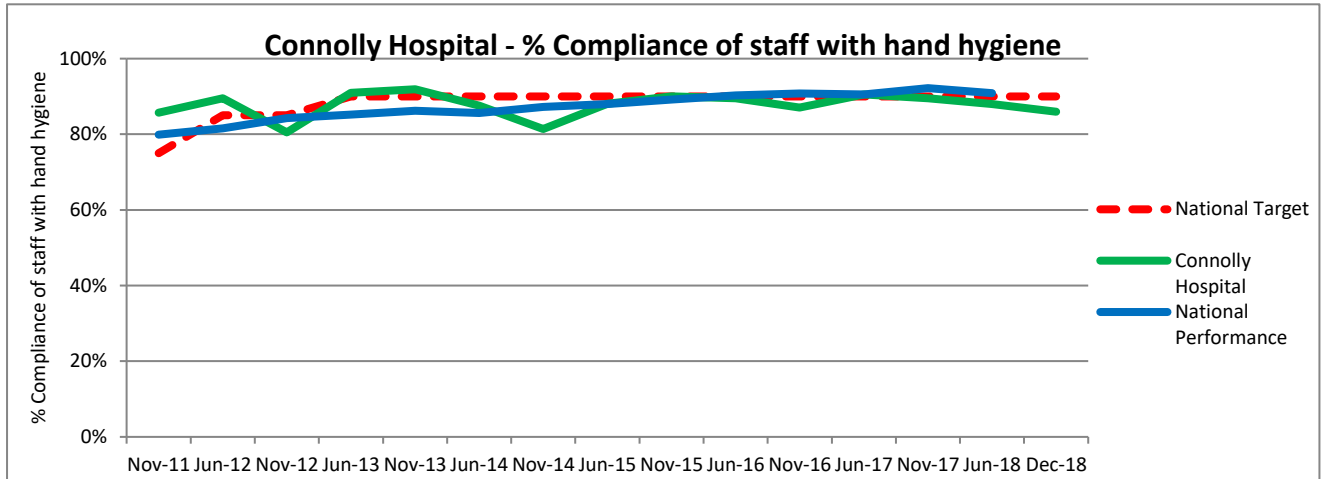
- Connolly Hospital is not achieving target (December 2018 86%)
- national performance not available at time of publication

Rotunda Hospital
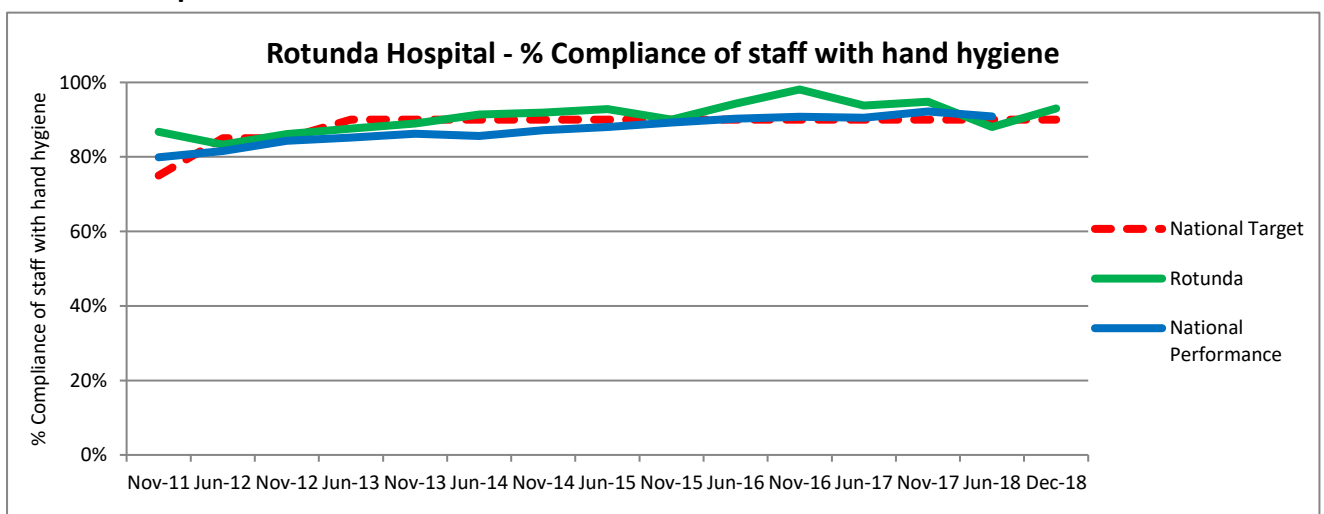
- Rotunda Hospital is achieving target (December 2018 93%)
- national performance not available at time of publication

Our Lady of Lourdes Hospital, Drogheda

OLOL Hospital - % Compliance of staff with hand hygiene
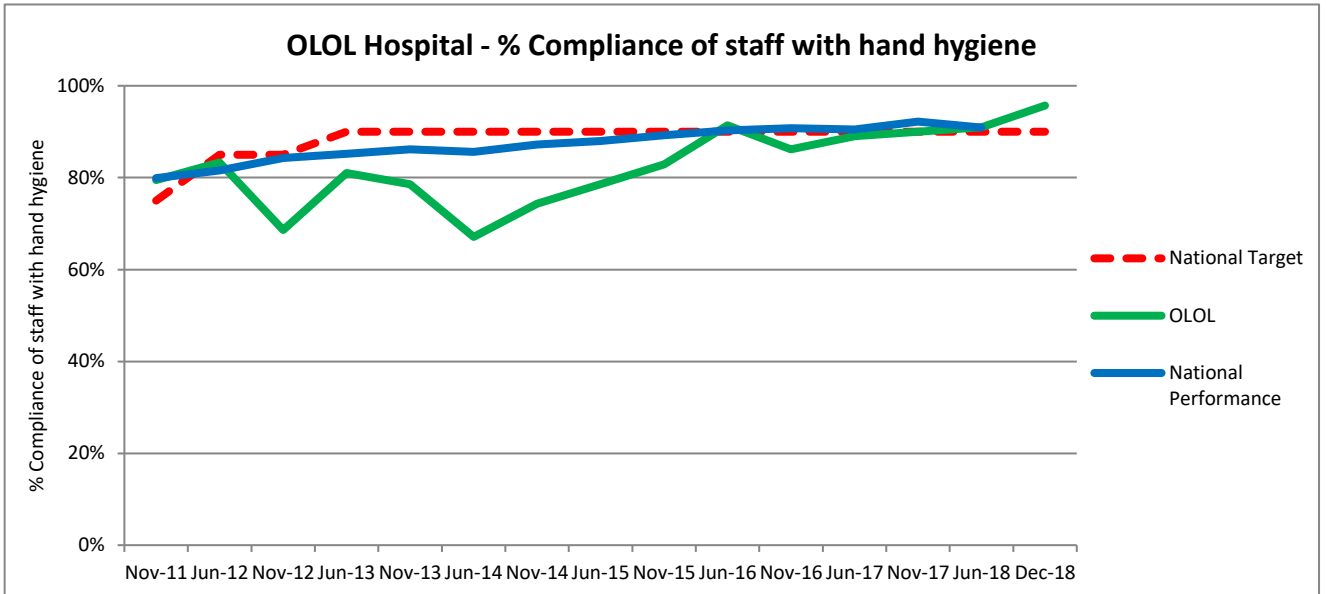
- OLOL Hospital is achieving target (December 2018 96%)
- national performance not available at time of publication

RCSI Hospital Group

RCSI Hospital Group - % Compliance of staff with hand hygiene
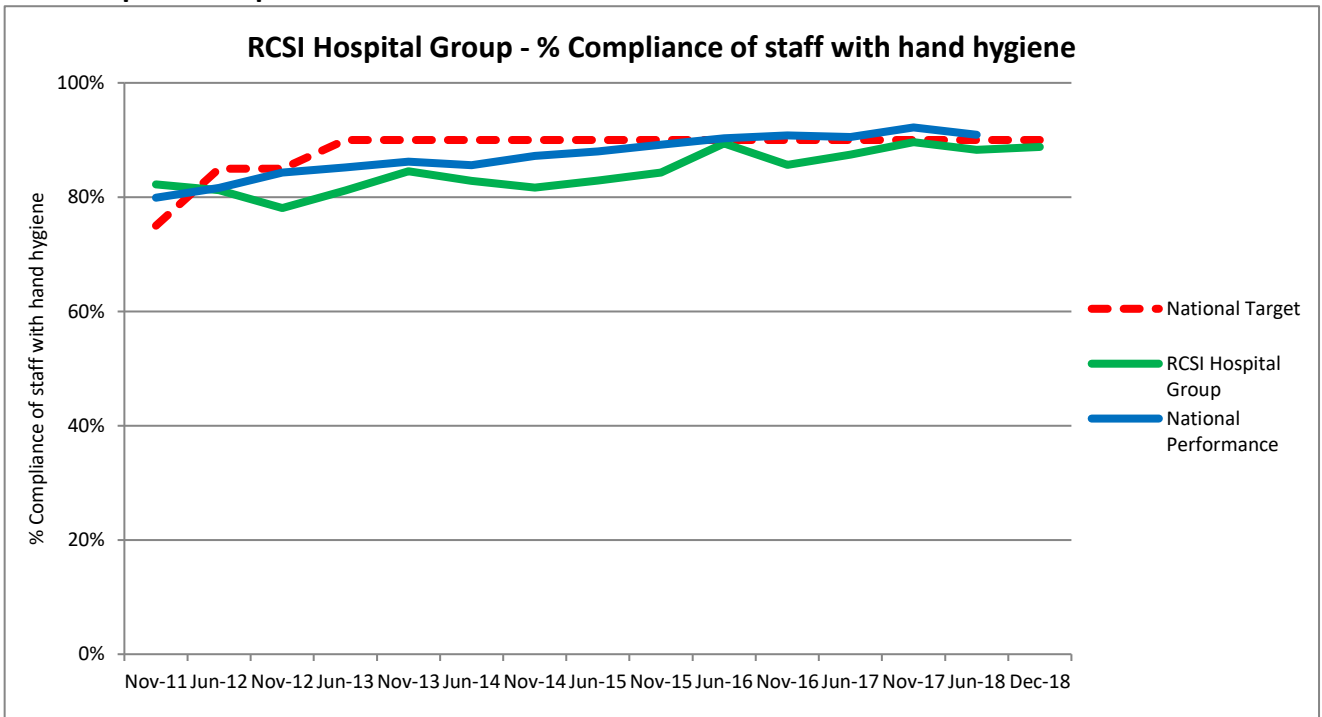
- overall RCSI HG is not achieving target (December 2018 89%)
- national performance not available at time of publication

4.5 PERCENTAGE OF STAFF UPTAKE OF 'FLU' VACCINATION

Rationale for measurement

Influenza (flu) can be a serious disease that can lead to hospitalisation and even death. Anyone can get very sick from the flu, including people who are otherwise healthy. By getting vaccinated, healthcare workers help protect themselves and their patients.

Measurement methodology and data sources

The proportion of healthcare workers who get vaccinated each year. Data source http://www.hpsc.ie/AZ/Respiratory/Influenza/SeasonalInfluenza/InfluenzaandHealthcareWorkers /HCWInfluenzaVaccineUptakebyHealthCareFacilitySeasonandStaff/.

Target

- HSE target increased for 2018-2019 to 60% proportion of healthcare workers who get vaccinated each year.

Performance

RCSI Hospital Group
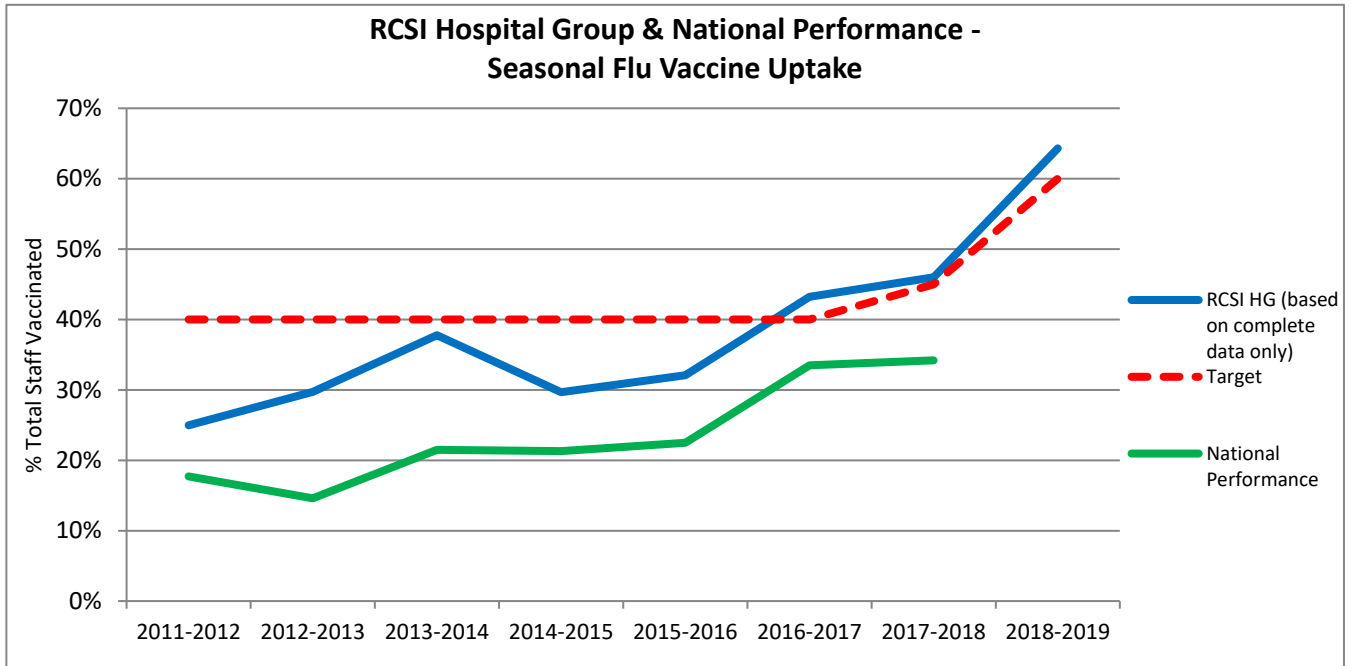
Note: Seasonal flu vaccine data for 2012-2013 unavailable for Rotunda; for 2014-2015 unavailable for Cavan Hospital; for Our Lady of Lourdes Hospital Drogheda is unavailable from 2012-2015

- RCSI HG has achieved national target this flu season 2018-2019. Flu season commenced October 2018.
- National performance unavailable at time of publication
- Hospital compliance (as of December 2018): Beaumont **(60%)**; Connolly **(62%)**; Rotunda **(77%)**; Cavan/Monaghan **(49%)**; OLOL/LCH **(75%);** RCSI Hospital Group **(64%)**

4:6 SEPSIS TRAINING

Background

Sepsis is a common and time-dependent medical emergency. It can affect a person of any age and from any social background. While it may occur more frequently in people with certain underlying medical conditions, it can also occur in healthy individuals. In 2016, the number of deaths amongst in-patients with a diagnosis of sepsis within Irish hospitals was 2,735. Sepsis is responsible for 37,000 deaths annually in the UK.

Internationally, approaches to optimal sepsis management, which are based on early recognition of sepsis with timely intervention within the first hour, have reported reductions in mortality from severe sepsis/septic shock in the order of 20-30%.

Rationale for measurement

In 2014 the HSE introduced the ***National No 6 Sepsis Clinical Guideline.*** This guideline endorses the concept of 'Sepsis Six' - a set of six tasks (including administration of oxygen, blood cultures, administration of antibiotics and intravenous fluids, lactate measurement and monitoring of urine output) to be completed within one hour by practitioners at the front line. In conjunction with this, the HSE have an on-line e–learning Sepsis module available as a teaching module for non-Obstetrics & Gynaecology clinical staff.

Sepsis Training modules specifically aimed at maternal sepsis recognition and treatment are available by completion of an accredited Maternity Sepsis Training module such as PROMPT - PRactical Obstetric Multi-Professional Training Maternity Sepsis Training.

Methodology

Monthly report from individual hospitals on the number and category of clinical staff who have completed:
* Sepsis e-learning module (non-Obstetrics & Gynaecology staff)
* PROMPT (or equivalent accredited Obstetrics & Gynaecology Sepsis Module, e.g. Rotunda Hospital Obstetric Emergency Training, RHOET)

Target

100% compliance

Performance

Q3 2018	Total Number of staff to be trained*	Total number of staff trained*	PERCENTAGE COMPLIANCE
Connolly Hospital	711	309	43%
Cavan/Monaghan Hospitals	619	470	76%
OLOL & LCH Hospitals	1348	811	60%
Beaumont Hospital	1788	273	15%
Rotunda Hospital (Q2 data)	252	153	61%
Total	4718	2016	43%

* Staff trained = NCHDs, Consultants, Nurses, Midwives, Obs & Gynae NCHDs, Obs & Gynae Consultants

* Data supplied by Rotunda Q2

CHAPTER 5: DIMENSION MEDICATION MANAGEMENT

Rationale for measurement

Medicines are the most common treatment used in health care and contribute to significant improvement in health when used appropriately. However, medicines can also be associated with harm and the common use of medicine means they are associated with more errors and adverse events than any other aspect of health care. While rates of serious harm are low, errors can affect health outcome. The prevalence of medication errors is of particular concern because the majority of these errors are generally preventable.

Measurement methodology

In the absence of an internationally accepted robust method for measuring medication incidents, incidents are calculated per 100 Bed Days Used (BDU).

- Data source: Hospital reporting to National Incident Management System (NIMS).
- Incidents are calculated per 100 Bed Days Used (BDU) https://report.nrls.nhs.uk/nrlsreporting/
- Medication errors are classified utilising the NCC/MERP Index http://www.nccmerp.org/types-medication-errors

Target

- there is no internationally accepted methodology for measuring medication errors or performance target and the RCSI HG does not have access to national performance data. However, internationally, incidents are estimated to occur at a rate of 1 error per hospitalised patient per day in the USA **(Institute of Medicine USA Prevention of Medication Errors - 2006).**

Performance

RCSI Hospital Group
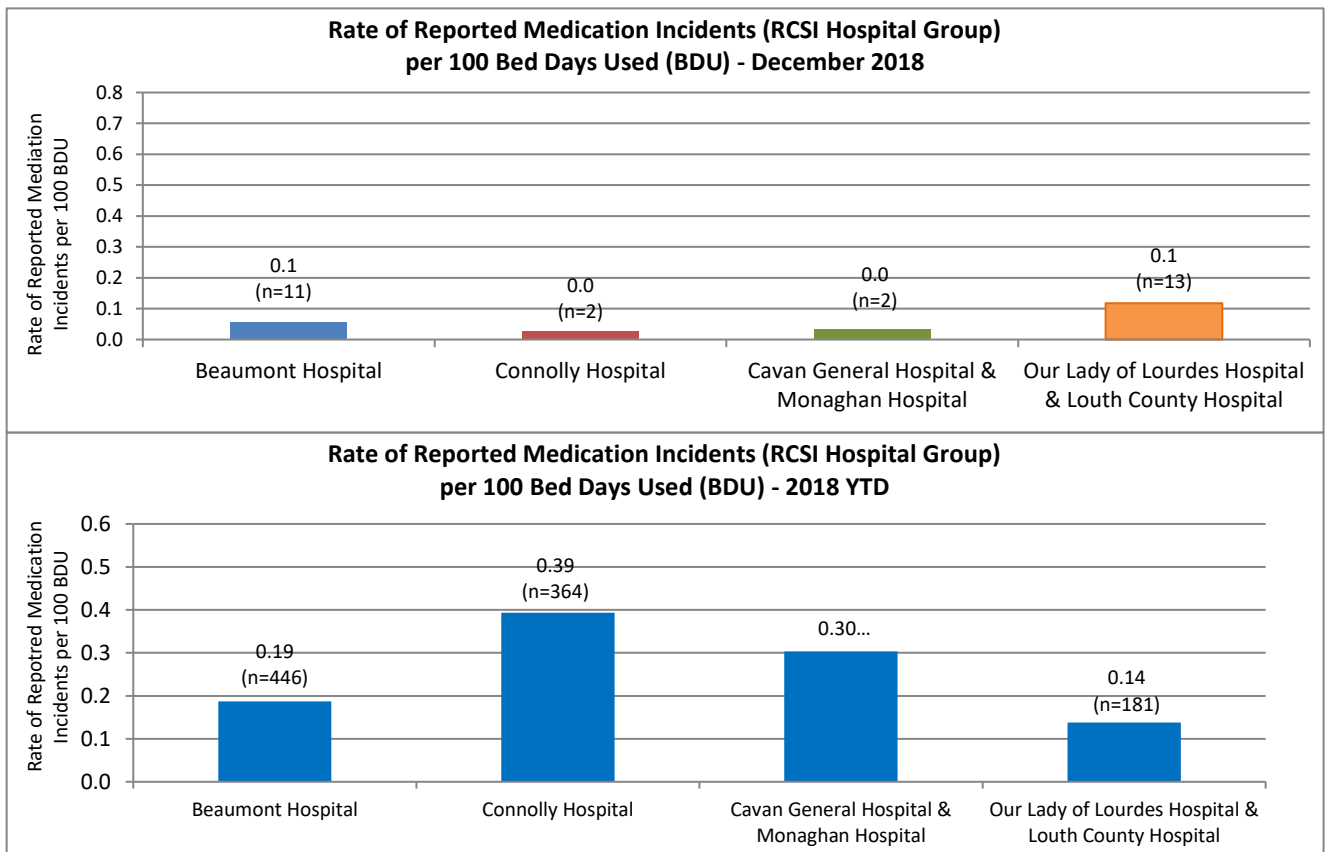
- whilst values demonstrated are significantly lower than US study, at this time there is evidence that current reporting control constructs are less than optimal with resultant under-reporting at this time

CHAPTER 6: DIMENSION: MATERNITY SERVICES

The aim of publishing metrics from each maternity unit in the RCSI Hospital Group is to enable patients, relatives and the general public to view activity in each of the three maternity units in the Group, (Cavan General Hospital, OLOLH and the Rotunda Hospital).

These metrics are comprised of a range of clinical activities, major obstetric events, modes of delivery and rates of attendance at clinical training.

When viewing these metrics, it is important to note that tertiary and referral maternity centres will care for a higher complexity of patients (mothers and babies). Therefore rates of clinical activity and outcomes will be higher and comparisons should not be drawn with units that do not look after complex cases. In addition these figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

6:1 CLINICAL ACTIVITIES

Rationale for measurement
Demonstrates the volume of clinical activity in each organisation and information is reported on the total number of mothers delivered, the total numbers of births, the number of multiple pregnancies, and transfers in and out to hospitals.

Measurement methodology and data sources:
Local extracts submitted monthly and extrapolated for analysis and publication.

Target
These figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

Performance

Hospital	Activity	2018 December	2018 Year to date
Cavan Hospital	Total Mothers delivered ≥500g (n)	121	1491
	Multiple pregnancies (n)	1	21
	Total births ≥500 g (n)	122	1512
	In utero transfer – admitted (n)	0	0
	In utero transfer – sent out (n)	0	7
Our Lady of Lourdes Hospital Drogheda	Total Mothers delivered >500g (n)	266	3019
	Multiple pregnancies (n)	6	49
	Total births >500 g (n)	273	3070
	In utero transfer – admitted (n)	0	3
	In utero transfer – sent out (n)	0	24
		2018 November	2018 Year to date
Rotunda	Total Mothers delivered >500g (n)	716	6966
	Multiple pregnancies (n)	7	135
	Total births >500 g (n)	723	7101
	In utero transfer – admitted (n)		49 to Sep 2018
	In utero transfer – sent out (n)		9 to Sep 2018

(n) = number
Total mothers delivered ≥500g: Total number of women delivering a baby weighing 500g or more. The infant weight of 500g is an internationally recognised weight measurement for counting numbers of mothers delivered.
Multiple pregnancies: Number of mothers delivering more than one baby from a single pregnancy. This is a count of mothers, not numbers of babies delivered.
Total births ≥500g: Total number of babies born, including live births and stillbirths, weighing 500g or more. The weight of 500g is an internationally recognised weight measurement for counting numbers of babies born.
In-utero transfers admitted: Number of pregnant women admitted to a maternity hospital from another hospital prior to delivery for reasons in the fetal/maternal interest.
In-utero transfers sent out: Number of pregnant women transferred from a maternity hospital to another hospital prior to delivery for reasons in the fetal/maternal interest.

6:1:2 PERINATAL MORTALITY RATE (ADJUSTED)

Definition

The Adjusted Perinatal Mortality Rate is defined as Stillbirth and early neonatal death > 2500 grams excluding lethal congenital defects/1000 deliveries.

Rationale for measurement

The perinatal mortality rate is recognised as an indicator of the quality and safety of antenatal and perinatal care.

Measurement methodology and data sources:

Local data extracts submitted monthly and extrapolated for analysis and publication.

Target

These figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

Performance

Hospital	2018 December	2018 Year to date
Cavan General Hospital	0	0.67 per 1,000 (n=1)
Our Lady of Lourdes Hospital Drogheda	0	0.98 per 1,000 (n=3)
	2018 November	2018 Year to date
Rotunda Hospital		0.7 TO NOVEMBER 2018

6:2 MAJOR OBSTETRIC EVENTS

Rationale for measurement

These are rare but potentially catastrophic events, which when they occur in obstetric patients can impact on the safety of both mother and baby. The RCSI Hospital Group reports the total combined rate (per 1,000 total mothers delivered) of the following major obstetric events,

- Eclampsia is a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure, often followed by coma and posing a threat to the health of mother and baby.
- Uterine rupture is a rare but potentially catastrophic event in which the uterus tears open along the scar line from a previous Caesarian-section or major uterine surgery. Hospital incidence of uterine rupture is rare. The main risk factors for uterine rupture are previous caesarean section or induction of labour (using prostaglandins).
- Peripartum hysterectomy is a hysterectomy which is usually performed following a caesarean section, but also includes hysterectomies performed during pregnancy and/or within seven completed days after delivery. Peripartum hysterectomy is rare and usually only performed in emergency situations, but it is a life-saving procedure in cases of severe haemorrhage.
- Pulmonary embolism (PE) is a blockage of the lung's main artery or one of its branches by a substance that travels from elsewhere in the body through the bloodstream.

Measurement methodology and data sources:

Local data extracts submitted monthly and extrapolated retrospectively for analysis and publication.

Numerator: Number of events
Denominator: per 1,000 total mothers delivered

Target

These figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

Performance

Hospital	Activity	2018 December	2018 YTD
Cavan General Hospital	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for following four obstetric metrics: Eclampsia / Uterine rupture / Peripartum hysterectomy / Pulmonary embolism	0	0.7 per 1,000 (n=1)
Our Lady of Lourdes Hospital Drogheda	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for following four obstetric metrics: Eclampsia / Uterine rupture / Peripartum hysterectomy / Pulmonary embolism	0	0.66 per 1,000 (n=2)
		2018 November	2018 YTD
Rotunda	Total combined rate (per 1,000 total mothers delivered) of major obstetric events for following four obstetric metrics: Eclampsia / Uterine rupture / Peripartum hysterectomy / Pulmonary embolism		1.9 TO SEPT 2018

6:3 DELIVERY METRICS

6:3:1 RATE OF INSTRUMENTAL DELIVERY

Rationale for measurement

Instrumental delivery: Percentage of 'Mothers delivered ≥500g' who require instrumental assistance during delivery. Instrumental assistance includes forceps delivery and vacuum extraction, excluding failed forceps and failed vacuum extraction. Also includes assisted breech delivery with forceps to after-coming head and breech extraction with forceps to after-coming head.

Most women aim for spontaneous vaginal delivery. An instrumental delivery may be performed in situations where imminent delivery of the infant is considered to be the safest option for both mother and baby.

Measurement methodology and data sources:
Local data extracts submitted monthly and extrapolated for analysis and publication.

Numerator: Rate of instrumental deliveries (%)
Denominator: per 1,000 total mothers delivered

Target
These figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

Performance

Hospital	Activity	2018 December	2018 YTD
Cavan General Hospital	Rate of instrumental delivery per total mothers delivered (%)	9.91%	11.40%
	Rate of nulliparas mothers with instrumental delivery (%)	20.00%	25.42%
	Rate of multiparas mothers with instrumental delivery (%)	3.94%	4.90%
Our Lady of Lourdes Hospital Drogheda	Rate of instrumental delivery per total mothers delivered (%)	10.53%	12.55%
	Rate of nulliparas mothers with instrumental delivery (%)	22.58%	26.50%
	Rate of multiparas mothers with instrumental delivery (%)	4.05%	5.33%
		2018 November	2018 YTD
Rotunda	Rate of instrumental delivery per total mothers delivered (%)	17.5%	15.9%
	Rate of nulliparas mothers with instrumental delivery (%)	30.7%	28.5%
	Rate of multiparas mothers with instrumental delivery (%)	6.8%	6.2%

6:3:2 RATE OF INDUCTION OF LABOUR

Performance

Hospital	Activity	2018 December	2018 YTD
Cavan General Hospital	Rate of induction of labour per total mothers delivered (%)	26.44%	26.00%
	Rate of nulliparas mothers with induction of labour (%)	33.33%	36.00%
	Rate of multiparas mothers with induction of labour (%)	22.36%	21.49%
Our Lady of Lourdes Hospital Drogheda	Rate of induction of labour per total mothers delivered (%)	31.95%	34.78%
	Rate of nulliparas mothers with induction of labour (%)	47.31%	47.38%
	Rate of multiparas mothers with induction of labour (%)	23.70%	28.26%
		2018 November	2018 YTD
Rotunda	Rate of induction of labour per total mothers delivered (%)	31.8%	31.1%
	Rate of nulliparas mothers with induction of labour (%)	37.9%	38.6%
	Rate of multiparas mothers with induction of labour (%)	27.0%	25.3%

Nulliparas = Women who have never had a previous pregnancy resulting in a live birth or stillbirth (≥ 500g).
Multiparas = Women who have had at least one previous pregnancy resulting in a live birth or stillbirth (≥ 500g)

6:3:3 RATE OF CAESAREAN SECTION

Rationale for measurement

Caesarean delivery, also known as a C-section, is a surgical procedure used to deliver a baby through incisions in the mother's abdomen and uterus. When medically justified, a Caesarean Section can reduce problems/complications for mother and baby (mortality and morbidity). Recovery from a C-section takes longer than does recovery from a vaginal birth. Like other types of major surgery, C-sections also carry risks. It is acknowledged that Caesarean rates are on the rise in many developed countries. Ireland's National Maternity Strategy (2016) identifies a number of possible reasons for this – including "reductions in the risk of Caesarean delivery, increasing litigation, increases in first births among older women and the rise in multiple births resulting from assisted reproduction."

Measurement methodology and data sources:

Local data extracts submitted monthly and extrapolated for analysis and publication.

Target

These figures are not formatted in a way to support comparison with other hospitals or aggregation with other data.

Performance

Hospital	Activity	2018 December	2018 YTD
Cavan General Hospital	Rate of Caesarean Section per total mothers delivered (%)	38.84%	37.75%
	Rate of nulliparas mothers with Caesarean Section (%)	44.44%	41.31%
	Rate of multiparas mothers with Caesarean Section (%)	35.52%	36.11%
Our Lady of Lourdes Hospital Drogheda	Rate of Caesarean Section per total mothers delivered (%)	39.10%	34.98%
	Rate of nulliparas mothers with Caesarean Section (%)	33.33%	34.76%
	Rate of multiparas mothers with Caesarean Section (%)	42.20%	35.09%
		2018 November	2018 YTD
Rotunda	Rate of Caesarean Section per total mothers delivered (%)	33.9%	33.6%
	Rate of nulliparas mothers with Caesarean Section (%)	35.1%	35.6%
	Rate of multiparas mothers with Caesarean Section (%)	33.0%	32.1%

[1] The national C-section rate per 100 live births for 2016 is 32.1% (data via IMIS National Report).

6:4 COMPETENCY TRAINING

The delivery of safe, evidence-based care in maternity services ultimately depends on the competency of clinical staff. Consequently the RSCI Hospital Group will be measuring attendance rates at training in two key areas cardiotocography and neonatal resuscitation.

6.4.1 CARDIOTOCOGRAPHY (CTG) TRAINING

Rationale for measurement

CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. CTG monitoring is used to assess fetal wellbeing and allows early detection of fetal distress. The inappropriate use or interpretation of fetal surveillance can contribute to adverse obstetric outcomes therefore accurate interpretation of the CTG is a core skill for all staff providing antenatal and intrapartum care.

Measurement methodology and data sources

Local data extracts submitted monthly and extrapolated for analysis and publication.

Numerator: No of staff trained (Expressed as %)
Denominator: No of staff eligible for training (Expressed as %)

Target

100% of relevant clinical staff are up to date with CTG training within the 2 year period.

Performance

Performance data for Q3 reporting period (data provided quarterly):

Hospital	Consultant training compliance (%)	NCHD Training compliance (%)	Midwife Training compliance (%)
Cavan	100%	100%	100%
OLOL	89%*	80%*	100%
Rotunda	100%	90%*	97%*

* relevant clinical staff who have not completed the CTG training will be supervised when involved with CTG (OLOL: Consultant n=1, NCHDs n=4; Rotunda: NCHDs n=3, Midwives n=3)

6:4:2 RESUSCITATION TRAINING

The Neonatal Resuscitation Programme® (NRP®) was developed by the American Heart Association and the American Academy of Pediatrics. The course conveys an evidence-based approach to care of the newborn at birth and facilitates effective team-based care for healthcare professionals who care for newborns at the time of delivery.

Rationale for measurement

Over 90% of babies born make the transition from life in the womb to life outside the womb at delivery, perfectly smoothly. A small percentage will require assistance. The NRP is intended to optimise the skills of staff in caring for these babies.

Measurement methodology and data sources

Local data extracts submitted monthly and extrapolated for analysis and publication.

Target

100% of relevant clinical staff are up to date with NRP certification (or UK equivalent) within the 2 year period.

Performance

Performance data for Q3 reporting period (data provided quarterly):

Hospital	Consultant training compliance (%)	NCHD Training compliance (%)	Neonatal Nurses compliance (%)	Labour Ward & Midwife Led Unit Midwives compliance (%)
Cavan	100%	100%	100%	100%
OLOL	100%	100%	100%	100%
Rotunda	78%*	100%	94%*	86%*

* relevant clinical staff who have not completed the NRP training will be supervised when involved with NRP (Rotunda: Consultants n=2, Neonatal Nurses n=5, Midwives n=11)

6:4:3 CHILDREN FIRST TRAINING

Rationale for measurement
The Children First Act 2015 puts elements of the Children First: National Guidance for the Protection and Welfare of Children (2011,) on a statutory footing and places a wide range of responsibilities on HSE and its funded services. All staff are required to complete E-Learning Module on "An Introduction to Children First".

Measurement methodology and data source
Local data extracts submitted monthly and extrapolated for analysis and publication.

Numerator
Number of staff trained (expressed as %)

Denominator
Number of staff eligible for training (expressed as %)

Target
100% of relevant staff are up to date with the national E-Learning Module on "An Introduction to Children First"

Performance

December 2018	Total number of staff to be trained	Total number of staff trained	Increase of staff trained	PERCENTAGE COMPLIANCE
Beaumont Hospital	3672	2751	32	75%
Cavan and Monaghan Hospitals	1306	1306	0	100%
Connolly Hospital	1410	1339	26	95%
Louth County Hospital	339	339	3	100%
Our Lady of Lourdes Hospital Drogheda	2210	2036	9	92%
Rotunda Hospital	876	767	0	87%
RCSI Hospital Group	9813	8538	70	87%

6:5 FETAL ANOMALY SCANNING

Introduction

The fetal anomaly scan is a detailed scan carried out in pregnant women at about 20 week's gestation (mid pregnancy) to check if the baby is developing normally. Prenatal scanning is of great importance as it contributes to appropriate management of the baby both during and after the pregnancy. Fetal anomaly scanning is very accurate but unfortunately it cannot identify all birth defects.

Rationale for measurement

Prior to November 2017, Fetal Anomaly Scanning for women in the North East was available only if they were referred to the Rotunda Hospital or if they chose to access this service privately.

A fetal anomaly scanning services has now commenced in Louth Hospitals and Cavan/Monaghan Hospitals. The initial service is criteria led with plans to expand into a more comprehensive service as the skilled workforce is developed and/or recruited to increase the service capacity. The RCSI Hospital Group intends to monitor the numbers of women availing of this service across the three maternity units of the RCSI Hospital Group, Cavan, Monaghan, Louth Hospitals and the Rotunda Hospital.

Measurement methodology and data sources

(1) Absolute number of women and
(2) percent of women accessing fetal anomaly scanning - Local Hospital data extrapolated for analysis and publication

Performance

DECEMBER 2018	ANOMALY SCANS PERFORMED
Cavan	49 Scans
Our Lady of Lourdes Hospital Drogheda	125 Scans

*Anomaly scan regional capacity calculated by number of births in previous year and the number of scans estimated to be required for same number of births

CHAPTER 7: DIMENSION: PATIENT CARE AND TREATMENT

7:1 PERCENTAGE OF EMERGENCY HIP FRACTURES SURGERIES UNDERTAKEN WITHIN 48 HOURS OF ADMISSION

Rationale for measurement

Hip Fracture, which is associated with increasing age, can lead to a significant risk of serious illness and sometimes death. The standard treatment for hip fracture is surgery. It is known that the outcomes for patients are better if surgery is timely i.e. that the surgery happens as soon as possible after admission and when the patient is ready and fit for surgery. This may mean that the patient needs to be stabilised and therefore, there can be a delay between admission and surgery, whether for medical stabilisation of the patient's co-morbidities, or for administrative / logistical reasons. A delay in surgery can mean that as well as an increased length of hospital stay for the patient, there may also be an associated increased risk of serious illness and death. Based on this evidence the HSE has a target of 95% of emergency hip fracture surgeries to be carried out within 48 hours of admission. Due to small numbers each month rolling 12 month rates are presented.

Measurement methodology and data sources
- Local HIPE data extrapolated from Hospital Performance Metrics HSE BIU. Supplied one month in arrears.
- Measurement has changed to only include the cohort of patients who are medically fit and requiring an emergency hip fracture.

Target
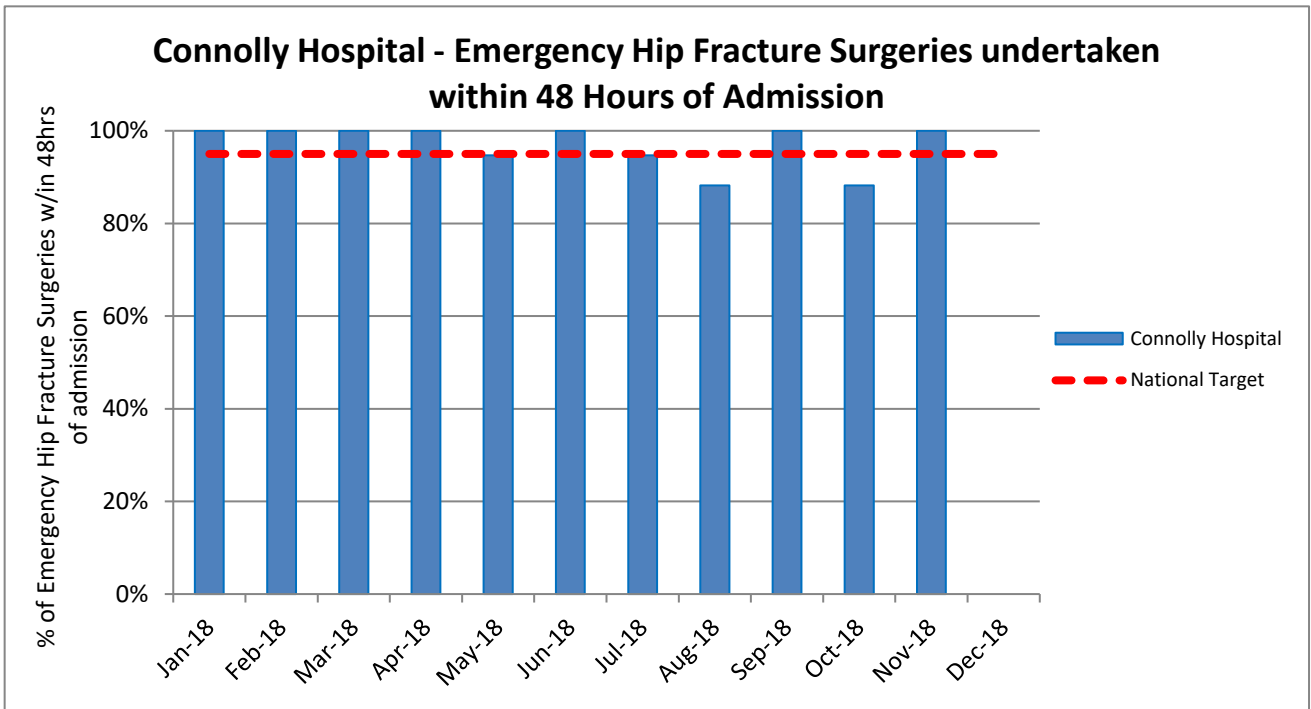- 95% of emergency hip fractures surgeries are carried out within 48 hours of admission
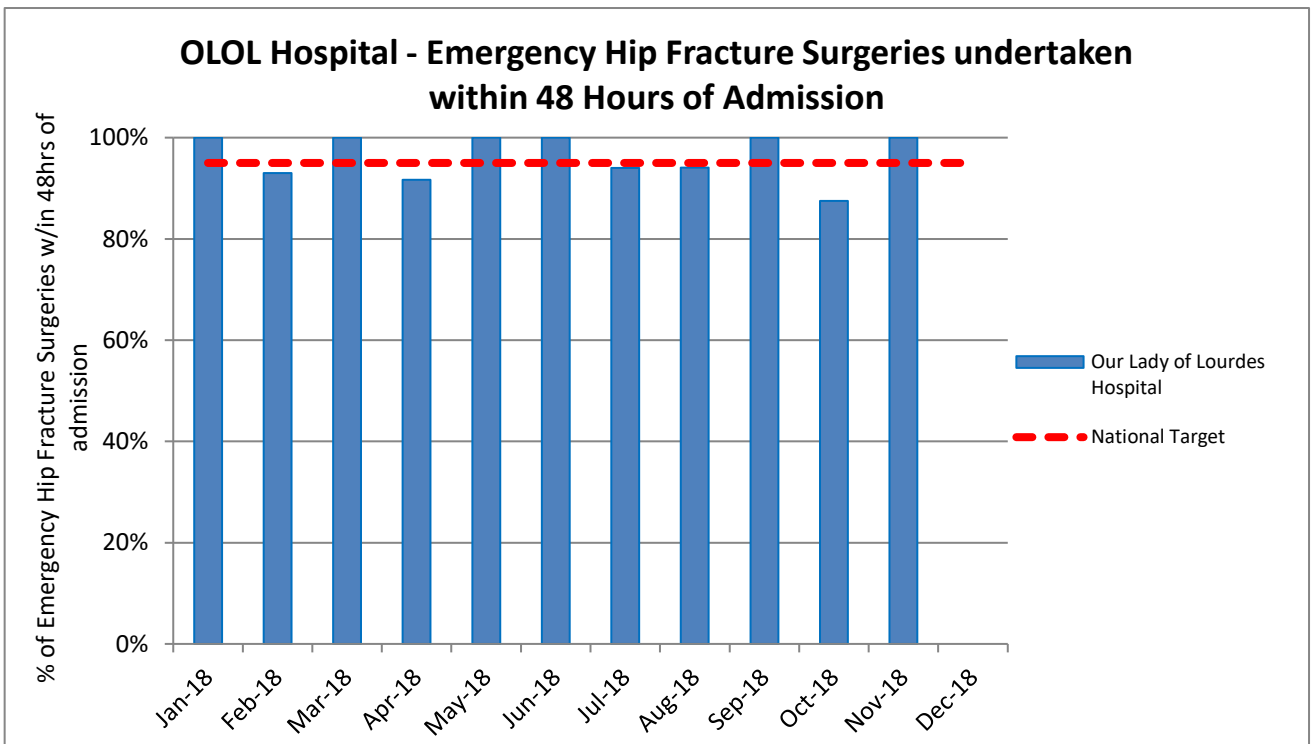
Performance

Beaumont Hospital
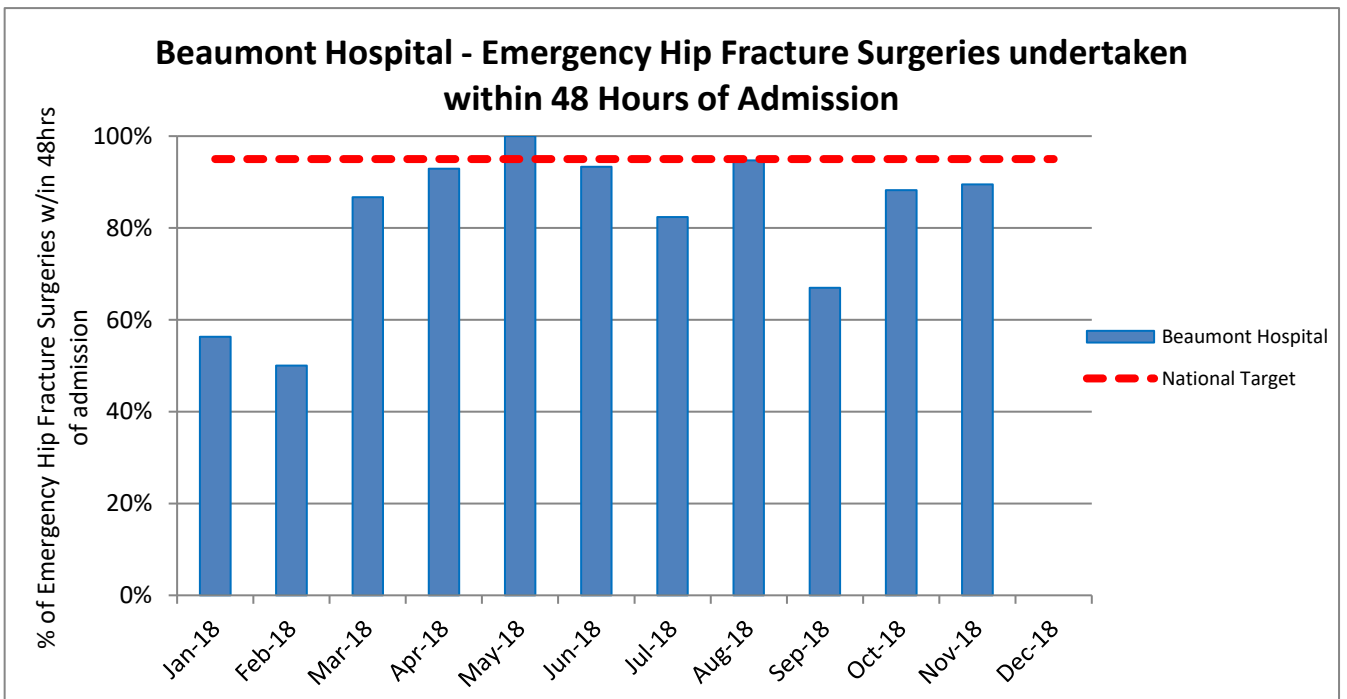
- Beaumont Hospital performance was below national target for period measured **(Nov 2018 90%)**

Connolly Hospital

Connolly Hospital - Emergency Hip Fracture Surgeries undertaken within 48 Hours of Admission

- Connolly Hospital performance was above national target for period measured **(Nov 2018 100%)**

Our Lady of Lourdes, Drogheda

**OLOL Hospital - Emergency Hip Fracture Surgeries undertaken within 48 Hours of Admission**

- Our Lady of Lourdes Hospital performance was above national target for period measured **(Nov 2018 100%)**

RCSI Hospital Group

RCSI Hospital Group - Emergency Hip Fracture Surgeries undertaken within 48 Hours of Admission
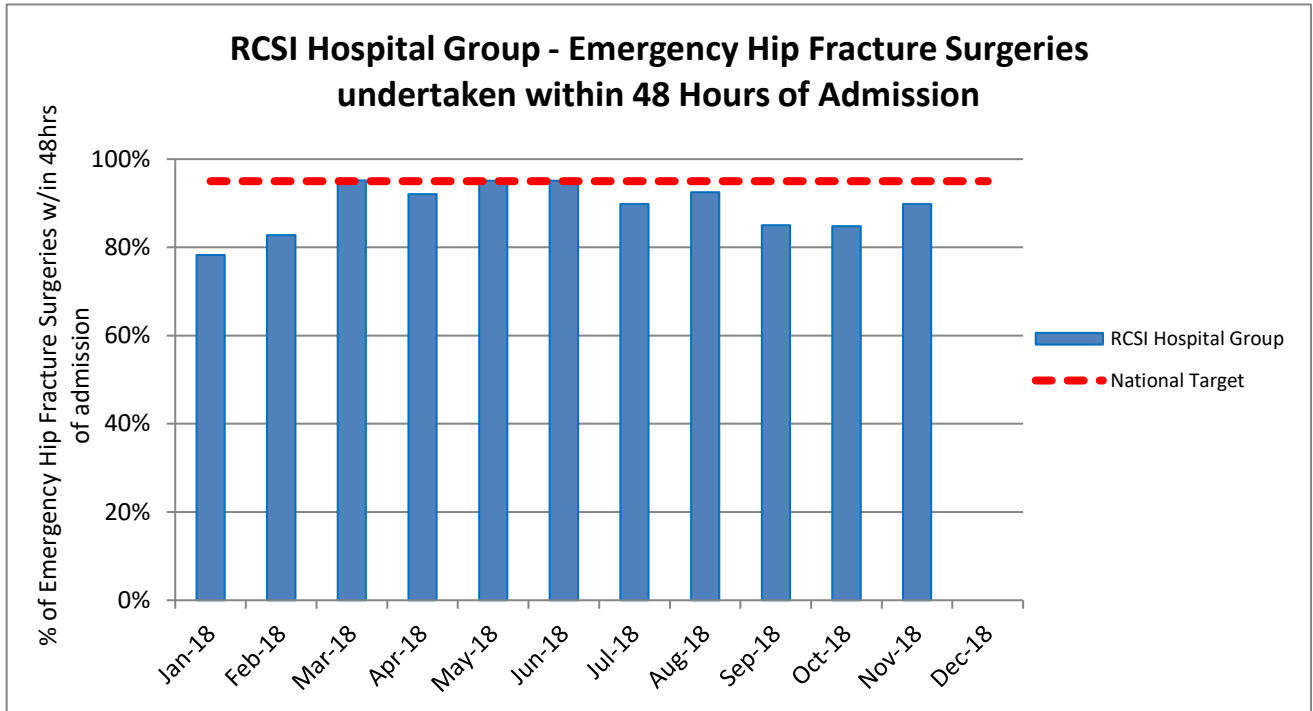
- RCSI HG performance was below national target for period measured **(Nov 2018 90%)**

National Performance Comparator

National Performance - Emergency Hip Fracture Surgeries undertaken within 48 Hours of Admission
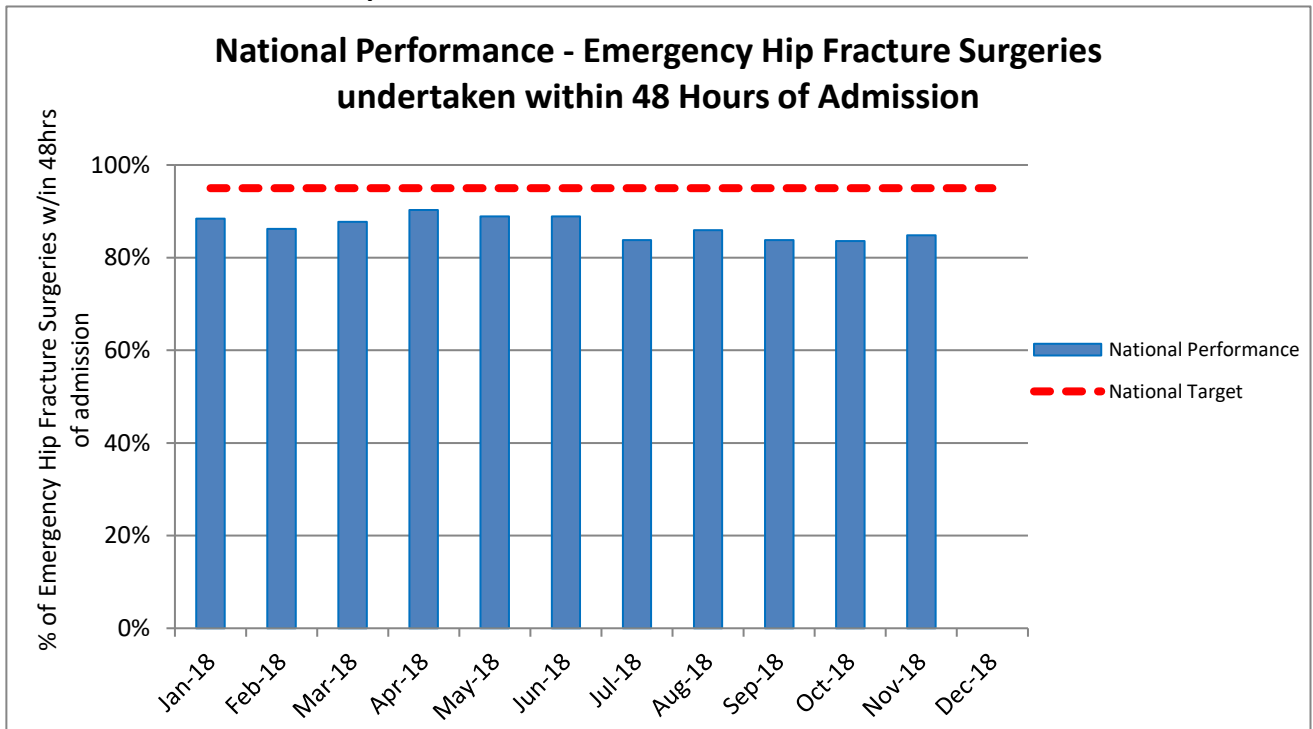
- Nationally this target has not been achieved **(Nov 2018 84.8%)**

7:2 SERIOUS FALLS

Rationale for measurement

Falls particularly in the elderly can lead to an increased time spent in Hospital and in significant health decline. As well as physical injuries suffered, the psychological and social consequences of falling can have a huge impact. Recurrent falls in the elderly can result in long term care, consequently falls prevention is a key area for hospitals. All Hospitals in the RCSI Group are committed to preventing patient falls where possible, and where not possible to minimising their incidence and impact.

Measurement methodology and data sources

- Number of patient falls associated with Patient death or disability whilst being cared for in a health service facility per 10,000 hospital bed days
- Local data extrapolated from Hospital Performance Metrics

Target

- No patient falls associated with mortality or morbidity whilst being cared for in a health service facility

Performance
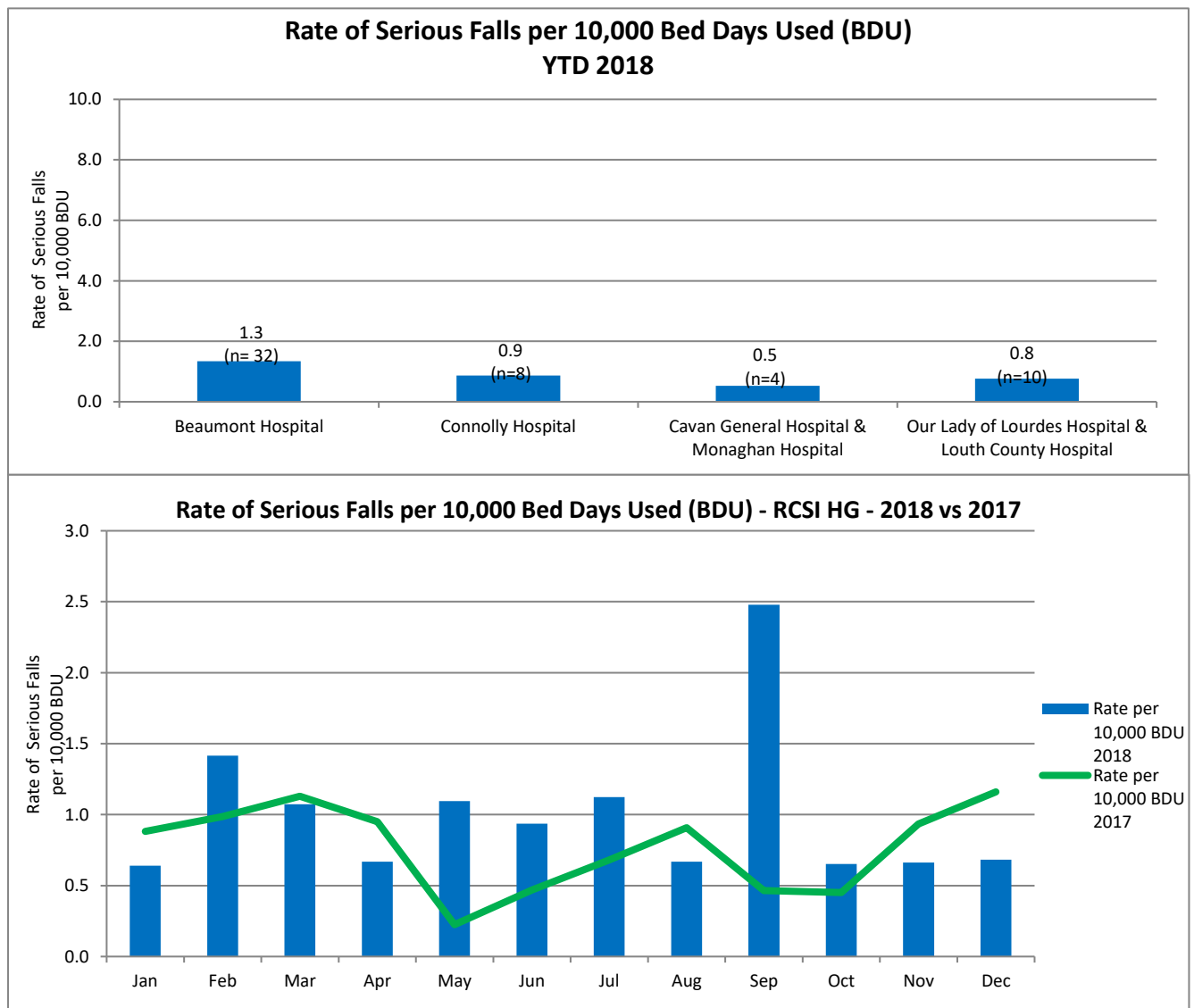
- the average rate of falls reported for 2018 YTD is comparable to the average rate of falls reported for the same period in 2017

7:3 DEVELOPMENT OF GRADE 3 OR 4 PRESSURE SORE (DECUBITUS ULCER) IN HOSPITAL

Rationale for measurement

Bedsores, also called pressure ulcers, are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Bedsores most often develop on skin that covers bony areas such as heels, ankles, hips and tailbone. Hospitalised and immobile persons can be at risk of pressure sores. Pressure sores can cause pain, poor recovery and lead to serious infections. Pressure sores are graded Stage 1 to 4. At Stage 3, the ulcer is a deep wound with loss of skin and the damage may extend beyond the primary wound and below layers of healthy skin. At Stage 4, the ulcer shows large scale loss of tissue and may expose muscle, bone and tendon. Prevention of Grade 3 and Grade 4 bed sores / ulcers are a marker of good care. The target therefore is to achieve no sores of Stage 3 or higher.

Measurement methodology and data sources

- Number of Stage 3 or 4 pressure sores per 10,000 hospital bed days
- Local data extrapolated from Hospital Performance Metrics
- Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. This stage may include undermining and tunneling.
- Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. This stage often includes undermining and tunneling. Exposed bone/muscle is visible or directly palpable.

Reference: European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers: quick reference guide. Washington DC.
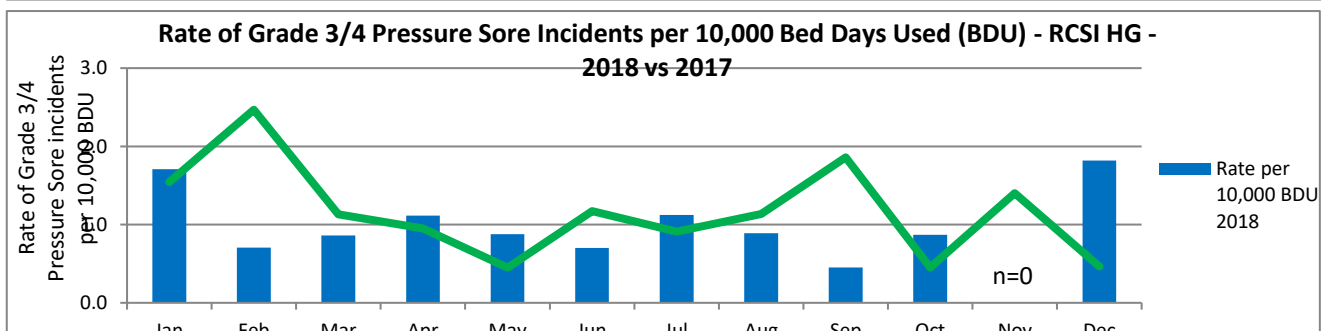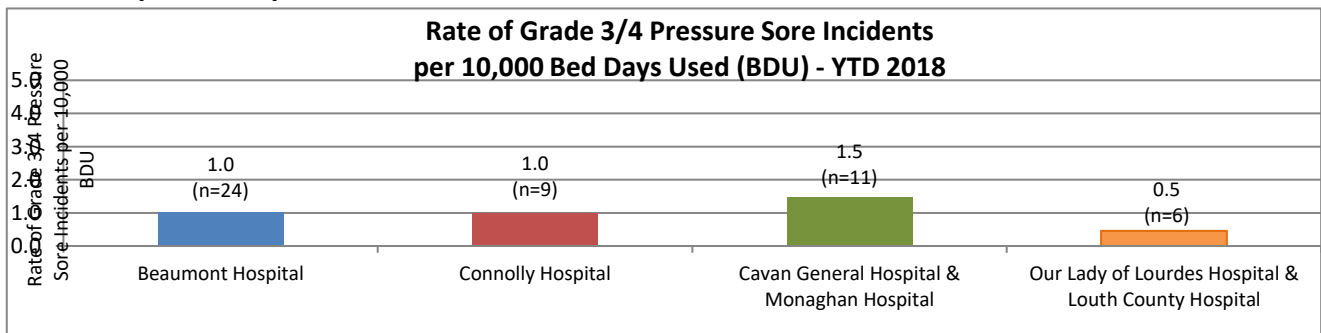
- Local hospital data (no national comparator data available)

Target

- No grade 3/4   pressure sores

Performance

RCSI Hospital Group

Rate of Grade 3/4 Pressure Sore Incidents per 10,000 Bed Days Used (BDU) - YTD 2018

Rate of Grade 3/4 Pressure Sore Incidents per 10,000 Bed Days Used (BDU) - RCSI HG - 2018 vs 2017

- whilst values demonstrate variance across the hospitals and low incidence, there is evidence that current reporting control constructs are less than optimal, particularly in relationship to identification of pressure sores present on admission rather than development during inpatient stay

7:4 PERCENTAGE OF PATIENTS READMITTED AS AN EMERGENCY WITHIN 30 DAYS OF DISCHARGE

Rationale for measurement

Readmissions rates can be influenced by a variety of factors, including the quality of inpatient and outpatient care, the effectiveness of the care transition and coordination, and the availability and use of effective disease management community based programmes. Whilst not all unplanned readmissions are avoidable, interventions during and after a hospitalisation can be effective in reducing rates **(Government of Alberta – Alberta Health Service Plan 2014-2017)**.

Measurement methodology and data sources
-   local retrospective HIPE data extracted, extrapolated and published by HSE – BIU. Published one month in arrears.

Target:
-   Surgical readmission to same hospital within 30 days ➔ <3%
-   Medical readmission to same hospital within 30 days ➔ <11.1% for 2017

Performance

RCSI Hospital Group

% Surgical Emergency readmissions to the same hospital within 30 days of discharge					
Hospital	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Beaumont Hospital	2.8%	2.5%	2.0%	2.0%	2.4%
Cavan General Hospital	2.0%	2.0%	1.4%	1.6%	0.9%
Connolly Hospital	1.1%	1.4%	1.9%	1.6%	1.2%
Our Lady of Lourdes Hospital	3.8%	3.5%	5.7%	3.7%	3.7%
RCSI Hospital Group	2.4%	2.3%	2.4%	2.0%	2.0%
National Target	< 3%	< 3%	< 3%	< 3%	< 3%
National Performance	1.9%	1.9%	2.1%	1.9%	1.9%

-   RCSI HG is achieving overall compliance with national target for reporting period

% Emergency readmissions for acute medical conditions to the same hospital within 30 days of discharge					
Hospital	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Beaumont Hospital	11.3%	11.3%	11.5%	12.7%	10.7%
Cavan General Hospital	10.7%	9.8%	11.3%	9.6%	9.1%
Connolly Hospital	7.6%	6.7%	6.0%	9.0%	9.0%
Our Lady of Lourdes Hospital	9.5%	9.2%	10.1%	8.6%	9.4%
RCSI Hospital Group	9.9%	9.5%	10.1%	10.1%	9.6%
National Target	<11.1%	<11.1%	<11.1%	<11.1%	<11.1%
National Performance	11.3%	10.8%	10.6%	10.2%	10.2%

-   RCSI HG is achieving overall compliance with national target for reporting period

7:5 NUMBERS OF PATIENTS IDENTIFIED AS REQUIRING HOME CARE PACKAGES / ACCESS TO LONG TERM CARE / REHABILITATION INAPPROPRIATELY REMAINING IN ACUTE BEDS

Rationale for measurement:

Patients who have been identified as no longer requiring acute medical care i.e. medically fit for discharge, but remain in hospital waiting for provision of Community Home Care, Long Term Care and Rehabilitation are described as experiencing a *"delayed discharge"*. This delay can result in increased likelihood of hospital acquired infection or a loss of confidence and necessary skills for daily living required for returning home. As well, their ongoing inappropriate accommodation in an acute bed causes resultant delays in accommodating other emergency / elective patient requiring acute hospital accommodation.
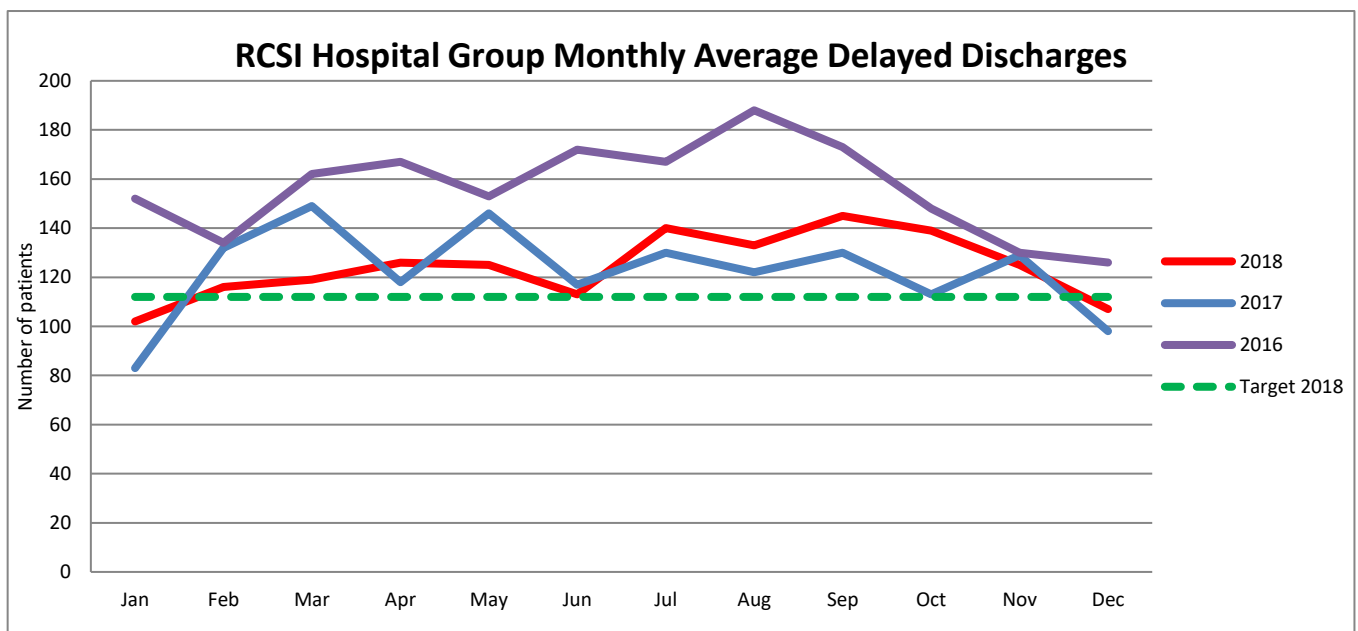
Measurement methodology and data sources

- periodic local data submitted weekly to the BIU for analysis and publication.

Target

- No more than 112 patients experiencing an inappropriately delayed discharge within the RCSI Hospital Group.

Performance

RCSI Hospital Group

RCSI Hospital Group Monthly Average Delayed Discharges

- target of <112 patients achieved for reporting period (n=107 December average)
- 2% increase 2018 / 2017 YTD in the average number of patients experiencing a *"delayed discharge"*
  - 9% increase Dec-18 vs Dec-17
    - monthly average of 3778 bed days were inappropriately utilised for accommodation of patients experiencing *"delayed discharge"* - equating to an acute bed day capacity equivalent to the monthly treatment and accommodation of 540 elective / emergency patients (based on a 7 day average length of stay)

7:6 HOSPITAL MORTALITY

7.6.1	Principal diagnosis of Acute Myocardial Infarction
7.6.2	Principal diagnosis of Heart failure
7.6.3	Principal diagnosis of Ischaemic Stroke
7.6.4	Principal diagnosis of Haemorrhagic Stroke
7.6.5	Principal diagnosis of Chronic obstructive pulmonary disease and bronchiectasis

Rationale for measurement:

It is important that every hospital measures and monitors mortality from specific conditions. Over the past two decades in-hospital mortality patterns have been used as one key indicator of quality of care internationally. Standardised Mortality Ratio (SMR) is a commonly used statistical method for examining hospital mortality patterns within a country or within a hospital group. The SMR compares the observed number of deaths to the expected number of deaths for a specific diagnosis.

Measurement methodology:

Standardised mortality ratio (SMR) is 2017 datasets for:
- Acute Myocardial Infarction (Acute MI)
- Ischaemic Stroke
- Haemorrhagic Stroke

Datasets for Heart Failure and Chronic obstructive pulmonary disease and bronchiectasis currently available for 2017 are for national and county only (and not for Hospital Groups)

Data provided by National Patient Safety Office (*National Healthcare Quality Reporting System*) in July 2018

Performance

7.6.1 RCSI Hospital Group Acute Myocardial Infarction (Acute MI)
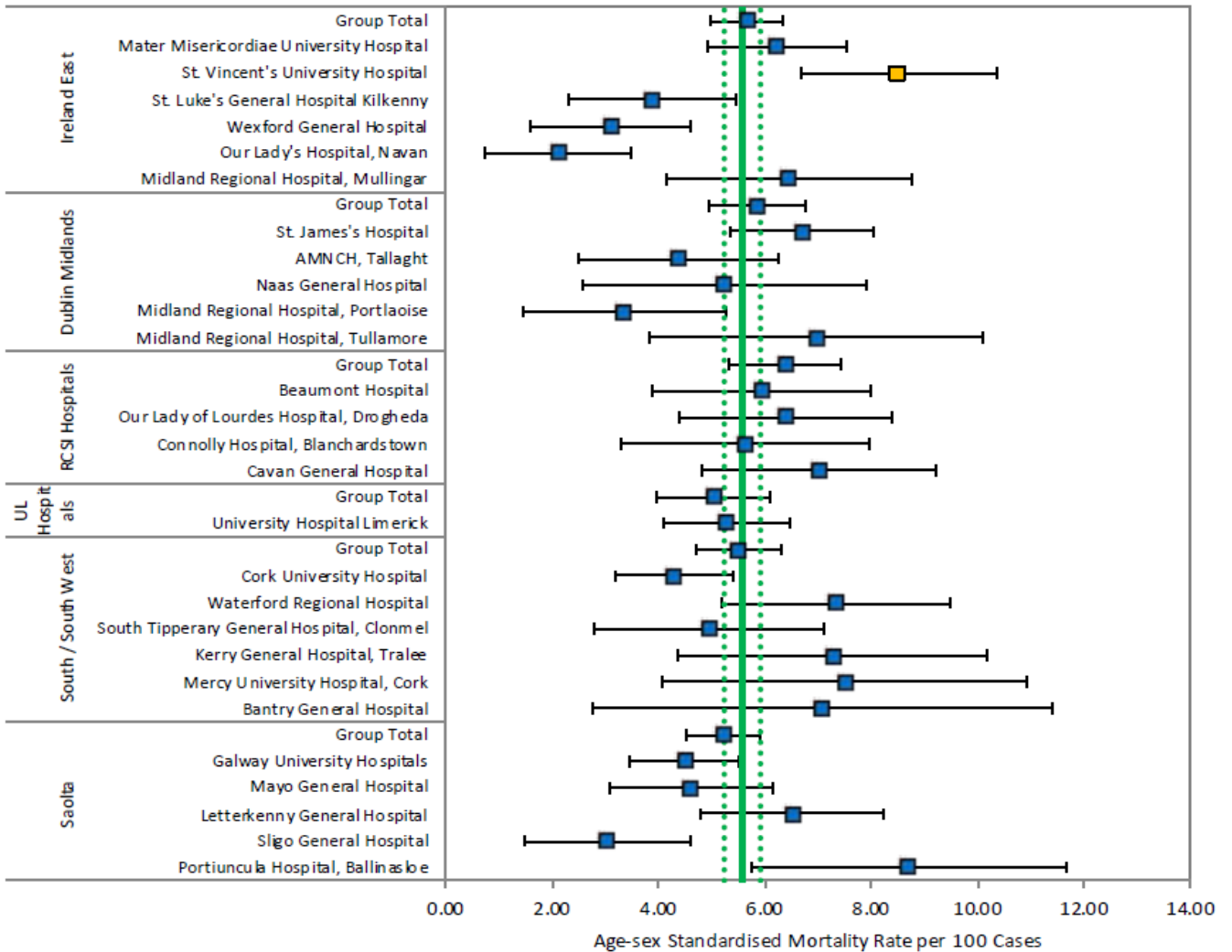
All hospitals in the RCSI Hospital Group had a SMR within the expected range for patients admitted with a principal diagnosis of AMI.

Description: Age-sex standardised in-hospital mortality within 30 days for acute myocardial infarction (AMI) (heart attack) is defined as the number of patients aged 45 and over who die in hospital within 30 days of being admitted with a principal diagnosis of an AMI, as a proportion of the total number of patients aged 45 and over admitted to that hospital with a principal diagnosis of an AMI.
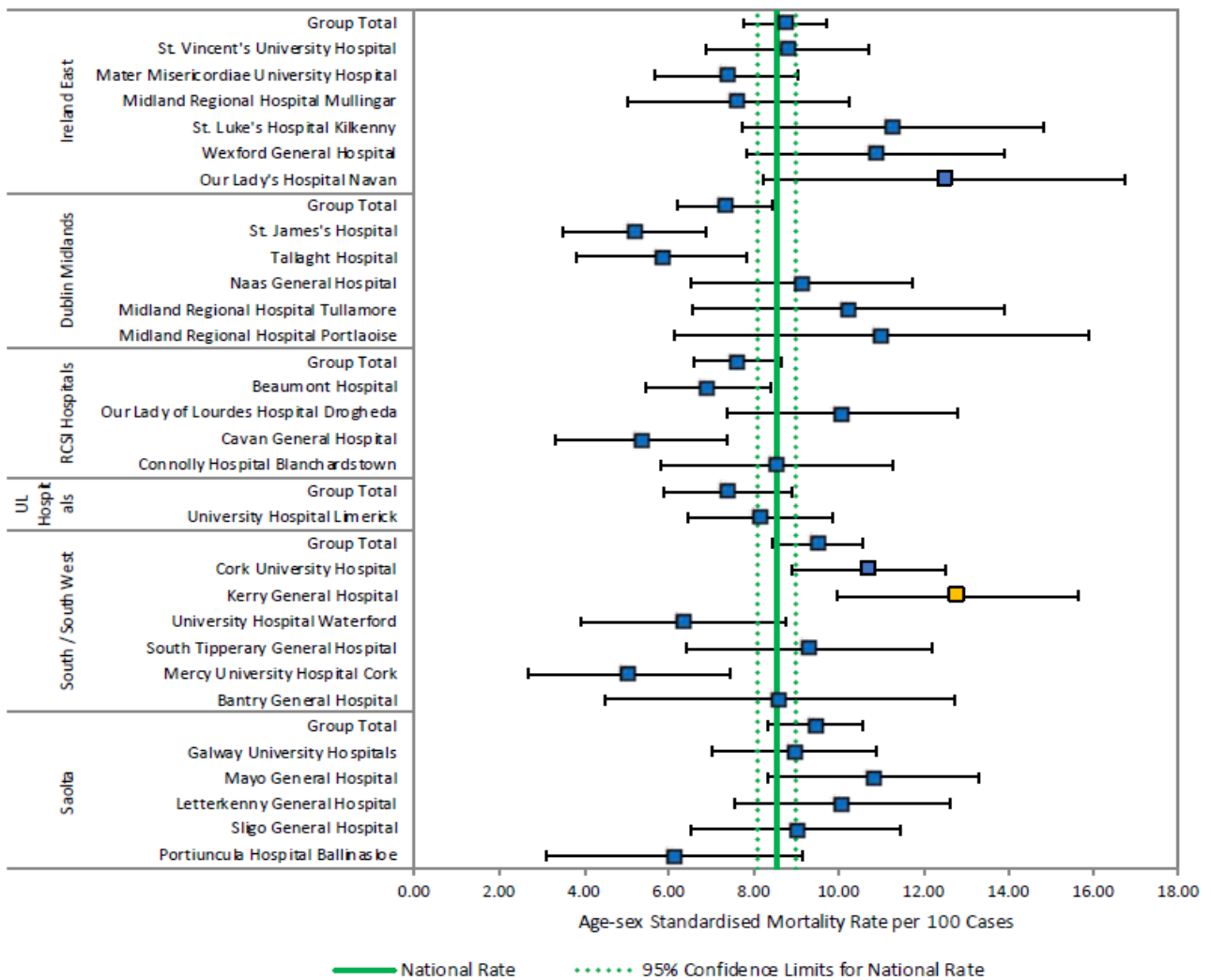
Notes:

Hospitals with small numbers of cases tend to have unstable rates and wider confidence intervals. For this report rates are not displayed for hospitals with less than 100 cases, although the data for these hospitals have been included in the calculation of the national rates. However some hospitals with more than 100 cases may still have unstable rates and caution should be exercised in interpreting rates with wide confidence intervals. The data presented above are age-sex standardised mortality rates per 100 cases. 95% confidence intervals for hospitals and hospital groups are shown by H. Where the 95% confidence interval for a hospital or hospital group overlaps the 95% confidence interval of the national rate (i.e. the dashed green lines), it can be concluded that the rate is not statistically significantly different from the national rate and so is within the expected range. Where the 95% confidence interval for a hospital or hospital group does not overlap the confidence interval of the national rate, it implies that the mortality rate is statistically significantly different from the national rate and is therefore outside the expected range.

There can be many reasons for variations in mortality rates including differences in patient profiles; data quality issues; and differences in the quality of care. Age-sex standardised mortality rates that are statistically significantly higher at the 95% confidence level than the national rate are shown in amber. Rates for all other hospitals and hospital groups are below or within the expected range of the national rate.

Performance

7.6.3 RCSI Hospital Acute Ischaemic Stroke

All hospitals in the RCSI Hospital Group had a SMR within the expected range for patients admitted with a principal diagnosis of Ischaemic Stroke.

Description: Age-sex standardised in-hospital mortality rate within 30 days after ischaemic stroke – caused by a blood clot, is defined as the number of patients aged 45 and over who die in hospital within 30 days of being admitted to hospital with a principal diagnosis of ischaemic stroke, as a proportion of the total number of patients aged 45 and over admitted to that hospital with a principal diagnosis of ischaemic stroke.
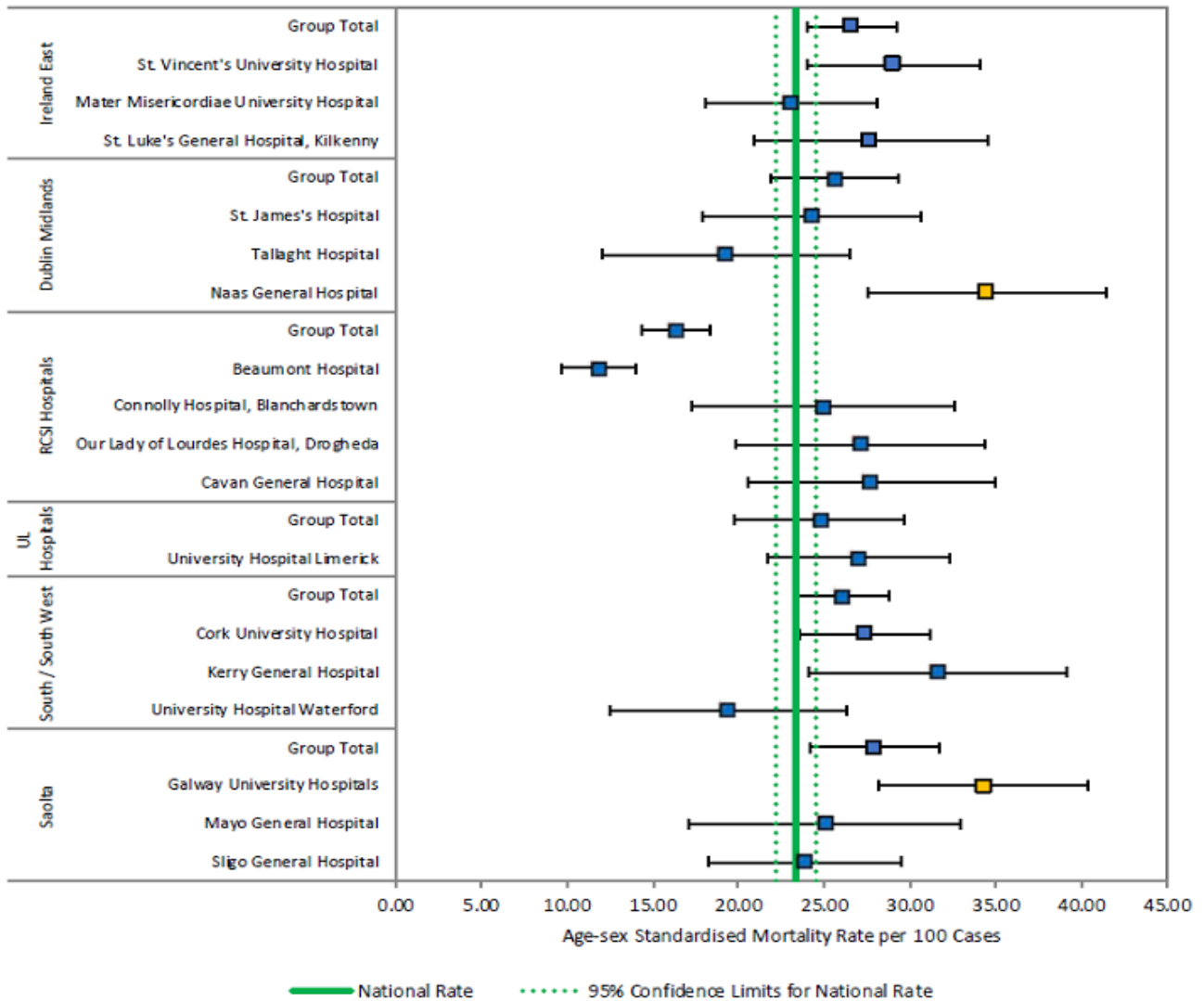
Notes:

Hospitals with small numbers of cases tend to have unstable rates and wider confidence intervals. For this report rates are not displayed for hospitals with less than 100 cases, although the data for these hospitals have been included in the calculation of the national rates. However some hospitals with more than 100 cases may still have unstable rates and caution should be exercised in interpreting rates with wide confidence intervals. The data presented above are age-sex standardised mortality rates per 100 cases. 95% confidence intervals for hospitals and hospital groups are shown by H. Where the 95% confidence interval for a hospital or hospital group overlaps the 95% confidence interval of the national rate (i.e. the dashed green lines), it can be concluded that the rate is not statistically significantly different from the national rate and so is within the expected range. Where the 95% confidence interval for a hospital or hospital group does not overlap the confidence interval of the national rate, it implies that the mortality rate is statistically significantly different from the national rate and is therefore outside the expected range.

There can be many reasons for variations in mortality rates including differences in patient profiles; data quality issues; and differences in the quality of care. Age-sex standardised mortality rates that are statistically significantly higher at the 95% confidence level than the national rate are shown in amber. Rates for all other hospitals and hospital groups are below or within the expected range of the national rate.

Performance

7.6.4 RCSI Hospital Haemorrhagic Stroke

All hospitals in the RCSI Hospital Group had a SMR within the expected range for patients admitted with a principal diagnosis of Haemorrhagic Stroke.

Description: Age-sex standardised in-hospital mortality rate within 30 days for haemorrhagic stroke – caused by bleeding, is defined as the number of patients aged 45 and over who die in hospital within 30 days of being admitted to hospital with a principal diagnosis of haemorrhagic stroke, as a proportion of the total number of patients aged 45 and over admitted to that hospital with a principal diagnosis of haemorrhagic stroke.

Notes:
Hospitals with small numbers of cases tend to have unstable rates and wider confidence intervals. For this report rates are not displayed for hospitals with less than 100 cases, although the data for these hospitals have been included in the calculation of the national rates. However some hospitals with more than 100 cases may still have unstable rates and caution should be exercised in interpreting rates with wide confidence intervals. The data presented above are age-sex standardised mortality rates per 100 cases.95% confidence intervals for hospitals and hospital groups are shown by H. Where the 95% confidence interval for a hospital or hospital group overlaps the 95% confidence interval of the national rate (i.e. the dashed green lines), it can be concluded that the rate is not statistically significantly different from the national rate and so is within the expected range. Where the 95% confidence interval for a hospital or hospital group does not overlap the confidence interval of the national rate, it implies that the mortality rate is statistically significantly different from the national rate and is therefore outside the expected range.

There can be many reasons for variations in mortality rates including differences in patient profiles; data quality issues; and differences in the quality of care. Age-sex standardised mortality rates that are statistically significantly higher at the 95% confidence level than the national rate are shown in amber. Rates for all other hospitals and hospital groups are below or within the expected range of the national rate.

7:7 THROMBOLYSIS IN PATIENTS WITH CONFIRMED ACUTE ISCHAEMIC STROKE

Rationale for measurement

A stroke occurs when the blood supply to the brain is interrupted or reduced. This deprives the brain of oxygen and nutrients, which can cause the brain cells to die. A stroke may be caused by a blocked artery (ischaemic stroke) or the leaking or bursting of a blood vessel (haemorrhagic stroke). Thrombolysis is a treatment to dissolve clots in blood vessels, improve blood flow, and thus help prevent damage to tissues and organs. Thrombolysis can be of benefit in patients with acute ischaemic stroke. The window of opportunity for effective thrombolysis is four and a half hours from the onset of the stroke. Therefore within that timeframe, a firm diagnosis of ischaemic stroke must be made.

Measurement methodology and data sources:

Periodic local data extracts extrapolated for analysis and publication

Rationale for measurement

Stroke is known to be a leading cause of disability and death in patients worldwide. Care in a Stroke Unit is provided in hospital by nurses, doctors and therapists who specialise in looking after stroke patients and work as a co-ordinated team. Evidence shows, that patients who receive this type of care are more likely to survive their stroke, return home and become independent in caring for themselves. Hospital based Stroke Units are associated with a reduction in death and institutional care of around 20%, with one additional patient returned to community living for every 20 patients treated (Stroke Clinical Care Programme, 2012).

Measurement methodology and data sources

KPI1 % of acute stroke patients who spend all or some of their hospital stay in an acute or combined stroke unit*

KPI2 For acute stroke patients admitted to an acute or combined stroke unit, the % of their hospital stay spent in the stroke unit*

KPI3 % of patients with confirmed acute ischaemic stroke who receive thrombolysis

The data is recorded at hospital level via a Stroke Portal within the HIPE file and data is collected by clinical staff. The data is reported quarterly to the BIU via the Health Pricing Office and the National Stroke Programme.

*A Stroke Unit is defined by the European Stroke Organisation as: *"a geographically discreet area with the capacity to monitor and regulate basic physiological function, access to immediate imaging and is staffed by a specialist multidisciplinary team".*
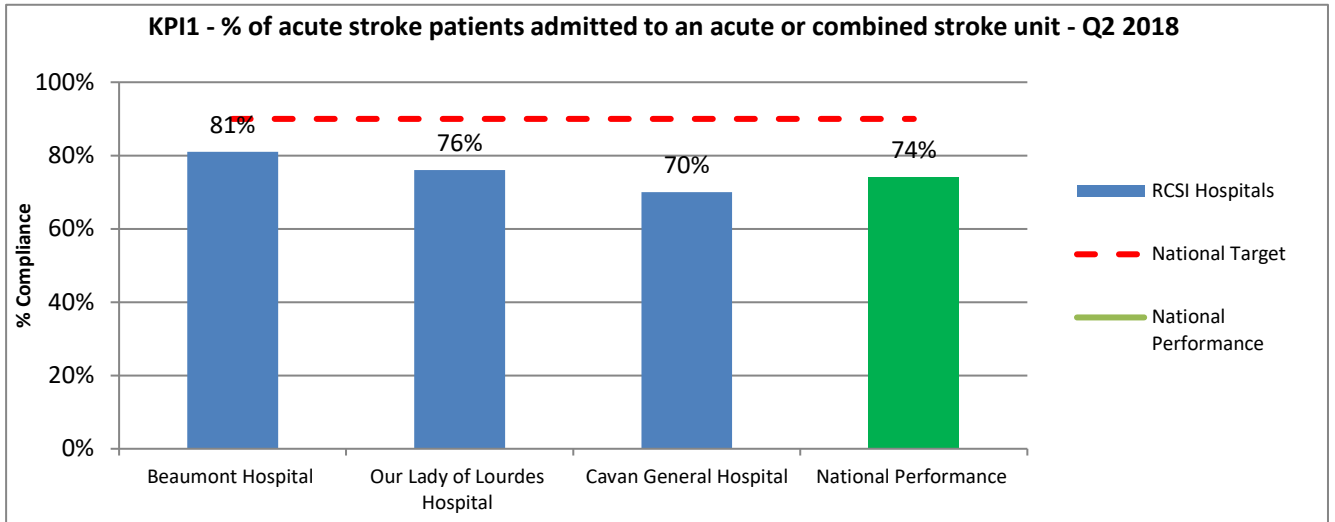
Targets

KPI1   90% of acute stroke patients are admitted to an acute or combined stroke unit

KPI2   90% of hospital stay for acute stroke patients should be spent in an acute or combined stroke unit

KPI3   12% of patients with confirmed acute ischaemic stroke receive thrombolysis

Performance

**KPI1 - % of acute stroke patients admitted to an acute or combined stroke unit - Q2 2018**

2018 YTD is reported against national KPI performance via validated National Stroke Programme data.
- RCSI Hospitals not achieving target of 90%. National performance not achieving target (74%)

KPI2 - % of hospital stay spent in stroke unit for acute stroke patients admitted to an acute or combined stroke unit - Q2 2018
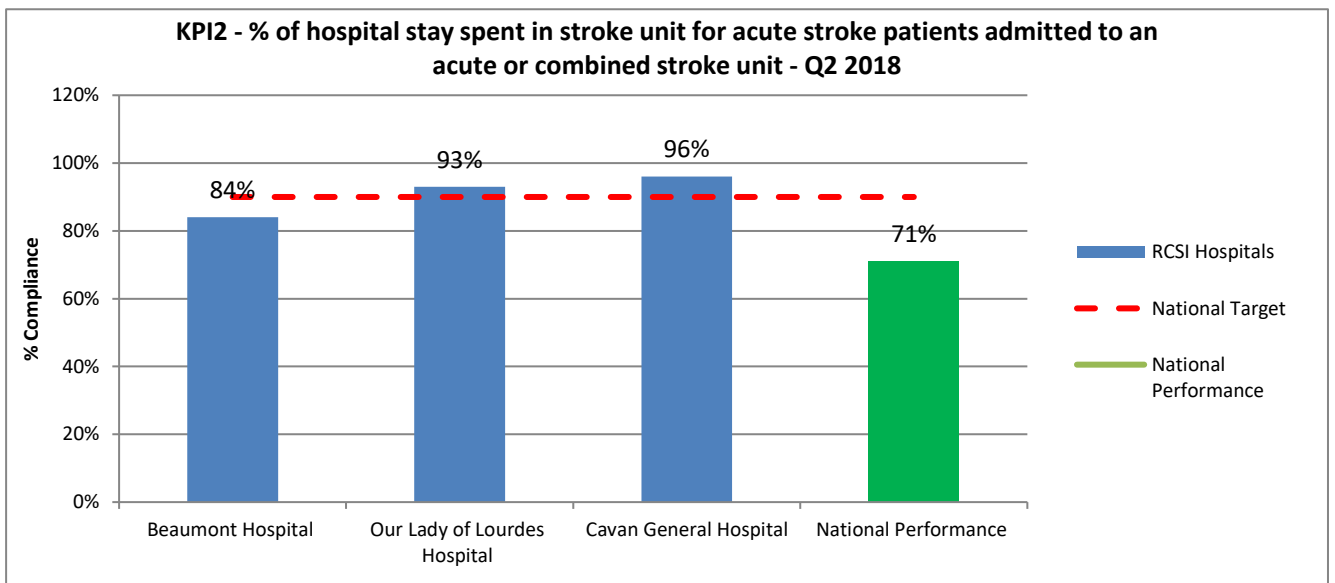
- Cavan Hospital (96%) and OLOL (93%) achieving target of 90%. National performance not achieving target (71%)

KPI3 - % of patients with confirmed acute ischaemic stroke receiving thrombolysis - Q2 2018
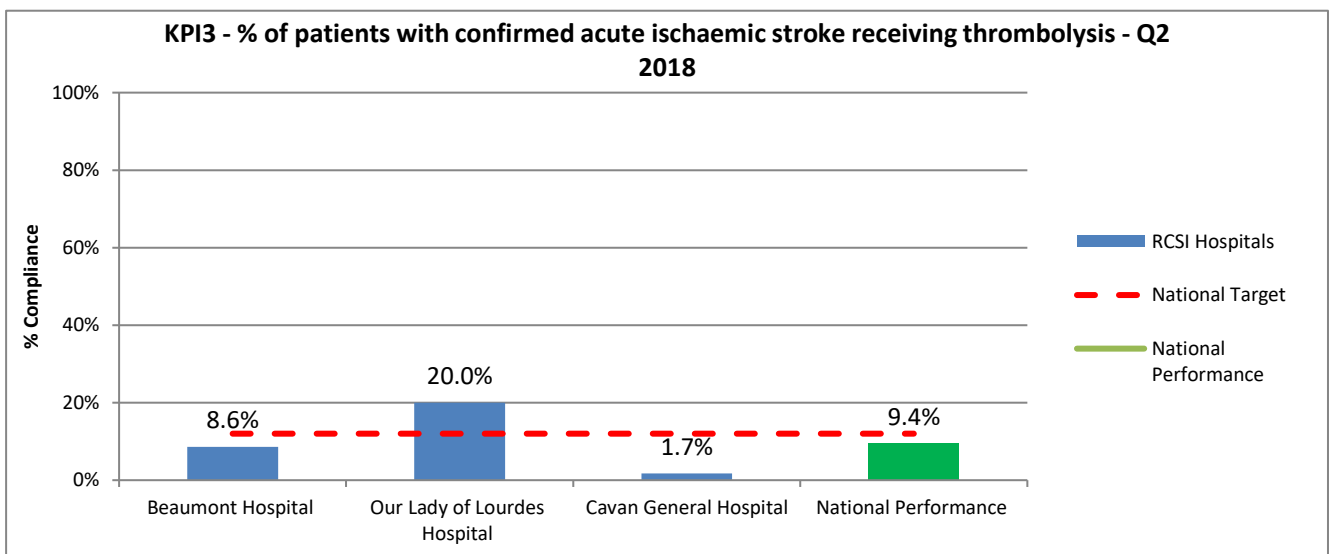
- OLOL (20%) achieving national target of 12%. National performance not achieving target (9.4%)

Appendix 1: Quality Assurance Key Performance Metrics

CHAPTER 8: DIMENSION: PATIENT AND FAMILY EXPERIENCE

8:1 PATIENT SATISFACTION STUDIES

Rationale for Measurement

The RCSI Hospital Group wishes to provide opportunities for patients and families to engage in relation to their experiences of care. Obtaining this feedback will mean it can be used to improve care for all patients. To enable this, the Hospital Group is working towards a mechanism of capturing the patient's experience. Participation in the National Patient Experience Survey (NPES) is one of the methods used to collect this data. The NPES Programme is a joint initiative by the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health.

Measurement Methodology and Data Sources

All adult patients, with a postal address in the Republic of Ireland, who spent 24 hours or more in one of the 40 participating hospitals and were discharged during May 2018 were asked to complete the survey. In total, 4288 patients of the RCSI Hospital Group were invited to participate in the survey and 1931 completed responses have been returned. *Ref: https://www.patientexperience.ie*

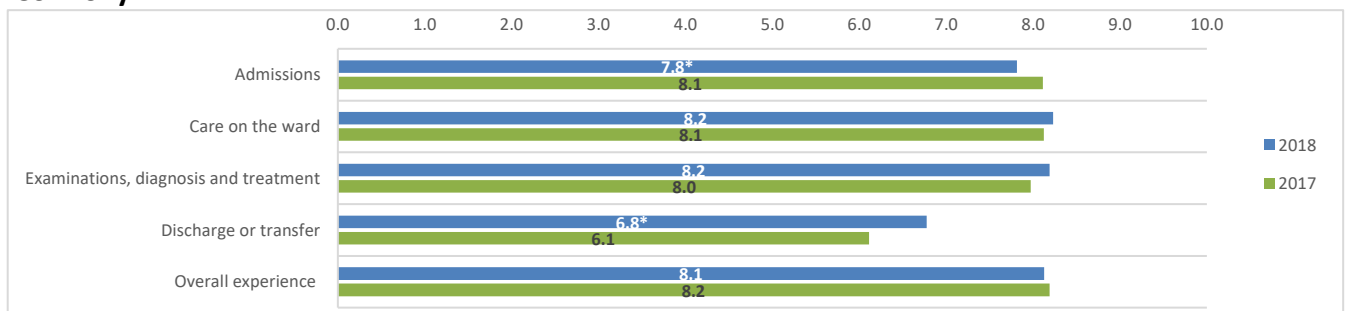The final datasets are listed below and have been broken into 5 themes:
1. Overall rating
2. Admissions
3. Care on the Ward
4. Examination, Diagnosis and Treatment
5. Discharge/Transfers

RCSI Hospital Group
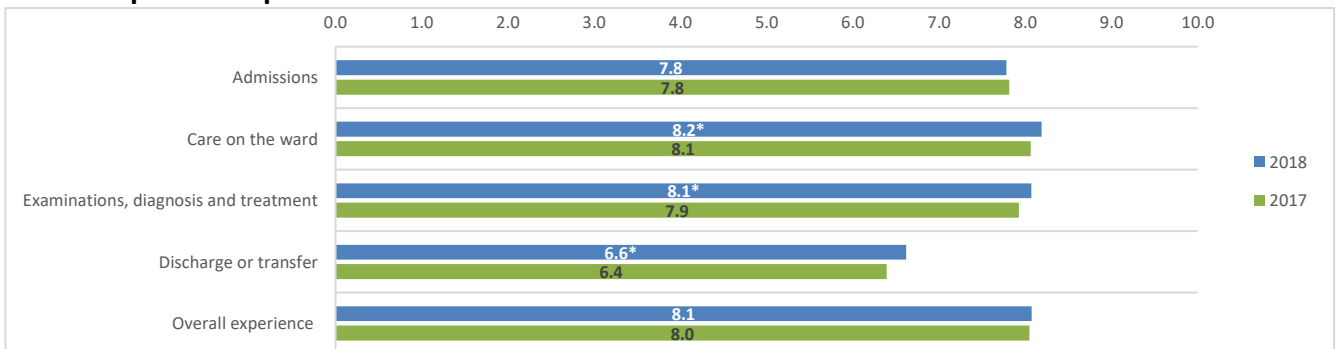
- overall the RCSI Hospital Group has demonstrated performance improvement in relation to patient experience (2018 v 2017)
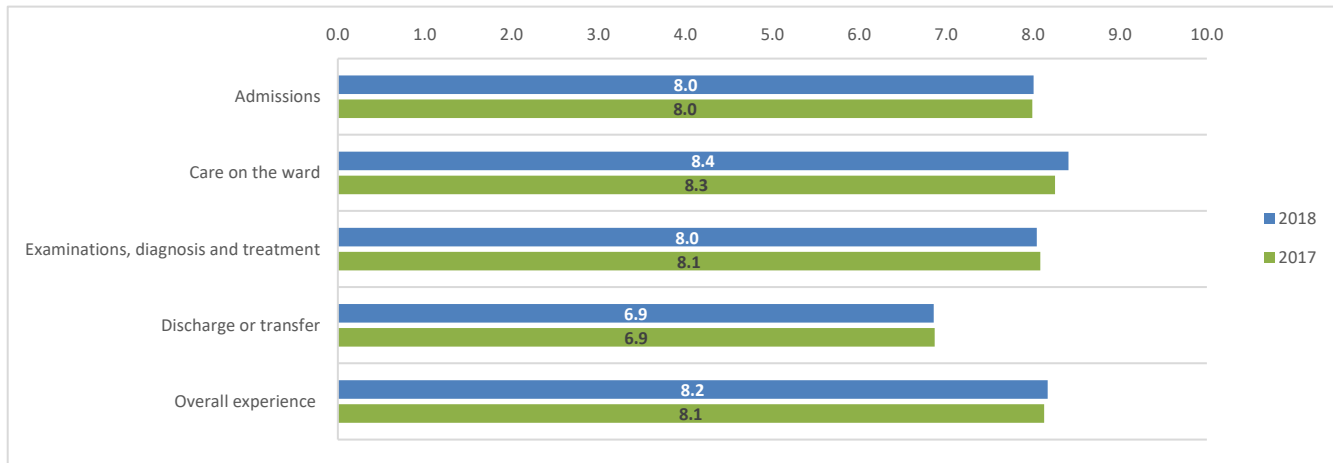
Connolly

- Connolly Hospital summary status report based on 2018 findings:
  - 97% of patients identifying they always, or to some extent, have confidence and trust in hospital staff.
  - 96% of patients identifying they always are, or to some extent, were treated with dignity and respect.
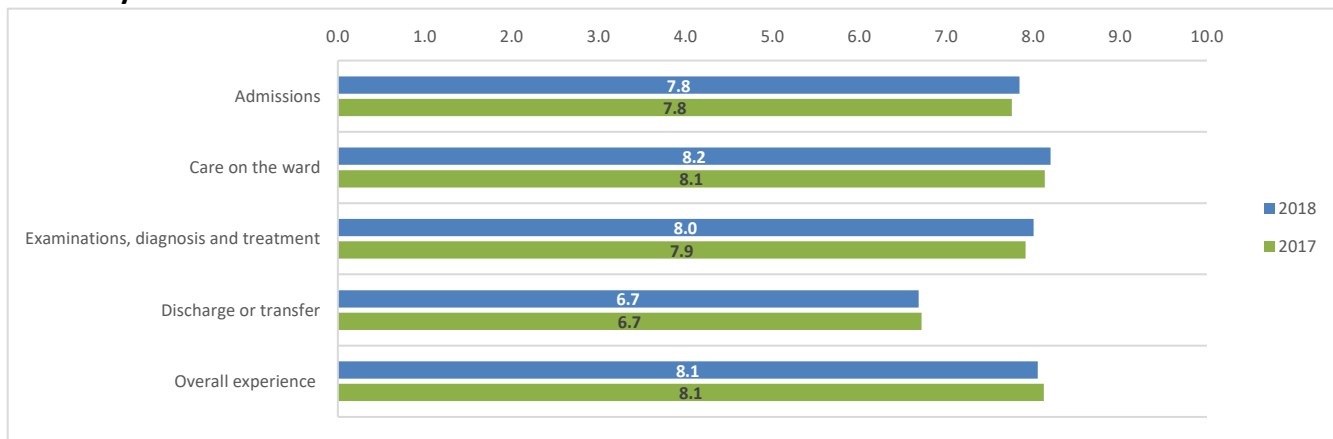
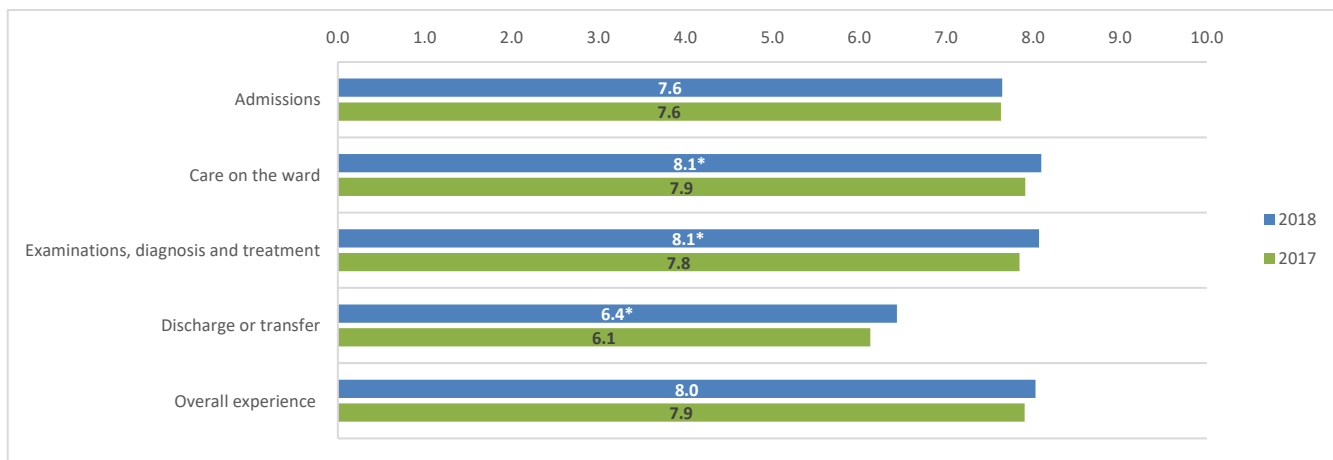## Appendix 1: Quality Assurance Key Performance Metrics

Cavan

- Cavan / Monaghan Hospital summary status report based on 2018 findings:
  - 96% of patients identifying they always, or to some extent, have confidence and trust in hospital staff.
  - 98% of patients identifying they always are, or to some extent, were treated with dignity and respect.

Our Lady of Lourdes

- OLOL Hospital summary status report based on 2018 findings:
  - 97% of patients identifying they always, or to some extent, have confidence and trust in hospital staff.
  - 98% of patients identifying they always are, or to some extent, were treated with dignity and respect.

Beaumont

- Beaumont Hospital summary status report based on 2018 findings:
  - 98% of patients identifying they always, or to some extent, have confidence and trust in hospital staff.
  - 98% of patients identifying they always are, or to some extent, were treated with dignity and respect.

8:2 PERCENTAGE OF COMPLAINTS RESOLVED WITHIN 30 DAYS

Rationale for measurement
- Patient complaints have been identified as a valuable resource for monitoring and improving patient safety.
- RCSI HG staff work very hard to get everything right first time, but understand that not all patients may be happy with service provision. However if staff can get their response to complaints right in terms of explanation of problem experienced and efforts introduced to prevent further reoccurrence, then patients effected are less likely to be unhappy and future problems can be prevented.
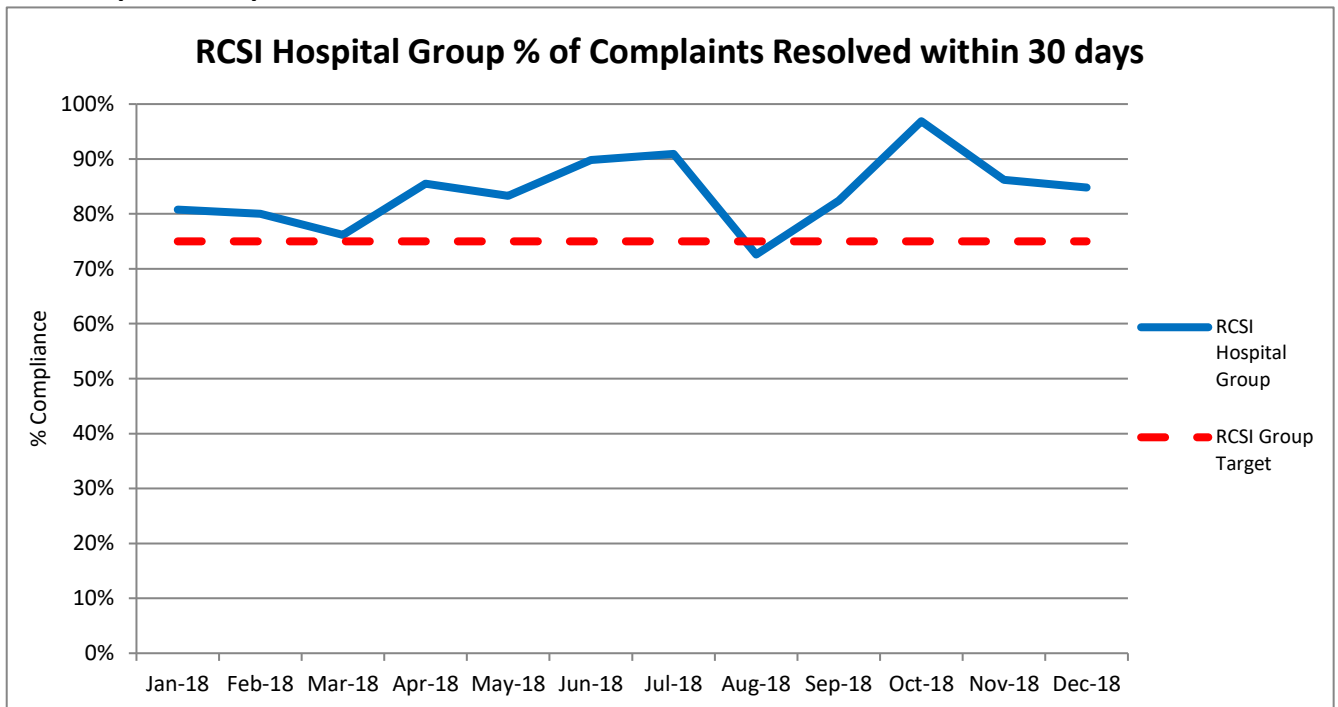
Measurement methodology and data sources
- Local data set from monthly hospital performance metrics. No national data.

Target
- 75% of complaints resolved within 30 days.

Performance

RCSI Hospital Group

- RCSI Hospital Group achieved target for 2018 reporting period **(December 84.8%)**

8:3 PARLIAMENTARY QUESTIONS (PQs)

Rationale for measurement

Parliamentary Questions (PQs) can be posed by any members of the Oireachtas and provide Ministers with regular opportunities to report publicly on matters for which they are responsible. There is a statutory requirement for all state bodies to respond in full to all referred PQs within a maximum of 10 working days as per Dáil Éireann Standing Orders relative to Public Business 2016, section 41(A).
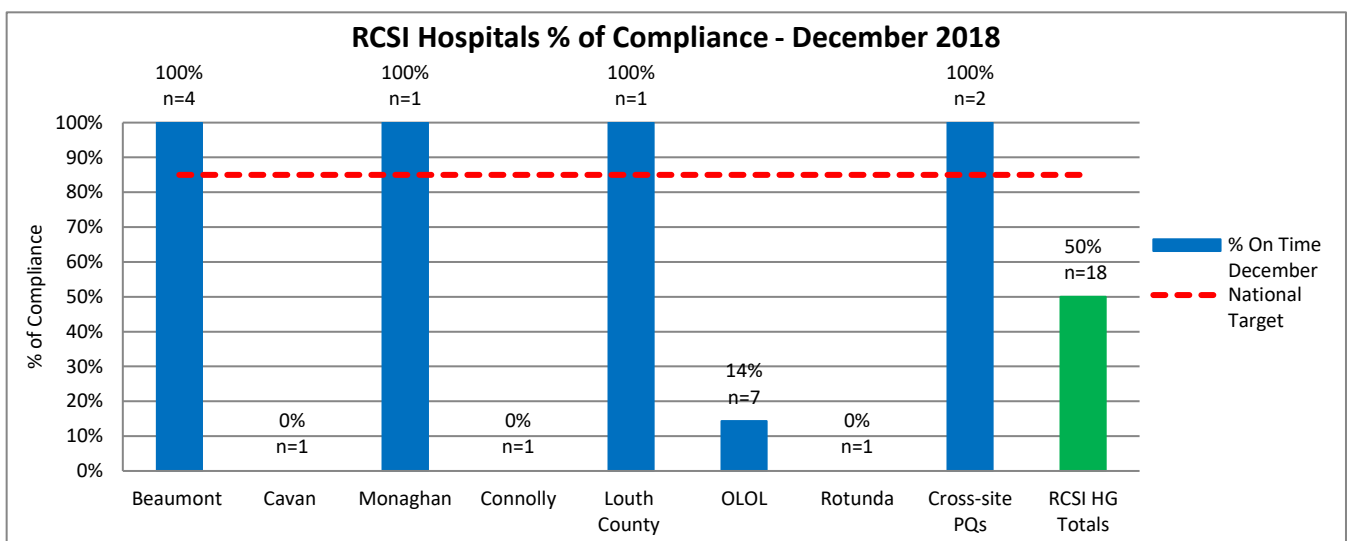
Measurement methodology and data sources

- Compliance % with <10 working days
- HSE National Data Base

Target

- Overall target is 85% waiting <10 days for response letter to be issued
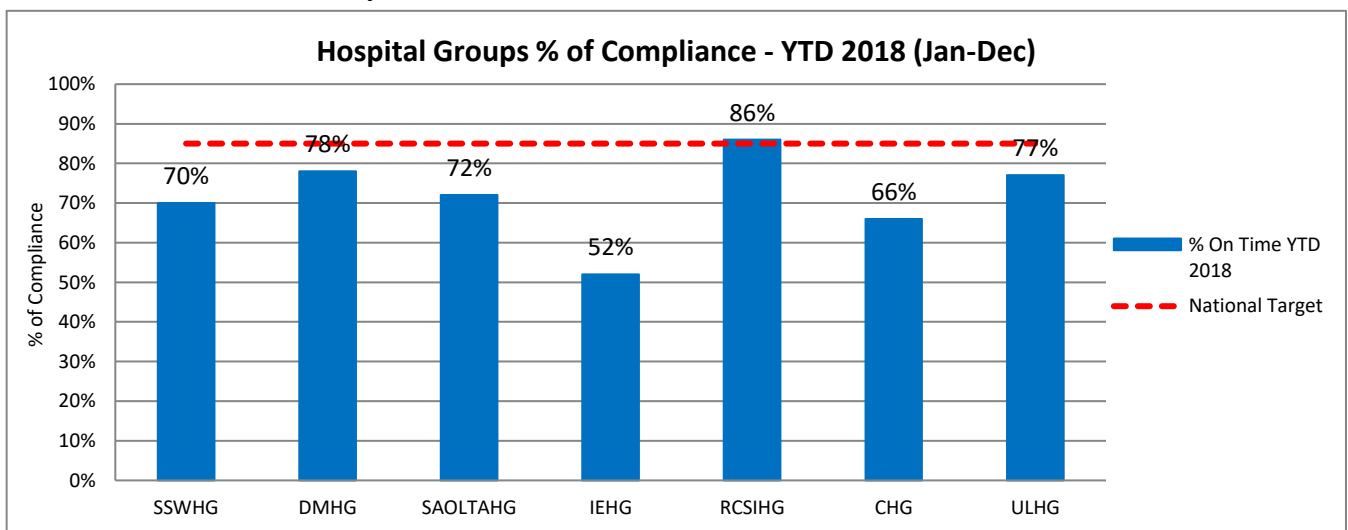
Performance

RCSI Hospital Group

- Beaumont, Monaghan and Louth County achieved compliance for December 2018. Overall Group compliance not achieved for December 2018

National Performance Comparator

- Only RCSI Hospital Group achieved target for YTD overall

CHAPTER 9: DIMENSION: STAFF

9:1 PERCENTAGE STAFF ABSENTEEISM

Rationale for measurement
The presence of an adequate number of health care staff is essential for optimal patient care. High absenteeism rates can potentially affect quality of patient care and staff morale. The resultant ad hoc use of temporary staff from an external Agency to cover sick leave can also impact on continuity of care for the patient.

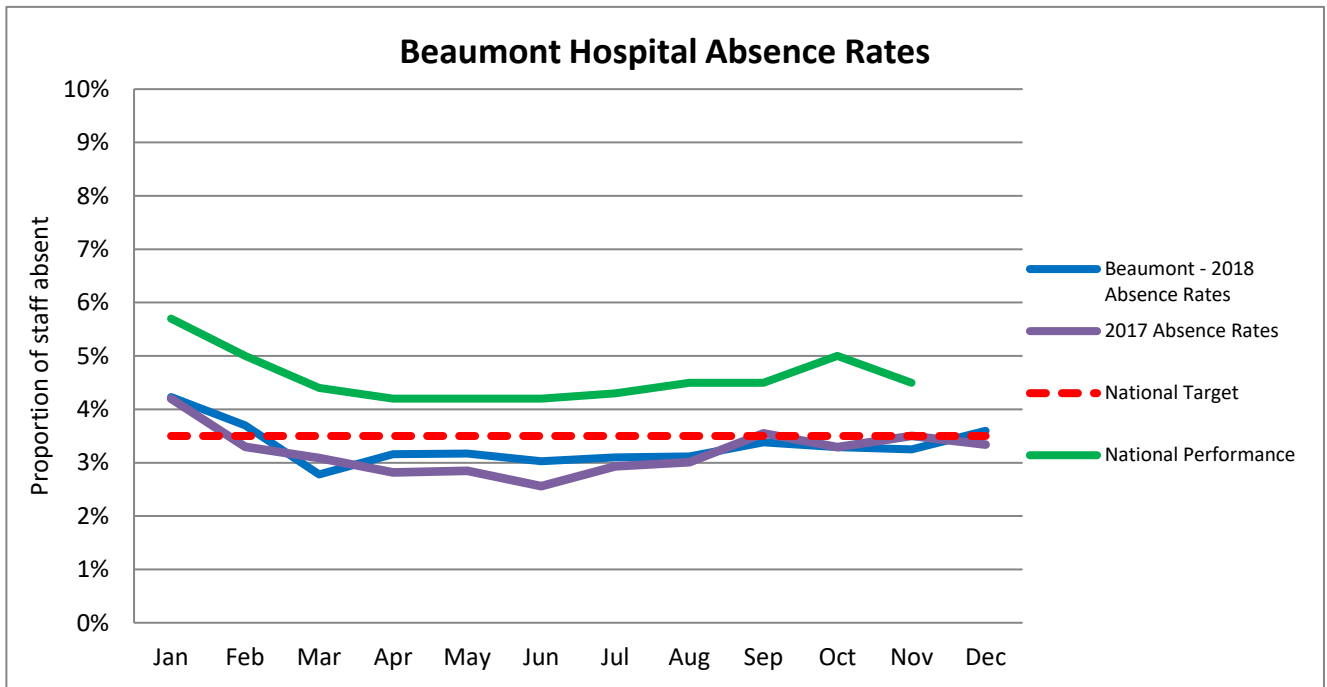### Measurement methodology and data sources
- Local data set from monthly performance metrics

Target
- 3.5%

Performance

Beaumont Hospital

- Beaumont Hospital absence rates higher than national target - **December 3.60%** (19,579 lost hours = 128WTE)
    - national performance not available at time of report publication

Cavan General Hospital
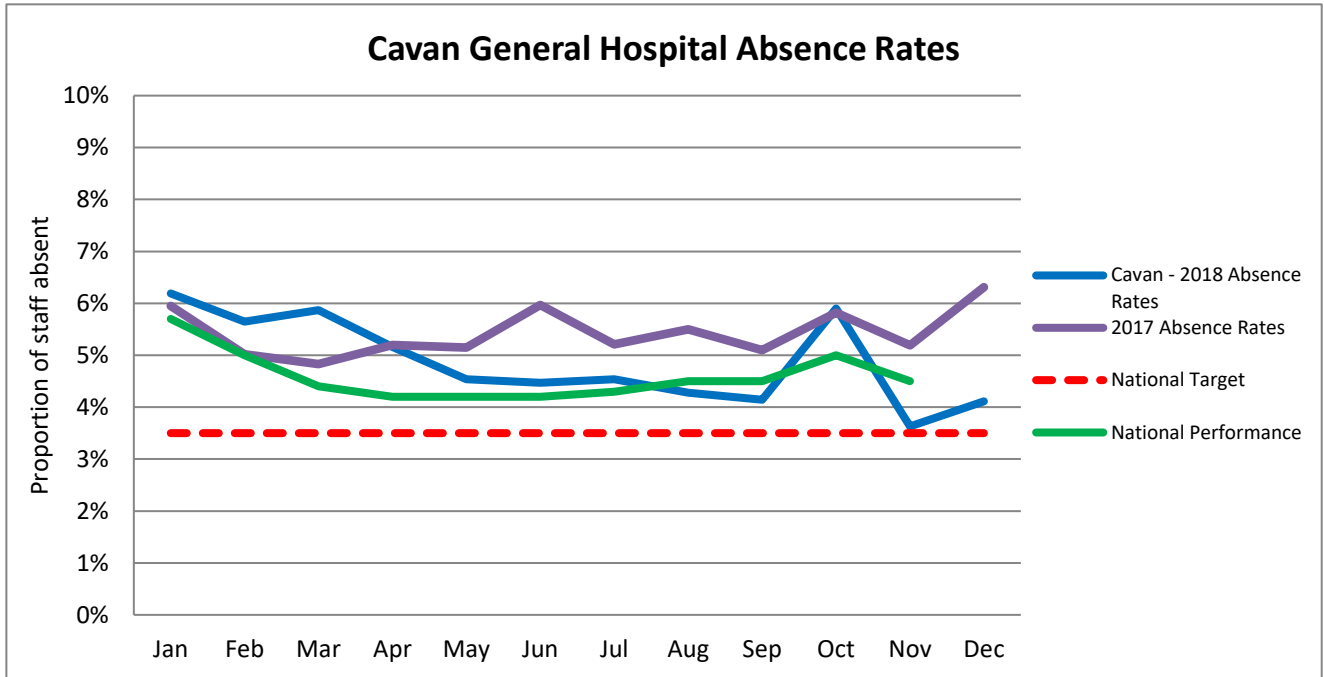
- Cavan Hospital reported absence rates higher than national target - **December 4.11%** (5,272 lost hours = 31WTE)
  - national performance not available at time of report publication

Monaghan Hospital

- Monaghan Hospital reported absence rates higher than national target - **December 8.59%** (1,196 lost hours = 7WTE)
  - national performance not available at time of report publication

Our Lady of Lourdes Hospital, Drogheda

- OLOL reported absence rates higher than national target - **December 5.93%** (12,438 lost hours = 323WTE)
  - national performance not available at time of report publication
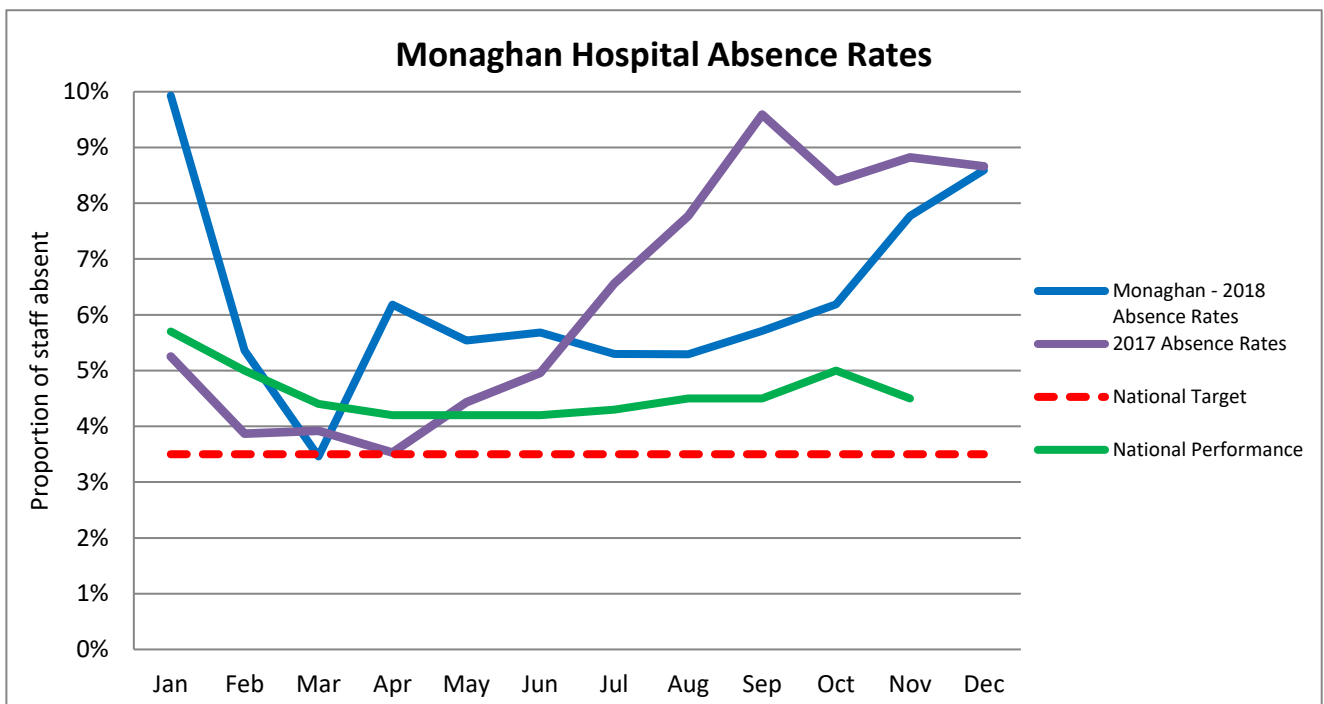
Louth County Hospital

- Louth Hospital reported absence rates higher than national target - **December 6.41%** (2,360 lost hours = 61WTE)
  - national performance not available at time of report publication

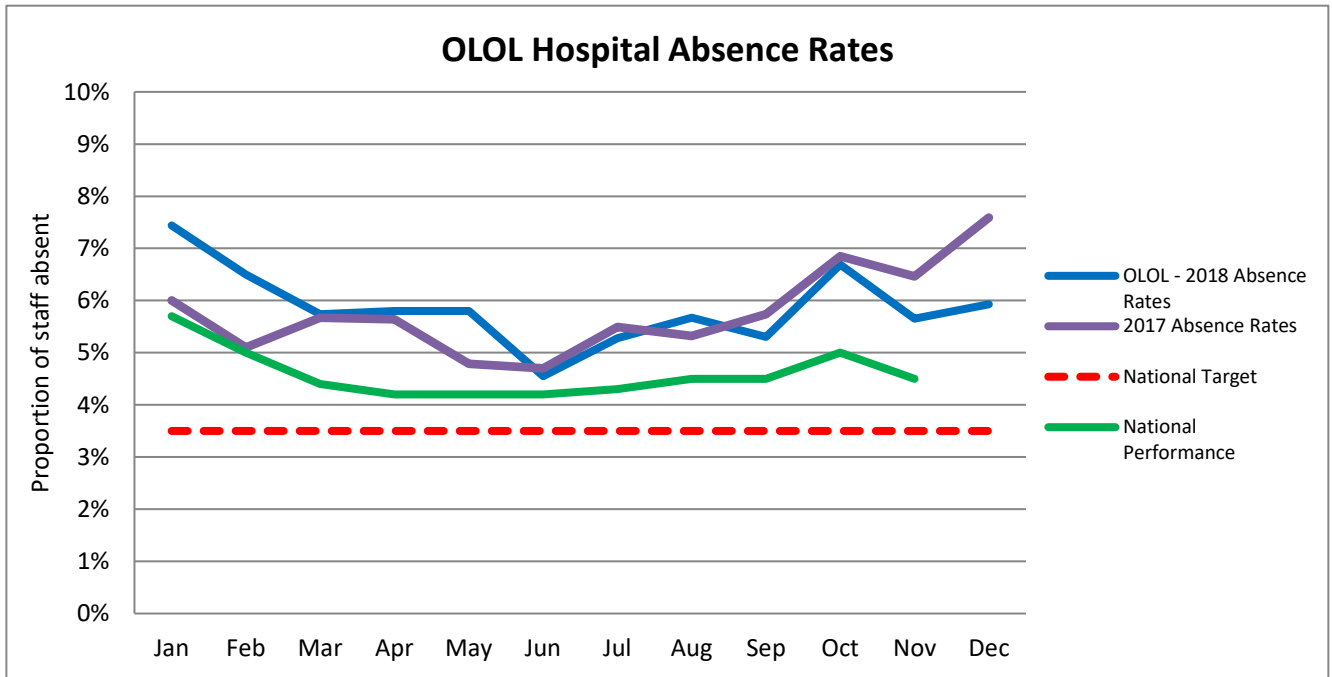**Connolly Hospital**

Connolly Hospital Absence Rates

- Connolly Hospital reported absence rates higher than national target - **December 3.64%** (7,462 lost hours = 46WTE)
    - national performance not available at time of report publication
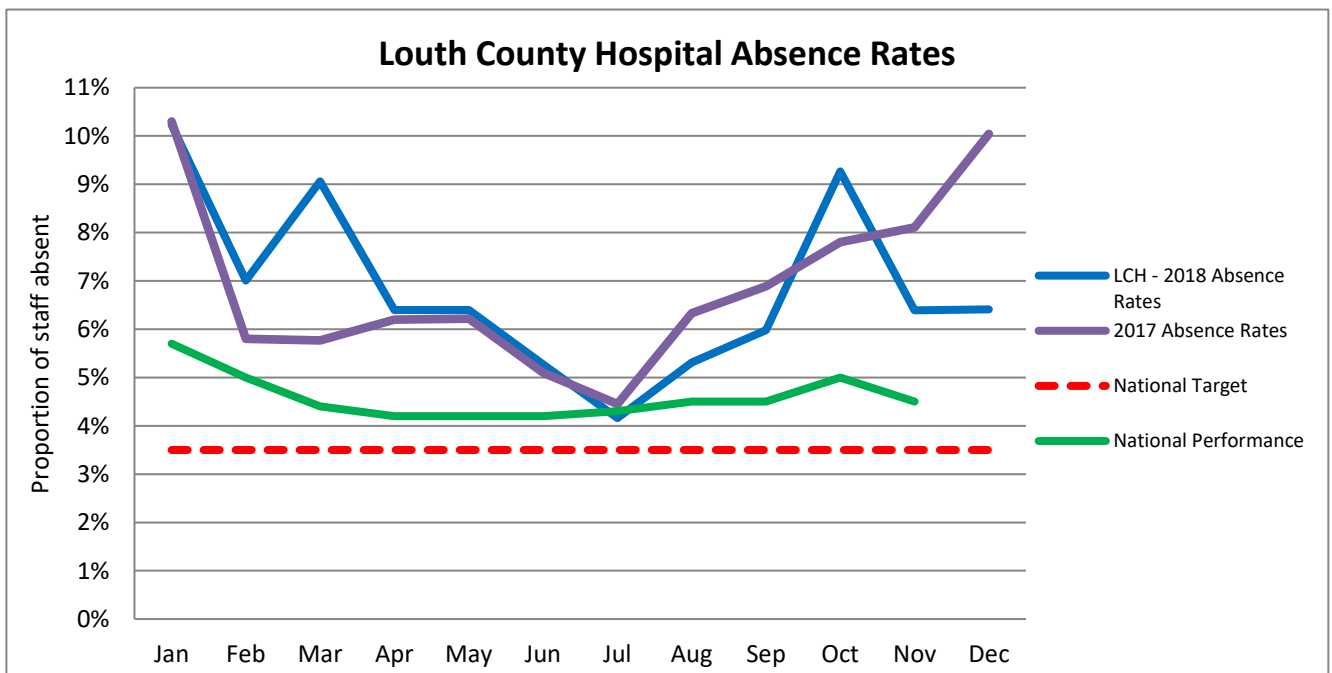
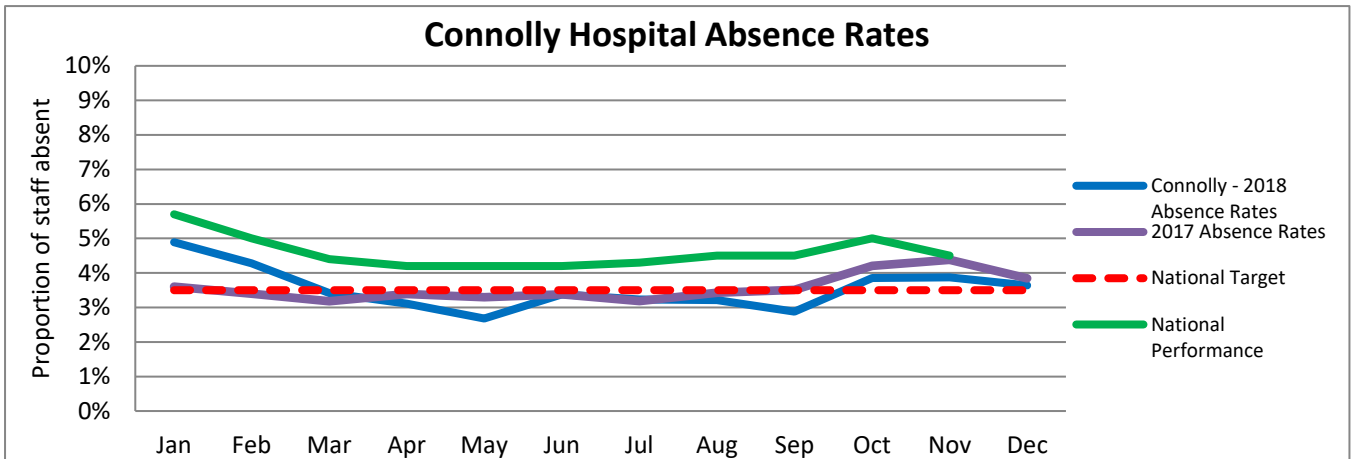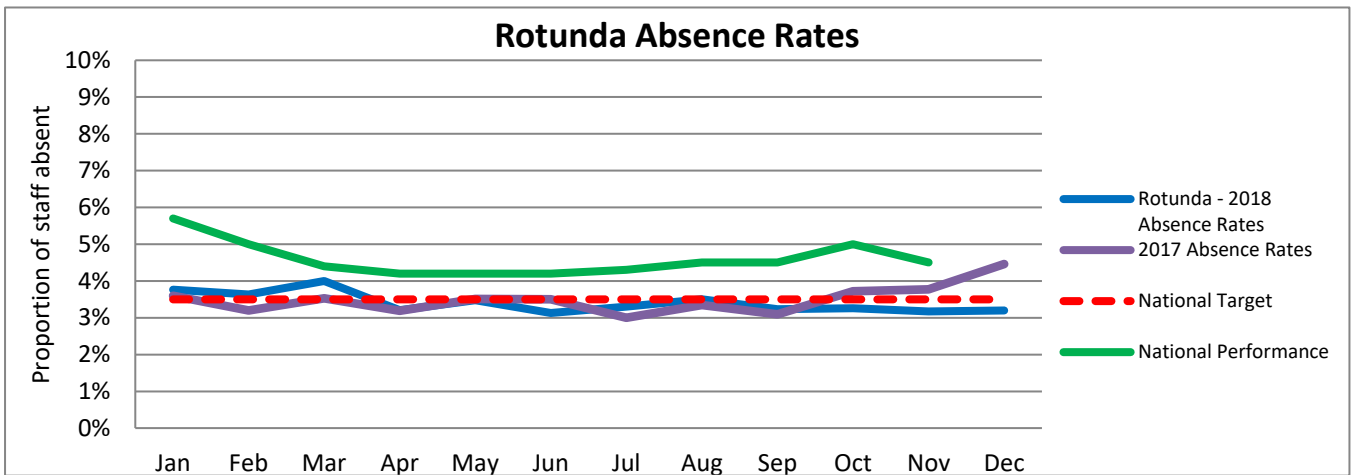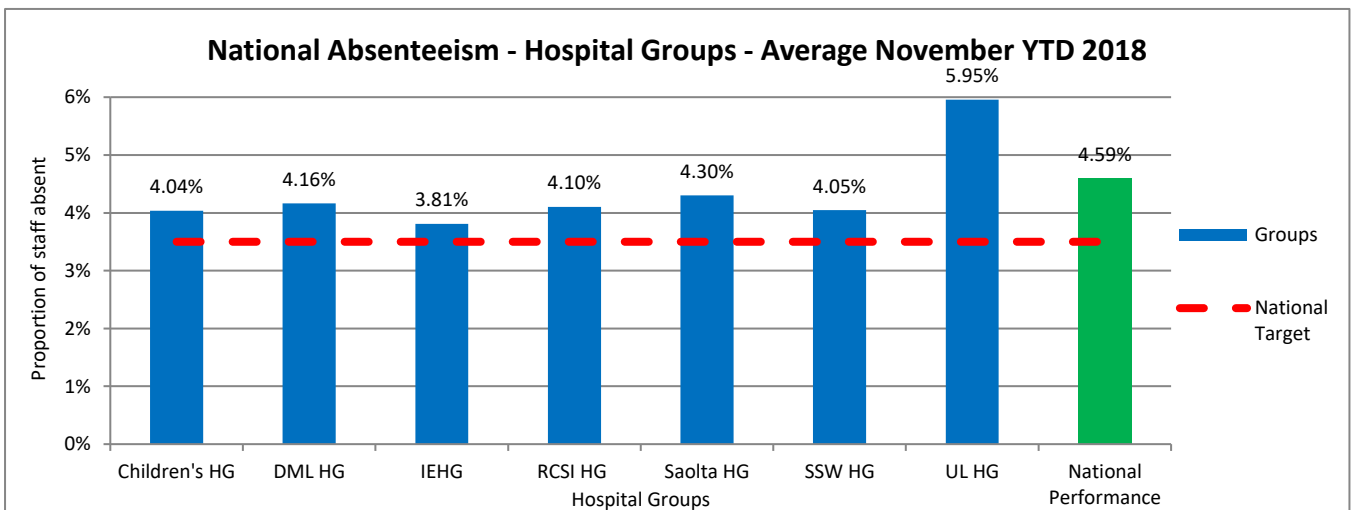**Rotunda Hospital**

Rotunda Absence Rates

- Rotunda Hospital reported absence rates lower than national target - **December 3.20%** (3,904 lost hours = 23WTE)
    - national performance not available at time of report publication

National Comparator – Hospital Groups

National Absenteeism - Hospital Groups - Average November YTD 2018

9:2 PERCENTAGE STAFF GARDA VETTING

Rationale for measurement

The National Vetting Bureau (Children and Vulnerable Persons) Acts 2012-2016 came into effect on 29 April 2016. This legislation makes it mandatory for people who carry out relevant work or activities in respect of children or vulnerable adults to be vetted by the National Vetting Bureau (NVB) of the Garda Siochana. The Acts define relevant work or activities as 'any work or activity which is carried out by a person, a necessary and regular part of which consists mainly of the person having access to, or contact with, children or vulnerable adults'.

Section 21 of the Act provides for the retrospective vetting of employees who are carrying out 'relevant work or activities' and who were not previously vetted. The Regulations (*SI No. 223 of 2016*) provide that applications for retrospective vetting disclosures shall be made not later than March 2018.

Measurement methodology and data sources

- Local data set from monthly performance metrics

Target

- 100% of employees engaged in 'relevant work'

Performance

Dec-18	Total staff with Garda Vetting secured	
	Value	**% value**
Cavan/Monaghan	1229	100%
OLOL	2116	100%
Louth County	325	100%
Connolly	1432	100%
Beaumont	4203	100%
Rotunda	974	100%
RCSI Group	**10279**	**100%**

Appendix 2: RCSI Hospital Group Activity

KPI Title	RCSI Outturn 2018	Beaumont Hospital - Target 2019	Beaumont Outturn 2018 (including St Jospehs)	Cavan General Hospital - Target 2019	Cavan Outturn 2018	Connolly Hospital - Target 2019	Connolly Outturn 2018	Louth County Hospital - Target 2019	Louth County Outturn 2018	Monaghan General Hospital - Target 2019	Monaghan Outturn 2018	OLOL - Target 2019	Drogheda Outturn 2018	Rotunda Hospital - Target 2019	Rotunda Outturn 2018	RCSI Expected Activity/ Target 2019
Discharge Activity Inpatient Cases	102,868	24,963	25,114	17,310	17,361	14,391	14,021	47	44		-	31,210	32,012	14,444	14,316	102,365
Inpatient Weighted Units	98,334	41,818	42,580	10,815	10,786	13,613	13,373	42	39		-	21,993	22,021	9,562	9,535	97,843
Daycase Cases (includes dialysis)	156,179	90,307	90,644	18,868	19,311	13,358	13,253	9,410	9,423	4,614	4,538	9,670	9,718	8,890	9,292	155,117
Day Case Weighted Units (includes dialysis)	142,375	77,687	78,135	17,013	17,310	15,856	15,858	10,810	10,842	3,676	3,729	9,209	9,367	7,998	7,134	142,249
Total inpatient & day cases Cases	259,047	**115,270**	**115,758**	**36,178**	**36,672**	**27,749**	**27,274**	**9,457**	**9,467**	**4,614**	**4,538**	**40,880**	**41,730**	**23,334**	**23,608**	**257,482**
Emergency Inpatient Discharges	68,670	19,223	18,967	13,357	12,575	12,267	11,661		-		-	23,467	23,267	2,946	2,200	71,260
Elective Inpatient Discharges	11,609	5,727	6,131	771	1,075	2,101	2,343	47	44		-	1,186	1,395	403	621	10,235
Maternity Inpatient Discharges	21,755	13	16	3,182	3,390	23	17		-		-	6,557	6,694	11,095	11,638	20,870
Inpatient Discharges ≥ 75 years	18,819	6,669	6,646	3,881	3,782	3,253	3,156		-		-	5,097	5,213	21	22	18,921
Day case dishcarges ≥ 75 years	27,877	18,351	18,197	4,806	4,766	1,227	1,232	1,492	1,484	442	433	1,770	1,740	24	25	28,112
Emergency Care - New ED attendances	181,039	54,821	54,430	32,567	32,025	38,102	37,903	-	-	-	-	56,745	56,681	-	-	182,235
- Return ED attendances	13,260	3,605	3,433	1,471	1,710	2,966	2,817	-	-	-	-	5,434	5,300	-	-	13,476
Injury Unit attendances	16,609	-	-	-	-	-	-	11,599	11,237	5,338	5,372	-	-	-	-	16,937
Other emergency presentations	6,257	473	449	5,620	5,808	-	-	-	-	-	-	-	-	-	-	6,093
Births Total number of births	13,096	-	-	1,492	1,512	-	-	-	-	-	-	3,060	3,070	8,493	8,514	13,045
Outpatients Number of new and return outpatient attendances	500,220	164,740	164,949	33,784	33,486	64,901	67,244	19,626	20,069	12,055	12,346	95,496	95,011	107,368	107,115	497,969

*Total inpatient & day cases Cases - NTPF Funded Activity	943
**Outpatients NTPF Funded Activity	2,501
*Total inpatient & day cases Cases - NTPF Funded Activity subtracted from Actual Total IPDC above	258,104
**Outpatients NTPF Funded Activity subtracted from Actual OP above	497,719

Appendix 3: Organisational Structure
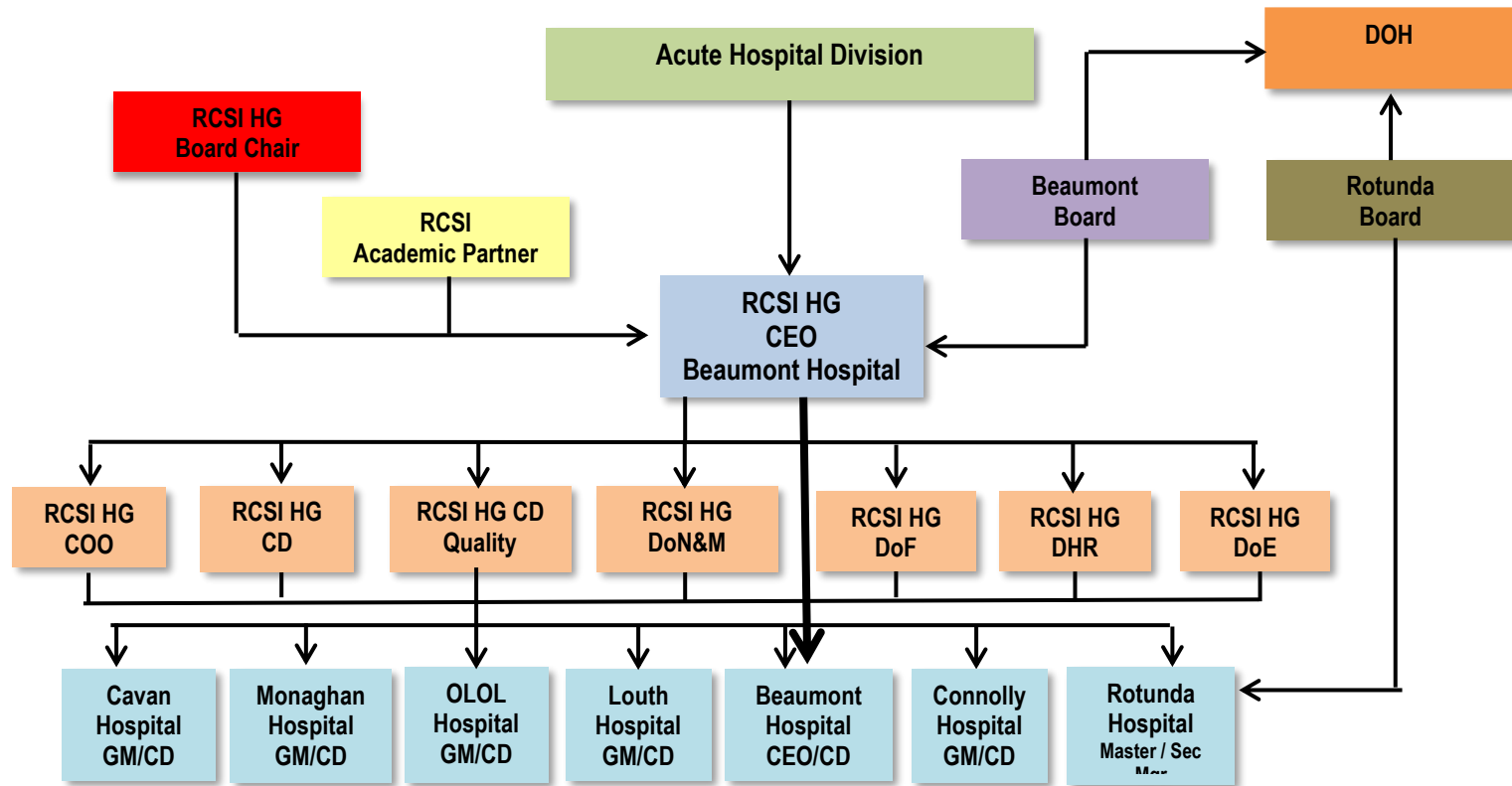
Appendix 4: 2019 WTE and Agency budgets by staff group / hospital site

Category / Hospital	Consultants	NHCD	Nursing	Pre-Reg Nurses	Allied Health Professionals	Management/Admin	General Support	Patient and Client Care	Agency	Total WTE Budget 2019
Cavan	31	107	389	-	106	145	71	138	94.6	**1081.6**
Louth	1	3	89	0	29	55	57	45	15.8	**294.8**
Rotunda	40	64	369	7.5	67	137	124	39	-	**847.5**
OLOL	97	230	833	27.5	183	272	189	170	79.1	**2080.6**
Connolly	65	127	474	1.5	162	179	127	155	55.4	**1345.9**
Monaghan	1	-	34	-	20	15	9	27	-	**106**
Beaumont	195	367	1305	27.5	533	599	446	258	161	**3891.5**
Group			2	-	1	22			-	**25**
Total	**430**	**898**	**3495**	**64**	**1101**	**1424**	**1023**	**832**	**405.9**	**9,673**

Appendix 5: Capital Infrastructure

RCSI GROUP - CAPITAL REQUIREMENT 2019		€M
Beaumont	New ED plus equipping	48.0
Beaumont	Trauma service bid	25.0
Beaumont	Rockfield - decant facility	2.2
Beaumont	Modular build - 30 beds expansion project	3.8
Beaumont	HDU redevelopment	2.1
Beaumont	Cochlear service (complete)	1.6
Beaumont	Hybrid theatre	1.8
Beaumont	Air handling replacement theatre, radiotherapy	1.6
Beaumont	Cystic Fibrosis 22 bed unit	12.0
Beaumont	Porta-cabin replacement programme - admin	2.4
Beaumont	DOSA unit	1.6
Beaumont	Neuro ICU upgrade	2.3
Beaumont	Fire and lighting upgrade	1.2
Beaumont	Theatre lights - 3 years	0.8
Beaumont	Neuro Interventional Radiology (Thrombectomy)	2.8
Beaumont	Fabric upgrade - asbestos main building	1.5
Beaumont	Energy Performance Contracting (EPC) – De-steam 1.5m; new boiler programme. CHP 2.5m; BMS system 1.0m; LED lighting 0.75m; replace air handling units 3.0m; replace R22 system 0.25m; new heat pumps 0.75m; chiller units 1.1m	10.9
Cavan	ED - resuscitation area	0.4
Cavan	Mental Health	5.5
Cavan	Ward refurbishment	0.8
Connolly	Radiology dept incl. CT	5.5
Connolly	Ward refurbishment	0.8
Connolly	Pathology lab	3.5
Connolly	OPD dept refurbishment	0.9
Connolly	Modular build - 30 beds expansion project	3.8
Connolly	Emergency theatres	2.4
Group	Minor capital - infrastructure risk	3.0
Group	General maintenance	3.0
Group	CSSD group wide on Connolly	0.0
Group	Programme of ward upgrades per annum	2.0
Group	Legionella risk, water quality / HIQA	2.0
OLOL	Phase II theatre and ward fit, equipment	16.0
OLOL	Neonatal unit expansion	0.6
Rotunda	Modular build NICU & theatre	7.5
Total		**179.2**

RCSI GROUP - EQUIPMENT REQUIREMENT 2019		€M
Group	Equipment replacement programme	12.0
OLOL	2nd CT	2.0
Cavan	Engineering replacement programme	0.5
Beaumont	Decontamination washer - theatre / St Josephs	0.2
Connolly	MRI	2.5
Group	Bed pan washer replacement	2.5
Total		**19.7**

Note: NZEB compliance will add 8% to costs above