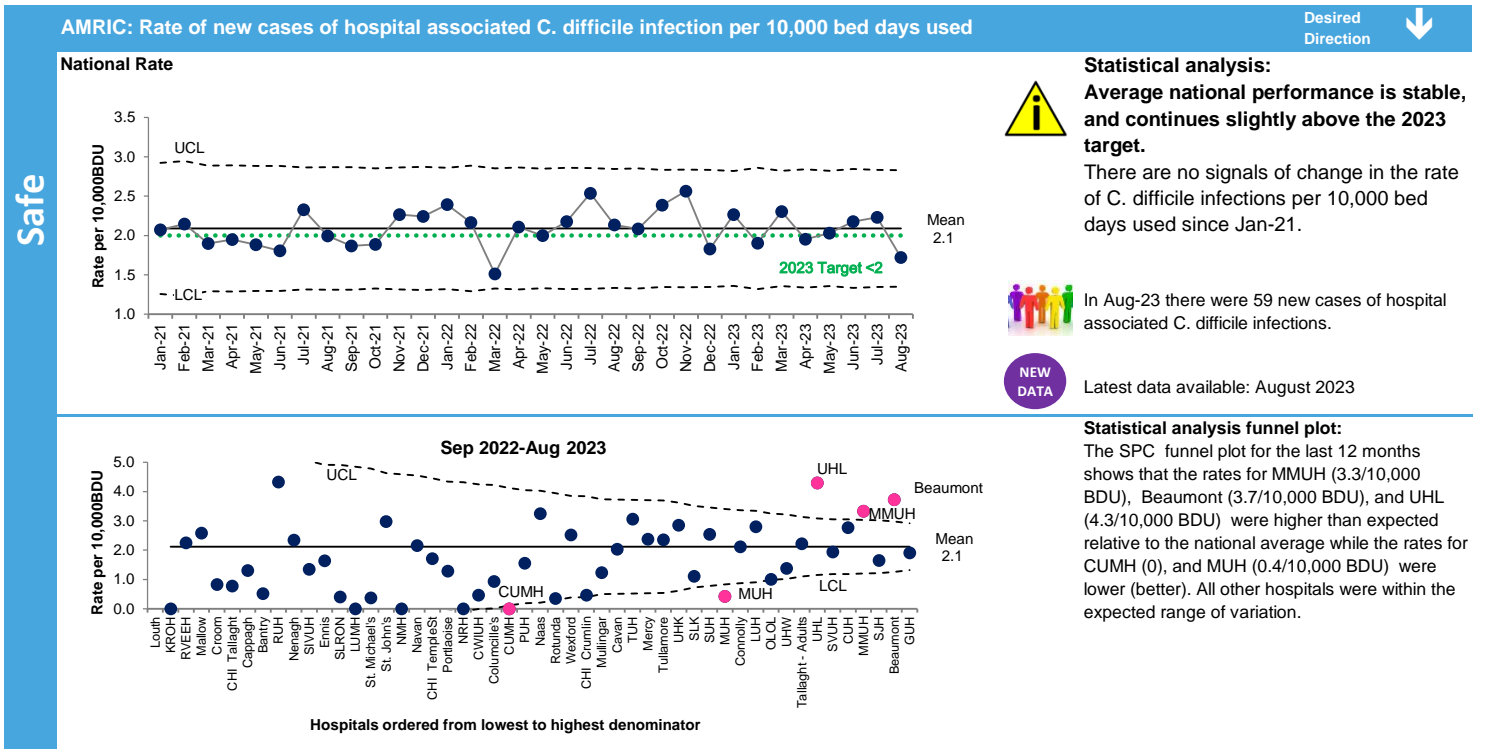


The purpose of the Quality and Safety Profile is to provide statistical insights into quality and patient safety data and to support understanding of variation in performance over time. It is separate to processes supporting the performance and accountability framework under which necessary improvement plans are developed and monitored by NPOG and reported on through EMT and the Monthly Performance reporting process up to and including the Board Strategic Scorecard.



Service analysis (updated 27/09/2023):

- There was a decrease in the national rate of C. difficile infections to 1.7 cases per 10,000 BDU in August 2023 (which is below the target threshold of <2.0) compared to 2.2 cases per 10,000 BDU in July. Of note the overall national rate YTD is 2.1 cases per 10,000 BDU
- HSE AMRIC Oversight and implementation/ working governance groups are in place with Acute Operations reps, and Hospital Group IPC/ AMS Steering Groups are in place in 5 Groups
- Performance KPIs and monitoring process in place for acute hospital HCAI KPIs which includes assessment of commentary from hospitals on rates above target in terms of appropriate review and actions taken
- Policies, Procedures & Guidelines available to hospitals and National AMRIC technical support / guidance/ webinars/ education supports provided.
- Ongoing monitoring of 2022-2025 AMRIC Implementation Plan objectives as they relate to acute services



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

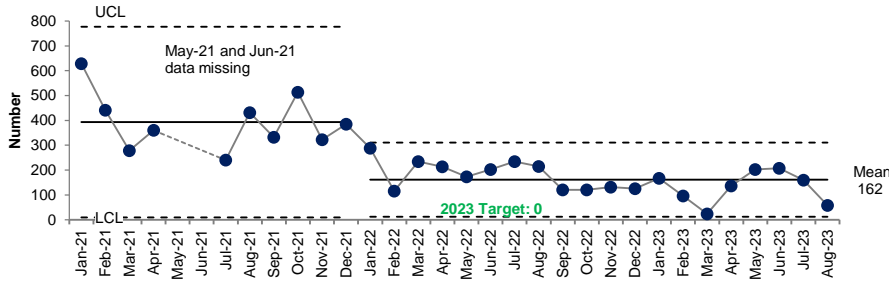
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: No. of new people waiting > four weeks for access to an urgent colonoscopy

Desired Direction ↓

Safe

National Data



Statistical analysis:
Average national performance is above the 2023 target. There have been signals of improvement since Jan-22.
 The statistical limits were recalculated to reflect the new average.



Aug-23: there were 58 people waiting over four weeks for access to an urgent colonoscopy.



Latest data available: August 2023

Note: As this indicator does not have a denominator, it is not possible to produce a funnel plot.

Service analysis (updated 28/09/2023):

Acute Operations continue to robustly monitor breaches across all hospitals.

Saolta Hospital Group have been issued with a Performance notice re Urgent Colonoscopy - Saolta have reverted with remedial actions and assurances.

Of the 58 new breaches in August 34 were linked to two hospitals, Tallaght University Hospital and Mater Misericordiae University Hospital. The reasons for same have been addressed and are being monitored by the Acute Operations Access team, the Hospital Groups and Hospitals.

Tallaght University Hospital TUH have reported breaches since July due to consultant staffing issues. TUH have engaged with the DPS and have commenced urgent scope lists, starting the August Bank holiday to date. TUH have implemented weekend lists to reduce the wait for all patients. The hospital also continues to outsource scopes to local private hospitals in order to create capacity.

Mater Hospital The hospital is currently experiencing a cumulative daily nursing shortage of 4WTE. An action plan is in place, with weekly monitoring. Funding for weekend capacity has been secured via the Access to Care funding stream. MMUH have not breached since 11 August.

St Columcille's Hospital The unit experiencing a lack of endoscopists with lower GI experience. The hospital management team and clinical lead are seeking solutions to this. Extended days have commenced to meet the demand and a locum consultant is in place.

Tipperary University Hospital This breach was an administrative error when recording the patient episode on the hospital administration system.

South Infirmary Victoria University Hospital These breaches were recorded due to consultant leave. New systems have been put in place for managing patients during periods of consultant leave.

MRH Portlaoise These breaches were due to capacity issues in the hospital.

Portiuncula University Hospital Two breaches relate to patients who required propofol (GA) for their procedure. The remaining breaches were incorrectly recorded as breaches, the patients had rescheduled appointments.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

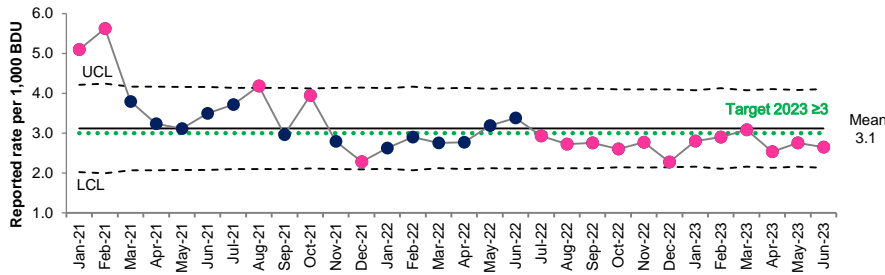
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Rate of medication incidents as reported to NIMS per 1,000 bed days

Desired Direction

Safe

National Rate



Statistical analysis:

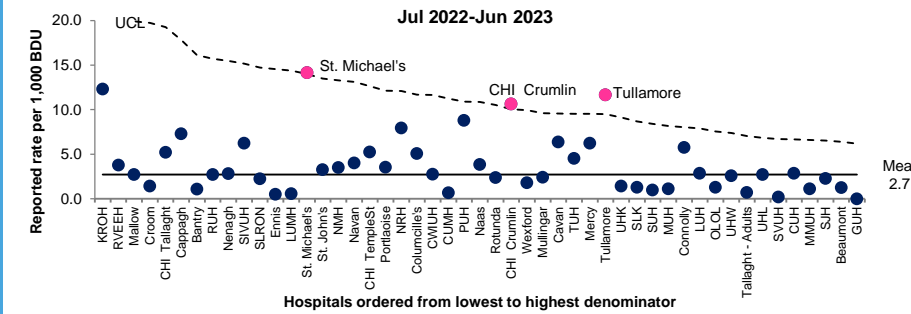
The average reported rate is higher than the 2023 target. However the reported rates for the last 12 months are all below the centre line which is a signal of a lower than expected reporting rates.



In Jun-23 there were 876 medication incidents reported to NIMS.



Latest data available: June 2023



Statistical analysis funnel plot:

The SPC funnel plot for the last 12 months shows that the reported rates for St. Michael's (14.2), CHI Crumlin(10.7) and Tullamore (11.7) are higher (better) than expected relative to the national average. All other hospitals were within the expected range of variation.

Service analysis (updated 27/09/2023):

This KPI provides insight into the rate of medication incident and near miss reporting from acute hospitals, as reported to NIMS.

Medicines are an essential component of effective, safe healthcare. Medicines can also be associated with adverse drug events (harm) and with medication errors. Incident and near miss reporting facilitates the identification of actual and potential medication safety issues. Analysis of incidents and trends should lead to improvement actions to reduce the risk of recurrence.

Improved reporting is a key recommendation of HIQA's overview report on Medication Safety Monitoring Programme in Public Acute Hospitals (<https://www.hiqa.ie/sites/default/files/2018-01/Medication-Safety-Overview-Report.pdf>). Reporting rates in UK hospitals achieve a mean of approximately 4.5 reports per 1000 bed days. The mean in Irish hospitals is currently lower in most hospitals. Hospitals are advised to ensure their rate of medication-related clinical incident reporting consistently exceeds 3 reports per 1000 bed days and aim to achieve a higher reporting rate reflective of a positive patient safety culture.

Observational studies and research evidence indicates medication error rates in the medicine use process far greater than those identified by incident reporting:

- prescribing error rate in hospital, 7% of prescription items (Lewis PJ et al. Drug Safety 2009;32(5)379-89)
- dispensing error rate in hospitals, 0.02 – 2.7% of dispensed medicines (James KL et al. Int J Phar Pract. 2009; 17:9-30)
- medicine administration errors in hospital, 3 – 8% (Kelly J et al. J Clin Nursing 2011.21, 13-14, 1806-1815)

Details of KPI and calculation:

The KPI records the rate of reporting to the NIMS system of an incident or near miss related to medication per 1000 in-patient bed days, in acute hospitals. An incident is defined as an unplanned, unexpected or uncontrolled occurrence, which causes (or has the potential to cause) injury, ill-health and/or damage, related to medication. Reports include adverse events, no harm incidents, near misses and hazardous conditions. Reports may relate to patients in inpatient, day case or outpatient services in an acute hospital.

Rate: Total number of medication-related incidents and near misses reported on NIMS in the given month, in acute hospitals * 1,000 / Total number of in-patient bed days

Interpretation:

It is not possible to gauge the rate of adverse drug events or medication errors occurring through interpretation of incident reporting. Reporting rate is considered an indicator of safety culture.

Rates are dependent on timely reporting and data entry to NIMS. Some hospitals with strong and active medication safety management systems and good reporting within the hospital, report a smaller volume on NIMS, in some cases only reports associated with patient harm.

Some hospitals have integrated electronic systems and/or clinical pharmacist reporting systems which facilitate much higher rates of reporting.

Engagement with Irish Medication Safety Network members is underway to understand the factors affecting reporting rates to NIMS at present.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

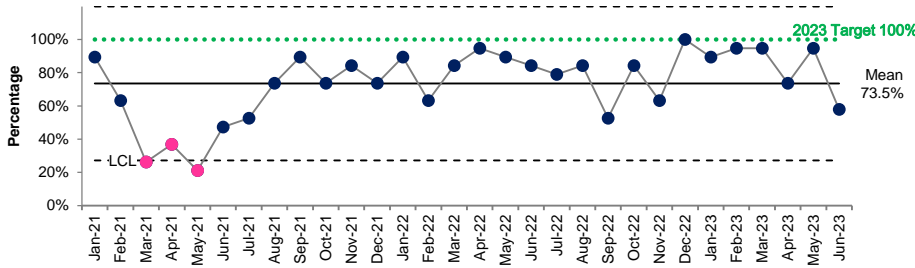
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Percentage of maternity hospitals / units that have completed and published monthly Maternity Safety Statements

Desired Direction

Safe

National Rate



Statistical analysis:

Average national performance is stable, and continues at an average below the 2023 target.

There are no signals of change in the rate of maternity statements published since Jun-21.



In Jun-23, out of the 19 maternity hospitals, there were 11 hospitals that have completed and published monthly Maternity Safety Statements.



Latest data available: June 2023

Note: As data for this indicator is published as monthly data points, it is not possible to produce a funnel plot.

Service analysis (updated 28/09/2023):

The annual target for the two MSS KPIs both A128 and A129 is 100%.

We have not found resistance within the system to publishing the MSS although small number of units have amended the pro-forma, this was established practice prior to NWIHP involvement.

We have found that delays in publishing are down to annual leave - as a task assigned to an individual person, and a delay caused due to a wait for a senior management team meeting, as they need to signed off by senior management at both local and hospital group level.

There is one hospital currently in arrears and NWIHP is working with them to get their reporting back on track



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

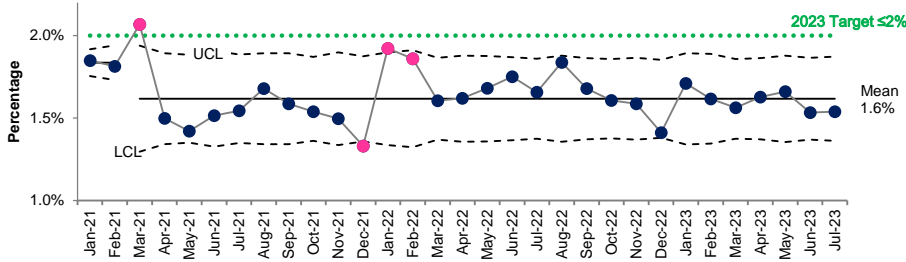
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Percentage of surgical re-admissions to the same hospital within 30 days of discharge

Desired Direction

Effective

National Rate



Statistical analysis:

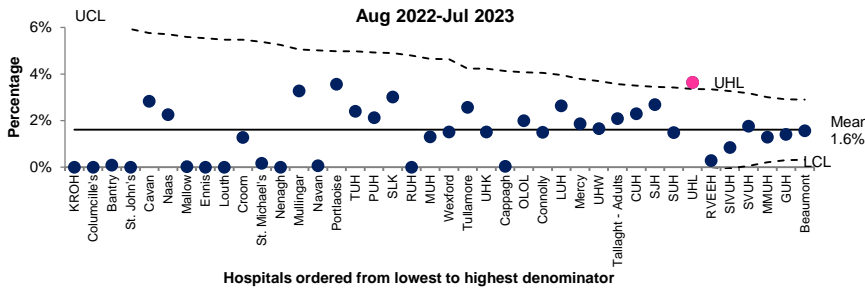
Average national performance is stable since Mar-22, and continues well below the 2023 target.



There were 34,229 surgical discharges in Jul-23 of whom 527 patients were re-admitted to the same hospital within 30 days of discharge.



Latest data available: July 2023



Statistical analysis funnel plot:

The SPC funnel plot for the last 12 months shows that the rate for UHL (3.6%) was higher than expected relative to the national average. All other hospitals were within the expected range of variation.

Service analysis (updated 27/09/2023):

The number of patients that were re-admitted was 527, this is down from 558 the previous month. The National Average is 1.5% Hospitals are encouraged to reduce surgical length of stay, it is important that re-admission rates are monitored to ensure that there is not an associated inappropriate increase of readmissions to surgical services.

Data is collected monthly in arrears, a low rate of surgical re-admissions is a good proxy measure for quality care; pre - and post-discharge care can improve care outcomes and reduce surgical readmission.

The Access team within Acute Operations monitor this target and link with groups as required.

UL Hospitals Group communicated with a number of Departments who were breaching the KPI. The Surgeons highlighted a number of factors contributing to UL Hospitals Group KPI which include:

- Vascular – The readmission rate at 10% is attributed to readmission for procedures on different sites or follow-up care and high acuity in the region.
- ENT - Follow-up care e.g. removal of nasal packs which is considered a planned admission.
- Orthopaedics - Many of the highlighted readmissions were planned i.e. scheduled.
- General Surgery – The acuity of the population of the Midwest as well as pent-up demand with Covid and limited surgical access since reconfiguration all contribute to our increased KPI. Again, readmissions were noted as required for follow-up care e.g. AHP, removal from a procedure performed at original admission.
- Urology – The Department responded that it would be necessary to audit individual cases. MRNs have been supplied to the department.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

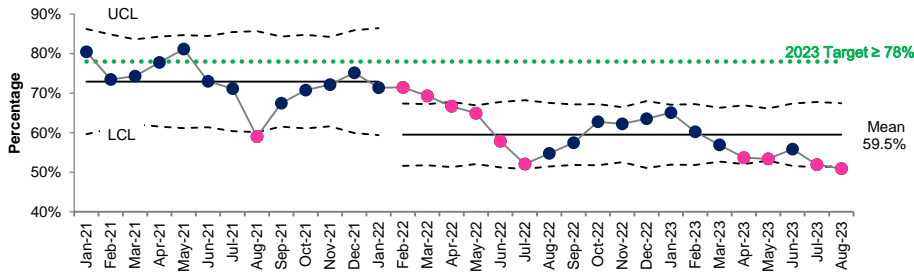
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

CAMHS: Percentage of accepted referrals / re-referrals offered first appointment and seen within 12 weeks

Desired Direction

Person-centred

National Rate

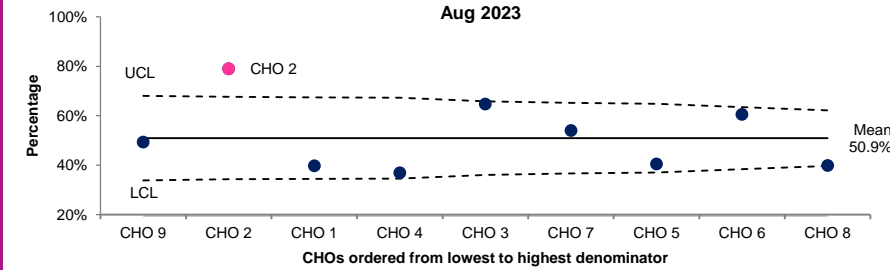


Statistical analysis:
Average national performance is below the 2023 target. There have been signals of disimprovement since Feb-22. The statistical process control limits were recalculated to reflect the new average. In addition the rates for Apr-23, May-23, Jul-23 and Aug-23 show a signal of disimprovement. There were 974 CAMHS appointments in Aug-23 (seen & DNA), of whom 496 were seen within 12 weeks.



NEW DATA

Latest data available: August 2023



Statistical analysis funnel plot:
The SPC funnel plot for Aug-23 shows that the rate for CHO2 (79%) is higher (better) than expected. All other CHOs were within the expected range of variation.

Service analysis (updated 25/09/2023):

Every effort is made to prioritise urgent cases so that the referrals of young people with high risk presentations are addressed as soon as possible and this is often within 24 to 48 hours. The severity of presenting symptoms as well as an assessment of risk is always taken into account in terms of waiting times.

The prioritisation of urgent cases, may impact on wait times for cases that are considered, by a clinician, to be less severe or a lower risk. CAMHS teams meet weekly to review all referrals and to assess the risk to any children and young people on their caseload.

In August year to date, 56% referrals were offered an appointment and seen within 12 weeks against a target of 78%. CHO 3 is currently at 75.8% compared to CHO 5 (40.6%) followed by CHO 4 (45.4%).

All other CHO's have not achieved the target CHO 1 (50.5%), CHO 2 (73.3%), CHO 6 (56.2%), CHO 7 (64.3%), CHO 8 (56.7%) and CHO 9 (54.5%).

There are ongoing issues with retention of CAMHS staff, also there has been an increase in urgent/complex presentations to CAMHS. The response to these urgent presentations has affected the ability to respond to lower complex presentations within the time frame.

94% of urgent referrals to CAMHS were responded to within three working days, above the ≥90% target. (MH73).

91.7% of new or re-referred cases were seen within 12 months in community CAMHS services YTD August 2023 (MH72).



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



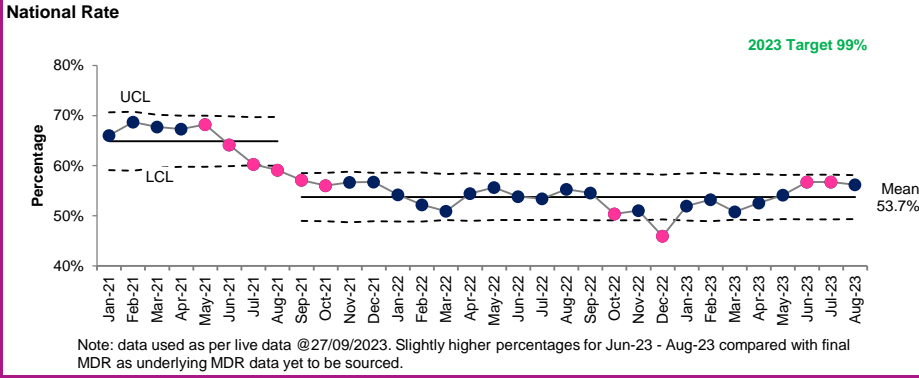
Indicates a new measure this month

Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 9 hours

Desired Direction

Person-centred



Statistical analysis:

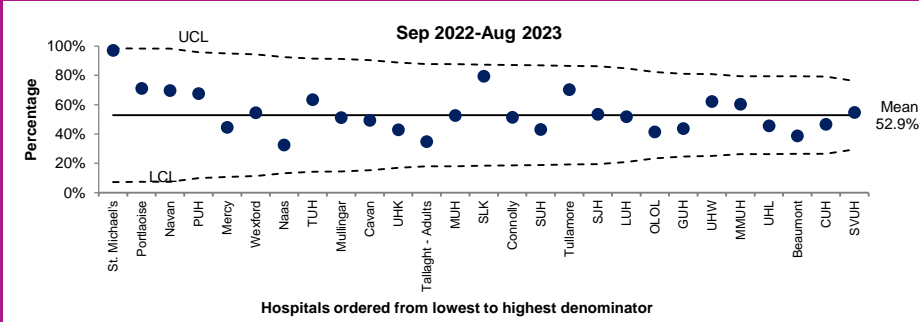
Average national performance is below target and relatively stable following disimprovements since May-21. The control limits have been recalculated to reflect this. In addition the rates for Oct-22 and Dec-22 showed a signal of disimprovement while the rates for Jun-23 and Jul-23 showed a signal of improvement.



Aug-23: 18,371 people 75+ years presented to ED, of whom 10,323 were discharged or admitted within 9 hours.



Latest data available: August 2023



Statistical analysis funnel plot:

The SPC funnel plot shows the range of variation among hospitals. All hospitals are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by hospital, but there are no statistical differences between hospitals with higher or lower rates.

Service analysis (updated 27/09/2023):

At end of August 2023, 56% of patients aged over 75 years were admitted/discharged within 9 hours. There are many reasons that result in longer waittimes such as volume of patients presenting to the Emergency Department and the requirement to prioritise, treat and care for the sickest and older cohort of patients and those with life threatening illnesses. This can mean that patients with less serious illnesses and conditions may need to wait longer for their treatment.

All hospital groups received communication from Acute Operations reminding of the zero tolerance for over 75s in ED. The Targets are also reviewed at monthly performance and access meetings.

The patient experience can include multiple steps such as: triage (the first nursing assessment of how urgent the patient's presenting condition is), registration, nursing assessment, consultant/registrar (or nurse practitioner) assessment, consultations, investigations (tests), treatments, and decisions to admit patients. Delays in any one of these events or services will increase a patient's wait time, and can create bottlenecks in the Emergency Department. Emergency Department wait times are also affected by events outside of the hospital Emergency Department, in both the hospital and the community. This includes such things as the availability of inpatient beds within acute hospitals for acute admissions, the availability of community beds and or home care support for those patients in acute settings who are medically fit for transfer or discharge to the community. These factors in turn slow down the transfer of patients from the ED.

The HSE Urgent and Emergency Care Plan which recognises the year round UEC pressures experienced in our hospitals. In order to support the management and delivery of UEC until year-end 2023, a UEC Operational Plan is being developed. The purpose of this UEC Operational Plan is to identify short-term initiatives and measures to be progressed to support UEC delivery until year end. This operational plan will lead into year one of the multi-annual UEC plan and will align with the governance structure of the overarching multi-annual UEC plan with key focus on 24 hour PET, 24 hour PET > 75, 8am trolley count, DTOC and NAS Turnaround times and Length of Stay.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

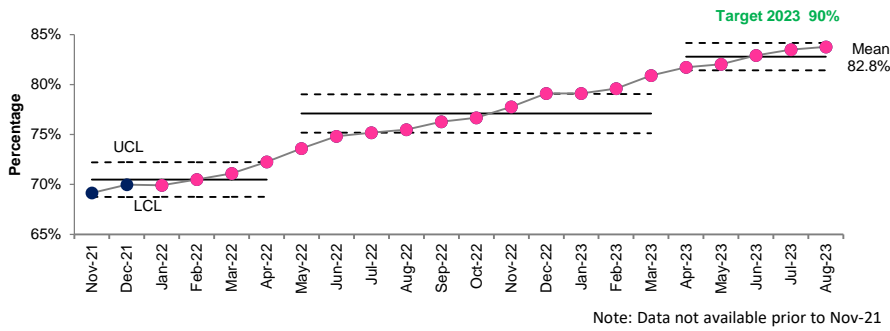
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Percentage of people waiting <15 months for first access to OPD services

Desired Direction

Timely

National Rate



Statistical analysis:
Average national performance is below 2023 target but there are signals of improvement for the past 20 months. The control limits have been recalculated to reflect the new average.



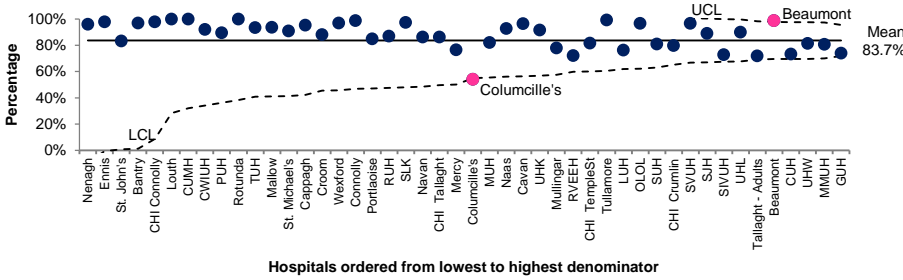
Aug-23: there were 600,819 people waiting for first access to OPD services, of whom 503,346 were waiting less than 15 months.



Latest data available: August 2023

Note: Data not available prior to Nov-21

Aug 2023



Statistical analysis funnel plot:
The SPC funnel plot for last month shows the range of variation in the rates by hospital. All hospitals are within the control limits, with the exception of Beaumont (99%) which is higher (better) than expected relative to the national average and Columcille's (54%) which is lower than expected.

Service analysis (updated 27/09/2023):

At the end of August 83.8% of patients on the outpatient waiting list were waiting less than 15 months, showing an improvement since July 2023 which was at 83.5%. The volume of patients waiting over 15 months in August 97,473 which has reduced since July 2023 where the volume was 99,222 a reduction of 1749 when compared to last month.

The 2023 Waiting List Action Plan sets out the ongoing priorities to continue to address waiting lists this year and build on the progress that has been made over the past 18 months. It is an ambitious plan targeting significant additional activity to reduce waiting lists in line with Sláintecare reforms and the Government has allocated €443 million to the plan this year.

The plan forms a part of an ongoing multi-annual approach to reduce waiting with a range of approaches including, additional activity funded by both once off and recurrent funding, chronological scheduling, capacity and demand analysis to support optimisation of resource utilisation. The plan is supported by, NTPF commissioning and HSE/NTPF validation. Activity and funding in this context is being targeted at longest waiting patient's to support overall wait time reductions.

Focused access meetings are taking place on a monthly basis with Hospital Groups in addition to the monthly Hospital Group Performance meetings and weekly engagement with Hospital Groups and sites in place to maximise waiting list improvements.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

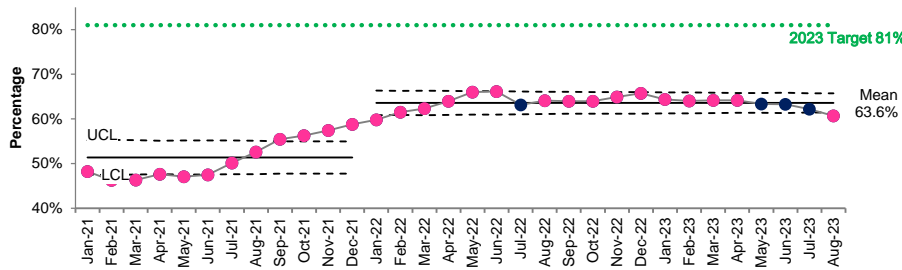
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

PRIMARY CARE: Percentage of psychology patients on waiting list for treatment ≤ 52 weeks

Desired Direction

Timely

National Rate



Statistical analysis:

Average national performance is below the target. There are ongoing signals of improvement since Jun-21. The control limits have been recalculated to reflect the current mean. The trend of improvement appears to have stopped since Mar-23.

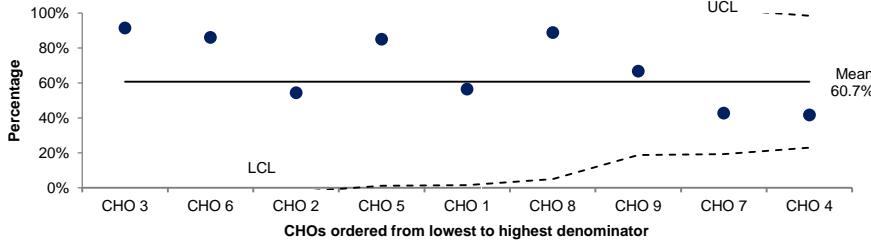


Aug-23: 19,853 people were on the waiting list for Primary Care Psychology treatment, of whom 12,052 were waiting less than 52 weeks.



Latest data available: August 2023

Aug 2023



Statistical analysis funnel plot:

The SPC funnel plot for the last month shows the range of variation among CHOs. All CHOs are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by CHO, but there are no statistical differences between CHOs with higher or lower rates.

Service analysis (updated 25/09/2023):

60.72% are waiting for treatment ≤ 52 weeks at the end of August 2023, compared to the target of 81% (PC103G).

The number of Psychology patients on waiting list for treatment ≤ 52 weeks will require an additional 4,029 people to be seen to reach the target of 81%

The number of people waiting longer than 52 weeks has increased by +5.3% from 7,410 in July to 7,801 in August (PC103E).

2,119 children and young people have been removed from the waiting list from January to August 2023 as a result of the WLAP waiting list initiatives referred to earlier in this commentary.

Numbers of referrals to date is 12,304 which represents an increase of +75.4% in expected activity (7,016) and +11.5% ahead of the same period last year (11,039) (PC38)

The number of new patients seen for first time at the end of August 2023 is 8,726 which is +34.5% ahead of same period last year position of 6,490 (PC40) CHOs 1,2,4,6 and 7 are over 10% of achieving this year's target for access

Note on Primary Care Services

Primary Care Services have been impacted by Covid waves over previous years with staff absence impacting on performance. Additionally, Primary Care has a key role in the Ukrainian response. This has inevitably impacted the delivery of Primary Care services to KPI targets.

One of the factors impacting on numbers of patients seen is the complexity of cases presenting.

Many patients require a multi-disciplinary approach and in a number of cases ongoing treatment is required for a prolonged period of time. Another significant factor impacting access performance is the increase in numbers of referrals across all therapy services which will also impact on numbers waiting. This increase in the number of referrals August result in longer waiting times as patients are clinically prioritised.

As indicated the performance metrics need to be read in the context of staff delivering front line services within the foregoing constraints. The challenges detailed above relate to all the services reported below. Overall, there was 98.8% return rate for data across Primary Care Services in August.

The underlying trend in numbers seen by Primary Care Therapy Services continues to improve. At August 2023 the total number of patients seen is +8.9% ahead of the same period in 2022.

Performance is discussed in the individual monthly engagements between the national Head of Operations for Primary Care with the CHO Heads of Service Primary Care. An increasing focus for these discussions are measures for increased productivity in terms of numbers seen per WTE relative to national averages for each service.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

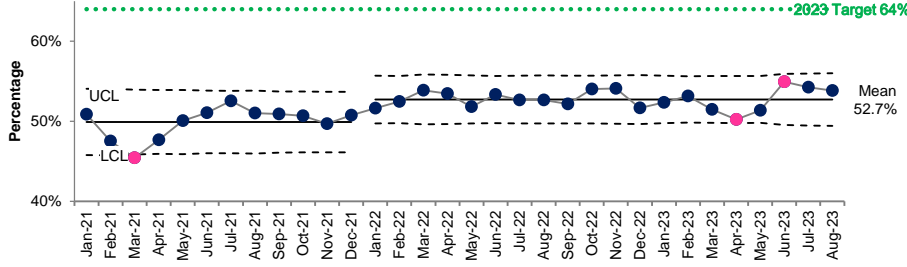
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

PRIMARY CARE: Percentage of ophthalmology patients on waiting list for treatment ≤52 weeks

Desired Direction

Timely

National Rate



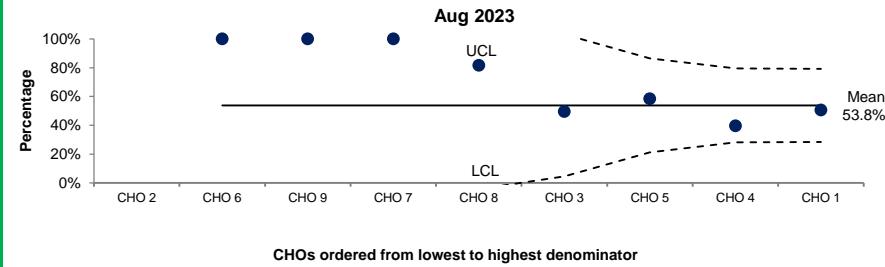
Statistical analysis:
Average national performance is below the target. There were signals of improvement since Jan-22. The SPC limits were recalculated to reflect the new average. The two recent signals of disimprovement Apr-23 and improvement in June-23 show increased variation.



Aug-23: 18,331 people were on the waiting list for Primary Care Ophthalmology treatment, of whom 9,867 were waiting less than 52 weeks.



Latest data available: August 2023



Statistical analysis funnel plot:
The SPC funnel plot for the last month shows the range of variation among CHOs. All CHOs are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by CHO, but there are no statistical differences between CHOs with higher or lower rates.

Service analysis (updated 25/09/2023):

53.8% are waiting for treatment ≤ 52 weeks at the end of August 2023, compared to the target of 64% (PC107G).

The number of Ophthalmology patients on waiting list for treatment ≤ 52 weeks will require an additional 1,865 people to be seen to reach the target of 64%. The number of people waiting longer than 52 weeks has decreased by -0.8% from 8,533 in July to 8,464 in August (PC107E).

Numbers of referrals to date is 17,524 which represents an increase of +7.7% in expected activity (16,272) and +6.0% ahead of the same period last year (16,534) (PC52)

The number of new patients seen for first time assessment at the end of August 2023 is 18,495 which is +30.2% ahead of same period last year position of 14,209 (PC54)

CHOs 2 and 3 are over 10% of achieving this year's target for access.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

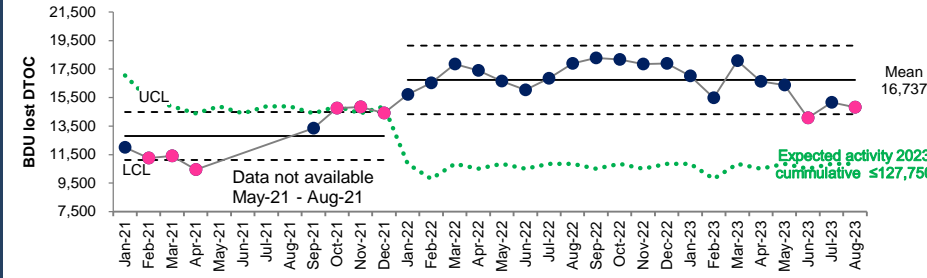
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

ACUTES: Number of acute bed days lost through delayed transfers of care

Desired Direction

Efficient

National Data



Statistical analysis:
Average national performance is above the target.

The annual cumulative target is distributed as monthly values and varies due to the number of days in each month. Additionally there are signals of improvement in Jun-23 and Aug-23.



Aug-23: 14,815 acute bed days were lost through delayed transfers of care. As of end of Aug-23 there were 501 beds subject to Delayed Transfer of Care.



Latest data available: August 2023

Note: As this indicator does not have a denominator, it is not possible to produce a funnel plot.

Service analysis (27/09/2023):

A person is ready for discharge or transfer from hospital after being in receipt of inpatient hospital care, when:

- A clinical decision has been agreed with the patient that they are ready for discharge to their home and/ or transfer to a post-acute hospital setting AND
- The post-acute hospital care pathway has been agreed with the patient, those important to them and the multidisciplinary team.

End August 2023 performance showed that 501 Delayed Transfers of Care / 14,815 Bed Days Lost were reported in acute hospitals. Monthly average DTOCs continue on a downward trajectory.

The National Delayed Transfer of Care (DTOC) Project, commissioned by the CEO and led by Community Operations in response to the continuing high levels of DTOC across acute hospitals / CHO areas and the sustained high urgent and emergency care pressures, is underway and nearing completion of the first phase of the initial site visits to the seven hospitals/aligned CHOs with the highest DTOCs / BDL:

1. Tallaght University Hospital
2. St. James's Hospital
3. Mater Misericordiae University Hospital
4. Cork University Hospital
5. Mercy University Hospital
6. St. Vincent's University Hospital
7. Galway University Hospital

Key strategic objectives of this project include the alignment of all hospital based and community based DTOC services to deliver joined up, integrated patient care as outlined in the HSE Regional Health Areas (RHA) Programme and delivery of the DTOC target set in the UEC Operational Plan 2023 of no greater than 440 patients listed by year end.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

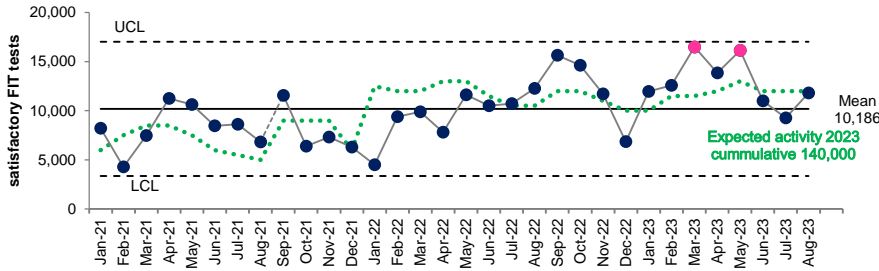
Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

NSP: No. of clients who have completed a satisfactory BowelScreen FIT test

Desired Direction

Wellbeing

National Rate



Statistical analysis:
The values for 10 of the last 13 months were on or above the target. Additionally, there are signals of improvement in Mar-23 and May-23. The monthly targets are included as per metadata specifications.



Aug-23: there were 11,807 people screened by the BowelScreen programme who have completed a satisfactory FIT test.



Latest data available: August 2023

Note: As this indicator does not have a denominator, it is not possible to produce a funnel plot.

Service analysis (updated 27/09/2023):

Eligible BowelScreen clients are aged 60-69 years and the screening round is a 2 year duration. The eligible population is invited over that a 2-year period (approximately 500,000 people). The primary screening test is the faecal immunochemical test (FIT).

The number of people who return a FIT is a surrogate indicator of uptake and allows for the calculation of the number of people who will require a follow up colonoscopy (approximately 5% of returned FIT kits). This in turn informs the level of colonoscopy provision required for the BowelScreen programme.

The number of men and women who have completed a satisfactory BowelScreen FIT test in the period (July 2023) was 9,278 which is below the target of 12,000 by 2,722 (22.7%). The number of men and women who have completed a satisfactory BowelScreen FIT test year to date (Jan-July 2023) was 91,301 which is above the target of 82,000 by 9,301 (11.3%).

BowelScreen monitors colonoscopy capacity; invitations to participate are issued based on maximising available capacity.

The BowelScreen Patient Reported Experience Measures (PREMs) programme currently has:- An overall response rate (Jan-Jun) of 40% - Response rate amongst FIT positive participants (i.e., had a colonoscopy) was 47%. Eighty-nine percent (90%) of respondents rated BowelScreen as 'good' or 'very good' - Participants reported high levels of satisfaction with the programme achieving a net promoter score (NPS) of 70.7% for the period Jan-July 2023, a score considered exceptional by international standards.



Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.



Indicates updated data for this measure this month



Indicates no updated data available for this measure this month



Indicates a new measure this month

Note: Special cause variation in the statistical process control (SPC) charts is highlighted using pink data points

HSE Board S&Q Committee: Quality and Safety Profile Discussion Prompts

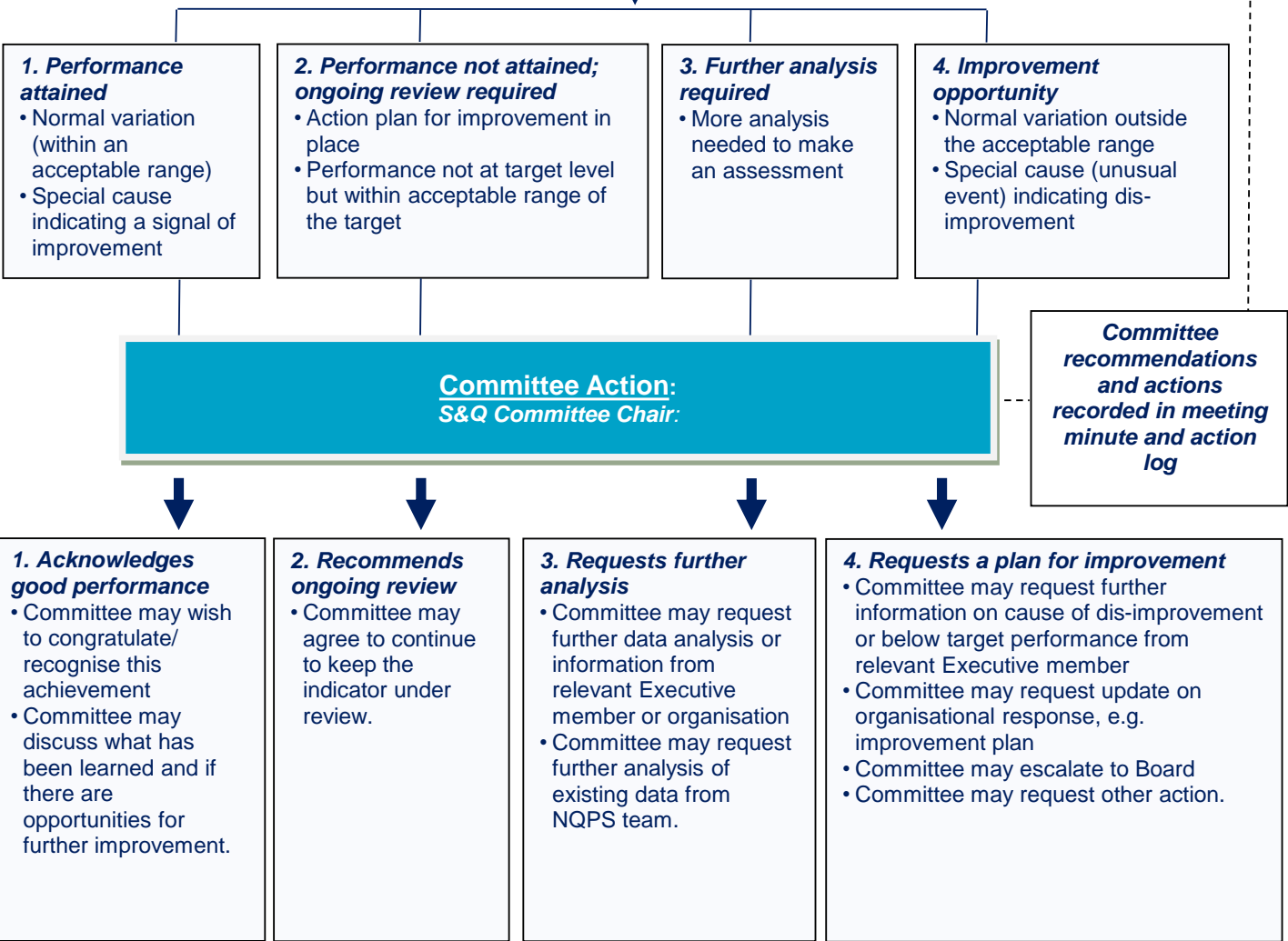
Receipt of HSE Quality and Safety Profile:
S&Q Committee members receive documents from Chief Clinical Officer (CCO)

At the S&Q Committee meeting the steps below are used by the committee members to discuss the Quality Profile

Committee Discussion:
CCO/ NQPS CD facilitates discussion on each indicator presented in the quality profile.

- What does the indicator show?
- Are there internal or external factors impacting the indicator?

Committee Assessment:
Committee members collectively make an assessment based on the information presented and their discussion



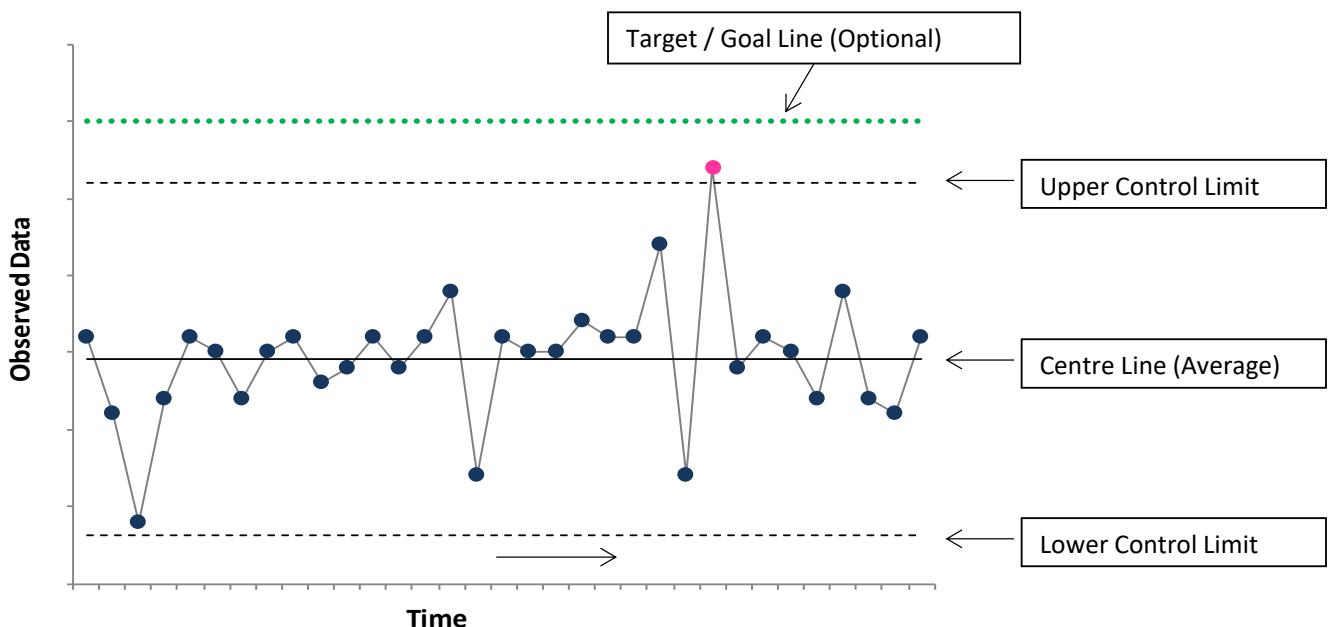
Anatomy of a Statistical Process Control Chart

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.

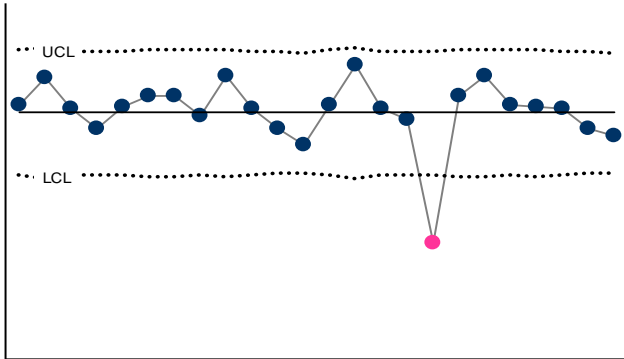


References

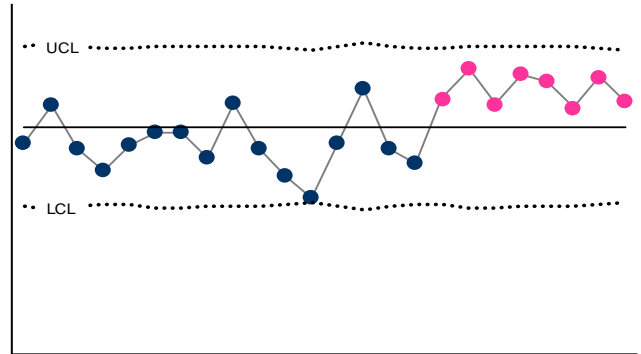
Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011

Rules for detecting special cause variation using statistical process control charts

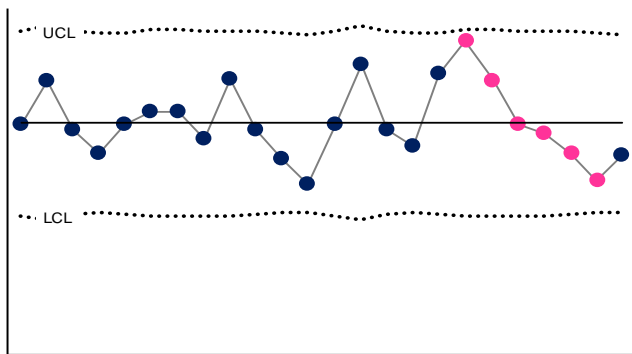
1. A single point outside the control limits (this doesn't include points exactly on the limit)



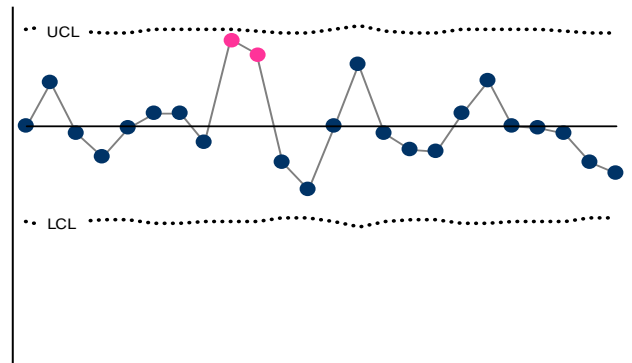
2. A run of 8 or more consecutive points above or below the centre line



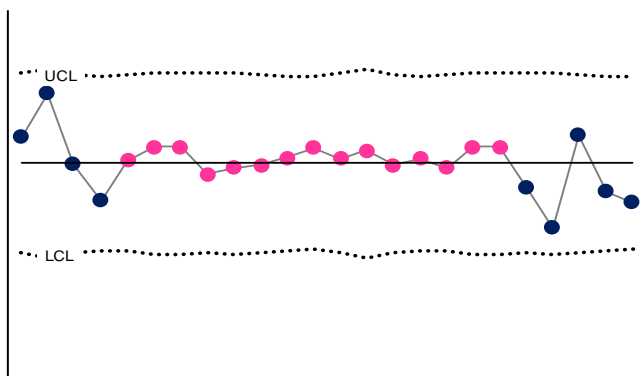
3. A trend of at least 6 consecutive points all going up or down



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)

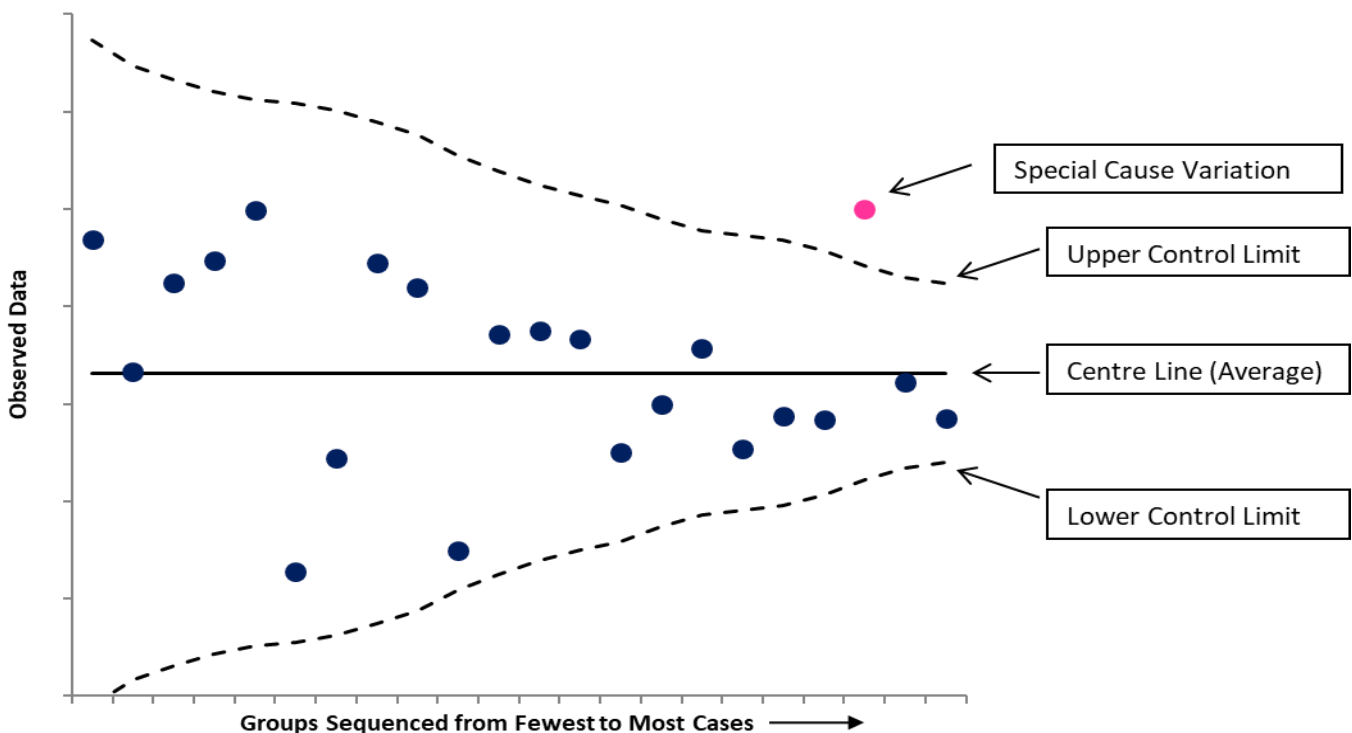


Anatomy of a Statistical Process Control Funnel Plot

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.

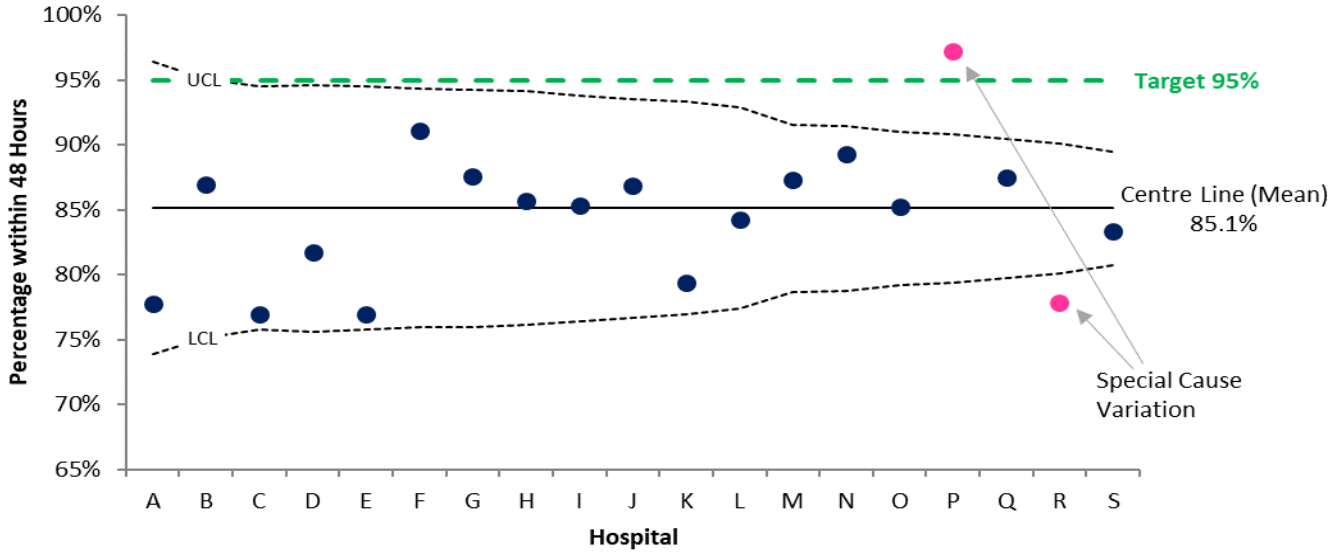
The control limits are based on the variation in the observed data. The control limits reflect the expected range of variation within the data, and do not reflect the desired range of variation in terms of quality of care. The probability of any data point falling outside of the control limits by chance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



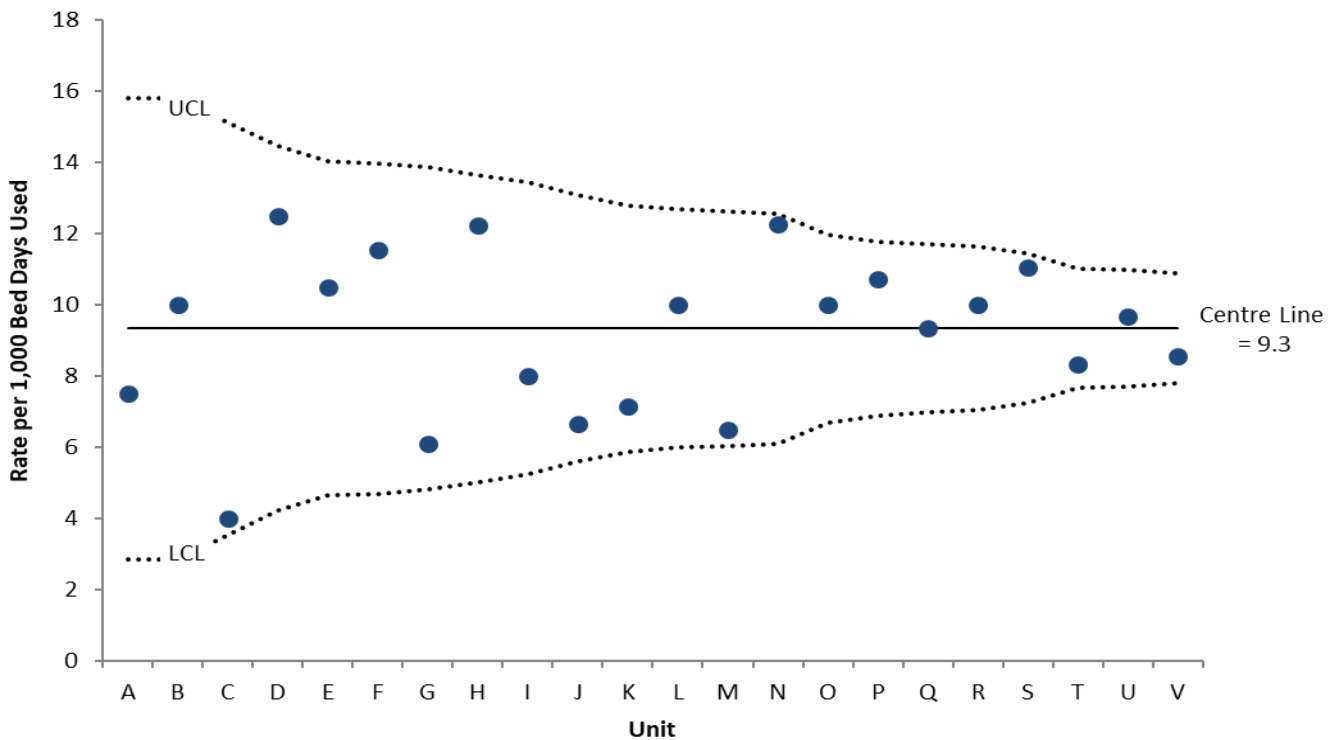
References

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

Example 1: Percentage of patients with a hip fracture undergoing surgery within 48 hours, by hospital



Example 2: Rate of falls per 1,000 bed days, by community nursing units



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

Safe

Calculation	Numerator: Number of new cases of hospital acquired S. aureus bloodstream infection. Denominator: Number of bed days used Rate is calculated as the numerator/denominator*10,000.
Details of analysis	National level data are displayed in an SPC U chart since January 2021
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	Indicator not included in this Quality and Safety Profile.
Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

AMRIC: Rate of new cases of hospital associated C. difficile infection per 10,000 bed days used

Safe

Calculation	Numerator: Number of new cases of hospital associated C. difficile infection. Denominator: Number of bed days used Rate is calculated as the numerator/denominator*10,000.
Details of analysis	National level data are displayed in an SPC U chart since January 2021
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

AMRIC: Number of patients confirmed with newly detected CPE

Safe

Calculation	Numerator: Number of patients confirmed with newly detected CPE.
Details of analysis	National level data are displayed in an SPC C chart since January 2021
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	Indicator not included in this Quality and Safety Profile.
Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

ACUTES: No. of new people waiting > four weeks for access to an urgent colonoscopy

Safe

Calculation	Count: Number of New patients waiting greater than 28 days for an Urgent Colonoscopy
Details of analysis	National level data are displayed in an SPC I chart since January 2021.
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

System wide: Percentage of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident

Safe

Calculation	Numerator: Number of incidents included in Denominator where the review was completed in no more than 125 calendar days. Denominator: Number of Category 1 Incidents involving service users, where a decision that 'further review is not necessary' was not made that were notified between last day of reporting month-125days and 12 months prior
Details of analysis	National level data are displayed in an SPC P chart since January 2021.
Data source	NIMS KPIs report
Data frequency	Monthly
Data coverage	Indicator not included in current Quality and Safety Profile.
Further information	https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/

ACUTES: Rate of defined and suspected venous thromboembolism (VTE, blood clots) associated with hospitalisation

Safe	Calculation	Numerator: Number of adult in-patient discharges with a length of stay of 2 or more days with an additional diagnosis of VTE. Denominator: Number of adult in-patient discharges with a length of stay of 2 or more days Rate is calculated as the numerator/denominator*1,000.
	Details of analysis	National level data are displayed in an SPC U chart since January 2021
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	Indicator not included in this Quality and Safety Profile.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

ACUTES: Rate of medication incidents as reported to NIMS per 1,000 bed days

Safe	Calculation	Numerator: number of medication-related incidents as reported on NIMS Denominator: number of in-patient bed days Rate is calculated as the numerator/denominator*1,000.
	Details of analysis	National level data are displayed in an SPC U Prime chart since January 2021
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

ACUTES: Percentage of maternity hospitals / units that have completed and published monthly Maternity Safety Statements

Safe	Calculation	% maternity hospitals that completed and published MSS = number of maternity hospitals that completed and published MSS/ total number of maternity hospitals
	Details of analysis	National level data are displayed in an SPC I chart since January 2021.
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

System wide: Extreme and major incidents as a percentage of all incidents reported as occurring

Safe	Calculation	Numerator: Number of Category 1 incidents that occurred in the reporting period. Denominator: Number of incidents that occurred in the reporting period
	Details of analysis	National level data are displayed in an SPC P chart since Q1 2018.
	Data source	NIMS KPIs reports from Jan 2022. For 2018-2021 data was re-calculated from NIMS system using same methodology as reports issued from 2022 to ensure a consistent approach.
	Data frequency	Quarterly
	Data coverage	Indicator not included in current Quality and Safety Profile.
	Further information	https://www.hse.ie/eng/about/who/nqpsd/gps-incident-management/nims/

ACUTES: Percentage of surgical re-admissions to the same hospital within 30 days of discharge

Effective	Calculation	Numerator: Number of Surgical discharges (inpatient & daycase) in the denominator period which resulted in an emergency readmission to the same hospital within 30 days Denominator: Number of Surgical discharges (elective and emergency) in the denominator period (denominator period is set 30 days in arrears)
	Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021.
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

CAMHS: Percentage of accepted referrals / re-referrals offered first appointment and seen within 12 weeks

Person-centred	Calculation	Numerator: Number of new / re-referred cases offered an urgent or routine appointment and seen up to 13 weeks Denominator: Total number offered an appointment, seen and DNA
	Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021.
	Data source	Community Healthcare Metric Report – QlikView
	Data frequency	Monthly
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/2023-mental-health-services-nsp-metadata.pdf

ACUTES: Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 9 hours

Person-centred	Calculation	Numerator - All ED patients aged >75 years of age, who are admitted to a ward or discharged in less than 9 hours from their Arrival Time. Denominator - All patient attendances at ED who are aged over 75 years of age who are admitted or discharged
	Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021.
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	No known current data coverage issues
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

ACUTES: Percentage of people waiting <15 months for first access to OPD services

Timely	Calculation	Numerator: Number of outpatient patients waiting to be seen less than 15 months Denominator: Total number of patients waiting to be seen in Outpatients
	Details of analysis	National level data are displayed in an SPC P Prime chart since November 2021
	Data source	Acute Management Data Report
	Data frequency	Monthly
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

ACUTES: Percentage of hip fracture surgery carried out within 48 hours of initial assessment

Timely	Calculation	Numerator: The number of inpatient discharges aged over 60 in the reporting period where emergency hip fracture surgery was carried out within 48 hours of initial assessment. Denominator: The number of inpatient discharges aged over 60 in the reporting period where emergency hip fracture surgery was carried out.
	Details of analysis	National level data are displayed in an SPC P chart since Quarter 1 2016.
	Data source	Irish Hip Fracture Database (IHFD)
	Data frequency	Quarterly in arrears
	Data coverage	Indicator not included in current Quality and Safety Profile.
	Further information	https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf

PRIMARY CARE: Percentage of psychology patients on waiting list for treatment ≤ 52 weeks

Timely	Calculation	Numerator: Number of new psychology patients in all age bands who are waiting ≤ 52 weeks to be seen by a psychologist (either in an individual or in a group environment). Denominator: Total number of psychology patients in all age bands waiting for these services.
	Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021
	Data source	Community Healthcare Metric Report – QlikView
	Data frequency	Monthly
	Data coverage	Data for Feb-23 - Aug-23 for LHO South Tipperary was outstanding at the time of production of the Quality and Safety Profile.
	Further information	https://www.hse.ie/eng/services/publications/kpis/2023-primary-care-services-nsp-metadata.pdf

PRIMARY CARE: Percentage of ophthalmology patients on waiting list for treatment ≤52 weeks

Timely

Calculation

Numerator: Number of ophthalmology patients in all age bands on the treatment waiting list for 0-52 weeks

Denominator: Total number of ophthalmology patients in all age bands on the treatment waiting list.

Details of analysis

National level data are displayed in an SPC P Prime chart since January 2021

Data source

Community Healthcare Metric Report – QlikView

Data frequency

Monthly

Data coverage

Data for Jun-23 - Aug-23 for LHO Galway and data for Jul-23 - Aug-23 for LHOs Mayo and Roscommon was outstanding at the time of production of the Quality and Safety Profile.

Further information

<https://www.hse.ie/eng/services/publications/kpis/2023-primary-care-services-nsp-metadata.pdf>

ACUTES: Number of acute bed days lost through delayed transfers of care

Efficient

Calculation

Count of bed days lost to patients who are Delayed transfer of care

Details of analysis

National level data are displayed in an SPC I chart since January 2021

Data source

Acute Management Data Report.

Data frequency

Monthly

Statistical analysis

Data coverage

No known current data coverage issues.

Further information

<https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf>

SOCIAL CARE: Disability Act Compliance: percentage of child assessments of need completed within the timelines

Equitable

Calculation

Numerator: The number of Assessments of Need completed within three months of their commencement or within a revised time frame negotiated as per the regulations.

Denominator: The total number of Assessments of Need completed.

Details of analysis

National level data are displayed in an SPC P chart since Quarter 1 2016.

Data source

Community Healthcare Metric Report – QlikView

Data frequency

Quarterly

Data coverage

Indicator not included in current Quality and Safety Profile.

Further information

<https://www.hse.ie/eng/services/publications/kpis/2023-disability-services-nsp-metadata.pdf>

NSP: No. of clients who have completed a satisfactory BowelScreen FIT test

Wellbeing

Calculation

Count of no. of clients screened by the BowelScreen programme who have completed a satisfactory FIT test in the reporting period. (FIT = faecal immunochemical test, which is a self-administered test carried out at home, satisfactory means that the kit was suitable for analysis)

Details of analysis

National level data are displayed in an SPC I Chart since January 2021

Data source

Acute Management Data Report.

Data frequency

Monthly in arrears

Data coverage

No known current data coverage issues.

Further information

<https://www.hse.ie/eng/services/publications/kpis/2023-national-screening-service-nsp-metadata.pdf>



Quality and Safety Profile Indicators Metadata

Hospitals abbreviations as per Corporate Reporting Guidelines

Hospital name	Abbreviation
Coombe Women and Infants University Hospital	CWIUH
MRH Portlaoise	Portlaoise
MRH Tullamore	Tullamore
Naas General Hospital	Naas
St. James's Hospital	SJH
St. Luke's Radiation Oncology Network	SLRON
Tallaght University Hospital	Tallaght - Adults
Mater Misericordiae University Hospital	MMUH
MRH Mullingar	Mullingar
National Maternity Hospital	NMH
National Orthopaedic Hospital Cappagh	Cappagh
National Rehabilitation Hospital	NRH
Our Lady's Hospital Navan	Navan
Royal Victoria Eye and Ear Hospital	RVEEH
St. Columcille's Hospital	Columcille's
St. Luke's General Hospital Kilkenny	SLK
St. Michael's Hospital	St. Michael's
St. Vincent's University Hospital	SVUH
Wexford General Hospital	Wexford
Beaumont Hospital	Beaumont
Cavan General Hospital	Cavan
Connolly Hospital	Connolly
Louth County Hospital	Louth
Monaghan Hospital	Monaghan
Our Lady of Lourdes Hospital	OLOL
Rotunda Hospital	Rotunda
Galway University Hospitals	GUH
Letterkenny University Hospital	LUH
Mayo University Hospital	MUH
Portlincula University Hospital	PUH
Roscommon University Hospital	RUH
Sligo University Hospital	SUH
Bantry General Hospital	Bantry
Cork University Hospital	CUH
Cork University Maternity Hospital	CUMH
Kilcreene Regional Orthopaedic Hospital	KROH
Mallow General Hospital	Mallow
Mercy University Hospital	Mercy
South Infirmary Victoria University Hospital	SIVUH
Tipperary University Hospital	TUH
UH Kerry	UHK
UH Waterford	UHW
Croom Orthopaedic Hospital	Croom
Ennis Hospital	Ennis
Nenagh Hospital	Nenagh
St. John's Hospital Limerick	St. John's
UH Limerick	UHL
UMH Limerick	LUMH
CHI at Connolly	CHI Connolly
CHI at Crumlin	CHI Crumlin
CHI at Tallaght	CHI Tallaght
CHI at Temple St	CHI TempleSt
CHI	CHI



Appendix 3: Underlying Data for the Quality and Safety Profile Indicators

Underlying data for	AMRIC: Hospital acquired new cases of S. aureus bloodstream infection per 10,000 bed days used																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator		37	16	38	28	25	26	31	34	40	29	31	25	37	24	29	29	31	37	35	39	24	31	30	30	21	30	26	28	28	28	29	26				
Denominator		270,429	256,331	295,004	292,577	297,214	299,319	313,540	310,761	310,513	323,153	313,350	307,477	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856	340,759	343,016				
Data point		1.4	0.6	1.3	1.0	0.8	0.9	1.0	1.1	1.3	0.9	1.0	0.8	1.2	0.8	0.9	0.9	1.0	1.2	1.1	1.2	0.7	0.9	0.9	0.6	1.0	0.7	0.8	0.8	0.8	0.9	0.8					

Numerator: new HA Staf Aureus cases // Denominator: Number of Bed Days Used // Data points: S. Aureus cases per 10,000 BDU

Underlying data for	AMRIC: Rate of new cases of hospital associated C. difficile infection per 10,000 bed days used																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator		56	55	56	57	56	54	73	62	58	61	71	69	76	64	49	66	65	69	81	70	67	81	86	62	80	60	81	65	71	72	76	59				
Denominator		270,429	256,331	295,004	292,577	297,214	299,319	313,540	310,761	310,513	323,153	313,350	307,477	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856	340,759	343,016				
Data point		2.1	2.1	1.9	1.9	1.9	1.8	2.3	2.0	1.9	1.9	2.3	2.2	2.4	2.2	1.5	2.1	2.0	2.2	2.5	2.1	2.1	2.4	2.6	1.8	2.3	1.9	2.3	2.0	2.2	2.2	1.7					

Numerator: new Ha C. difficile cases // Denominator: Number of Bed Days Used // Data points: S. Aureus cases per 10,000 BDU

Underlying data for	AMRIC: Number of patients confirmed with newly detected CPE																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Data point		42	37	40	44	29	37	82	85	77	81	65	63	54	56	51	69	53	64	95	100	83	102	75	70	84	57	64	81	64	88	99					

Count: Number of patients confirmed with newly detected CPE

Underlying data for	ACUTES: No. of new people waiting > four weeks for access to an urgent colonoscopy																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Data point		629	441	279	360			240	431	332	513	323	385	288	116	235	214	173	203	235	215	120	120	132	126	167	96	24	137	203	208	160	58				

Count: Number of New patients waiting greater than 28 days for an Urgent Colonoscopy

Underlying data for	System wide: Percentage of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator		16	18	17	20	10	16	14	7	12	20	18	13	18	19	17	14	15	22	15	18	11	17	18	22	22	18	22	16								
Denominator		110	48	38	34	23	25	29	30	39	34	37	22	33	36	34	41	37	35	33	38	35	40	50	52	48	38	48	40								
Data point		15%	38%	45%	59%	43%	64%	48%	23%	31%	59%	49%	59%	55%	53%	50%	34%	41%	63%	45%	47%	31%	43%	36%	42%	46%	47%	54%	40%								

Numerator: Number of incidents reviewed in ≤ 125 calendar days. // Denominator: Number of Category 1 patient safety incidents requiring review // Data points: % reviews completed in ≤ 125 days.

Underlying data for	ACUTES: Rate of defined and suspected venous thromboembolism (VTE, blood clots) associated with hospitalisation																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator		290	359	308	287	250	196	230	246	255	271	277	315	267	283	267	273	247	239	268	246	246	253	255	274	277	211	253	239	273	224						
Denominator		18,292	18,313	22,819	23,152	22,514	23,818	24,435	23,105	23,663	23,061	22,899	23,413	20,681	21,325	23,104	22,315	23,123	23,089	23,112	23,748	23,729	23,348	23,452	23,067	23,911	21,405	24,483	21,766	23,832	21,929						
Data point		15.85	19.60	13.50	12.40	11.10	8.23	9.41	10.65	10.78	11.75	12.10	13.45	12.91	13.27	11.56	12.23	10.68	10.35	11.60	10.36	10.37	10.84	10.87	11.88	11.58	9.86	10.33	10.98	11.46	10.21						

Numerator: Number of adult in-patient discharges (2days+) with a diagnosis of VTE. // Denominator: Number of adult in-patient discharges with a length of stay of 2 or more days // Data points: rate of VTE occurring during hospitalisation per 1,000 discharges.

Underlying data for	ACUTES: Rate of medication incidents as reported to NIMS per 1,000 bed days																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator		1378	1442	1118	947	926	1046	1166	1299	920	1276	876	702	834	857	892	868	1038	1072	935	894	885	883	929	772	989	915	1083	845	964	876						
Denominator		270,429	256,331	295,004	292,577	297,214	299,319	313,540	310,761	310,513	323,153	313,350	307,477	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856						
Data point		5.10	5.63	3.79	3.24	3.12	3.49	3.72	4.18	2.96	3.95	2.80	2.28	2.62	2.90	2.75	2.77	3.19	3.38	2.93	2.72	2.75	2.60	2.77	2.28	2.80	2.90	3.08	2.54	2.75	2.65						

Numerator: Number of medication-related incidents as reported on NIMS. // Denominator: Number of Bed Days Used // Data points: Rate of medication incidents reported per 1,000 BDU.

Underlying data for	ACUTES: Percentage of maternity hospitals / units that have completed and published monthly Maternity Safety Statements																																				
	SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Data point		89.5%	63.2%	26.3%	36.8%	21.1%	47.4%	52.6%	73.7%	89.5%	73.7%	84.2%	73.7%	89.5%	63.2%	84.2%	94.7%	89.5%	84.2%	78.9%	84.2%	52.6%	84.2%	63.2%	100.0%	89.5%	94.7%	94.7%	73.7%	94.7%	57.9%						

Data points: Percentage of maternity hospitals that have completed and published monthly Maternity Safety Statements = number of maternity hospitals that completed and published MSS/ total number of maternity hospitals

Underlying data for	System wide: Extreme and major incidents as a percentage of all incidents reported as occurring																																				
	SAFE	2018				2019				2020				2021				2022				2023				2024											
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
Numerator		222	228	222	241	249	237	228	234	288	427	206	285	403	212	254	263	236	215	206	438	445	215														
Denominator		39521	40813	39779	37482	37682	39569	39963	38579	41671	38259	40385	40984	45330	38260	41285	42740	53032	46807	46278	71996	81073	36690														
Data point		0.6%	0.6%	0.6%	0.6%	0.7%	0.6%	0.6%	0.6%	0.7%	1.1%	0.5%	0.7%	0.9%	0.6%	0.6%	0.6%	0.4%	0.5%	0.4%	0.6%	0.5%	0.6%														

Numerator: Number of Category 1 incidents // Denominator: Number of incidents that occurred in the reporting period // Data points: % of Category 1 incidents of total incidents occurring in the reporting period



Appendix 3: Underlying Data for the Quality and Safety Profile Indicators

Underlying data for	ACUTES: Percentage of surgical re-admissions to the same hospital within 30 days of discharge																																				
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Numerator	518	304	447	438	445	401	476	491	467	530	420	445	544	481	579	531	555	619	631	603	616	621	576	565	498	486	596	596	540	558	527						
Denominator	28,012	16,762	21,612	29,243	31,310	26,475	30,823	29,257	29,423	34,423	28,074	33,443	28,288	25,870	36,048	32,768	33,035	35,341	38,078	32,827	36,671	38,636	36,313	39,999	29,103	30,081	38,153	36,607	32,502	36,386	34,229						
Data point	1.8%	1.8%	2.1%	1.5%	1.4%	1.5%	1.5%	1.7%	1.6%	1.5%	1.5%	1.3%	1.9%	1.9%	1.6%	1.7%	1.8%	1.7%	1.8%	1.7%	1.6%	1.6%	1.6%	1.6%	1.7%	1.6%	1.4%	1.6%	1.7%	1.5%	1.5%						

Numerator: Number of surgical discharges (inpatient & daycase) which resulted in an emergency readmission to the same hospital within 30 days // Denominator: Number of surgical discharges (inpatient & daycase) // Data points: % emergency surgical readmissions

Underlying data for	CAMHS: Percentage of accepted referrals / re-referrals offered first appointment and seen within 12 weeks																																					
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23		
Numerator	738	844	1056	974	951	896	734	592	845	817	919	725	635	704	708	601	721	518	421	515	599	642	782	541	690	621	744	592	744	546	466	496						
Denominator	917	1,149	1,421	1,253	1,172	1,227	1,032	1,003	1,252	1,154	1,274	965	890	985	1,022	901	1,110	895	808	940	1,043	1,023	1,257	851	1,060	1,031	1,307	1,103	1,394	978	897	974						
Data point	80.5%	73.5%	74.3%	77.7%	81.1%	73.0%	71.1%	59.0%	67.5%	70.8%	72.1%	75.1%	71.3%	71.5%	69.3%	66.7%	65.0%	57.9%	52.1%	54.8%	57.4%	62.8%	62.2%	63.6%	65.1%	60.2%	56.9%	53.7%	53.4%	55.8%	52.0%	50.9%						

Numerator: Number of new / re-referred cases offered an urgent or routine appointment and seen up to 13 weeks // Denominator: Total number offered an appointment, seen and DNA // Data points: % accepted ref/ re-ref offered first appointment and seen <12weeks

Underlying data for	ACUTES: Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 9 hours																																					
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23		
Numerator	7451	7444	9210	9746	9918	9692	9874	9309	8775	8381	7825	8646	8049	7592	8552	8496	9405	9042	8933	9426	8934	8272	8322	8170	8148	8046	8837	8826	9754	9972	10100	10323						
Denominator	11,283	10,834	13,602	14,476	14,540	15,102	16,375	15,749	15,363	14,954	13,796	15,230	14,851	14,548	16,799	15,608	16,889	16,801	16,731	17,047	16,370	16,426	16,305	17,789	15,677	15,113	17,398	16,800	18,021	17,574	17,800	18,371						
Data point	66.0%	68.7%	67.7%	67.3%	68.2%	64.2%	60.3%	59.1%	57.1%	56.0%	56.7%	56.8%	54.2%	52.2%	50.9%	54.4%	55.7%	53.8%	53.4%	55.3%	54.6%	50.4%	51.0%	45.9%	52.0%	53.2%	50.8%	52.5%	54.1%	56.7%	56.7%	56.2%						

Numerator: All ED patients aged >= In Jun-23 there were 0 defined and suspected VTE blood clots associated with hospitalisation.

Underlying data for	ACUTES: Percentage of people waiting <15 months for first access to opd15m services																																					
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23												
Numerator	440,280	432,163	437,392	441,730	444,502	451,509	459,628	466,897	472,046	475,149	477,239	470,888	468,858	462,604	466,559	474,585	481,313	487,245	492,974	496,041	501,918	503,346																
Denominator	636,695	617,448	625,513	626,658	625,056	624,773	624,444	623,903	627,856	629,447	625,673	614,225	602,832	584,626	589,670	596,099	594,858	596,265	600,888	598,228	601,140	600,819																
Data point	69.2%	70.0%	69.9%	70.5%	71.1%	72.3%	73.6%	74.8%	75.2%	75.5%	76.3%	76.7%	77.8%	79.1%	79.1%	79.6%	80.9%	81.7%	82.0%	82.9%	83.5%	83.8%																

Numerator: Number of outpatient patients waiting to be seen less than 18 months // Denominator: Total WL OPD // Data points: % people waiting <15 months for OPD

Underlying data for	ACUTES: Percentage of hip fracture surgery carried out within 48 hours of initial assessment																																				
	2016				2017				2018				2019				2020				2021				2022				2023								
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Numerator	599	547	489	557	584	540	583	607	649	677	589	646	641	614	644	638	781	568	522	627	771	628	647	723	706	756	652	648	704								
Denominator	756	721	765	787	804	802	858	872	900	906	861	887	828	816	840	849	1019	738	737	863	944	835	915	945	906	1015	908	894	918								
Data point	79.2%	75.9%	63.9%	70.8%	72.6%	67.3%	67.9%	69.6%	72.1%	74.7%	68.4%	72.8%	77.4%	75.2%	76.7%	75.1%	76.6%	77.0%	70.8%	72.7%	81.7%	75.2%	70.7%	76.5%	77.9%	74.5%	71.8%	72.5%	76.7%								

Numerator: I/P disch.s >60 years where emergency hip fr. surgery within 48h of initial assessment // Denominator: I/P disch > 60y with emergency hip fracture surgery // Data points: % his surgery <48h initial assessment

Underlying data for	PRIMARY CARE: Percentage of psychology patients on waiting list for treatment <= 52 weeks																																					
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23		
Numerator	5,272	4,829	5,007	5,465	5,156	5,293	5,622	6,061	6,718	6,937	6,996	7,336	7,442	7,707	7,752	8,145	9,000	9,035	9,041	9,630	9,856	9,931	10,476	10,546	10,596	10,879	11,465	11,955	12,093	11,469	12,206	12,052						
Denominator	10,931	10,441	10,814	11,473	10,955	11,143	11,216	11,526	12,119	12,324	12,178	12,477	12,446	12,524	12,433	12,732	13,638	13,656	14,323	15,015	15,410	15,530	16,130	16,047	16,462	16,986	17,865	18,622	19,078	18,116	19,616	19,853						
Data point	48.2%	46.3%	46.3%	47.6%	47.1%	47.5%	50.1%	52.6%	55.4%	56.3%	57.4%	58.8%	59.8%	61.5%	62.4%	64.0%	66.0%	66.2%	63.1%	64.1%	64.0%	63.9%	64.9%	65.7%	64.4%	64.0%	64.2%	64.2%	63.4%	63.3%	62.2%	60.7%						

Numerator: Number of new psychology patients waiting <= 52 weeks to be seen by a psychologist // Denominator: Total number of psychology patients // Data points: % psychology patients waiting <= 52 weeks

Underlying data for	PRIMARY CARE: Percentage of ophthalmology patients on waiting list for treatment <= 52 weeks																																					
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23		
Numerator	9,550	8,876	8,998	9,685	10,102	10,740	11,216	10,614	11,296	11,399	11,283	11,455	11,495	11,940	11,012	11,083	11,339	12,102	11,655	11,539	11,565	11,944	11,713	10,850	11,788	12,618	11,922	11,504	11,863	10,683	10,117	9,867						
Denominator	18,778	18,675	19,811	20,309	20,169	21,030	21,352	20,809	22,197	22,485	22,707	22,574	22,265	22,763	20,437	20,736	21,882	22,686	22,135	21,917	22,169	22,118	21,657	21,006	22,520	23,746	23,161	22,899	23,103	19,447	18,650	18,331						
Data point	50.9%	47.5%	45.4%	47.7%	50.1%	51.1%	52.5%	51.0%	50.9%	50.7%	49.7%	50.7%	51.6%	52.5%	53.9%	53.4%	51.8%	53.3%	52.7%	52.6%	52.2%	54.0%	54.1%	51.7%	52.3%	53.1%	53.3%	50.2%	51.3%	54.9%	54.2%	53.8%						

Numerator: Number of ophthalmology patients waiting for 0-52 weeks // Denominator: Total number of ophthalmology patients on waiting list // Data points: % of community ophthalmology patients waiting <=52 weeks

Underlying data for	ACUTES: Number of acute bed days lost through delayed transfers of care																																					
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23		
Data point	11,999	11,246	11,401	10,444					13,344	14,747	14,841	14,410	15,717	16,529	17,845	17,394	16,649	16,027	16,847	17,900	18,280	18,175	17,838	17,895	17,015	15,487	18,086	16,627	16,383	14,064	15,165	14,815						

Data points: Number of acute bed days lost through delayed transfers of care

Underlying data for	SOCIAL CARE: Disability Act Compliance: percentage of child assessments of need completed within the timelines																																					
	2016				2017				2018				2019				2020				2021				2022				2023									
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4						
Numerator	157	156	261	169	194	210	392	119	111	97	83	83	51	98	108	68	60	87	50	125	386	207	320	311	354	132	133	133	104	120								
Denominator	800	791	845	672	690	875	1,116	937	983	1,078	1,199	1,232	833	923	785	771	848	770	666	1,627	2,693	1,268	2,243	2,149	1,719	455	447	560	874									
Data point	19.6%	19.7%	30.9%	25.1%	28.1%	24.0%	35.1%	12.7%	11.3%	9.0%	6.9%	8.1%	6.1%	10																								