NOCA
AT A GLANCE
2018

WORKING TO ACHIEVE EXCELLENT HEALTHCARE FOR IRELAND, SHAPED BY RELIABLE DATA.
The last few years for the Irish Healthcare Service have been, and continue to be, very challenging. Funding, staff recruitment and retention are impacting care. Demand is increasing and patient experiences vary. We know the healthcare teams across the country work really hard to provide high quality care despite these challenges. The need for reliable data to drive improvement and support planning and funding decisions is more important than ever.

Clinical audit supports the health service to deliver the best patient care and outcomes, through the provision of reliable audit data to identify areas for improvement and support planning and policy decisions. NOCA oversees the collection, analysis and reporting of national clinical audits as well as the establishment of new audits. We work closely with service providers to ensure they know their data and understand how it can be used locally to improve care. We also actively encourage the use of our audit data for research purposes to distill what may not always be obvious.

In 2018, eight national reports across maternity, hip fracture, major trauma and hospital mortality were published.

While national clinical audit is still quite new to the Irish Healthcare system, we can already see the difference they are making. The Irish Hip Fracture Database is showing year on year improvement across the six key standards of care which are proven to improve patient outcomes. These standards now form the basis of a best practice tariff. The Major Trauma Audit is providing vital data for the planning of the new Major Trauma Network.

2018 was a significant year for the National Perinatal Epidemiological Centre (NPEC), as they celebrated 10 years of translating clinical audit data and epidemiological evidence into improved maternity care for families in Ireland. The NPEC maternity audits have always strategically aimed to close the audit loop and since the establishment of the National Women and Infants Health Programme in January 2017, a number of the NPEC recommendations have been progressed.

In line with our 2017-2020 Strategy, we have expanded our audit portfolio to include the Stroke and Acute Coronary Syndrome (ACS) audits. We have also worked very closely with our public and patient representatives to expand and embed public involvement in our audits. During the year, NOCA also completed a review of national clinical audit on behalf of the HSE and following on from this, is managing a project to produce guidance documentation to support good audit design and governance at local and national level.

It is our intention for 2019 to continue our focus on the intentional use of clinical audit to improve care. Clinical audit combined with an active culture of quality improvement is proven to benefit patient care and outcomes.

We will also implement the recommendations emerging from the HSE Clinical Audit Review, commence work on the development of patient reported outcomes across and select an IT system to support faster audit implementation and real time dashboard style reporting.

Finally, we would like to thank everyone who makes these audits happen; our staff, NOCA Board, HSE, Department of Health and most importantly our clinical leads, audit committee members and the audit teams in each hospital who collect and use the data to support better outcomes for each patient. Many of these people contribute their time voluntarily on top of busy workloads. These audits could not happen without this commitment.

A MESSAGE FROM OUR CHAIR AND EXECUTIVE DIRECTOR

Prof Conor O’Keane
Chair
NOCA Governance Board

Collette Tully
Executive Director
NOCA

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NOCA
NOCA was established in 2012 to create sustainable clinical audit programmes at national level. NOCA enables those who manage and deliver healthcare to improve the quality of care through national clinical audit. NOCA is funded by the Health Service Executive Quality Improvement Division, governed by an independent voluntary board and operationally supported by the Royal College of Surgeons in Ireland.

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X Did not attend
NA

8 NATIONAL CLINICAL AUDITS

- Irish Hip Fracture Database (IHFD)
- Irish National Orthopaedic Register (INOR)
- Major Trauma Audit (MTA)
- National Audit of Hospital Mortality (NAHM)
- The National Perinatal Epidemiology Centre (NPEC)
  - Perinatal mortality in Ireland
  - Severe maternal morbidity in Ireland
  - Very Low Birth Weight infants in the Republic of Ireland
**OVERVIEW**

The IHFD is a clinically led, web-based audit which measures the care and outcomes of patients with hip fractures. The IHFD grew out of a collaboration between the Irish Gerontological Society (IGS) and the Irish Institute for Trauma and Orthopaedic Surgery (IITTOS). Since 2013, the IHFD has been under the management and governance of NOCA. The IHFD reports on six key clinical standards known as the Irish Hip Fracture Standards (IHFS) across the 16 eligible hospitals. NOCA feeds back on the performance of each hospital quarterly to the hospitals and hospital groups. Each hospital, through the formation of a hospital hip fracture governance committee (HFGC), is encouraged to use these reports for continuous quality improvement.

Last year was a significant year for the IHFD due to the publication of the fifth national report and the implementation of the Best Practice Tariff (BPT). The latter was supported by Dr Colm Henry as the National Clinical Advisor of the Best Practice Tariff (BPT). The latter was supported by the Healthcare Pricing Office, National Clinical Programme for Trauma and Orthopaedics and the Irish Hip Fracture Database (IHFD) in the National Office of Clinical Audit. The purpose of the tariff is to drive further improvements in the standard of hip fracture care.

Hip fracture are an ideal condition to measure as they serve as a marker condition for how well a trauma service is functioning and how well we care for older patients in acute hospitals. The IHFD has matured as a robust national clinical audit that lends itself towards a tariff based process. Using the defined clinical standards that underpin the database and data quality standards, we can accurately measure the number of patients receiving the optimum standard of care. The IHFD is intended to drive a reduction in the variation in the standards of care across the individual hospitals as has been demonstrated in other jurisdictions e.g. the UK. Hospitals that are compliant with all standards will receive €1000 for each patient that has achieved the optimum standard of care. To date, payments for the first six months of 2018 have been paid totalling €105,000. The majority of the money (70%) is intended for the trauma service and the remaining 30% is for the hospital. This money is to be used by the local hip fracture governance committee to improve the quality of patient care in the trauma service.

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The maturity and success of the IHFD as a national clinical audit clearly demonstrates the benefit of measuring the care we deliver against defined standards. We have seen the growth of orthogeriatric services across the country, a national bypass strategy for hip fractures and crucially the implementation of the best practice tariff*.

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*Dr Emer Ahern, Clinical Geriatric Lead, IHFD*
The Irish National ICU Audit (INICUA) was established by NOCA in 2013 and focuses on the care of patients in adult and paediatric Intensive Care Units, the very sickest patients in the hospital.

IRISH NATIONAL ICU AUDIT OBJECTIVES
- Measure the quality of care in ICU by benchmarking outcomes
- Use the Audit to drive improvements in the quality of care
- Measure activity to inform the configuration of critical care
- Provide data to support the Hospital In-Patient Enquiry system and activity-based funding
- Audit healthcare-associated infection
- Audit potential organ donors and organ donation.

IMPLEMENTATION STATUS
Irish National ICU Audit is currently live in 16 adult hospitals, (encompassing 20 Critical Care Units) and in 2 specialist paediatric hospitals. Audit implementation is scheduled in a further 6 adult hospitals during 2019.

IRISH NATIONAL ICU AUDIT ANNUAL REPORT 2017
The Irish National ICU Audit (INICUA) report for 2017 provides data on 58% of national ICU activity in adult hospitals (12 Units in 9 hospitals) and on all ICU activity in both specialist paediatric hospitals in the Republic of Ireland (ROI).

KEY FINDINGS (ADULT)
1. There was considerable variability between the Units included in many of the metrics measured.
2. Irish Units are very busy; bed occupancy was above recommended levels for safe patient care.
3. Illness severity on admission to the Unit was greater in Irish Units than in UK Units; as were the levels of organ support provided.
4. Despite higher markers of illness severity, mean length of stay was the same in Ireland and the UK (five days).
5. The rate of unplanned discharges out-of-hours to the ward was greater in Irish Units. A considerable number of bed days in ICU were occupied by patients who had been cleared for discharge to the ward but discharge was delayed.
6. Irish patients need to be sicker than patients in the UK to be admitted to ICU. For a given illness severity on admission, the ward was greater in Irish Units. A considerable number of bed days in ICU were occupied by patients who had been cleared for discharge to the ward but discharge was delayed.
7. Outcome measures in Irish Units were comparable to UK Units. This indicates that ICU was a relatively safe environment for Irish patients.
8. Data from one hospital showed an increase in risk-adjusted mortality related to a sharp increase in numbers of admissions. This indicates the effect of excess demand on patient outcomes.
9. Length of stay in hospital after ICU discharge was longer in Ireland than in the UK.

KEY FINDINGS (PAEDIATRIC)
10. The number of bed days delivered in the ROI was approximately 10,000 annually from 2015–2017. Children under the age of one made up 57% of admissions to Our Lady’s Children’s Hospital, Crumlin (OLCHC) and 38% of admissions to Temple Street Children’s University Hospital (TSCUH).
11. Bed occupancy in both Irish paediatric ICUs (PICUs) was high in 2017 (97% in OLCHC and 86% in TSCUH). These are above the recommended levels for safe patient care.
12. Quality metrics such as risk-adjusted mortality and emergency readmissions in both PICUs were within the expected range. These findings show that PICUs were safe for patient care in the ROI in 2017, despite the pressure on beds.
13. PICUs have shared their experiences of learning from previous PICANet Annual Reports to improve their prevention of unplanned extubation.
14. There was an improvement in journey commencement times in 2017 for the Irish Paediatric Acute Transport Service (IPATS). However, IPATS only operates on weekdays during the daytime.
15. There was considerable variability in nursing staffing levels and nursing vacancies between participating Units in the PICANet Annual Report 2018.

KEY RECOMMENDATIONS
- The HSE should identify Units operating at or above capacity and provide enough beds for these Units to deal with peak demand.
- The HSE should increase bed capacity across both PICUs.
- Doctors should clearly identify patients for Unit discharge and managers should expedite these discharges and minimise discharge from ICU during night-time hours.
- Clinicians and managers should use INICUA data to identify variance in their own activity and use it to promote improvements in their local practice.
- Hospital managers should ensure adequate resources are in place to collect INICUA data for continuous and complete reporting.
- NOCA should prioritise a national database for adult ICU data, to provide a wide range of reports not currently available (including reports on children cared for in adult critical care, organ donation, infection rates in ICU, obstetric patients in critical care and patient transfers between hospitals).
- The HSE should support the NOCA ICU Bed Information System, to optimise the use of adult critical care beds, and allow for more efficient referrals.
- The Mobile Intensive Care Ambulance Service and Paediatric Acute Transport Service transport should be resourced to provide a 24 hour service, 365 days a year.
- Doctors should ensure that the “Time of decision to admit to ICU” is documented to meet the new HSE key performance indicator for time to access an ICU bed.
- NOCA should consider ways to introduce patientreported outcome measures, promote national surveillance of catheter-related bloodstream infection and a dataset for rates of medical staff for Irish PICUs.

"Irish Units have reassuring outcome measures despite the strains placed on them; they provide a high quality of care for patients and are a relatively safe environment for critically ill patients. The 2017 report covered 58% of national adult ICU activity, but a fuller picture will be available in the 2018 report, which will provide 78% coverage. In 2019, we hope to achieve full coverage of ICU activity in HSE-funded hospitals. Other priorities include developing a National ICU Audit database to make full use of the large dataset available. Our ICU database also has the potential to provide live data on ICU bed occupancy and bed availability, a national ICU Bed Information System.”

Dr Rory Dwyer, Clinical Lead, Irish National ICU Audit
OVERVIEW
The Major Trauma Audit (MTA) was established by the National Office of Clinical Audit (NOCA) in 2013. This audit focuses on care of the more severely injured trauma patients in our healthcare system. The methodological approach for the MTA is provided by the Trauma Audit & Research Network (TARN). In 2016, the MTA became the first national clinical audit endorsed by the National Clinical Effectiveness Committee (NCEC) and mandated by the Minister for Health. Since 2016, all 26 eligible hospitals have been participating in the audit and data have been collected on more than 15,000 trauma patients to date. The maturing nature of the audit now enables us to look at hospital-level data for the first time in the MTA National Report 2017.

Following the publication of the MTA National Report 2016, the Department of Health published a report entitled A Major Trauma System for Ireland: Report of the Trauma Steering Group. The MTA Governance Committee for NOCA welcomed this report, which sets out the future plan for the development of an inclusive trauma system in Ireland with a specific focus on the prevention of unnecessary deaths and improved access to trauma specialist services in order to enable people who sustain major trauma to attain the best possible recovery. The report highlighted the role of national clinical audit in providing reliable and robust data that can measure access to care, standards of care, processes and outcomes. The MTA will capture the changes brought about by the creation of the new inclusive trauma system and its effect on performance and outcomes, and can be used by healthcare commissioners, stakeholders and society to monitor the effects of the reconfiguration of trauma care delivery.

It has been proven that the introduction of a Major Trauma System in Australia and London has resulted in a 50% reduction in mortality in major trauma patients. In the UK overall, a 20% reduction in deaths was observed with similar dramatic reductions in severe disability. With regard to deaths due to road traffic accidents alone in Ireland, it has been estimated that we have one avoidable death per fortnight and two patients suffering avoidable severe disability per week. There is no other disease in the developed world where there are similar gains to be made in terms of saving lives. Introduction of coordinated systems in cancer, stroke and cardiac care in Ireland have been successful in achieving improvements in outcomes in these areas. Any delay in introducing a trauma system in Ireland will result in significant ongoing avoidable loss of life from major trauma.

The MTA now provides an excellent baseline of data from which to measure and support the development of the emerging trauma networks in Ireland. This year, a major focus for the audit will be towards gathering long term outcome measures. The recommendations coming from this report are summarised as follows:

- The MTA Governance Committee welcomes A Trauma System for Ireland: Report of the Trauma Steering Group urging the implementation of a coordinated trauma system.
- A multi-agency, multidisciplinary strategy is required to prevent the most common mechanism of injury in Ireland, low falls, in a similar approach to that achieved with road accidents by the Road Safety Authority.
- To address the variation in hospital performance, each participating hospital should support the actions recommended by its local MTA Governance Committee.
- NOCA will support hospitals to enhance, and where required, re-establish their local MTA Governance Committees.
- The MTA recommends stakeholder collaboration to agree key definitions for the audit, including trauma team and activation criteria and rehabilitation prescription.

Dr Conor Deasy, Clinical Lead, MTA
NATIONAL AUDIT OF HOSPITAL MORTALITY (NAHM)

OVERVIEW

The National Audit of Hospital Mortality (NAHM) reports on hospital mortality patterns and SMR in 44 acute public hospitals in Ireland across six key diseases/medical conditions. Many in-hospital deaths are not unexpected, due to the patient’s clinical condition and co-morbidities on admission. However, there is increased awareness that some deaths may be prevented by improving quality of care and reducing adverse incidents. Hospital mortality is one measure which can be used as a quality indicator to improve the care provided to patients in hospitals. Differences in mortality do not always imply poor quality of care as there are many specialist hospitals caring for patients with more complex and challenging conditions.

In December 2014, the National Office of Clinical Audit (NOCAs) was tasked by the Quality Improvement Division, HSE, to undertake an audit to identify unusual or unexpected patterns of mortality in Irish acute hospitals. The Health Intelligence Unit, Strategic Planning and Transformation, HSE, developed NAHM, which is one of a number of National Quality Assurance Intelligence System (NQAIS) tools.

NAHM uses data sourced from the Hospital In-patient Enquiry System (HIPE) via the Healthcare Pricing Office (HPO). A standardised mortality ratio (SMR) is calculated which is based on the principal diagnosis (after investigation, what is found to be the main reason a patient is admitted to hospital for treatment), however this is not always the cause of the patient’s death. The SMR shows the number of actual deaths compared to the number of deaths which would have been expected when eight factors, which affect in-hospital mortality, are taken into consideration e.g. age, existing illnesses, in-patient palliative care treatment etc. The hospitals SMR for a diagnosis group (e.g. Respiratory) or individual diagnoses (e.g. Pneumonia) is then compared to a National “average” or “expected” for the cohort of patients in question. It is not possible to compare hospitals to one another as no two hospitals have the same patient profile or case-mix.

NAHM aims to promote reflection on mortality data and patient care and identify areas for improvement. To help achieve this, NAHM has been deployed to 44 acute hospitals. Each hospital or hospital group has identified personnel to have access to their data through the NQAIS NAHM web-based tool. Data is updated quarterly so that patterns and trends can be examined throughout the year. Where an SMR is significantly higher than expected, hospitals are requested to carry out reviews in line with NOCAs monitoring and escalation policy.

NAHM published their third annual report in December 2018. This report includes hospital identifiable data across six key diagnoses, acute myocardial infarction (heart attack), heart failure, ischaemic stroke, haemorrhagic stroke, chronic obstructive pulmonary disease (COPD) and pneumonia.

“As the public and patient representative on the NAHM Governance Committee, I can assure you that hospitals are given every support to monitor their in-hospital mortality. The inclusion of hospitals feedback in a published report is a testament to the continued engagement with NAHM”.

Alan Egan, NAHM PPI

NATIONAL AUDIT OF HOSPITAL MORTALITY ANNUAL REPORT 2017

The National Audit of Hospital Mortality Annual Report 2017 was published in December 2018. The main highlights from this report are:

- There are no statistical outliers at year end for the diagnoses published.
- One hospital had a statistical outlier during the year of 2017 for AMI, a summary of the review is included in the report.
- Thirty two hospitals have their data included and they are identified for transparency.
- There has been variation in some coded data identified—the NQAIS NAHM web-based tool has undergone some development and enhancements to make it more user friendly and user training is ongoing.
- 20% of respiratory cases had a principal diagnosis of acute lower respiratory infection (unspecified).

The recommendations coming from this report are summarised as follows:

IMPROVING DATA QUALITY

- Cooperation between clinicians and clinical coders will lead to more accurate medical records and improved data quality however this will require protected time for clinicians.
- Hospital management should lead the way with regard to improvement in data quality.
- Clinicians need to fully and accurately complete discharge summaries using consistent terminology. This should be done for all patients including those whom have died.
- Hospitals should review cases of acute lower respiratory infection to ensure this is the correct principal diagnosis.

IMPROVING THE NQAIS NAHM WEB-BASED TOOL

- The NAHM Governance Committee will explore the possibility of expanding the heart failure group under NQAIS NAHM to allow for international benchmarking.
- The ‘acute bronchitis’ CCS group within NQAIS NAHM should be renamed ‘acute lower respiratory infection (unspecified)’.

USING NQAIS NAHM

- The NQAIS NAHM web-based tool and this report should be continually used by hospitals to learn from their findings and improve quality of care for patients.

“The 2019, we will explore how we may expand the report to include surgical data and other conditions not reported on to date”.

Ms Bridget Egan, Clinical Lead, NAHM
OVERVIEW
Established in 2007, the National Perinatal Epidemiology Centre (NPEC) has collaborated with the Irish maternity services to translate clinical audit and epidemiological data into improved maternity care for families in Ireland. National clinical audits include: Perinatal Mortality (PM), Very Low Birthweight Babies and Severe Maternal Morbidity (SMM). Operation of the NPEC audits is in accordance with standards and policies set by NOCA. All 19 Irish maternity units contribute data to these audits and it is with sincere thanks that the NPEC acknowledges unit coordinators who collate data at centre level.

While pregnancy and childbirth is a normal life event, it must be acknowledged that adverse perinatal outcomes can occur in both the mother and baby.

Perinatal mortality is a significant measure of obstetric and neonatal care. In the mother, severe maternal morbidity is acknowledged as an important quality indicator of maternity care, particularly in developing countries where maternal death rates are relatively low. However, it is important that we do not focus only on maternal outcomes. Mortality is a significant measure of obstetric and neonatal care. In the mother, severe maternal morbidity is acknowledged as an important quality indicator of maternity care, particularly in developed countries where maternal death rates are relatively low. However, it is important that we do not focus only on maternal outcomes.

The fundamental aim of the audits is to provide a national view of the adverse perinatal outcomes, to identify quality improvement initiatives and make recommendations for the improvement of the maternity services. The information provided contributes to a body of evidence that will guide clinical practice, counselling of bereaved parents, public health interventions and inform policy makers. Recommendations from earlier NPEC reports have been implemented and the adoption by the National Women and Infant’s Health Programme (NWHiP) of more recent recommendations is most welcomed.

DEFINING PERINATAL MORTALITY
Number of stillbirths and early neonatal deaths (death of a live born baby occurring within 7 completed days of birth) per 1,000 births (live births and stillbirths from 24 weeks gestation or weighing >500g).

KEY MESSAGES, PERINATAL MORTALITY 2016
- Perinatal Mortality Rate: 5.6/1,000 births or 1 in 172 births
- Low birthweight is associated with perinatal death, particularly stillbirths.
- The main causes of perinatal death in Ireland in 2016 were: Stillbirth: Major congenital anomaly (31.2%), placental disease (28.0%), unexplained (15.2%).
- Early neonatal deaths: Major congenital abnormality (34.8%), respiratory disorder secondary to prematurity (29%).

DEFINING SEVERE MATERNAL MORBIDITY
Severe maternal morbidity (SMM) is defined as a pregnant or recently-pregnant woman (i.e. up to 42 days following the pregnancy end) who experienced any of the following sixteen, clearly defined, morbidities: major obstetric haemorrhage (≥2.5 Litres), uterine rupture, eclampsia, renal or liver dysfunction, pulmonary oedema, acute respiratory dysfunction, pulmonary embolism, cardiac arrest, coma, cerebrovascular event, status epilepticus, septic shock, anaesthetic complications and maternities involving peripartum hysterectomy, admission to an intensive care unit (ICU) and interventional radiology.

KEY MESSAGES, SEVERE MATERNAL MORBIDITY 2016
- There was a statistically significant increase in the rate SMM and major obstetric haemorrhage (MOH) in 2016 compared to previous years.
- The rate of SMM was 6.46 per 1000 maternities or one in 155 maternities.
- MOH remains the most commonly reported morbidity. This highlights the necessity for obstetric haemorrhage protocols.
- Variation in rates MOH were identified between units. This may reflect differences in estimating blood loss across units.
- One in 109 women required higher levels of care (Level 2 or Level 3 care).

VERMONT OXFORD NETWORK (VON)
- The Vermont Oxford Network (VON) is a non-profit international voluntary collaboration of health care professionals dedicated to improving the quality and safety of medical care for newborn infants and their families.
- Data is collected on the care and outcomes of very low birthweight infants (VLBW) such as those born ≤500g and/or ≤29 weeks.
- The VON Network is today comprised of over 900 Neonatal Intensive Care Units around the world. The database provides unique, reliable and confidential data to participating units for use in quality management, process improvement, internal audit and peer review.
- The National Perinatal Epidemiology Centre (NPEC) facilitates membership of the VON on behalf of all 19 neonatal units in Ireland, making it possible to have composite national data on all very low birthweight (VLBW) infants born in Ireland.
- The report published in 2018 focuses on death of VLBW babies. Specifically:
  - Did VLBW infants born in Ireland in 2014-2016 have a higher than expected risk of death?
  - Did VLBW infants born at specific gestational ages have a higher than expected risk of death?
  - Was the increased risk of death related to an established clinical practice or model of care?

KEY MESSAGES, MORTALITY RISK AMONGST VERY LOW BIRTH WEIGHT INFANTS IN THE REPUBLIC OF IRELAND REPORT 2014-2016
- Over the three-year period, 298 (one in six) VLBW infants born in Ireland died before they were discharged from hospital or before they reached their first birthday. This represented a 17% higher risk of death than expected.
- Further investigation revealed that:
  - Babies born at 22-23 weeks had a 23% higher risk of death than expected.
  - Babies born at 24-27 weeks in a tertiary unit did not experience higher than expected mortality. However, those who were born in a non-tertiary unit had a 78% higher mortality risk than expected.
  - Babies with a gestational age of at least 28 weeks did not have a higher mortality risk than expected.

RECOMMENDATIONS
- All women anticipated to deliver at a gestational age of 23 weeks should be administered antenatal steroids and magnesium sulphate and the neonatology team should be alerted prior to delivery.
- Resuscitation should be administered to all infants born at 23 weeks who present in favourable condition, i.e. without congenital anomaly, severely small for gestational age, severe hypoxia or severe infection.
- In line with the existing Model of Care for Neonatal Services in Ireland, infants born before reaching a gestational age of 28 weeks should ideally be delivered at one of the four tertiary neonatal units.

GET INVOLVED
The NPEC disseminate unit specific reports to all maternity units which benchmarks perinatal outcomes against national rates. You might like to consider how findings from the national NPEC reports inform your practice and contact the co-ordinator in your unit for findings specific to your service. Co-ordinators at centre level are acknowledged in all NPEC reports.

FURTHER INFORMATION
Please check the NPEC website for all up to date information: https://www.ucc.ie/en/npec/
Please contact the NPEC at npec@ucc.ie for further information or with any queries.

“The NPEC have a number of key aims for 2019: We aim to showcase the work that has been completed by the NPEC in the last 10 years. We aim to highlight the data and show what can be achieved with good data. We aim to continue collaborations not only in the maternity service but also across the health system. As Director of the NPEC, I am proud that the maternity services in Ireland through the NPEC are collecting data that can influence and improve patient care”.

Prof Richard Greene, Director, NPEC
The Irish National Orthopaedic Register (INOR) aims to improve the quality of services and care provided to patients having elective hip and knee replacement surgery. By using patient scoring systems and recording on implant performance and patient outcomes, INOR aims to monitor the safety of implants and support hospitals should an implant recall occur.

**AIMS & OBJECTIVES**

The primary objective of INOR is to provide information that is designed to help improve the quality of care and clinical outcomes of joint replacement recipients. The introduction of a National Arthroplasty Register will enable early detection of failing devices, procedures, institutions or surgeons to limit the impact for future patients. Implementation of INOR will increase patient safety, confidence and overall experience while reducing surgical revision and providing orthopaedic surgeons the opportunity to participate and contribute to measurable clinical audit.

Unlike other International Arthroplasty Registers, who collate the data retrospectively, INOR data collection is real-time and is entered electronically at the point of care by the nurses, doctors and patients into a bespoke secure web application.

“The completion of the roll-out of INOR to all public hospitals and the continued engagement with the private sector will ensure we eventually have data on every hip and knee replacement performed in Ireland”.

**KEY ACHIEVEMENTS 2018**

INOR is currently live in five hospitals nationally, South Infirmary Victoria University Hospital, Midland Regional Hospital Tuammore, Croom Orthopaedic Hospital, Kilcreene Orthopaedic Hospital and Our Lady’s Hospital, Navan. Engagement with the private hospitals commenced in 2018 with a plan for a pilot site roll out in 2019. All public hospitals are engaged with the national team and are at varying stages of implementation.

INOR received a recommendation in the Irish Healthcare Awards in the area of Best Use of Technology in Hospitals in November 2018.

**PLANS FOR 2019**

INOR is planned to Go Live in four public hospitals in 2019. Merlin Park University Hospital and Cappagh National Orthopaedic Hospital will Go Live in Q1 and Q2 2019 respectively. Collaboration with the private hospitals will continue to plan an agreed implementation schedule. In parallel, a reporting strategy for INOR is in development to facilitate reporting to Clinicians, Hospitals and Patients with the production of a publicly-accessible aggregated annual report.

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**INTRODUCTION**

Capturing patient perspectives are one of the most effective approaches to gain a thorough understanding of patient experience. Patient perspectives can be used to enhance understanding of clinical data, thereby informing the quality improvement (QI) aspects of clinical audit. They are a powerful way of increasing focus and engagement with quality and safety issues, highlighting aspects of care covered by NOCA clinical audits. These perspectives can be used to inspire, educate, enable learning & improvement and for media.

In 2018, NOCA and the HSE Quality Improvement Division (QID) partnered to collaboratively design (co-design) the inclusion of patient perspectives in NOCA audits.

**PURPOSE**

The purpose of this work was to co-design a methodology to collate patient perspective in form of a story for NOCA reports. Learning arising from this work will be shared to ensure knowledge and outputs are transferred within the Irish healthcare system.

**METHODS**

The NOCA HSE QID Co Design Working Group, a short life working group (SLWG) was convened to co-design a methodology to collate patient perspective for NOCA. The SLWG comprised of representatives from both organisations, front-line clinicians (doctors, nurses, health & social care professionals) and public and patient interest (PPI) representatives. Thirty percent of the SLWG were PPI representatives.

A co-design workshop brought together the members of the SLWG to discuss and collaboratively decide how best to include patient perspectives. Workshop participants engaged in a series of brainstorming and discussion based tasks, designed to develop ideas and to share their knowledge and experience. The mix of patient and clinical representatives ensured a patient-centered perspective and feasible approach was maintained throughout. This was followed up with a series of meetings to develop and approve resources for the project.

**OUTPUTS**

It was planned to use the Irish Hip Fracture Database (IHFD) as an early adopter of this work, but work was not advanced at that time to achieve a patient story for this report. However, a patient story was captured and identified for the NOCA Irish National ICU Audit report, which will be published today. During the course of this work, a number of resources were developed to support this project.

**CONCLUSION**

The purpose of this work was to co-design a methodology to collate patient perspective in form of a story for NOCA reports. While this was achieved in the case of the national ICU audit, it was noteworthy that two further NOCA reports included a distinct commentary from audit PPI representatives. This demonstrates the role of NOCA PPI representatives to clinical audit and quality improvement.
NOCA EVENTS IN 2018

- NOCA Annual Conference January 2018
- Major Trauma Audit Workshop March 2018
- NOCA HSE Co-Design Workshop for capturing patient perspectives April 2018
- NOCA Clinical Leads Symposium May 2018
- Irish National Orthopaedic Register Workshop October 2018
- Irish Hip Fracture Meeting November 2018
- Irish National ICU Audit Workshop November 2018