



Directorate Quality Profile

May 2019

Safe	Hospital acquired new cases of <i>S. aureus</i> bloodstream infection per 10,000 bed days used Hospital acquired new cases of <i>C. difficile</i> infection per 10,000 bed days used Number of new cases of CPE
Effective	Return of spontaneous circulation (ROSC) at hospital
Person-centred	Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration Bed days used in CAMHS inpatient units as a percentage of total bed days
Timely	Percentage of people waiting <13 weeks following a referral for routine colonoscopy or OGD Hip fracture surgery within 48 hours
Efficient	Weekly number of delayed discharges Day of surgery admission rate
Equitable	Homeless services: service users' health needs assessed within 2 weeks of admission
Better Health & Wellbeing	MMR vaccination rate

Directorate Quality Profile

Version 1 - May 2019

The HSE Directorate sets the agenda, investment level, culture and strategy for the organisation, and its members are individually and collectively accountable for quality within the Irish health system.

In developing a picture of quality to support a standing agenda item at Directorate meetings, the Directorate agreed a set of 12 measures to be included in a Directorate Quality Profile. These measures are aligned to 7 Domains of Quality that include Person Centred, Safe, Effective, Timely, Equitable, Efficient, Better health and Wellbeing.

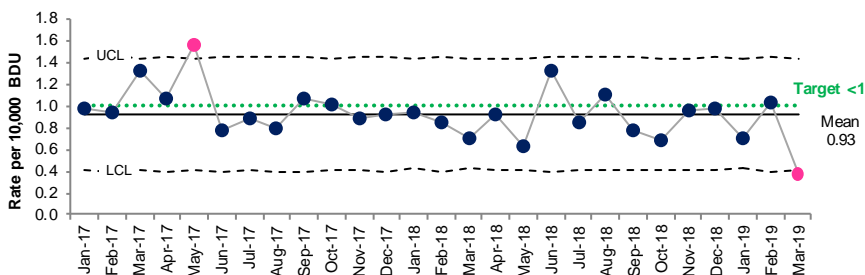
The information is presented using Statistical Process Control (SPC) charts. This helps Directorate members in understanding the variation in the data and supports effective decision making.

The profile was co-designed and tested through a series of 6 PDSA cycles from January 2018 to May 2019. It is recommended that the content of the Profile be reviewed no later than May 2020 to ensure it includes the most relevant information.

Hospital acquired new cases of *S. aureus* bloodstream infection per 10,000 bed days used

Desired Direction 

National Rate



Average national performance is on target and shows a signal of improvement in March 2019.



The rates for 3 hospitals are above the upper control limit.




Latest data available: March 2019



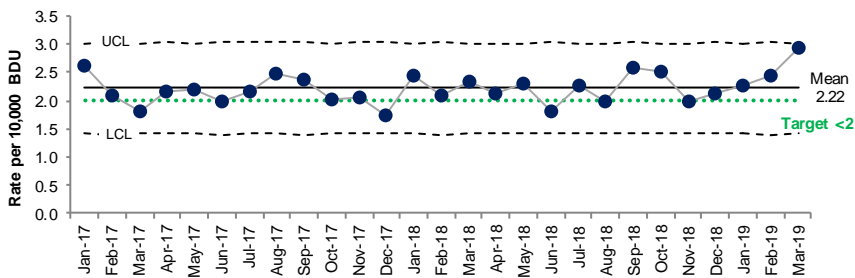
Page 6

Safe

Hospital acquired new cases of *C. difficile* infection per 10,000 bed days used

Desired Direction 

National Rate



Average national performance is stable but worse than the target.



The rates for 3 hospitals are above the upper control limit. The rates for 6 hospitals are below the lower control limit.



Latest data available: March 2019

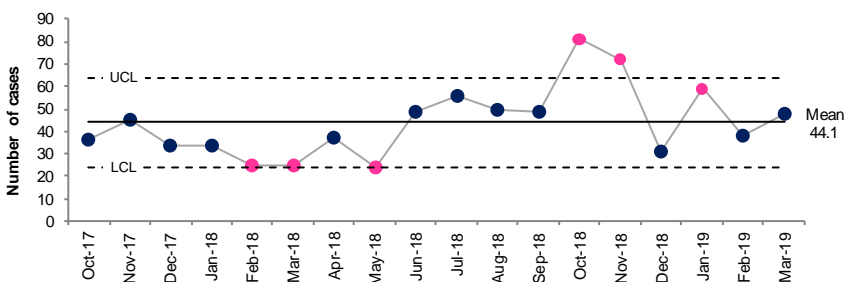


Page 7

Safe

Number of new cases of CPE

National Rate



Unstable

The number of newly detected cases of CPE per month is unstable with special cause variation signalling an increase in Oct & Nov-18, and Jan-19.




Latest data available: March 2019



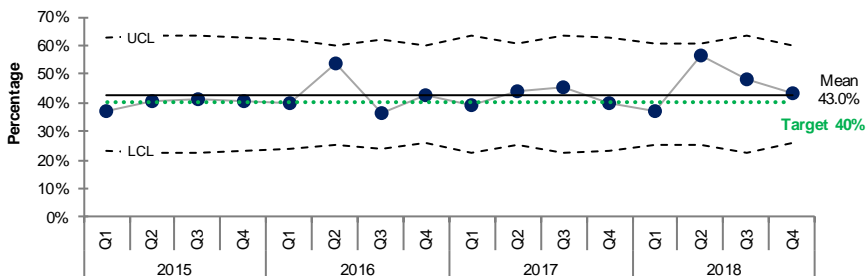
Page 8

Safe

Return of spontaneous circulation (ROSC) at hospital

Desired Direction 

National Rate



Average national performance is on target & stable



Latest data available: Quarter 4 2018



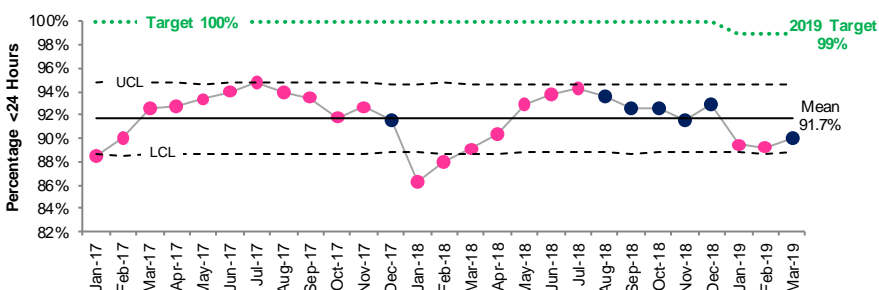
Page 9

Effective

Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours

Desired Direction 

National Rate



Average national performance is worse than the target & unstable



The rates for 20 of the 27 hospitals are outside the control limits indicating more variation across the system than expected.



Latest data available: March 2019



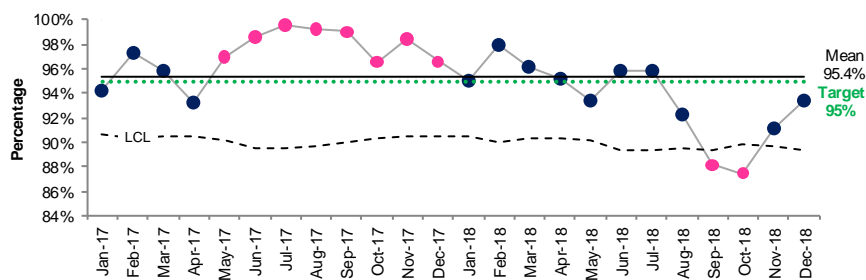
Page 10

Person-centred

Bed days used in CAMHS inpatient units as a percentage of total bed days

Desired Direction

National Rate



Average national performance is better than the target.

The rates for Sept & Oct 2018 were below the LCL, but the rates for the last Nov & Dec 2018 were within the control limits.



The rates for 5 CHOs are above the UCL. The rates for 2 CHOs are below the LCL.



Latest data available: December 2018

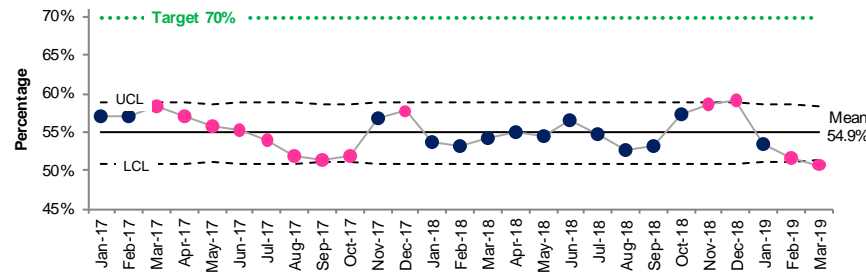


Page 11

Percentage of patients waiting <13 weeks following a referral for routine colonoscopy or OGD

Desired Direction

National Rate



Average national performance is worse than the target and unstable.



The rates for 31 of the 39 hospitals are outside the control limits indicating more variation across the system than expected.



Latest data available: March 2019

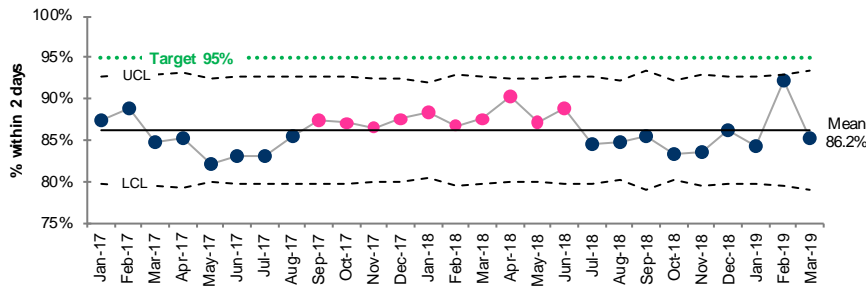


Page 12

Hip fracture surgery within 48 hours

Desired Direction

National Rate



Average national performance is worse than the target.



The rates for 2 hospitals are above the UCL. The rates for 2 hospitals are below the LCL.



Latest data available: March 2019

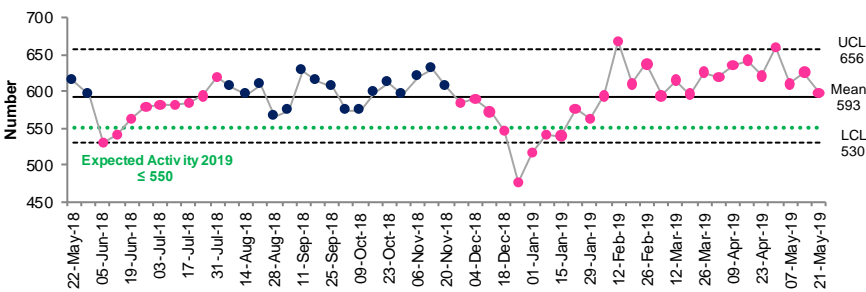


Page 13

Weekly number of delayed discharges

Desired Direction

National Data



Average national performance is above the expected level of activity and shows a signal of disimprovement



Latest data available: 21 May 2019

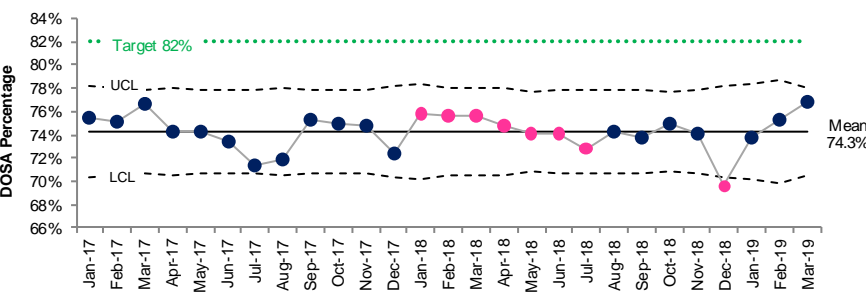


Page 14

Day of surgery admission (DOSA) rate

Desired Direction

National Rate



Average national performance is worse than the target.



The rates for 2 hospitals are below the LCL. The rate for 1 hospital is above the UCL.



Latest data available: March 2019



Page 15

Person-centred

Timely

Timely

Efficient

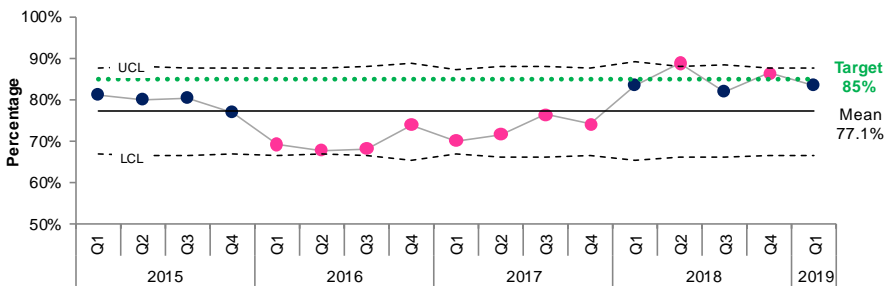
Efficient

Homeless services: service users' health needs assessed within 2 weeks of admission

Desired Direction ↑

Equitable

National Rate



Average national performance is below target although there was a signal of improvement in 2018.



Latest data available: Q1 2019



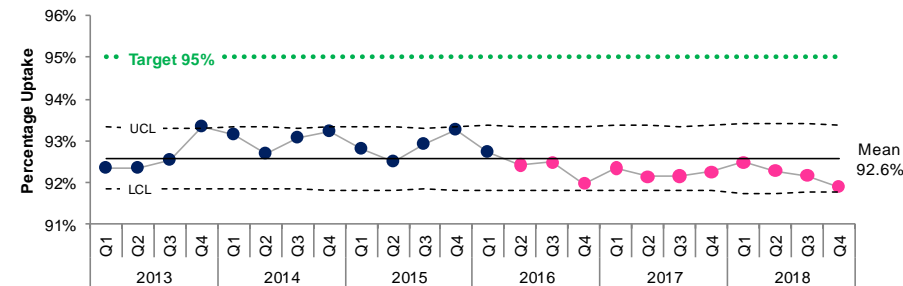
Page 16

Better Health & Wellbeing

MMR vaccination rate

Desired Direction ↑

National Rate



Average national performance is worse than the target, with a sustained reduction since Q2 2016.



The rates for 4 CHOs are above the UCL. The rates for 4 CHOs are below the LCL.



Latest data available: Q4 2018



Page 17

Hospital acquired new cases of *S. aureus* bloodstream infection per 10,000 bed days used

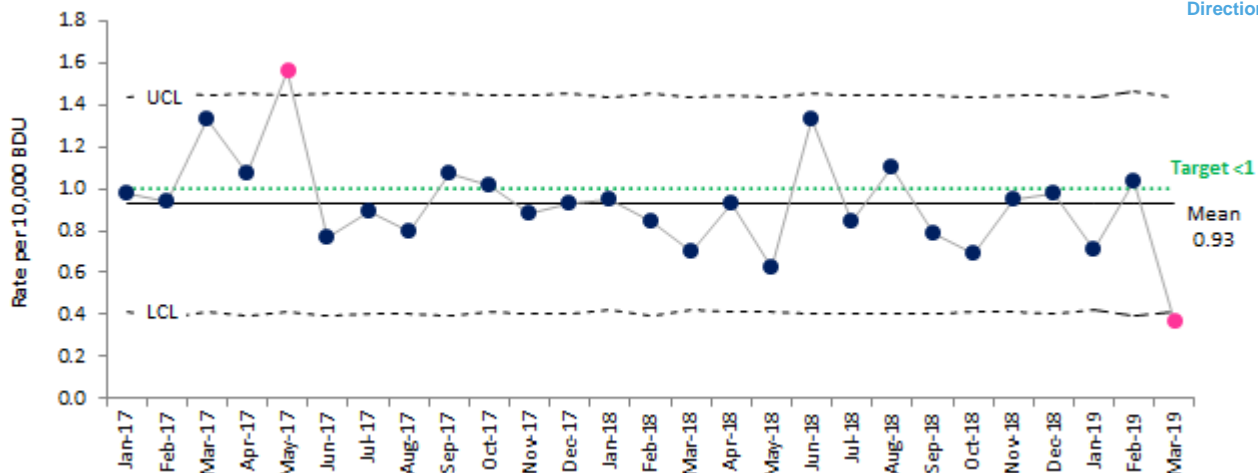
NEW DATA

Assessment

Performance at national level is on target and shows a signal of improvement in March 2019.

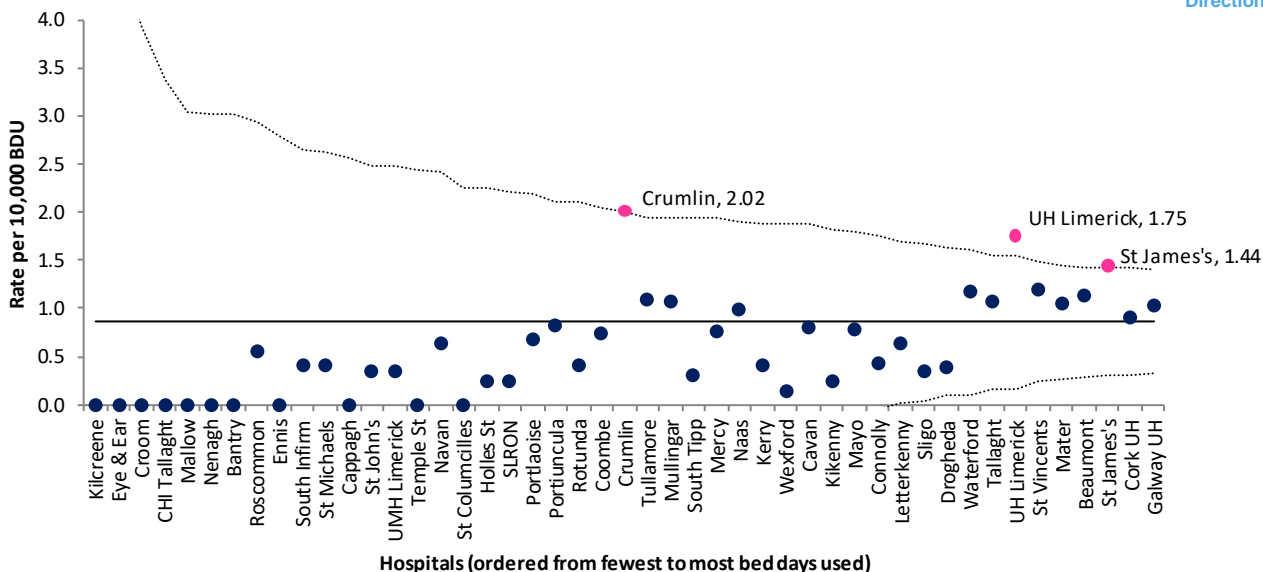
The rates for 3 hospitals are above the upper control limit indicating unexpected variation, i.e. not due to chance.

National rate



- The average national rate since January 2017 is 0.93 cases per 10,000 bed days used. This equates to an average of 29 cases per month.
- The rate for March 2019 (0.38 per 10,000 bed days used) is below the lower control limit. This is unlikely to have occurred by chance alone and is a signal of improvement.
- While the average rate is just below the target, it can be expected that the monthly rates will fluctuate between approximately 0.4 and 1.5 per 10,000 bed days due to normal variation/ chance.

Rates by hospital, last 12 months



- The rates for all hospitals over the last 12 months were within the expected range of variation for this indicator, with the exception of Our Lady's Children's Hospital Crumlin, University Hospital Limerick and St James's Hospital where the total rates of hospital acquired cases of *S. aureus* bloodstream infection were above the upper control limit.
- This is unlikely to have occurred by chance alone and is an indicator of unexpected variation. Case mix and complexity are among factors that may contribute to such variation.

Safe

Directorate Quality Profile
May 2019

Hospital acquired new cases of *C. difficile* infection per 10,000 bed days used

NEW DATA

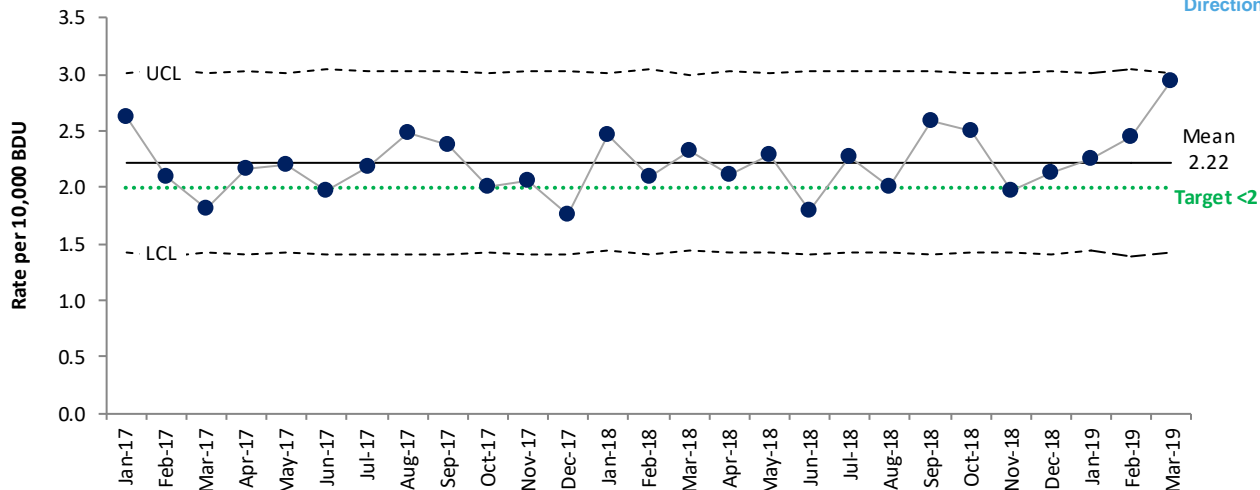
Assessment

Performance at national level is stable but worse than the target. The rates for 3 hospitals are above the upper control limit and the rates for 6 hospitals are below the lower control limit indicating unexpected variation, i.e. not due to chance.

C. difficile is a gut bug that can cause serious gastrointestinal infection. This is a useful indicator of Antibiotic Stewardship (evidence based use of antibiotics to reduce antibiotic resistance) as *C. difficile* is usually caused by over or inappropriate antibiotic prescribing.

National rate

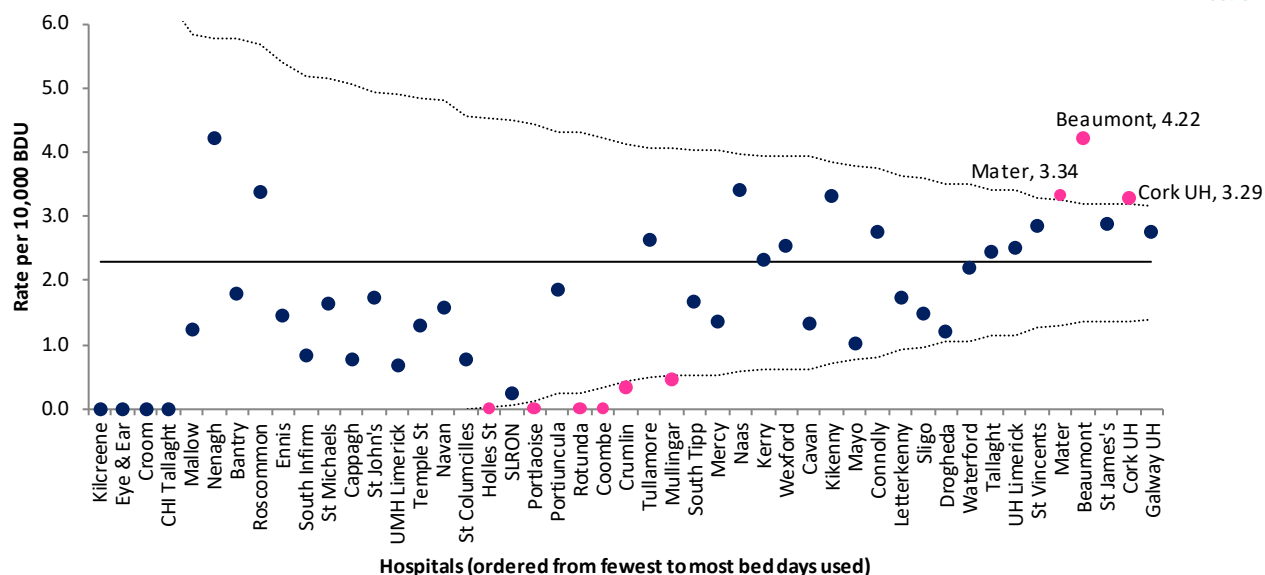
Desired Direction ↓



- The average national rate since January 2017 is 2.22 cases per 10,000 bed days used. This is above the target of <2 cases per 10,000 bed days used and equates to an average of 69 cases per month.
- The variation from month to month is within the expected range, i.e. the rate is stable and the variation seen is due to chance alone. It can be expected that the monthly rates will fluctuate between approximately 1.4 and 3.0 per 10,000 bed days due to normal variation/ chance.

Rates by hospital, last 12 months

Desired Direction ↓

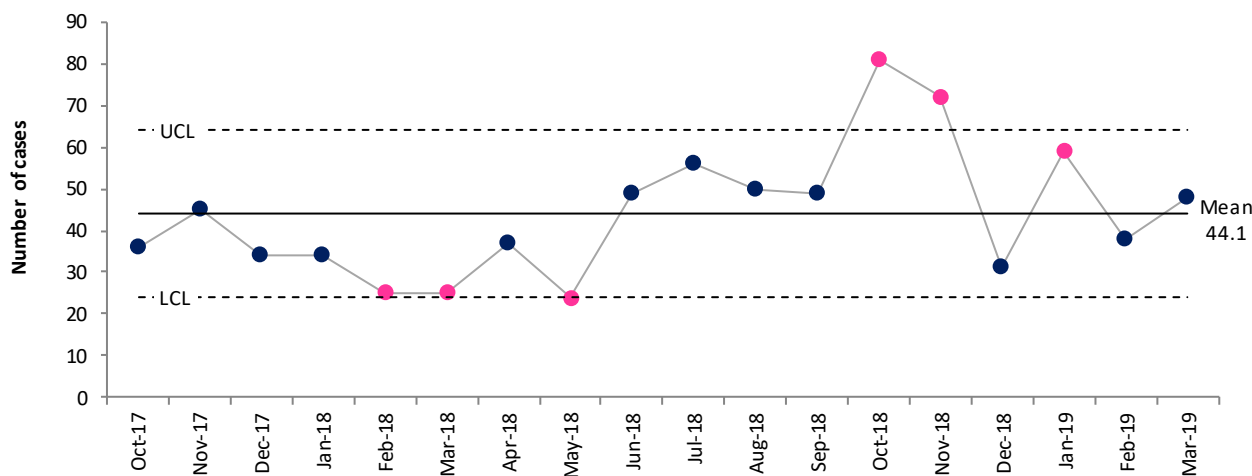


- The rates for three hospitals (Mater, Beaumont and Cork University Hospital) over the last 12 months were above the upper control limit for this indicator.
- The rates for six hospitals (NMH Holles Street, MRH Portlaoise, Rotunda, Coombe, Crumlin and MRH Mullingar) were below the lower control limit.
- These occurrences of special cause variation are unlikely to have occurred by chance alone and are an indicator of unexpected variation. Case mix and complexity are among factors that may contribute to such variation.

Carbapenemase Producing Enterobacteriaceae (CPE) is an antimicrobial resistant organism. It is a gut bug which can cause serious infection if it spreads to blood or other areas. Infection with CPE is very difficult to treat with antibiotics. A public health emergency to address CPE was declared by the Department of Health in 2017 (managed by NPHET).

The number of newly detected cases of CPE is unstable, with special cause variation signalling an increase in October & November 2018 and January 2019. This is likely to be explained in part by increased testing.

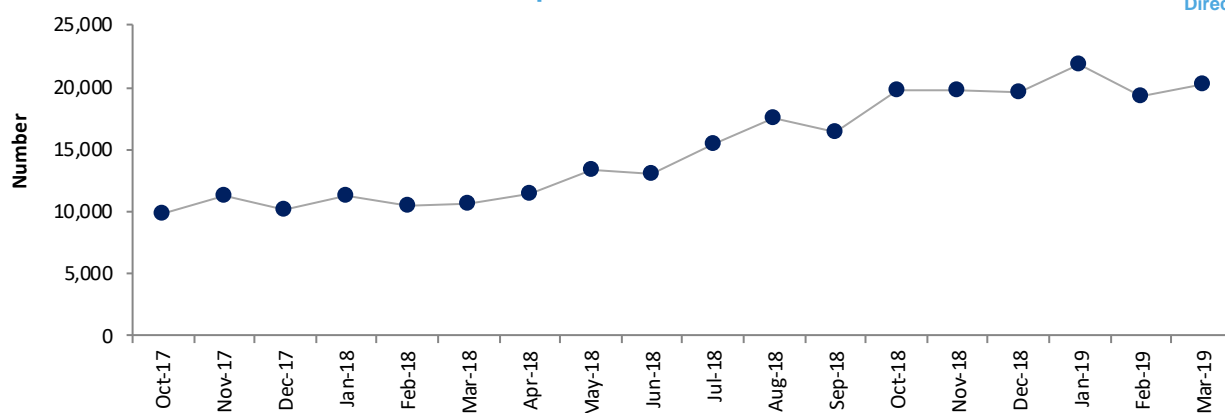
National rate



- The average number of new cases of CPE diagnosed per month since October 2017 is 44.1. This includes those colonised and those infected.
- The SPC chart shows that in October and November 2018 the numbers of new cases of CPE were above the upper control limit. This is likely to be explained at least in part by the increase in the number of samples tested for CPE has increased (see chart below).
- In addition to the data point in Nov-18, the number of cases in January 2019 was in the upper third of the control limits. Using SPC rules (two out of three points in the outer third), this is a signal of special cause variation.

Total number of rectal swabs / faeces samples tested for CPE

Desired Direction ↑



- There is a policy to increase the number of screenings for CPE, and since October 2017 the monthly number of samples tested for CPE has increased from just under 10,000 to over 20,000 in March 2019, an increase of more than 100%.
- Increased screening and increased detection of people colonised is a useful step towards a more accurate picture of the incidence of CPE however the desired direction of the number of new cases of CPE is downwards.
- Note that there are not enough data points to produce a control chart for this data (20 data points are required for an I chart).

* Note that data from one Model 4 hospital is missing for March 2019.

Return of spontaneous circulation (ROSC) at hospital

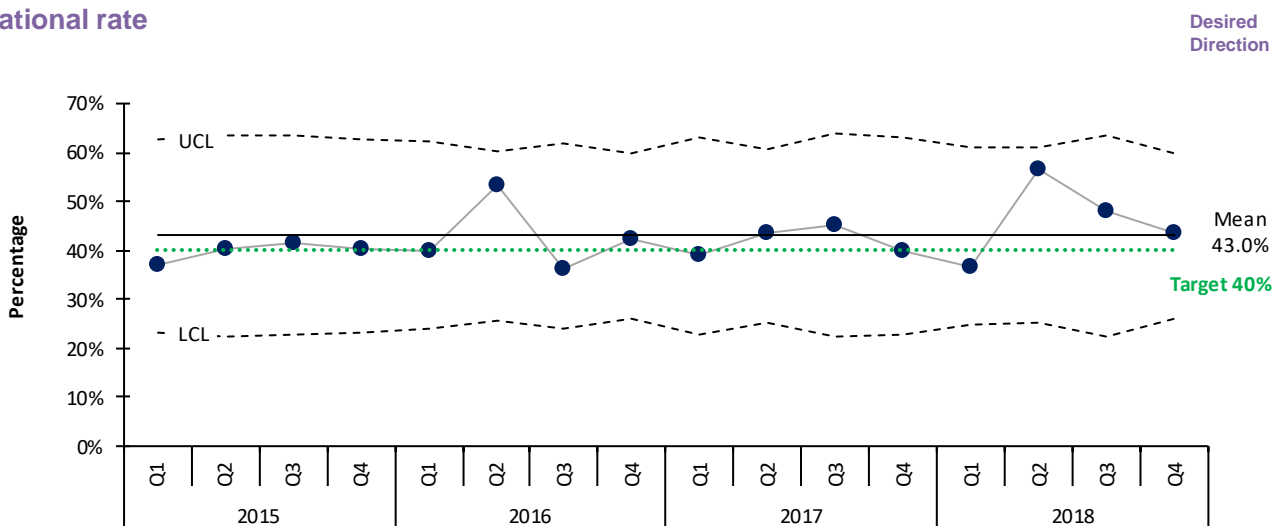
NEW DATA

Assessment

The average national performance is better than the target.

The variation between quarters is within the expected range.

National rate



Desired Direction ↑

- The average national rate of return of spontaneous circulation on arrival at hospital is 43% since 2015. This is better than the target of 40%.
- The variation from quarter to quarter is within the expected range, i.e. the rate is stable.
- While the average rate is above the target, it can be expected that the quarterly rates will fluctuate between approximately 24% and 62% due to normal variation.

Notes:

- The control limits of the SPC chart above have been updated based on the numerators and denominators used to calculate the ROSC percentage.
- In 2017 there were 1,908 of out-of-hospital cardiac arrests (OHCAs) confirmed and attended by the National Ambulance Service where resuscitation was attempted. 13% (256 cases) were in the Utstein subgroup.
- The Utstein Comparator group includes patients aged over 17, with presumed cardiac cause (i.e. excluding patients with evidence of another cause e.g. trauma, asphyxiation, drug overdose), bystander witnessed collapse, and an initially shockable cardiac arrest rhythm
- There is wide variation in patient characteristics and circumstances of OHCA. The use of the Utstein comparator group subset facilitates a more standardised comparison of patient outcomes between systems and over time
- Utstein factors have been shown to account for approximately 50% of variation in survival from OHCA internationally. This means that there are unmeasured factors outside of a resuscitation attempt that may affect the chances of a patient having ROSC at hospital arrival.¹

1. Dyson K, Brown SP, May S, et al. International variation in survival after out-of-hospital cardiac arrest: a validation study of the Utstein template. *Resuscitation* 2019;138:168-81. doi: 10.1016/j.resuscitation.2019.03.018 [published Online First: 2019/03/23]

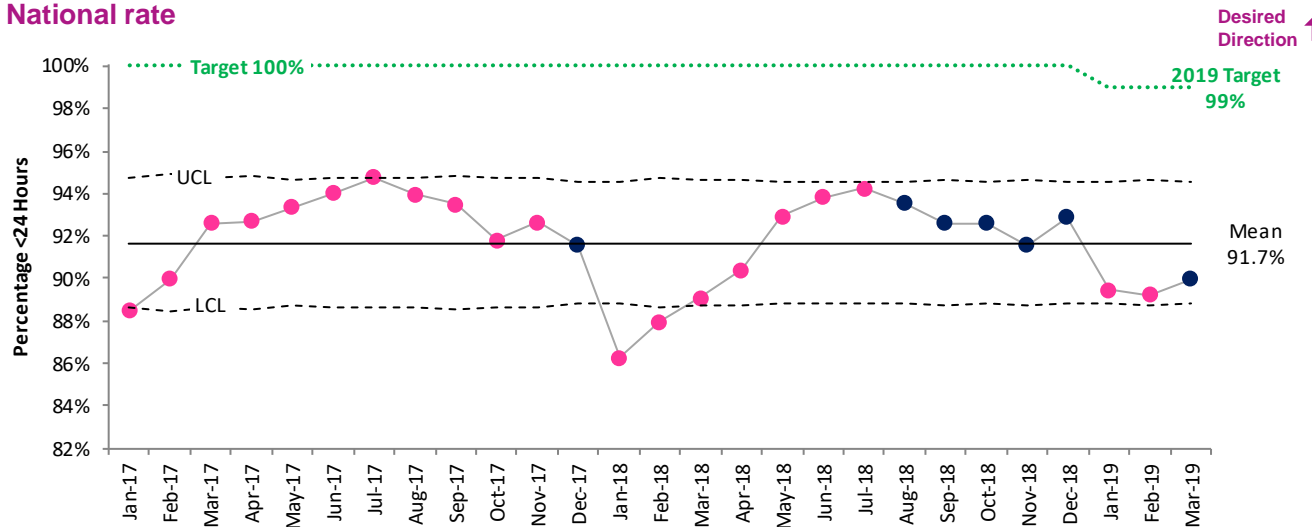
Percentage of attendees aged over 75 at ED who are in ED <24 hours

This indicator measures the percentage of attendees aged over 75 at ED who have a patient experience time of less than 24 hours. Long waiting times in ED are linked to poorer outcomes, including death and poor patient experience. Patients waiting more than 24 hours should be cared for in a more appropriate care setting than an ED.

Assessment

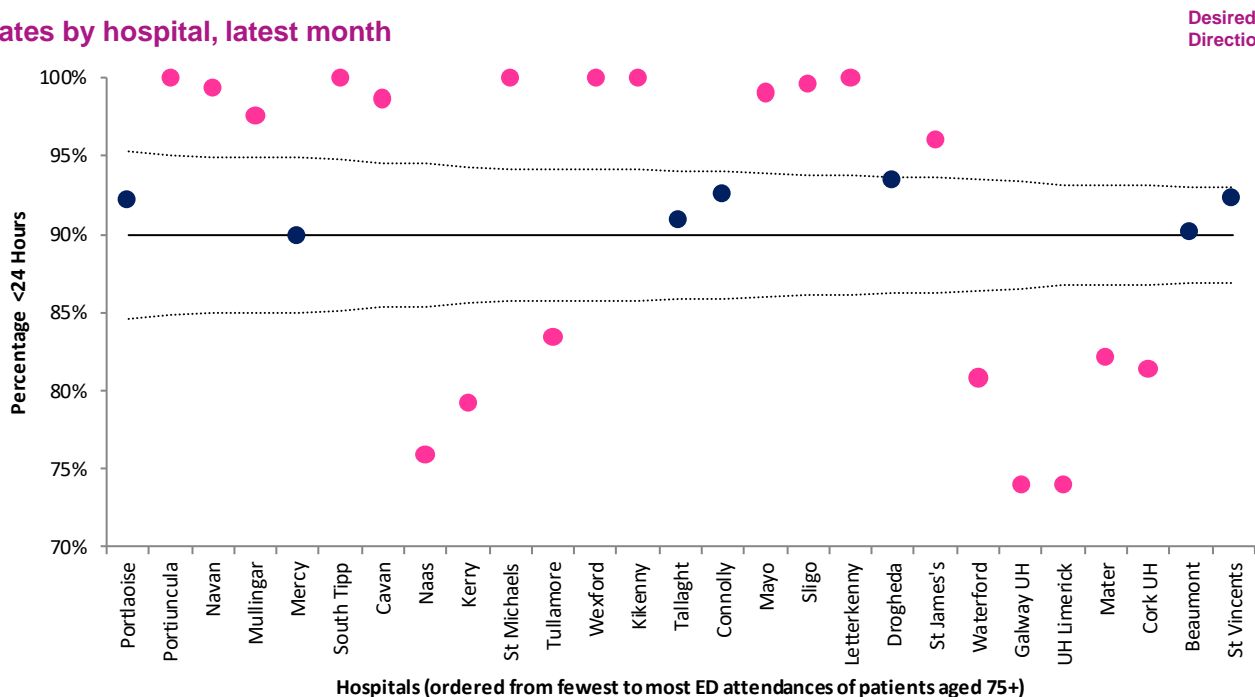
Average national performance is worse than the target and is unstable. There was a signal of improvement between January and July 2018, however data for January and February 2019 indicates that this improvement has not been sustained.

National rate



- Since January 2017, 91.7% of attendees aged over 75 at ED have been waiting in ED for less than 24 hours. This is worse than the current target of 99%, and equates to over 1,000 patients aged over 75 per month in ED for more than 24 hours.
- Performance over time is unstable, with a number of occurrences of unexpected (special cause) variation. There was a signal of improvement between January and July 2018, however data for January and February 2019 indicates that this improvement has not been sustained.

Rates by hospital, latest month



- Data for March 2019 shows that the rates for 20 of the 27 hospitals are outside the control limits.
- This is overdispersion, and indicates that the variation across the system is greater than expected.
- The reasons for the variation across the system should be understood so that the learning can be used to guide future improvements.

Bed days used in CAMHS inpatient units as a percentage of total bed days

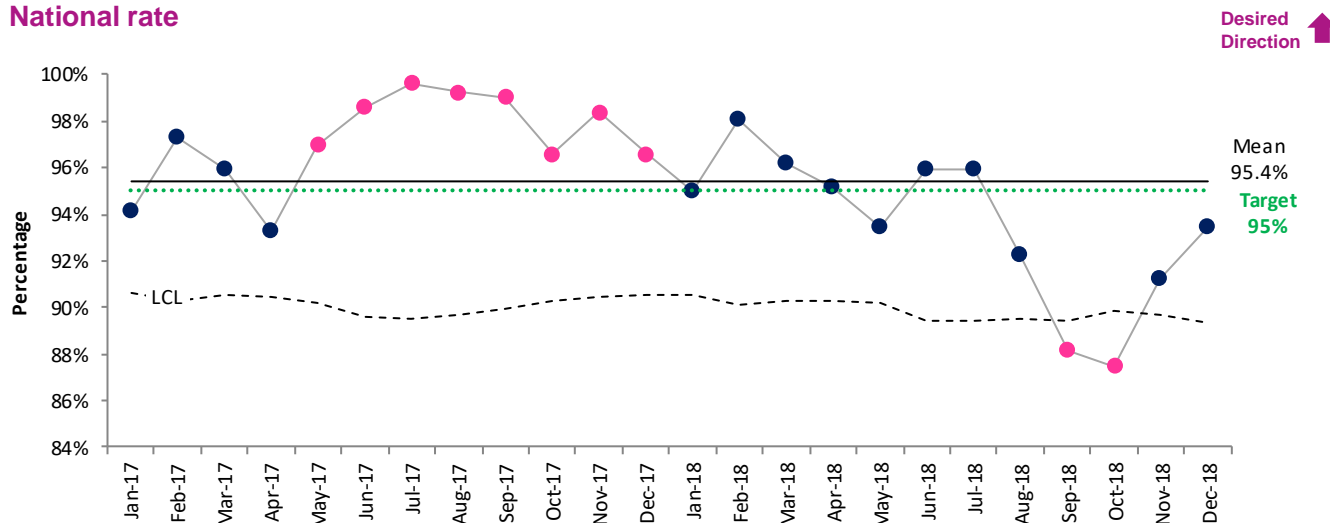
NO NEW DATA

Assessment

This indicator measures the proportion of time spent in a dedicated child and adolescent mental health unit for children who require admission to mental health services. Children and adolescent mental health is effectively managed in CAMHS units and stays in adult mental health units are not appropriate or person centred.

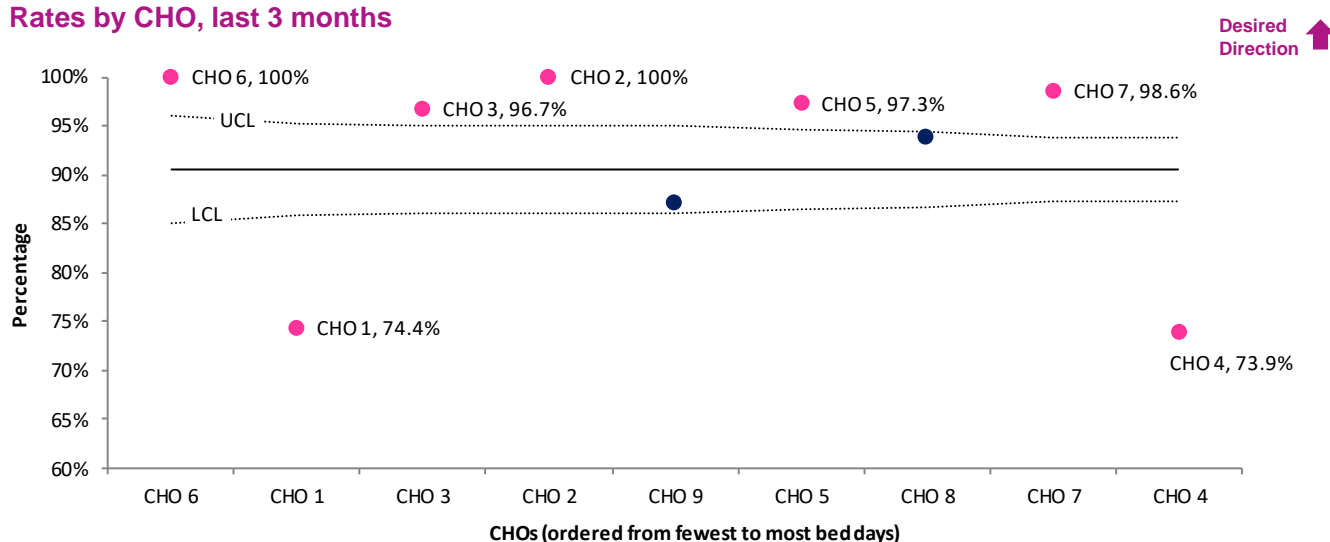
Average national performance is better than the target. The rates for Sept & Oct 2018 were below the lower control limit indicating unexpected poor performance, however the rates for the most Nov & Dec 2018 were within the control limits.

National rate



- Since January 2017, 95.4% of bed days used by children have been in CAMHS inpatient units (target 95%). This equates to an average of around 1,620 bed days of children per month in HSE mental health inpatient units, with 75 of these spent in adult mental health inpatient units each month.
- The rates for September 2018 (88.2%) and October 2018 (87.6%) were below the lower control limit. This is an indication of unexpected variation and suggests that something unusual occurred during these months. The reasons for this should be investigated as there may be an opportunity to learn from the cause of the variation.

Rates by CHO, last 3 months



- The variation in the proportion of bed days used in CAMHS units among CHOs over the last 3 months is greater than expected, with the rates for 7 of the 9 CHOs falling outside the control limits.
- The rates for CHOs 2, 3, 5, 6 and 7 were above the upper control limit indicating performance that is better than expected relative to the national average.
- The rates for CHO 4 (73.9%) and CHO 1 (74.4%) were below the lower control limit indicating an unexpectedly low rate of bed days used in CAMHS units as a percentage of total bed days in these CHOs. This variation is unlikely to have occurred by chance alone.

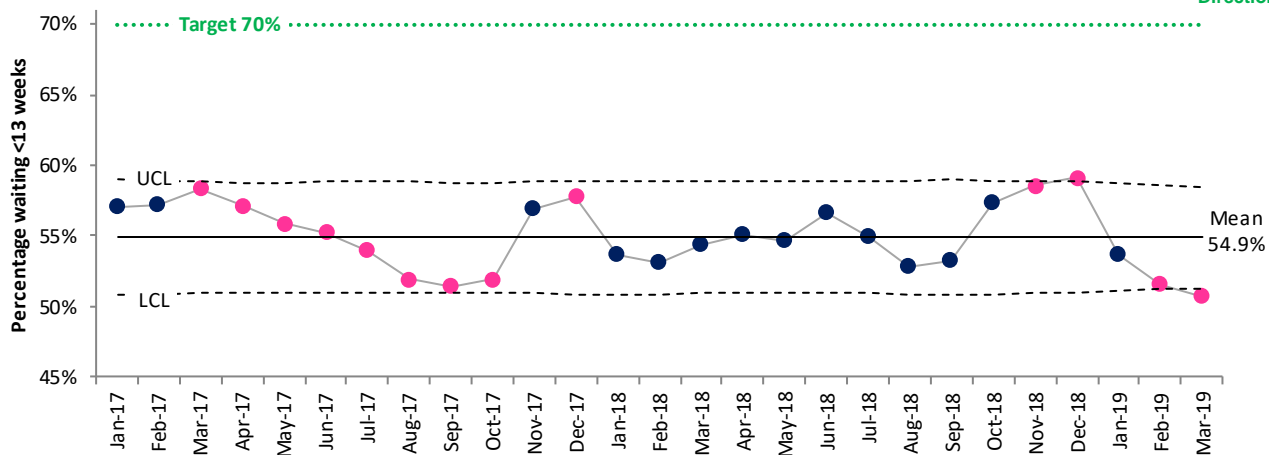
Percentage of patients waiting <13 weeks following a referral for routine colonoscopy or OGD

NEW DATA

Assessment

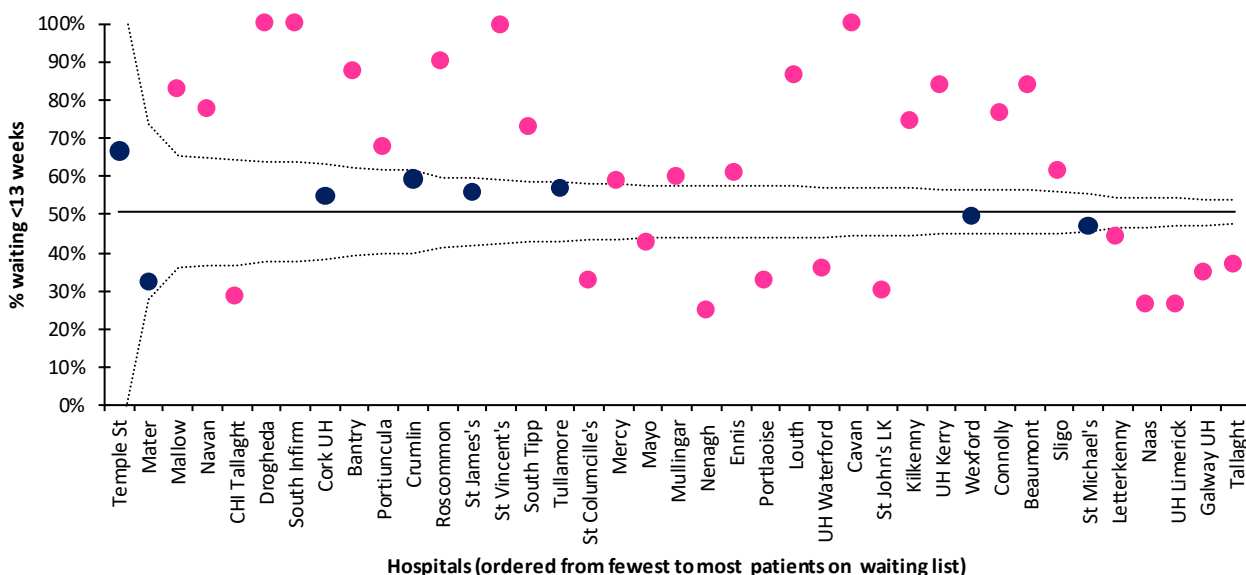
Average performance at national level is worse than the target and since November 2018 shows more variation than expected between months. The rate for March 2019 is below the lower control limit. The funnel plot shows more variation among hospitals than expected.

National rate



- Since January 2017, 54.9% of patients referred for a routine colonoscopy or OGD have been waiting less than 13 weeks. This is worse than the target of 70%.
- The rate for March 2019 (50.7%) is below the lower control limit. This is a signal of disimprovement. Note that the rate of 50.7% is based on a total of 22,192 patients referred for a routine colonoscopy or OGD, of which 10,933 people were waiting more than 13 weeks.
- There are a number of signals of special cause variation, indicating that performance over time is unstable.

Rates by hospital, most recent month



- Data for March 2019 shows that the rates for 31 of the 39 hospitals are outside the control limits.
- This is overdispersion, and indicates that the variation across the system in the percentage of patients waiting <13 weeks following a referral for routine colonoscopy or OGD is greater than expected.
- The reasons for the variation across the system should be understood so that the learning can be used to guide future improvements.

Timely

Directorate Quality Profile
May 2019

NEW DATA

Hip fracture surgery within 48 hours

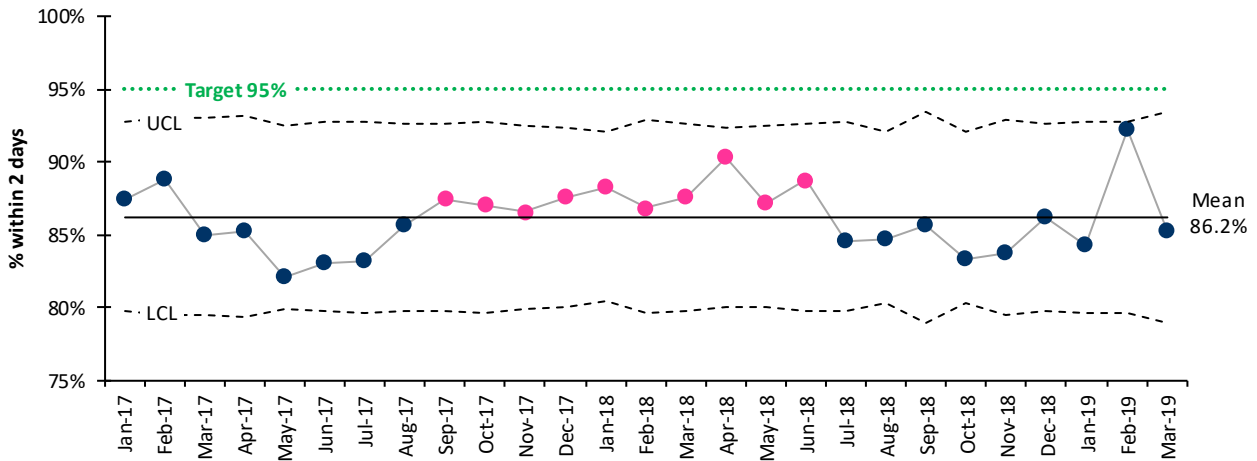
This indicator measures the proportion of patients aged over 65 with a hip fracture who have surgery within 2 days of admission. Delay in time to hip fracture surgery of more than 48 hours is associated with increased mortality and impairment of quality of life. Timely access to surgery is dependent on multidisciplinary care pathway including emergency admission, diagnostics and surgery.

Assessment

Average performance at national level is worse than the target. The rates for 2 hospitals are better than expected. The rates for 2 hospitals are below the expected level. The reasons behind these variations could be used to direct future improvements.

National rate

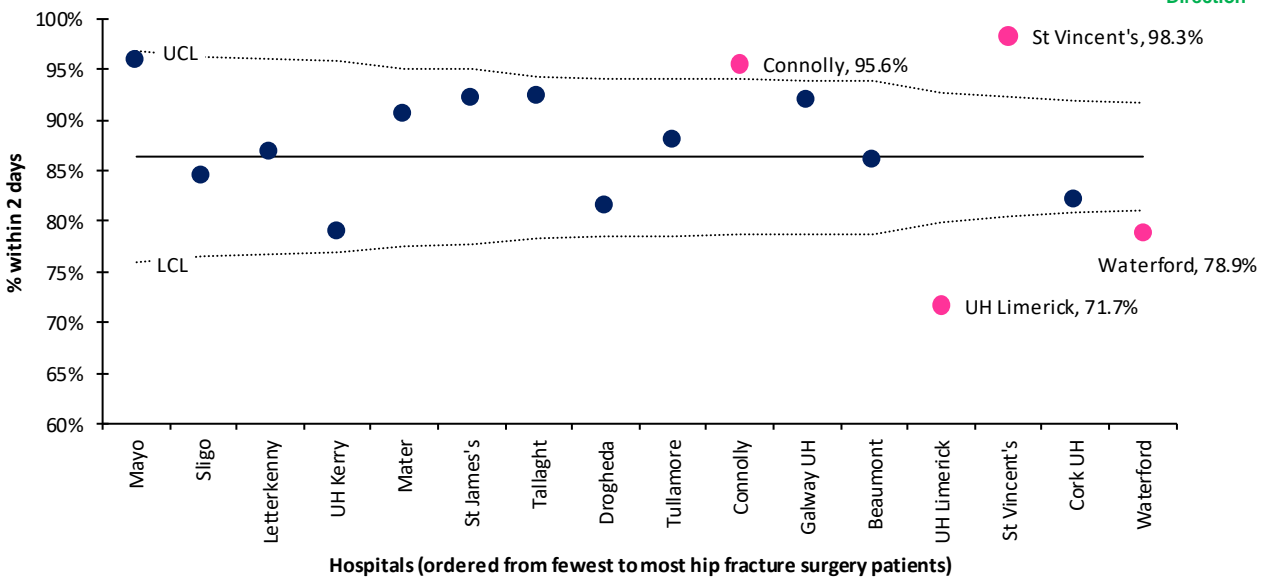
Desired Direction



- Since January 2017, 86.2% of patients aged over 65 with a hip fracture had surgery within 2 days of admission. The rate can be expected to fluctuate between 79% and 93% due to normal variation. This is below the target of 95%.
- There was a signal of improvement between September 2017 and June 2018 that has not been sustained. The reason for this should be understood as it may provide an opportunity to learn from the cause of the variation.

Rates by hospital, last 12 months

Desired Direction



- Over the last 12 months, the rates for 2 hospitals (Connolly and St Vincent's) were above the upper control limit. This is a signal that the performance in these hospitals is better than expected.
- The rates for 2 hospitals (University Hospital Limerick and University Hospital Waterford) were below the lower control limit. This is a signal that the performance in this hospital over the past 12 months was below the expected level.
- These occurrences of unexpected (special cause) variation should be examined so that the learning can be used to direct future improvements.

Weekly number of delayed discharges

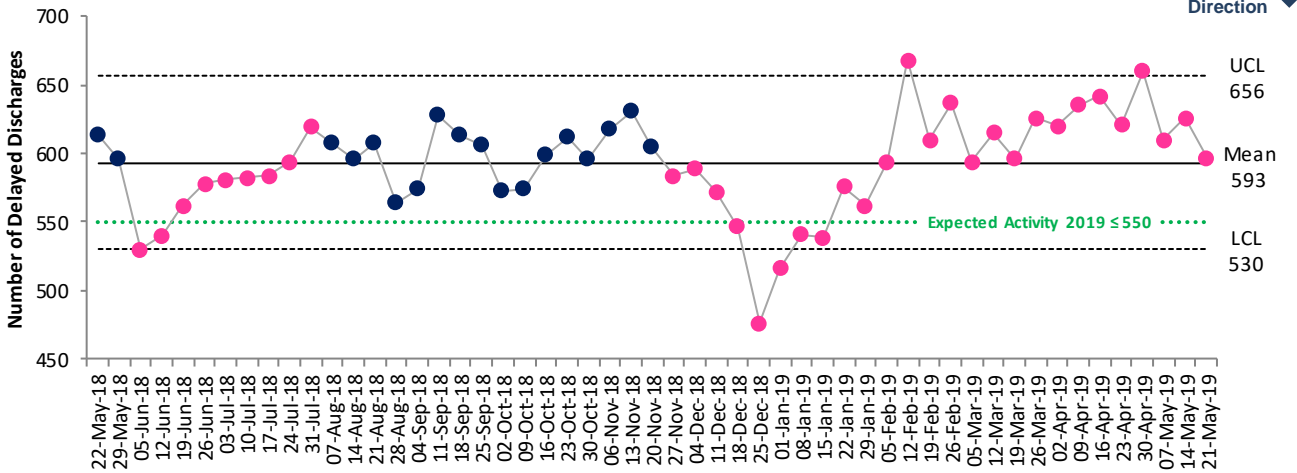
NEW DATA

Assessment

Achieving safe, timely and person centred discharge from hospital to home is an important indicator of quality and a measure of efficient and integrated care. Delayed discharges are used in assessment of quality of care, costs and efficiency.

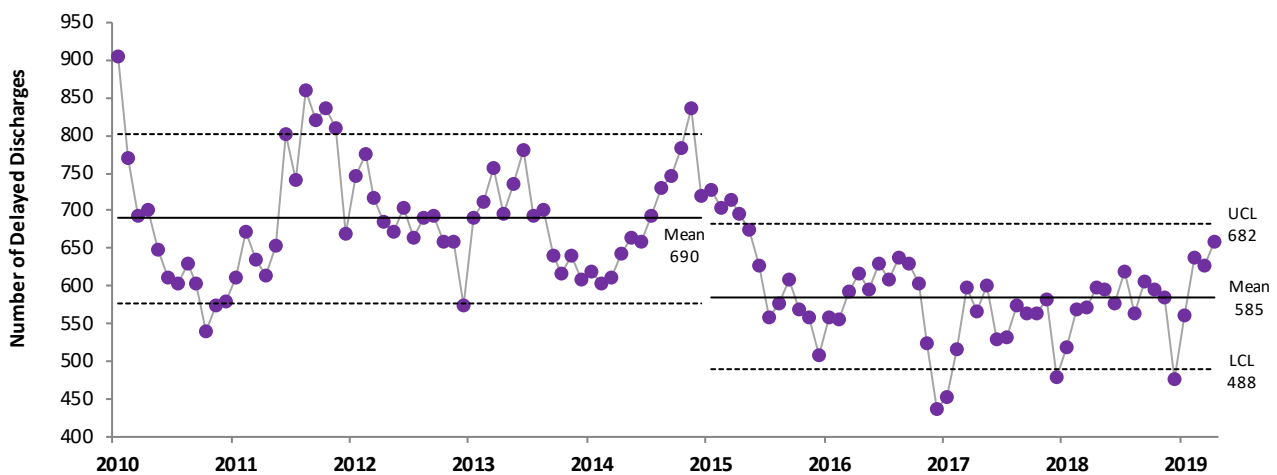
The average national number of delayed discharges is above the expected level and is unstable. While there was an improvement in Dec-18/Jan-19, the latest data shows a signal of disimprovement in the number of delayed discharges since February 2019.

National rate by week, last 12 months



- The average weekly number of delayed discharges over the past 12 months is 593. This is above the expected activity in 2019 of ≤ 550.
- There was a signal of improvement in the number of delayed discharges during December 2018 and January 2019 (a series of 8 points below the mean).
- However the latest data since February 2019 shows a series of 16 consecutive weeks above the mean. This is unlikely to have occurred by chance alone, and using SPC rules is a signal of special cause variation, i.e. a signal that the number of delayed discharges was higher than expected during those weeks.

National rate, last week of each month, 2010 - 2019



- The SPC chart above shows the monthly number of delayed discharges (based on the last week of each month) between January 2010 and April 2019.
- Between 2010 and 2014 the average number of delayed discharges was 690. Using SPC rules there was a signal of improvement, and between 2015 and to date in 2019 the average number of delayed discharges is 585.
- While there have been some signals of improvement in the number of delayed discharges since 2015 (usually during December each year), there are no signals of a sustained improvement in the number of delayed discharges since 2015.

Day of surgery admission (DOSA) rate

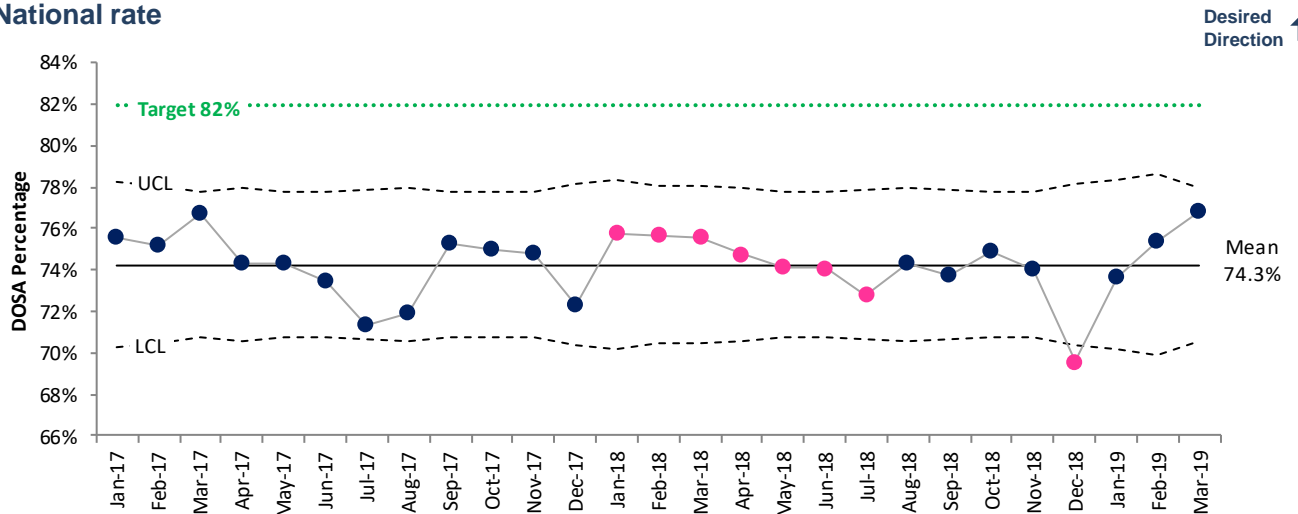
NEW DATA

Assessment

This indicator refers to the percentage of elective surgical inpatients who had their principal procedure carried out on the day of admission. This indicator allows for the measurement of the effect of improved pre-admission assessment services which facilitate day of surgery admission.

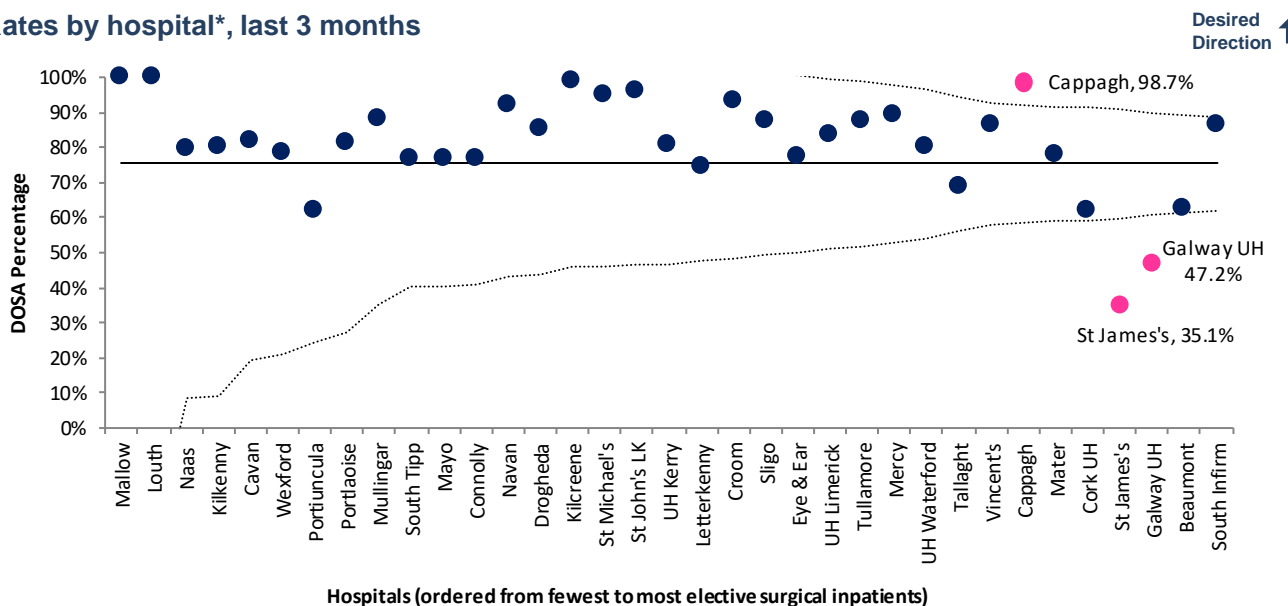
Performance at national level is below target. In 2018 there was a signal of disimprovement although has since resolved. The rates for 2 hospitals are below the lower control limit indicating unexpected variation. The rate for 1 hospital was above the upper control limit.

National rate



- The average rate of elective surgical inpatients who had their principal procedure carried out on the day of admission since January 2017 is 74.3%. The target / expected activity is 82%.
- The rate for December 2018 was below the lower control limit. This is unlikely to have occurred by chance alone, and indicates that the DOSA rate for that month was unexpectedly low. However the rates for January to March 2019 were within the control limits.

Rates by hospital*, last 3 months



* Note that there are individual DOSA targets for each hospital

- The rates for 2 hospitals (St James's and Galway University Hospitals) are below the lower control limit. This is a signal that the performance in these hospitals is lower than expected relative to the national average. Note however that the 2019 target is 36.5% for St James's and 51.4% for Galway University Hospitals.
- The rate for Cappagh National Orthopaedic Hospital is above the upper control limit. This is a signal that performance is better than expected relative to the national average. Note that 2019 target for this hospital is 98.1%.

Efficient

Directorate Quality Profile
May 2019

Homeless services: service users' health needs assessed within 2 weeks of admission

NEW DATA

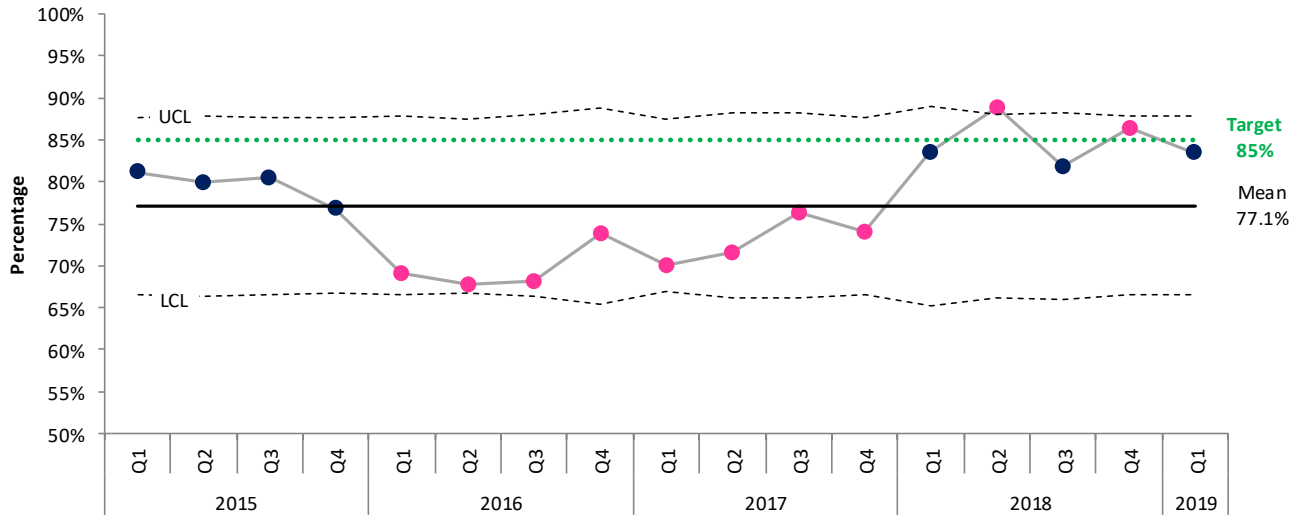
Assessment

This indicator refers to the percentage of service users admitted to homeless emergency accommodation hostels / facilities whose health needs have been assessed within two weeks of admission. Completion of a health needs assessment is required to facilitate the effective operation of a care planning system to address the health and care needs of homeless people.

Performance at national level is below target. However there was a signal of improvement in 2018. The reasons for this should be understood to direct further improvements.

National rate

Desired Direction



- The number of service users admitted to homeless emergency accommodation hostels / facilities since 2015 averages around 1,400 per quarter. The target is that 85% of people will receive a health needs assessment within 2 weeks of admission.
- Since 2015, an average of 77.1% of people have received a health needs assessment within 2 weeks of admission, below the target of 85%.
- In Quarter 2 2018 the percentage of people who received a health needs assessment within 2 weeks of admission was above the upper control limit. This is unlikely to have occurred by chance alone. In addition, in Quarter 4 2018 the rate was in the outer third of the control limits (near the upper control limit). Using SPC rules this is a signal of improvement in this measure.

Note: Data are not currently displayed at CHO or LHO level due to data gaps.

MMR vaccination rate

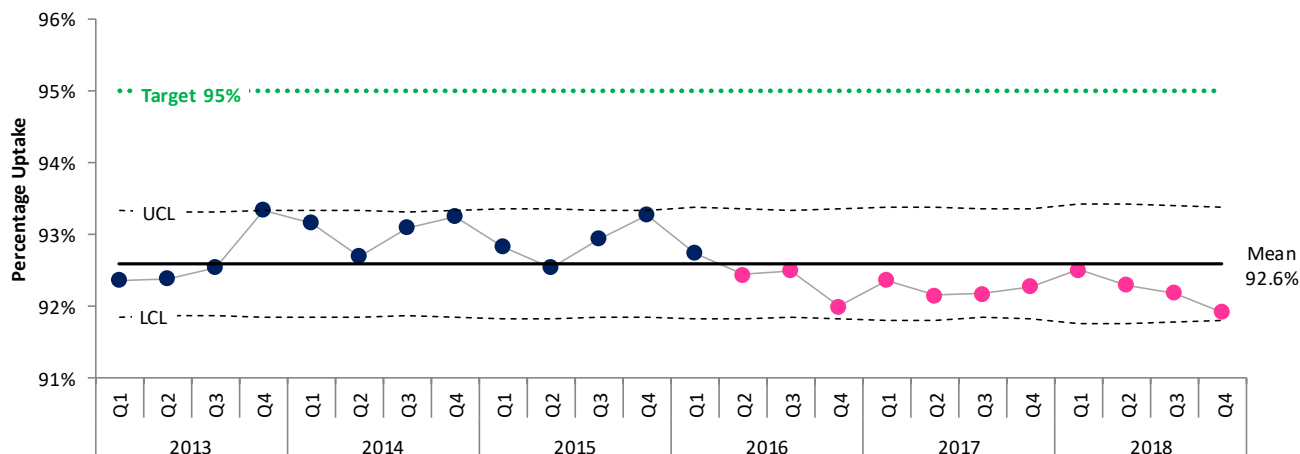
This indicator refers to the percentage of children who have received the MMR vaccine at 24 months of age. MMR vaccination prevents measles, mumps and rubella infection. 95% of the population must be vaccinated to provide population immunity. There is a measles outbreak due to pockets of population with low vaccination rates.

NEW DATA

Assessment

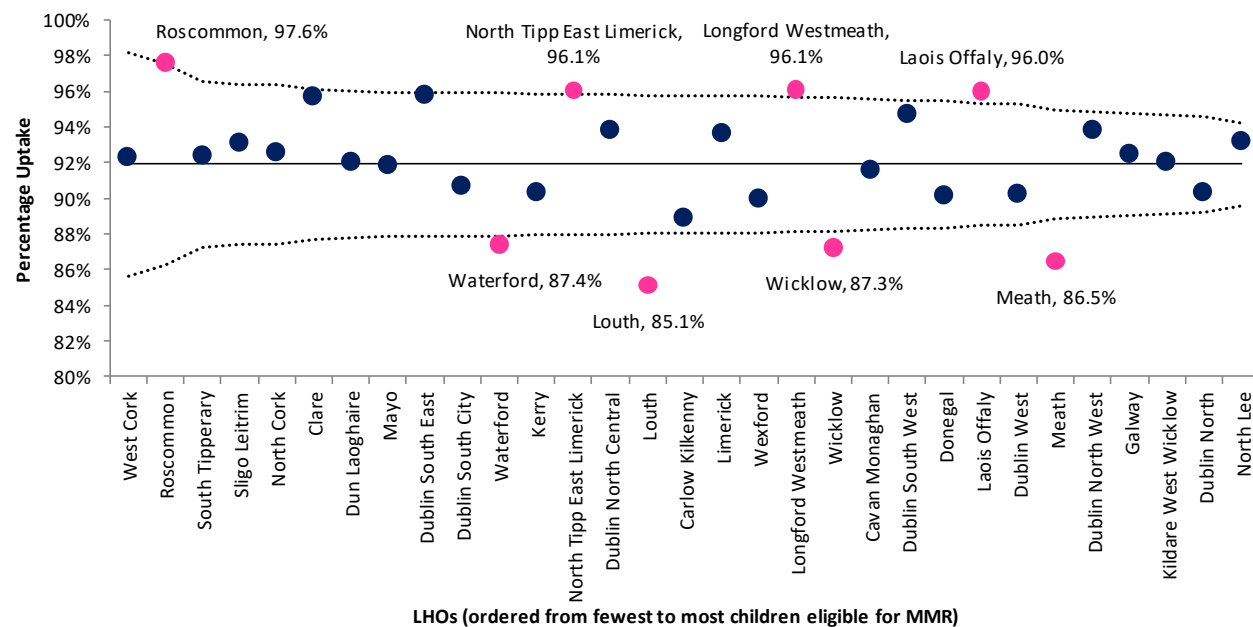
Performance at national level is below target since 2013, with a further sustained disimprovement since Q2 2016. There is more variation among LHOs than would be expected by chance. Understanding this variation may provide opportunities for improvement.

National rate



- MMR uptake rates are below the target level of 95% since 2013. The average rate is 92.6%, and it can be expected that the rate will vary between 91.8% and 93.3% by chance alone.
- Since Quarter 2 2016 there have been a series of 11 consecutive quarters where the rate was below average. This is unlikely to have occurred by chance and is a signal of special cause variation, in this case a reduction in the uptake rate.

Rates by LHO, latest quarter (Q4 2018)



- Data by LHO for the latest available quarter show that 4 LHOs (Roscommon, North Tipperary East Limerick, Longford Westmeath and Laois Offaly) had uptake rates that were above the upper control limit indicating performance that was better than expected.
- The rates for 4 LHOs (Waterford, Louth, Wicklow and Meath) were below the lower control limit indicating uptake rates that were lower than expected.



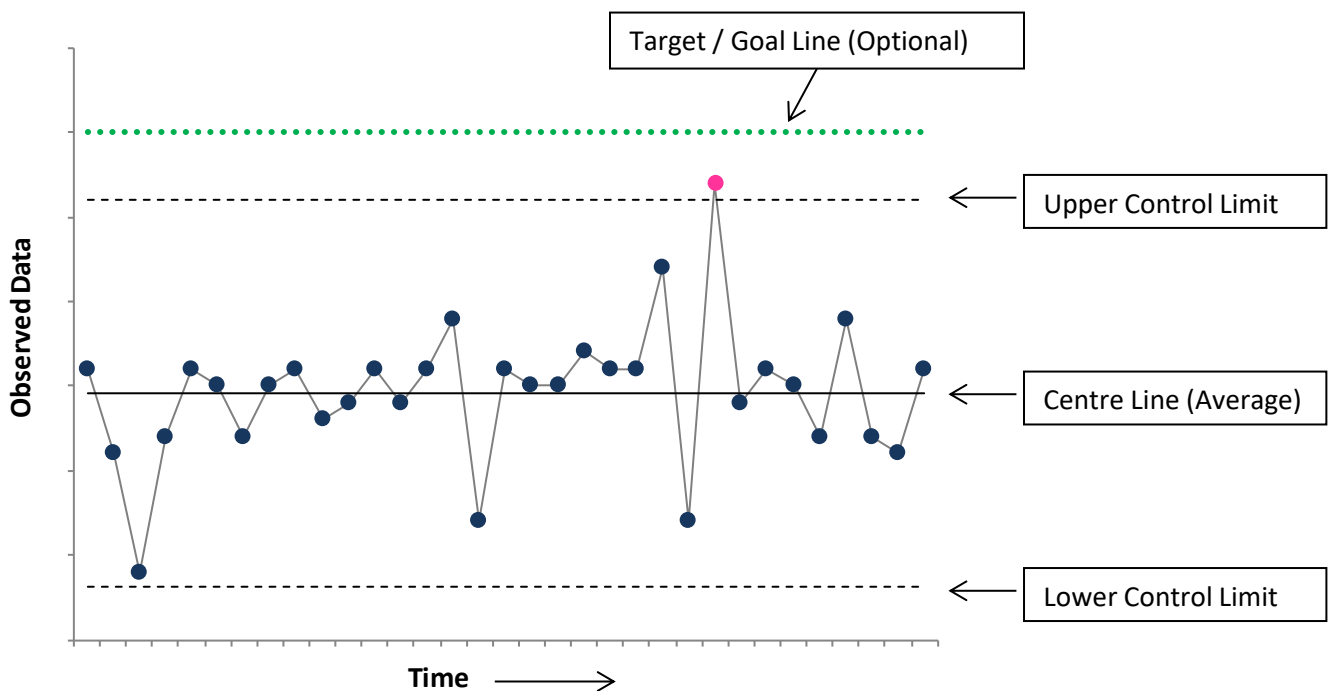
Anatomy of a Statistical Process Control Chart

A **Statistical Process Control (SPC)** Chart consists of data plotted in order, usually over time (weeks, months etc). It includes a centre line based on the average (mean) of the data. It also includes upper and lower control limits based on statistical calculations (3 sigma deviations from the average).

The control limits are based on the variation in the observed data. The control limits reflect the expected range of variation within the data, and do not reflect the desired range of variation in terms of quality of care. The probability of any data point falling outside of the control limits by chance alone is very small.

Points that are above or below the control limits are an indication of special cause variation. In addition to a data point outside of the control limits, there are four other rules that indicate non-random (special cause) variation.

The target / goal line is interpreted differently to the other lines in the chart. It is not determined by the data and so is not normally part of an SPC chart, but it can be useful to display it to help focus improvement efforts.



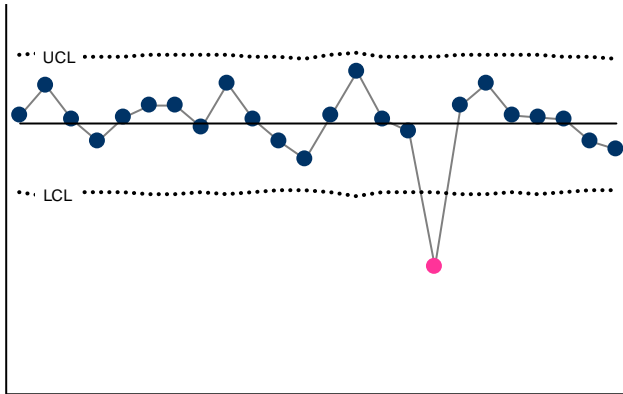
References

Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011

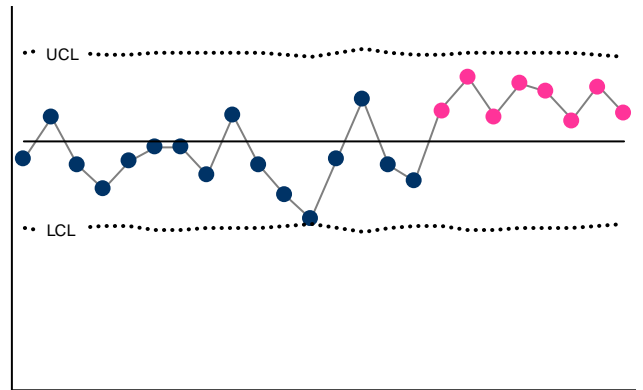


Rules for detecting special cause variation using statistical process control charts

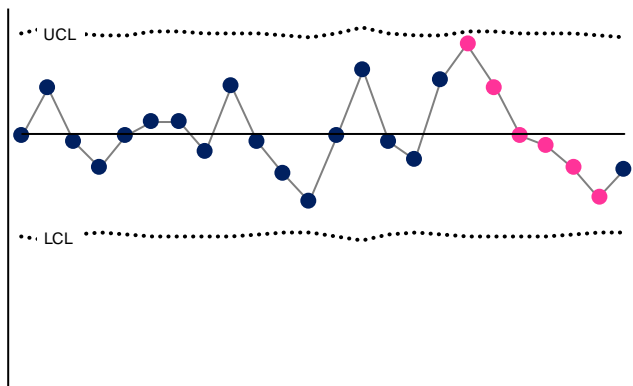
1. A single point outside the control limits (this doesn't include points exactly on the limit)



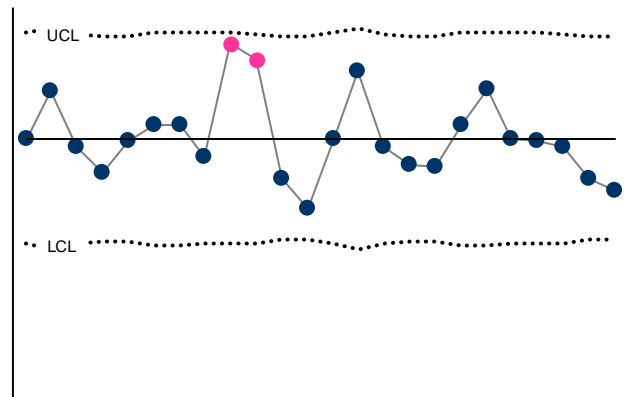
2. A run of 8 or more consecutive points above or below the centre line



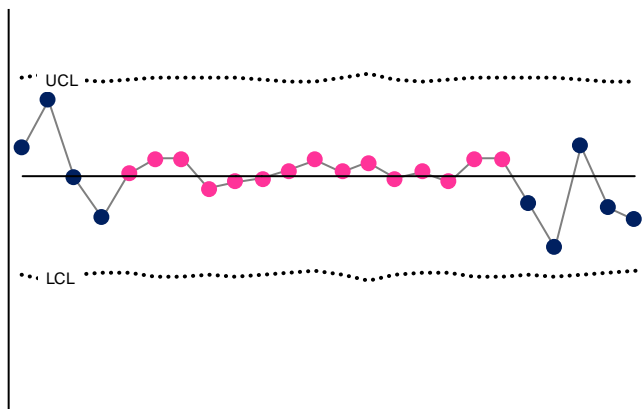
3. A trend of at least 6 consecutive points all going up or down



4. Two out of three consecutive points in the outer third (or beyond)



5. A series of 15 consecutive points close to the centre line (in the inner one-third)



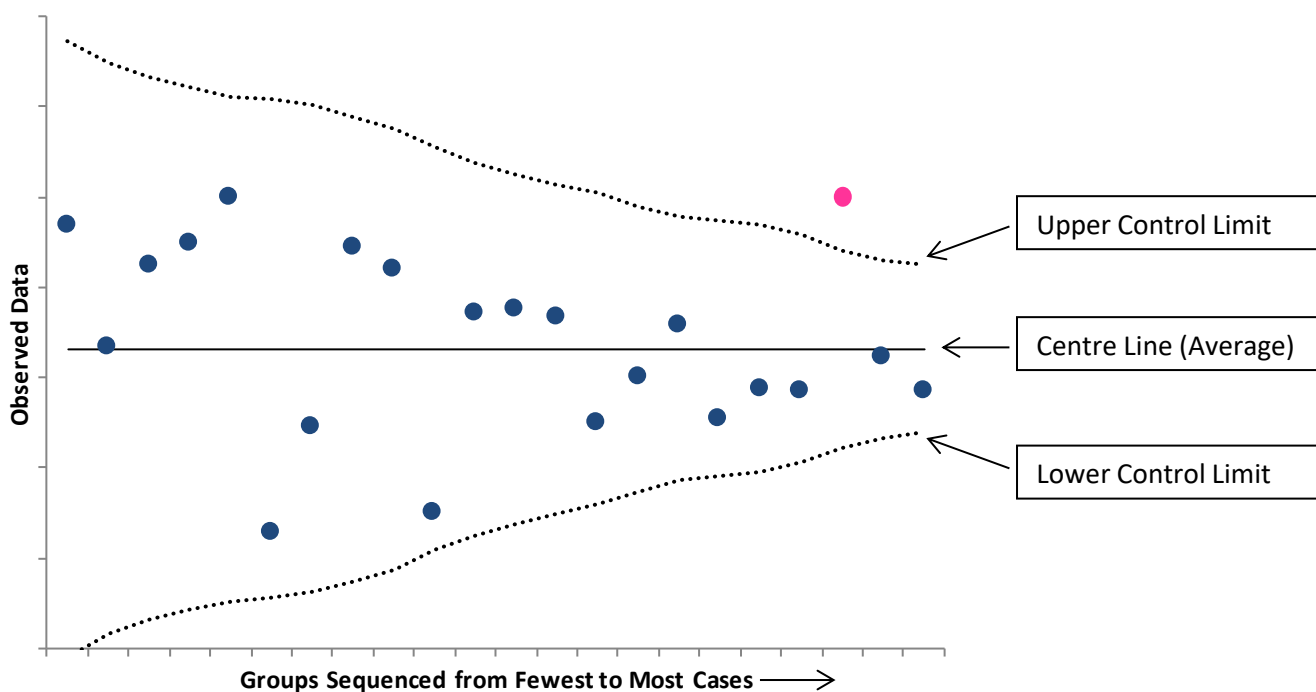


Anatomy of a Statistical Process Funnel Plot

A **Statistical Process Control** (SPC) Chart consists of data plotted in order, including a centre line based on the average of the data and upper and lower control limits based on statistical calculations (3 sigma deviations from the average).

SPC charts are commonly used to display data over time. However it is also possible to use SPC charts to display data for different groups (such as hospitals) within control limits. The control limits are calculated in the same way as an SPC chart over time, but the data are ordered by denominator size rather than by time. This gives a funnel shape to the SPC chart. Points that are above or below the control limits in a funnel plot are an indication of special cause variation. The other rules for detecting special cause variation in SPC charts do not apply to funnel plots.

The control limits are based on the variation in the observed data. The control limits reflect the expected range of variation within the data, and do not reflect the desired range of variation in terms of quality of care. The probability of any data point falling outside of the control limits by chance alone is very small.



References

Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011

HSE Directorate Quality Profile: Directorate Meeting discussion prompt sheet

From November 2018, the HSE Directorate is testing how they receive and monitor a *HSE Directorate Quality Profile* comprising quality of clinical care indicators incrementally introduced over six months. For this quality improvement project, Directorate members use *Discussion, Decisions and Actions* as a useful way to structure their discussion around the *Quality Profile* during monthly directorate meetings.

Receipt of HSE Directorate Quality Profile:

Directorate members receive documents prepared by Chief Clinical Officer (CCO) (in Directorate monthly meeting pack in advance of each meeting)

At the Directorate meeting the steps below are used by the Directorate members to discuss the Directorate Quality Profile

Discussion:

CCO/Nominee facilitates discussion on each indicator presented in the quality profile.

- Are there internal or external factors impacting the indicator?

Decision:

Directorate members collectively agree a decision based on the information presented and their discussion

1. Further analysis

- More data analysis needed to make a decision

2. Performance attainment

- Normal variation (within an acceptable range)
- Special cause providing signal of improvement

3. Improvement opportunity

- Normal variation outside the acceptable range
- Special cause (unusual event) indicating dis-improvement

Action:

Directorate members collectively request action of the relevant Director

1. Request further analysis

- Request further data analysis from CCO

2. Congratulate Directors and staff

- What can we learn?
- Opportunities for further improvement?

3. Request operational response

- Request further information on cause of dis-improvement from relevant Director
- Request improvement plan
- Request other

Directorate decisions and actions recorded in meeting minute and action log

Appendix: Initial list of proposed indicators for the Directorate Quality Profile as identified at the Directorate Workshop in October 2018

Indicators in bold are included in the Directorate Quality Profile for May 2019

Safe: Avoid harm to patients from the care that is intended to help them.	
Apex Indicators	Health and social care acquired pressure ulcers ¹
	Hospital acquired Staph. aureus bloodstream infection
	CPE infection
	Hospital acquired C. difficile
Supporting Indicators	Category 1 Serious Incidents
	Serious Reportable Events
	Falls in health and social care settings
	Rate of medication incidents that are major / extreme
	Hospital antimicrobial consumption
	Community antimicrobial consumption
Community acquired C. difficile	
Priority for Development	
Effective: Provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit (i.e. avoid underuse and misuse of services, respectively).	
Apex Indicators	Survival for breast cancer
	Survival for cervical cancer
	Survival for colorectal cancer
	Return of spontaneous circulation (ROSC) at hospital
	Caesarean section ¹
Supporting Indicators	In-hospital mortality following stroke
	In-hospital mortality following AMI
	% compliance with regulations following HIQA inspection of disability residential services
	% compliance with regulations following HIQA inspection of older persons residential services
	Hospital admission COPD ¹
Priority for Development	Suicide post discharge
Person-centred: Provide care that is respectful of and responsive to individual patient preferences, needs, and values and ensure that patient values guide all clinical decisions.	
Apex Indicators	% of all attendees at ED who are discharged or admitted within 6 hours of registration
	% of all attendees at ED who are in ED <24 hours²
	Staff absenteeism
	Number of complaints
Supporting Indicators	% bed days used in CAMHS units as total of bed days used by children in mental health acute inpatient units
Priority for Development	Patient experience (monthly)
	Staff experience (monthly)
Timely: Reduce waits and sometimes harmful delays for both those who receive and those who give care.	
Apex Indicators	Hip fracture surgery within 48 hours
	% of accepted referrals/ re-referrals offered 1st appointment and seen within 12 weeks by CAMHs team
	% of people waiting < 13 weeks following referral for routine colonoscopy or OGD

1. These apex indicators are not existing KPIs and so require indicator specifications to be agreed before inclusion in the Profile
 2. Following feedback from the Project Advisory Group the measure included refers to patients aged 75 and over

Timely: Reduce waits and sometimes harmful delays for both those who receive and those who give care.

Supporting Indicators	% of patients attending lung rapid access clinic who attended or were offered an appointment within 10 days
	% of patients triaged as urgent who adhered to the standard of 2 weeks for referrals
	% of patients attending prostate rapid access clinic, who attended or were offered an appointment within 20 days
	% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat
Priority for Development	Referral to treatment for cancer - whole journey measure
	Diagnostic waiting times for 4 scopes, CT and MRI
	Waiting time for first access to OPD services
	Waiting time for first access to inpatient elective procedure

Efficient: Avoid waste, including waste of equipment, supplies, ideas, and energy.

Apex Indicators	Number of weekly delayed discharges
	Day of surgery admission rate
Supporting Indicators	Readmission rate medicine
	Readmission rate surgery
Priority for Development	Compliance against BADS directory of day cases

Equitable: Reduce inequalities between patients with respect to their ability to access health services, and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

Apex Indicators	Homeless services: service users health needs assessed within 2 weeks of admission
Supporting Indicators	Substance Misuse: No. and % of substance misusers for whom treatment has commenced within one calendar month following assessment
Priority for Development	Access to mainstream services for disadvantaged or marginalised groups
	Health outcomes for disadvantaged or marginalised groups

Better Health & Wellbeing: Provide care that seeks to identify and take opportunities to support patients in improving their own health and wellbeing

Apex Indicators	HPV vaccination rate
	MMR vaccination rate
	% of eligible women with at least one satisfactory CervicalCheck screening in a 5 year period
Supporting Indicators	Staff flu vaccination rate long term care
	Staff flu vaccination rate acute hospitals
	% BowelScreen uptake rate
	% BreastCheck screening uptake rate
	% of smokers on cessation programmes who were quit at one month
Priority for Development	Childhood obesity
	Alcohol use and outcomes

Note:

- Apex indicators were identified at the Directorate workshop (Oct 2018) and a subsequent meeting with the DG as the most important areas for inclusion in the Quality Profile
- Supporting indicators are indicators that would be useful for occasional review to support the apex indicators.
- Priorities for development are indicators recognised as important but where there is no appropriate data currently available and future development of these is considered worthwhile.