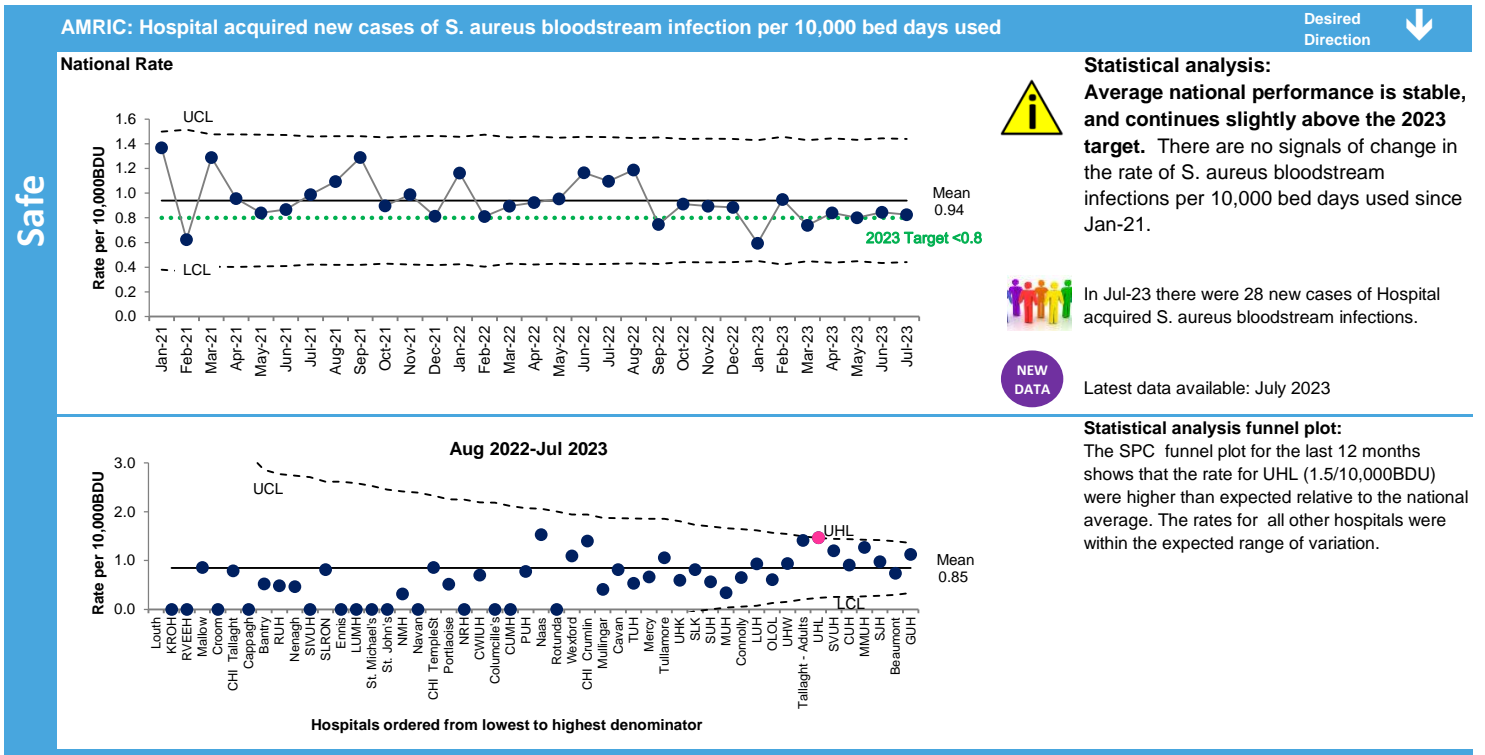The purpose of the Quality and Safety Profile is to provide statistical insights into quality and patient safety data and to support understanding of variation in performance over time. It is separate to processes supporting the performance and accountability framework under which necessary improvement 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.

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

Desired Direction ↓

Safe

National Rate

Statistical analysis:

Average national performance is stable, and continues slightly above the 2023 target. There are no signals of change in the rate of S. aureus bloodstream infections per 10,000 bed days used since Jan-21.

In Jul-23 there were 28 new cases of Hospital acquired S. aureus bloodstream infections.

NEW DATA Latest data available: July 2023

Aug 2022-Jul 2023

Hospitals ordered from lowest to highest denominator

Statistical analysis funnel plot:
The SPC funnel plot for the last 12 months shows that the rate for UHL (1.5/10,000BDU) were higher than expected relative to the national average. The rates for all other hospitals were within the expected range of variation.
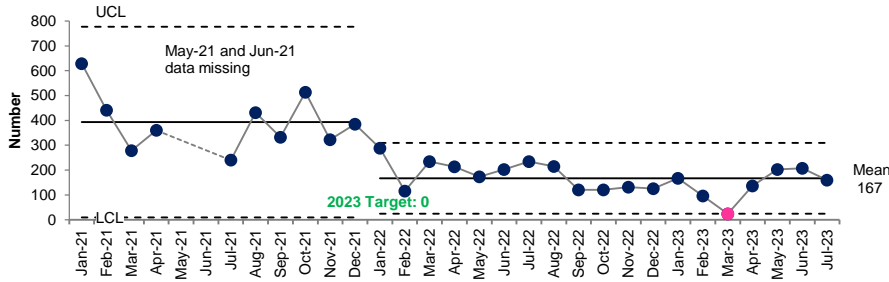
Service analysis (updated 25/08/2023):

• July 2023 rate of S. aureus bloodstream infections is 0.8, which is just on the target of <0.8 and will continue to be monitored

• YTD 2023 rate of S. aureus bloodstream infections is at 0.8.

• HSE AMRIC Oversight and implementation/working governance groups in place with Acute Operations reps, and Hospital Group IPC/AMS Steering Groups in place in 5 Groups.

• Performance KPIs and monitoring process in place for acute hospital HCAI KPIs and 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 2021-2025 AMRIC Implementation Plan objectives as they relate to acute services.

• To date Intravenous care teams have been established in 6 Model 4 hospitals and one model 3 hospital, recruitment is ongoing to have teams in place in remaining model 4 hospitals

| ⚠ | Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target. | **NEW DATA** Indicates updated data for this measure this month | **NO NEW DATA** Indicates no updated data available for this measure this month | **NEW** ◆ 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

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

Statistical analysis:
Average national performance is above the 2023 target. There were signals of improvement since Jan-22. The statistical limits were recalculated to reflect the new average. Furthermore the rate for Mar-23 shows a signal of improvement.

Jul-23: there were 160 people waiting over four weeks for access to an urgent colonoscopy.

Latest data available: July 2023

Service analysis (updated 26/06/2023):

Acute Operations continue to robustly monitor breaches across all hospitals. Hospitals have been instructed to include both public and private patients on weekly urgent colonoscopy returns to the BIU.

May saw a significant increase from April with 203 new breaches reported. However of these breaches a large amount, 116, were from the Mater Misericordiae University Hospital (MMUH). Acute Operations have wrote to MMUH seeking an improvement plan with focus on recovery and actions taken to address the breaches.

Roscommon University Hospital 55, this is due to a reporting matter, the hospital has moved from a manual to automated reporting system but have no returned to the manual system.
Data from Mid-June is showing improvements since the move back. Acute Operations will discuss all breaches within the Saolta Hospital Group at their monthly performance meeting.

Safe

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

Desired Direction ⬆

National Rate
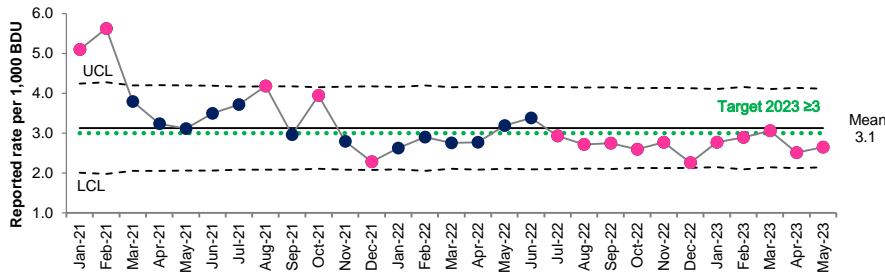
Statistical analysis:

⚠️ **The average reported rate is higher than the 2023 target.** However the reported rates for the last 11 months are all below the centre line which is a signal of a lower than expected reporting rates.

In May-23 there were 926 medication incidents reported to NIMS.
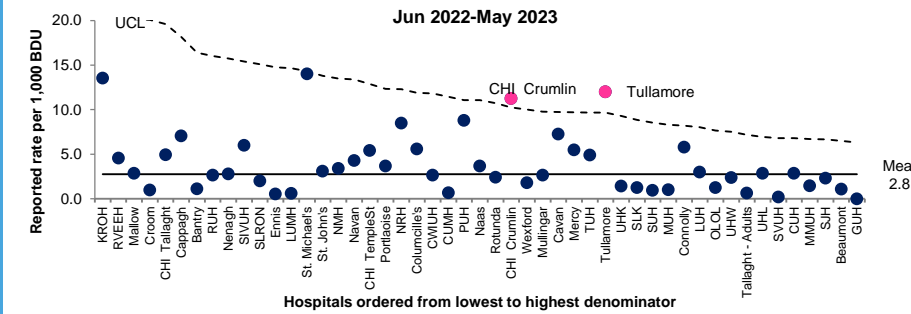
NEW DATA Latest data available: May 2023

Jun 2022-May 2023

Statistical analysis funnel plot:
The SPC funnel plot for the last 12 months shows that the reported rates for CHI Crumlin(11.27) and Tullamore (12) are higher (better) than expected relative to the national average. All other hospitals were within the expected range of variation.

Service analysis :

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.

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

NEW DATA Indicates updated data for this measure this month

NO NEW DATA Indicates no updated data available for this measure this month

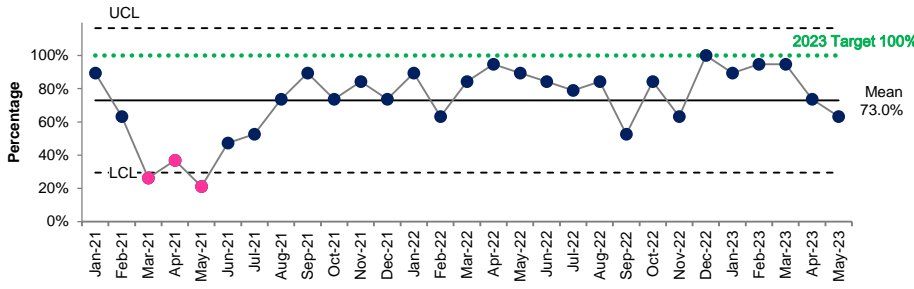**NEW** ◆ Indicates a new measure this month

Note: Specialcause 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 May-23, out of the 19 maternity hospitals, there were 12 hospitals that have completed and published monthly Maternity Safety Statements.

NEW Latest data available: May 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 08/06/2023):

The recommendation comes from then CMOs report to Dr. James O'Reilly, then Minister for Health "HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date)" back in 2014. The report made a number of national recommendations including the publication of a monthly patient safety statement for all acute services.

The CMO requirement is specific in that each maternity hospital has to publish a monthly Patient Safety Statement and states at page 72:

Recommendation O.R.10:

The HSE should ensure that every maternity service (and later every health service provider) be required to complete a Patient Safety Statement which is published and updated monthly.

Responsibility:	HSE
Timeframe:	End Quarter 1, 2014

Patient Safety Statements from maternity services initially and thereafter from all healthcare providers could be used with other available information to risk-rate services and to target quality improvement measures that enhance local ownership and capability. It is important that this is the first element of oversight as it will ensure that primary responsibility for oversight of safety and quality must remain with the service and those responsible for it. It will also have the advantage of creating a source of information that is much more accessible and transparent for the purposes of external scrutiny including by the public.

A patient safety statement can provide up to date information on key patient safety issues. The precise format of the patient safety statement and the data it should contain will need to be defined. The patient safety statement should be updated each month and become a core element of clinical governance arrangements. In particular it should be discussed at the management team meeting each month and at the Board level each month as a standing agenda item. It should set out activity, interventions, complaints, adverse incidents, serious incidents, never events, transfers, staffing and any other appropriate information from the perspective of patient safety and quality. This model should quickly be applied to all services rather than just maternity services.

(See Appendix 4 for an example of the types of information that should be considered for inclusion in a patient safety statement.)

At the time the HSE, Acute Operations, formed a working group, of relevant stakeholders, to implement the CMOs recommendations including this one on the MSS. It was this group that defined the pro-forma, documents and process. The recommendation does not specifically state the metrics to be used but the working group did define them as part of that process. The HPSIR (Hospital Patient Safety Indicator Report) is the acute hospital version of this recommendation and a new working group (chaired by QPS Acute Ops) was convened in 2016 to get that across the line across the 49 acute hospitals. The MSS pre-dates NWIHP but they were handed over to us back in 2017. The responsibility of populating and publishing is with the hospital but we submit monthly returns to the BIU which informs a KPI in the NSP. Originally A128 and A129 were recorded as just one KPI however NWHIP teased it out to allow for more accurate data. Additionally NWIHP subsequently, on HIQA's request, removed all reference to Portlaoise Hospital and the word "patient".

The Maternity Safety Statements should be published on the MSS pro-formas. They can be published directly to the hospital's own website (if they have one) or published to the dedicated HSE webpage via digital@hse.ie. The statements are published two months in arrears and are a standing item at NWIHPs meetings with the maternity networks and NWIHPs meetings with the Department of Health.

The annual target for the two MSS KPIs both A128 and A129 is 100%. We have found no resistance to the MSS within the system. 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 are down to annual leave, as a task assigned to an individual person, and diary conflicts as they need to signed off by senior management at both local and hospital group level.

⚠ Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.	**NEW DATA** Indicates updated data for this measure this month	**NO NEW DATA** Indicates no updated data available for this measure this month	**NEW** 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
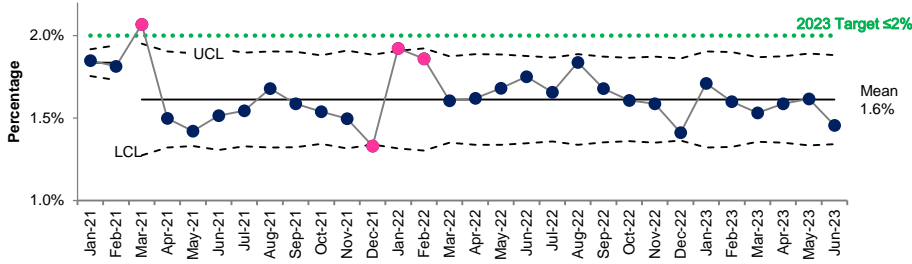
Statistical analysis:
Average national performance is stable since Mar-22, and continues well below the 2023 target.

There were 33,918 surgical discharges in Jun-23 of whom 494 patients were re-admitted to the same hospital within 30 days of discharge.
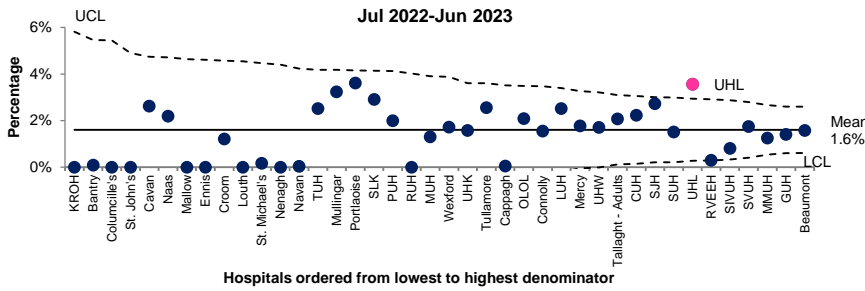
NEW DATA Latest data available: June 2023

Jul 2022-Jun 2023

Hospitals ordered from lowest to highest denominator

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 30/08/2023):

There was 494 surgical readmissions in June 2023 representing 1.5% of total admissions.

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.

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

NEW DATA Indicates updated data for this measure this month

NO NEW DATA Indicates no updated data available for this measure this month

NEW Indicates a new measure this month

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

Person-centred

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

Desired Direction ↑
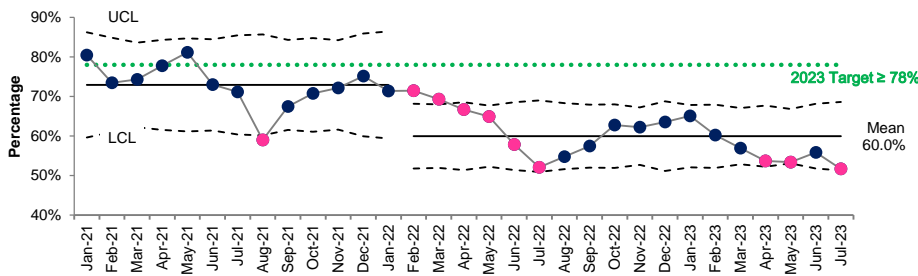
National Rate

Statistical analysis:
Average national performance is below the 2023 target. There are 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 and Jul-23 show a signal of disimprovement.

There were 877 CAMHS appointments in Jul-23 (seen & DNA), of whom 453 were seen within 12 weeks.

Latest data available: July 2023

Jul 2023

Statistical analysis funnel plot:
The SPC funnel plot for July shows that the rate for CHO3 (70%) is higher (better) than expected. All other CHOs were within the expected range of variation.
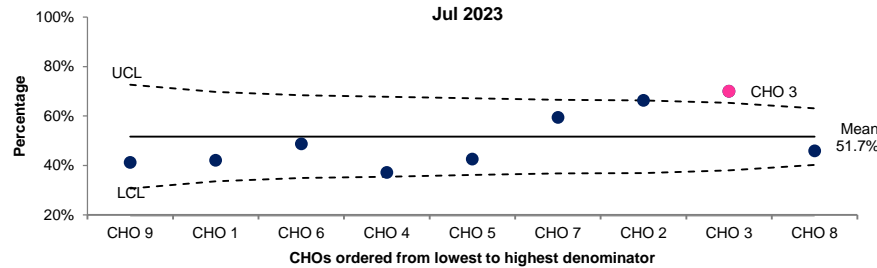
Service analysis (updated 22/08/2023):

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 July year to date, 56.6% referrals were offered an appointment and seen within 12 weeks against a target of 78%.

CHO 3 is currently at 77.1% compared to CHO 5 (40.6%) followed by CHO 4 (46.5%).
All other CHO's have not achieved the target CHO 1 (51.9%), CHO 2 (72.6%), CHO 6 (55.1%), CHO 7 (65.8%), CHO 8 (59.1%) and CHO 9 (55.2%).

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.

There is also 6.1% DNA (did not attend) rate for those offered a new or re-referred appointment.

Person-centred

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

Desired Direction ↑

National Rate

2023 Target 99%
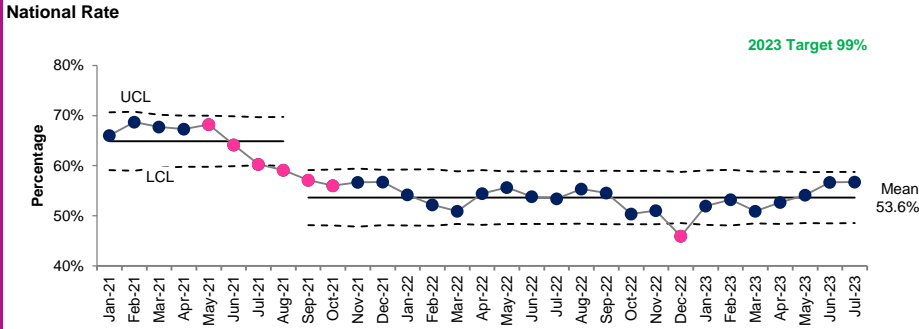
Statistical analysis:
Average national performance is below target and relatively stable following disimprovements since May-21. The control limits have been recalculated to reflect this. In addition the rate for Dec-22 showed a signal of disimprovement.

Jul-23: 17,901 people 75+ years presented to ED, of whom 10,163 were discharged or admitted within 9 hours.

NEW DATA Latest data available: July 2023

Aug 2022-Jul 2023

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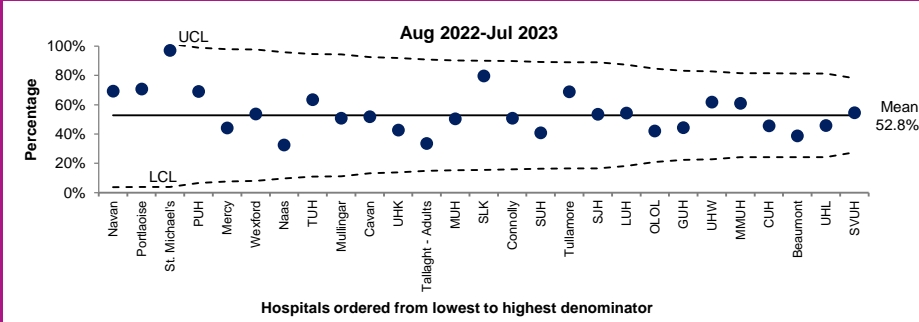
Statistical analysis funnel plot:
The SPC funnel plot shows the range of variation among hospitals. All hospitals are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by hospital, but there are no statistical differences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

Service analysis (updated 30/08/2023):

At end of July 2023, 57% of patients aged over 75 years were admitted/discharged within 9 hours. There are many reasons that result in longer wait times 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.

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

Desired Direction ↑

Timely

National Rate

Note: Data not available prior to Nov-21

Statistical analysis:
Average national performance is below 2023 target but there are signals of improvement for the past 19 months. The control limits have been recalculated to reflect the new average.

Jul-23: there were 601,140 people waiting for first access to OPD services, of whom 501,918 were waiting less than 15 months.

Latest data available: July 2023
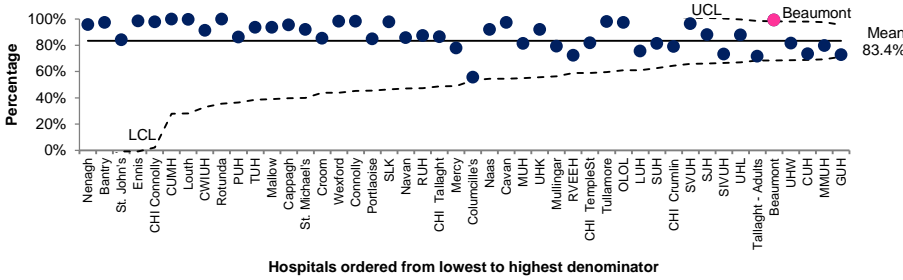
Jul 2023

Hospitals ordered from lowest to highest denominator

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 (99.3%) which is higher (better) than expected relative to the national average.

Service analysis (updated 30/08/2023):

At the end of June 83.5% of patients on the outpatient waiting list were waiting less than 15 months, showing an improvement since May 2023 which was at 82%. The volume of patients waiting over 15 months in June is 99,222 which has reduced since May 2023 where the volume was 102,187 a reduction of -2965 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.

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

Desired Direction ⬆

Timely

National Rate
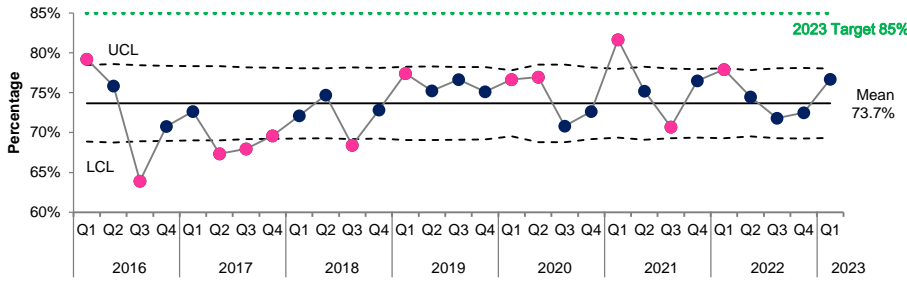
Statistical analysis:
Average national performance is below the target. Although there were signals of improvement in Q1 & Q2 2020, Q1 2021 and inQ1 2022 there are no current signals of improvement in the most recent 4 quarters.

Q1-23: 918 inpatient discharges 60+ years had emergency hip fracture surgery, of which 704 were within 48h of initial assessment

Latest data available: Q1 2023

Q2 2022-Q1 2023

Hospitals ordered from lowest to highest denominator
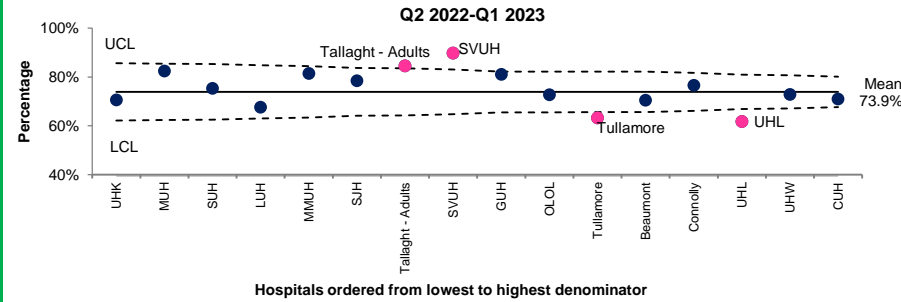
Statistical analysis funnel plot:
The SPC funnel plot for last 4 quarters shows the rates forTallaght-Adults (84%) and SVUH (89%) are above the expected limits (better) while Tullamore (63%) and UHL(62%) are below the expected limits.

Service analysis (30/08/2023):

Acute Operations (AO) will communicate to hospital group outliers.

The achievement of this target is significantly impacted by emergency pressures and the flow of emergency patients requiring admission. Feedback from hospitals have indicted that some patients deemed within target are actually not suitable for surgery, this factor does impact on achievement of the target.

⚠	Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.	**NEW DATA** Indicates updated data for this measure this month	**NO NEW DATA** Indicates no updated data available for this measure this month	**NEW** Indicates a new measure this month	**Note:** Specialcause 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 ⬆
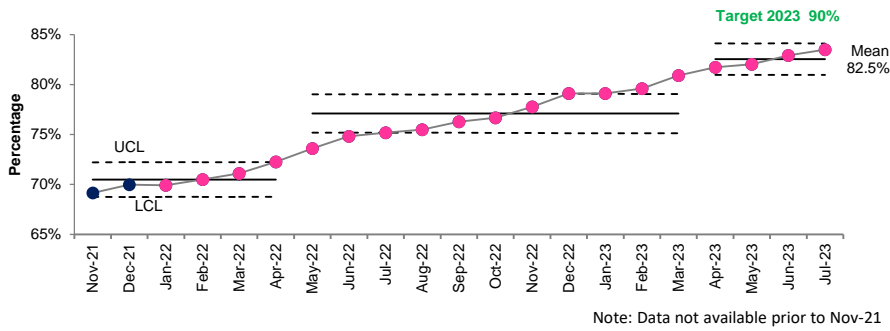
Timely
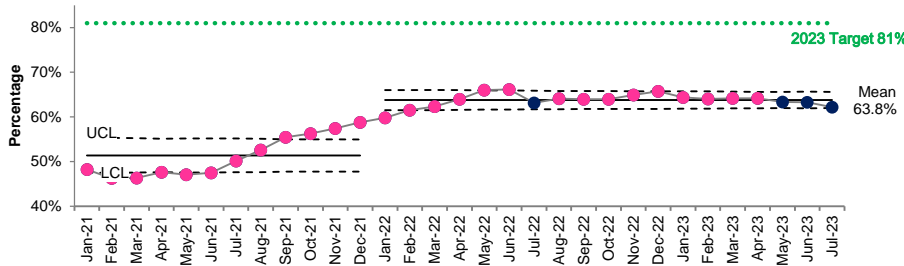
National Rate

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 rates are stable for the last 3 months.

Jul-23: 19,603 people were on the waiting list for Primary Care Psychology treatment, of whom 12,194 were waiting less than 52 weeks.

NEW DATA Latest data available: July 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.
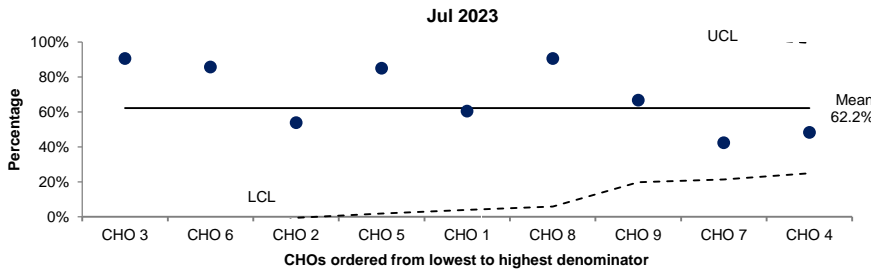
Service analysis (updated 22/08/2023):

62.2% are waiting for treatment ≤ 52 weeks at the end of July 2023, compared to the target of 81% (PC103G).
The number of Psychology patients on waiting list for treatment ≤ 52 weeks will require an additional 3,684 people to be seen to reach the target of 81%
The number of people waiting longer than 52 weeks has increased by +11.5% from 6,647 in June to 7,409 in July (PC103E).

1,844 children and young people have been removed from the waiting list from January to July 2023 as a result of the WLAP waiting list initiatives referred to earlier in this commentary.

Numbers of referrals to date is 10,814 which represents an increase of +76.2% in expected activity (6,139) and +11% ahead of the same period last year (9,742) (PC38)

The number of new patients seen for first time at the end of July 2023 is 8,060 which is +36.5% ahead of same period last year position of 5,904 (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 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.
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 98.3% return rate for data across Primary Care Services in July.
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 may result in longer waiting times as patients are clinically prioritised.
The underlying trend in numbers seen by Primary Care Therapy Services continues to improve. At July 2023 the total number of patients seen is +9.9% 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.

Prepared by the Quality Patient Safety Directorate QPSI@hse.ie. **Preliminary data at 16:00 on 30th August 2023 subject to change until published.**

Page 10

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

Desired Direction ↑

Timely

National Rate
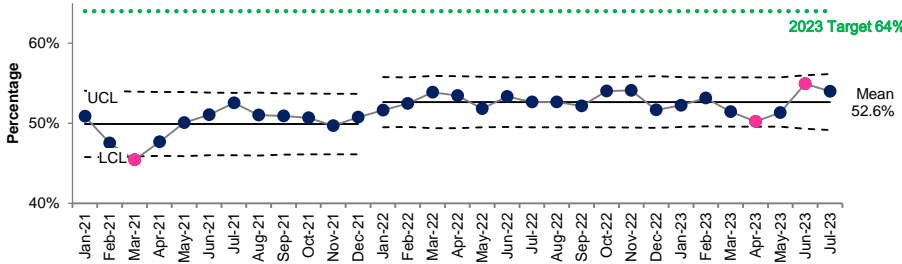
Statistical analysis:

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.

Jul-23: 17,799 people were on the waiting list for Primary Care Ophthalmology treatment, of whom 9,606 were waiting less than 52 weeks.

NEW DATA Latest data available: July 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.
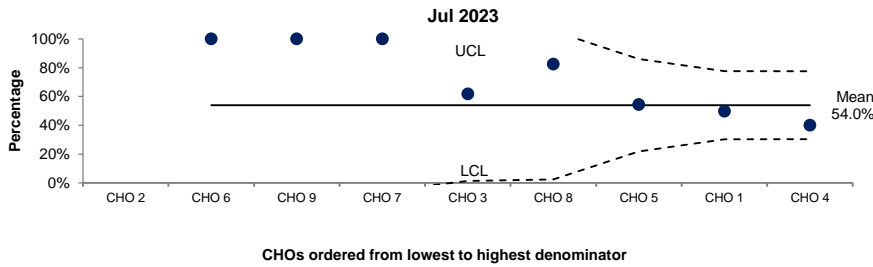
Service analysis (updated 22/08/2023):

54% are waiting for treatment ≤ 52 weeks at the end of July 2023, compared to the target of 64% (PC107G).

The number of Ophthalmology patients on waiting list for treatment ≤ 52 weeks will require an additional 1,785 people to be seen to reach the target of 64% The number of people waiting longer than 52 weeks has decreased by -6.5% from 8,764 in June to 8,193 in July (PC107E).

Numbers of referrals to date is 15,623 which represents an increase of +9.7% in expected activity (14,238) and +5.5 % ahead of the same period last year (14,805) (PC52)

The number of new patients seen for first time assessment at the end of July 2023 is 15,583 which is +27.5% ahead of same period last year position of 12,221 (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.

NEW DATA Indicates updated data for this measure this month

NO NEW DATA Indicates no updated data available for this measure this month

NEW Indicates a new measure this month

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

Efficient

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

Desired Direction ↓

National Data
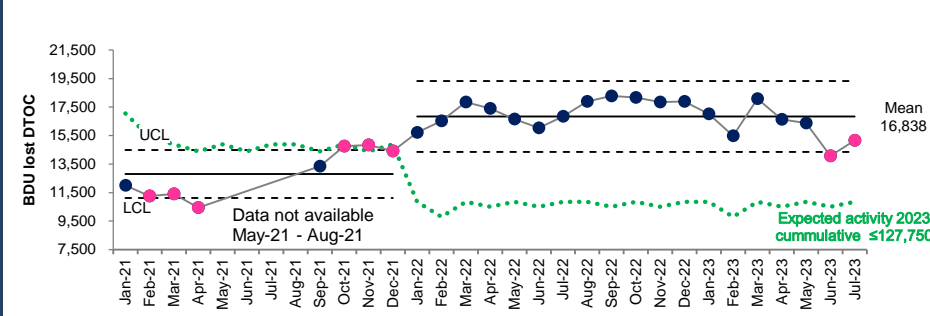
Statistical analysis:
Average national performance is above the target.
The annual cumulative target is distributed as monthly values and varies due to the number of days in each month. Additionally there is a signal of improvement in the last 2 months.

Jul-23: 15,165 acute bed days were lost through delayed transfers of care. As of end of Jul-23 there were 510 beds subject to Delayed Transfer of Care.

NEW DATA Latest data available: July 2023

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

Service analysis (30/08/2023):

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 settingAND
• The post-acute hospital care pathway has been agreed with the patient, those important to them and the multidisciplinary team.

End July 2023 performance showed that 510 Delayed Transfers of Care / 15,165 Bed Days Lost were reported in acute hospitals. Monthly average DTOCs continue on a downward trajectory, with the July monthly average DTOC recording a smaller decrease from 494 DTOCs (June) to 493 DTOCs (July).

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.

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NO NEW DATA Indicates no updated data available for this measure this month

NEW Indicates a new measure this month

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

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

Desired Direction ↑

National Rate

Target 100%

UCL
LCL
Mean 13.2%

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
2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023
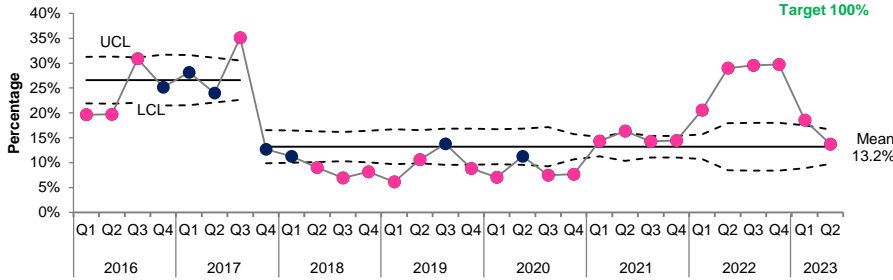
Statistical analysis:
Average national performance is below the target with a sustained reduction since Q4 2017. However the rates for the past 10 quarters indicate signals of improvement. Rates for Q1-22 - Q1-23 are above the upper control limit.

Q2-23: 874 Assessments of Need were completed, of which 120 within three months of their commencement or within a revised time frame negotiated as per the regulations

NEW DATA — Latest data available: Q2 2023

Q3 2022-Q2 2023

UCL

Mean 21.0%

CHO 5 CHO 3 CHO 2 CHO 6 CHO 9 CHO 7 CHO 1 CHO 4 CHO 8

CHOs ordered from lowest to highest denominator
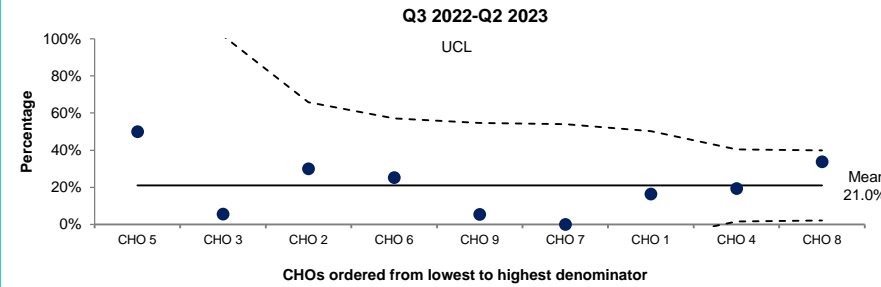
Statistical analysis funnel plot:
The SPC funnel plot for the last 4 quarters shows the range of variation among CHOs. All CHOs are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by CHO, but there are no statistical differences between CHOs with higher or lower rates.

Service analysis (22/08/2023):

A High Court judgement delivered on 11th March 2022 has impacted on the completion of assessments since that date. As a consequence of the judgement, Assessment Officers cannot complete assessments based on the agreed Preliminary Team Assessment format. As a result, activity for the second quarter of 2023 indicates that there has been an increase in the total number of applications 'overdue for completion', which now stands at 6,259 (excluding those applications for which an extended time-frame was negotiated with the parent on the grounds of there being exceptional circumstances as provided for in paragraph 10 of the regulations).

The requirement to provide diagnostic assessments under the terms of the Act for children whose assessments were completed based on the Preliminary Team Assessment format will further impact on compliance in the coming months. These additional assessments for children whose status has already been recorded as "complete" must be progressed in parallel with new applications for AON.

The HSE's National Clinical Programme for People with Disability (NCPPD) has led the process of developing Interim Clinical Guidance to replace the element of the Standard Operating Procedure which was found to be non-compliant with the Disability Act (2005) – the Preliminary Team Assessment. This guidance has been reviewed by the HSE's and Department of Health's legal advisors and feedback provided. It has also been agreed with staff representative bodies. It is now being finalised by NCPPD and will be completed and launched in July 2023.

NCPPD has also committed to establishing a Task Group on Assessment of Need to address other issues related to the Assessment of Need process that are not addressed in the Interim Clinical Guidance. This group will include representatives from all the key stakeholders and particularly those with lived experience, and will meet monthly over the next 12 months.

The Disability Act outlines the statutory timelines under which Assessments of Need under the Act must be completed. In summary, the assessment report must be completed within 6 months of the date the application was received. While the HSE endeavours to meet its legislative obligations under the Act, it has struggled to achieve compliance with these timeframes. At end of Quarter 2, 2023, 15.6% of assessments were completed within the timeframes set out in the Disability Act 2005 and accompanying Regulations (DIS3).

The second quarter of 2023 has seen a further increase in the number of applications for assessment of need received (4,258 to date) which is up 29.6% on the profiled target for the period (DIS1).

The number of applications for Assessment of Need under the Act has risen steadily since its implementation in June 2007. The non-commencement of the Education for Persons with Special Education Needs (EPSEN) Act (2004) is a significant contributory factor. When originally implemented it was envisaged that the Assessment of Need would apply to children aged less than five years. Following a High Court ruling in 2009 eligibility was expanded to include all persons born on or after June 1st 2002. This has also contributed to the rise in applications. A new commencement order (S.I. No. 3 of 2022) subsequently confirmed that Part 2 of the Disability Act applies to persons born on or after 1st June 2002.

The provision of diagnostic ASD assessments through the Assessment of Need process is the most significant factor in waiting lists for children's disability services. Approximately €11m has been allocated to address waiting lists and it is intended that this funding will be utilised to procure diagnostic ASD assessments from the private sector. In parallel, a large scale international procurement process is being progressed.

To address the challenges in outsourcing AON, National Disability Services is working with HSE Procurement to develop a tender process and Service Specification for the delivery of Assessment of Need from private providers. A successful procurement process will facilitate the CDNTs to focus on the provision of intervention for children on their caseloads. This is at an advanced stage and will be concluded towards the end of July.

The HSE is also committed to the development of six Regional Hubs to undertake AON Assessments and is working across the CHO Areas to have these in place by 1st August this year.

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

NEW DATA — Indicates updated data for this measure this month

NO NEW DATA — Indicates no updated data available for this measure this month

NEW — 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 child health & development assessments completed on time or before 12 months of age

Desired Direction ⬆

Wellbeing

National Rate

Percentage on time

2023 Target 95%

UCL
LCL

Mean 83.0%
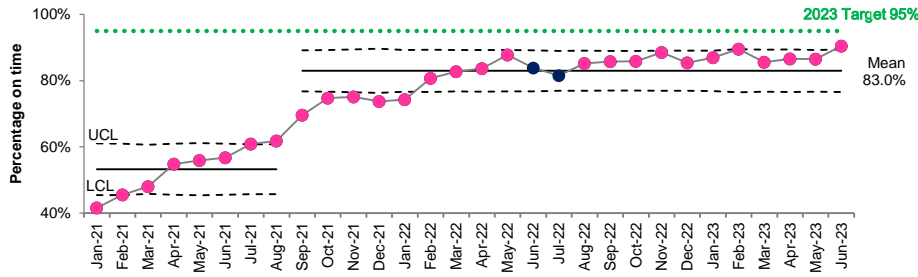
Statistical analysis:
Average national performance is below the 2023 target, with ongoing signals of improvement Jan-21 to May-22. The control limits have been recalculated to reflect this improvement. In addition, there are signals of improvement in the last 11 months.

Jun-23: 4,352 babies were reaching 12 months of age, of which 3,937 had a health & development assessment completed.

NEW DATA Latest data available: June 2023

Jul 2022-Jun 2023

Percentage

Mean 86.4%

LCL

CHO 1 CHO 3 CHO 6 CHO 5 CHO 2 CHO 7 CHO 4 CHO 8 CHO 9

CHOs ordered from lowest to highest denominator

Statistical analysis funnel plot:
The SPC funnel plot for the last 12 months shows that the rates for all CHOs were within the expected range of variation.
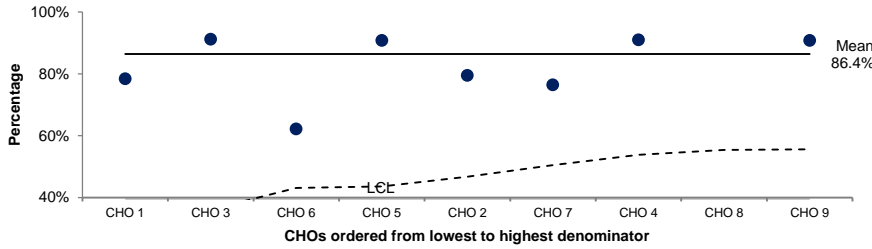
Service analysis (updated 22/08/2023):

The national performance at June YTD (Data one month in arrears) is 87.6% compared to a target of 95% (PC153). Performance in June of 90.5% compared to a monthly performance of 86.5% in May.

Performance is being addressed with relevant CHOs who are advising that performance is expected to show continued improvement in 2023, in most areas, due to a combination of factors including;

• Reduced Covid related staff illness (assuming a reduction in Covid across the year)

• Less DNAs / cancellations from clients due to reduced impact of Covid

• Measures being taken to address non-return of data

• Overall reduction in backlogs

• It must be noted that challenges remain in relation to the recruitment and retention of Public Health Nurses in some areas especially some parts of Dublin and Galway. A national community nursing oversight group has been established to develop proposals and recommendations in order to increase recruitment and retention of Public Health Nurses (PHNs) and Community RGNs (CRGNs) in Community Services.
Performance will continue to be monitored in 2023 with relevant CHOs including in the monthly engagement meetings

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

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

Desired Direction ↑

Wellbeing

National Rate
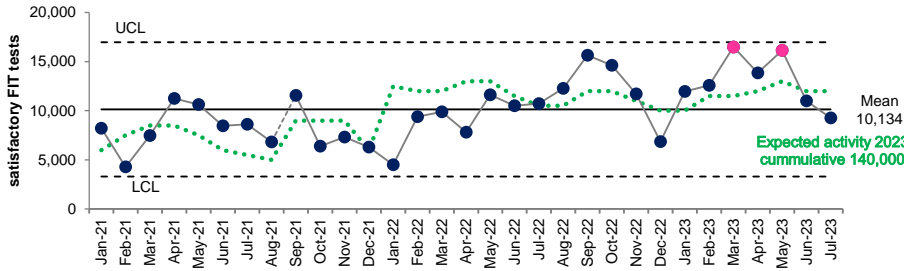
Statistical analysis:
The values for 10 of the last 12 months were on or above the target. Additionally, there are signals of improvement in Mar-23 and May-23. The monthly targets are included as per metadata specifications.

Jul-23: there were 9,278 people screened by the BowelScreen programme who have completed a satisfactory FIT test.

NEW DATA

Latest data available: July 2023

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

Service analysis (updated 23/08/2023):

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 people who have completed a satisfactory BowelScreen FIT test in the period (June 2023) was 11,011 which is below the target of 12,000 by 989 (8.2%). The number of people who have completed a satisfactory BowelScreen FIT test year to date (Jan-June 2023) was 82,023 which is above the target of 70,000 by 12,023 (17.2%).
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 (89%) 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 75% for the period Jan-Jun 2023, a score considered exceptional by international standards.

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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

1. Performance attained
- Normal variation (within an acceptable range)
- Special cause indicating a signal of improvement

2. Performance not attained; ongoing review required
- Action plan for improvement in place
- Performance not at target level but within acceptable range of the target

3. Further analysis required
- More analysis needed to make an assessment

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

Committee Action:
S&Q Committee Chair:

Committee recommendations and actions recorded in meeting minute and action log

1. Acknowledges good performance
- Committee may wish to congratulate/ recognise this achievement
- Committee may discuss what has been learned and if there are opportunities for further improvement.

2. Recommends ongoing review
- Committee may agree to continue to keep the indicator under review.

3. Requests further analysis
- Committee may request further data analysis or information from relevant Executive member or organisation
- Committee may request further analysis of existing data from NQPS team.

4. Requests a plan for improvement
- Committee may request further information on cause of dis-improvement or below target performance from relevant Executive member
- Committee may request update on organisational response, e.g. improvement plan
- Committee may escalate to Board
- Committee may request other action.

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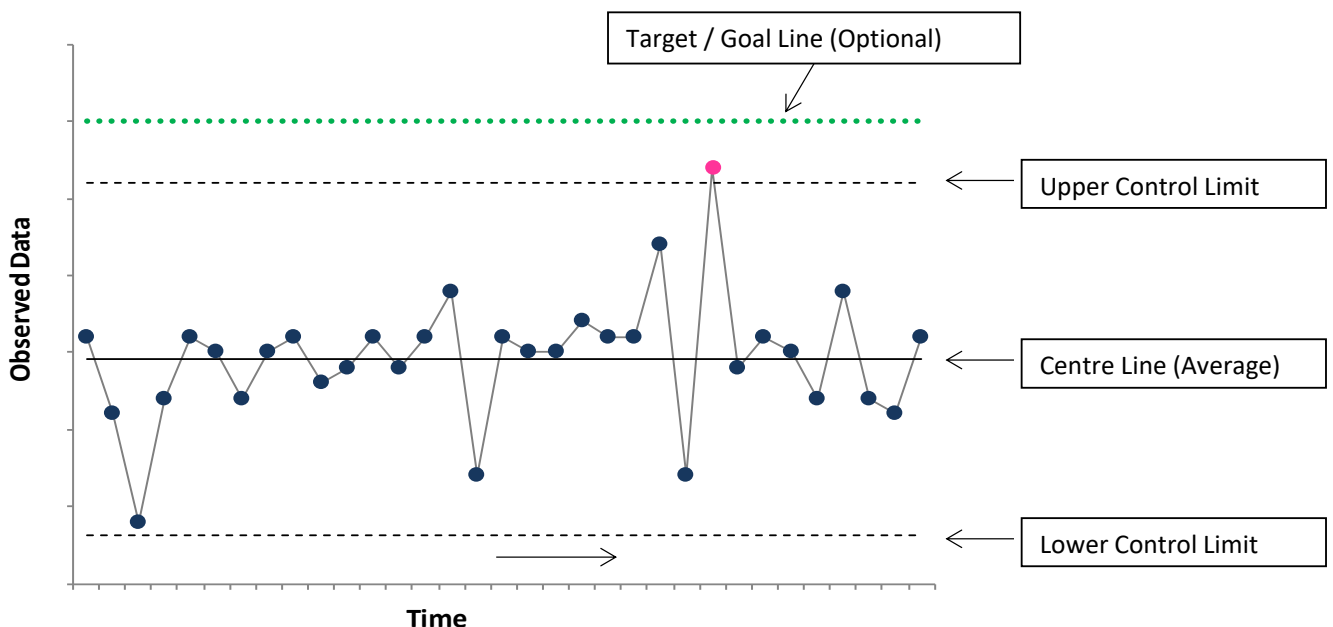
References
Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011

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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)
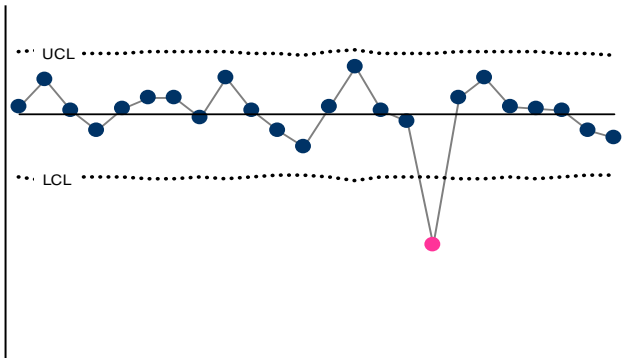
2. A run of 8 or more consecutive points above or below the centre line
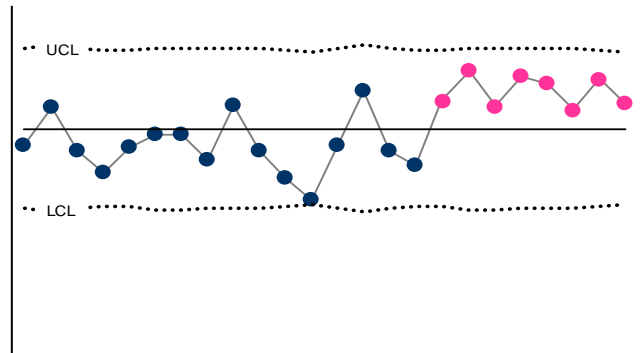
3. A trend of at least 6 consecutive points all going up or down
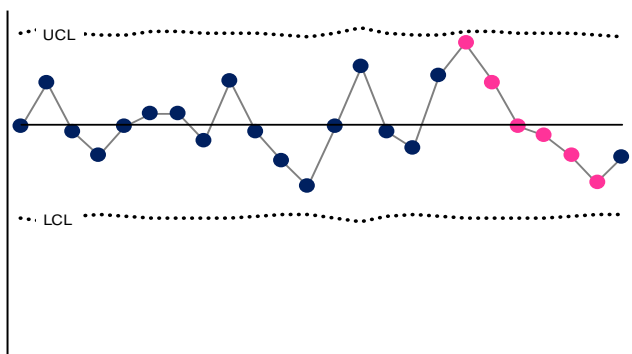
4. Two out of three consecutive points in the outer third (or beyond)
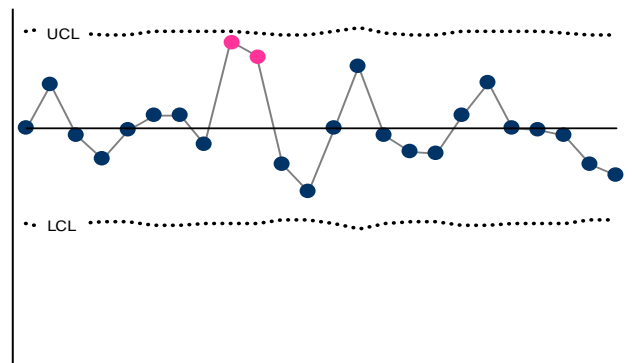
5. A series of 15 consecutive points close to the centre line (in the inner one-third)

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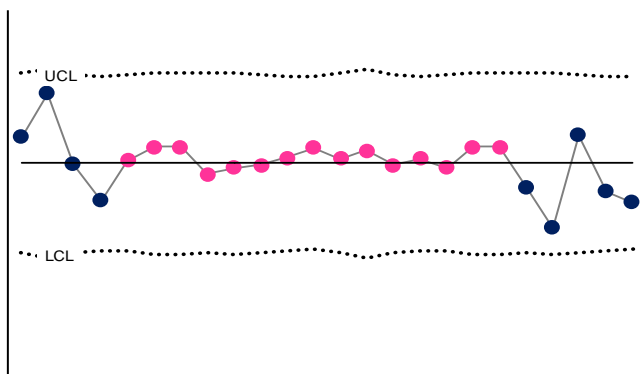
Anatomy of a Statistical Process Control Funnel Plot

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

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Statistical Process Control Funnel Plot Examples
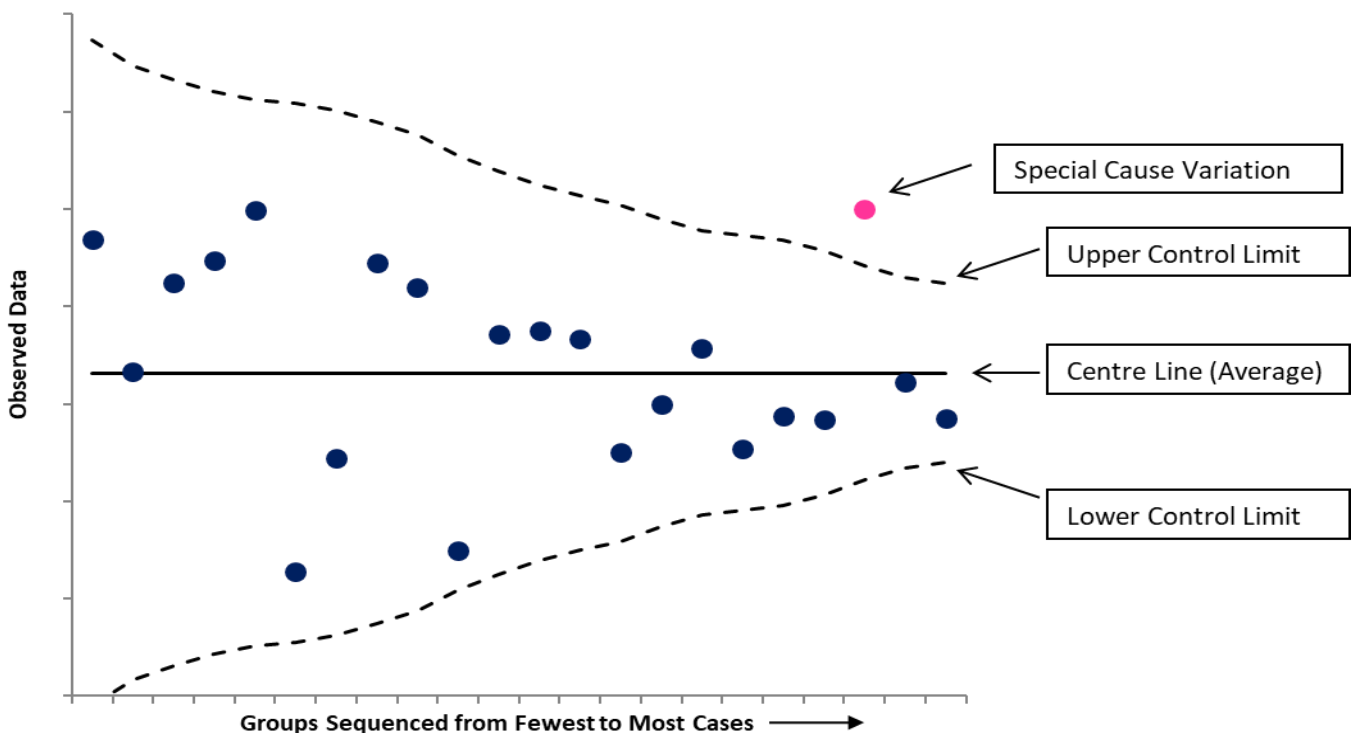
Example 1: Percentage of patients with a hip fracture undergoing surgery within 48 hours, by hospital
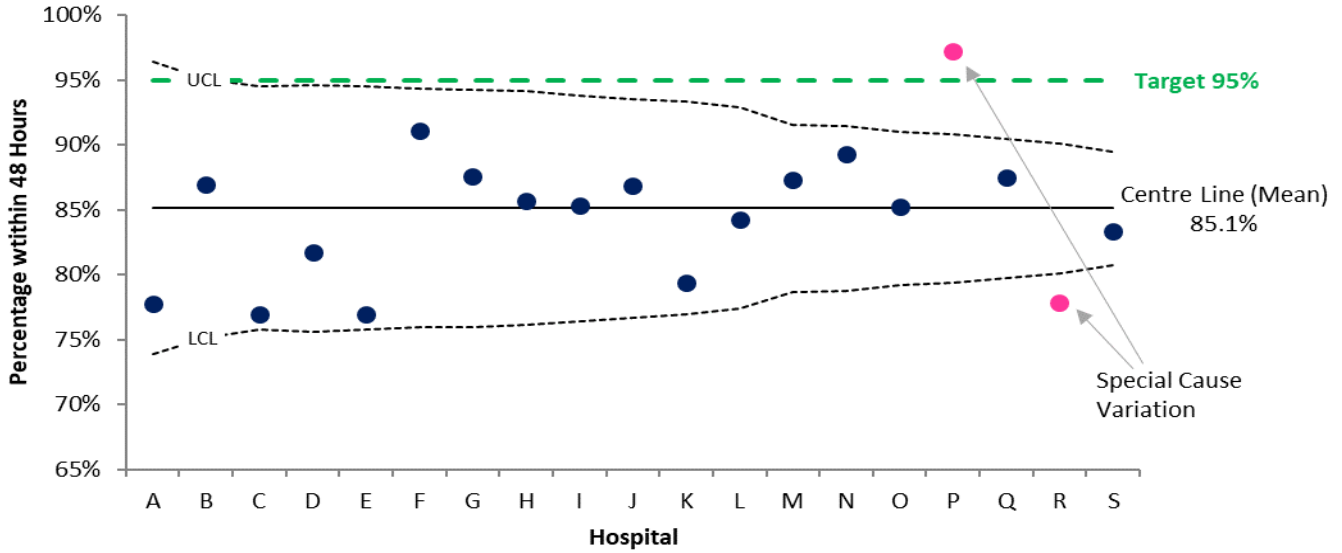
Example 2: Rate of falls per 1,000 bed days, by community nursing units
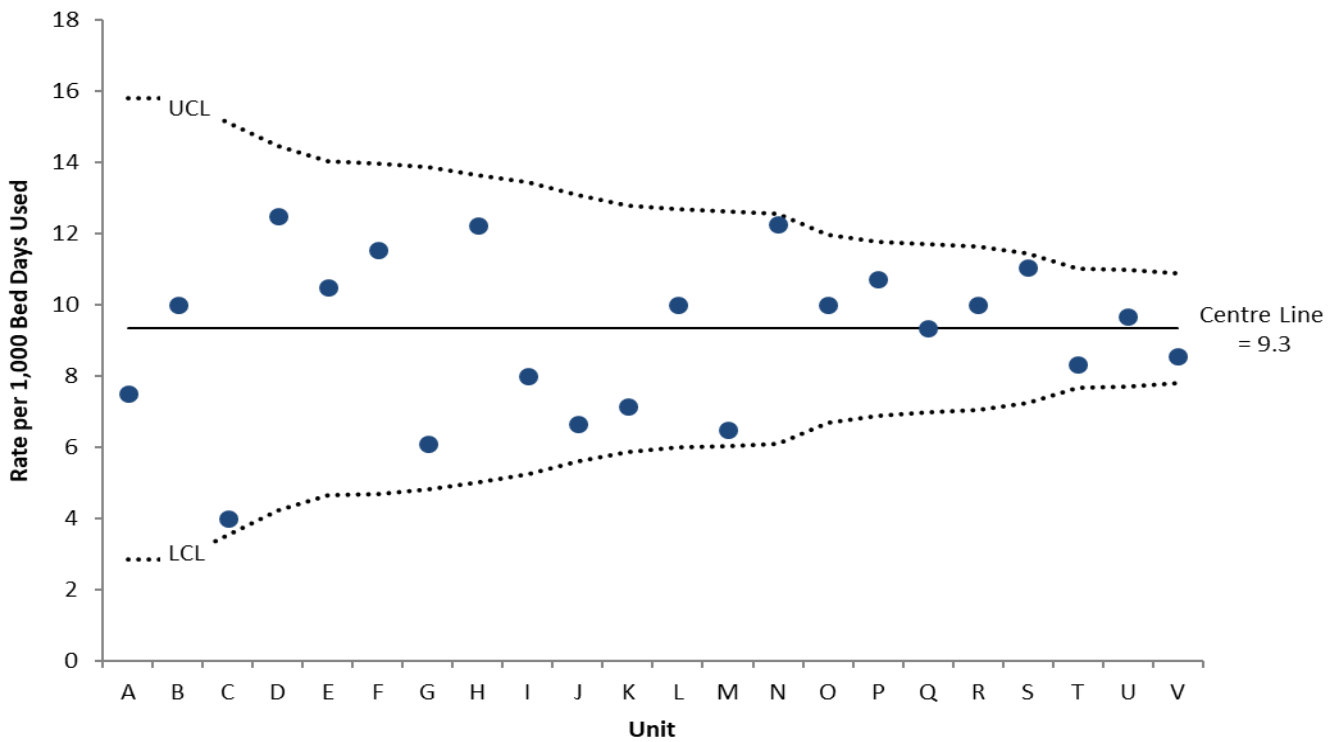
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Quality and Safety Profile Indicators Metadata

<table>
<tr><td></td><td colspan="2">AMRIC: Hospital acquired new cases of S. aureus bloodstream infection per 10,000 bed days used</td></tr>
<tr><td rowspan="7">Safe</td><td rowspan="3">Calculation</td><td>Numerator: Number of new cases of hospital acquired S. aureus bloodstream infection.</td></tr>
<tr><td>Denominator: Number of bed days used</td></tr>
<tr><td>Rate is calculated as the numerator/denominator*10,000.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC U chart since January 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Cappagh bed days used outstanding for Jul-23 was outstanding at the time of production of the Quality and Safety Profile.</td></tr>
<tr><td></td><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">AMRIC: Rate of new cases of hospital associated C. difficile infection per 10,000 bed days used</td></tr>
<tr><td rowspan="7">Safe</td><td rowspan="3">Calculation</td><td>Numerator: Number of new cases of hospital associated C. difficile infection.</td></tr>
<tr><td>Denominator: Number of bed days used</td></tr>
<tr><td>Rate is calculated as the numerator/denominator*10,000.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC U chart since January 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Indicator not included in this Quality and Safety Profile.</td></tr>
<tr><td></td><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">AMRIC: Number of patients confirmed with newly detected CPE</td></tr>
<tr><td rowspan="5">Safe</td><td>Calculation</td><td>Numerator: Number of patients confirmed with newly detected CPE.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC C chart since January 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Indicator not included in this Quality and Safety Profile.</td></tr>
<tr><td></td><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">ACUTES: No. of new people waiting > four weeks for access to an urgent colonoscopy</td></tr>
<tr><td rowspan="5">Safe</td><td>Calculation</td><td>Count: Number of New patients waiting greater than 28 days for an Urgent Colonoscopy</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC I chart since January 2021.</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>No known current data coverage issues.</td></tr>
<tr><td></td><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">System wide: Percentage of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident</td></tr>
<tr><td rowspan="5">Safe</td><td rowspan="2">Calculation</td><td>Numerator: Number of incidents included in Denominator where the review was completed in no more than 125 calendar days.</td></tr>
<tr><td>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</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P chart since January 2021.</td></tr>
<tr><td>Data source</td><td>NIMS KPIs report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Indicator not included in current Quality and Safety Profile.</td></tr>
<tr><td></td><td>Further information</td><td>https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/</td></tr>
</table>

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Quality and Safety Profile Indicators Metadata

<table>
<tr><th colspan="3">ACUTES: Rate of defined and suspected venous thromboembolism (VTE, blood clots) associated with hospitalisation</th></tr>
<tr><td rowspan="6">Safe</td><td>Calculation</td><td>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.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC U chart since January 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Indicator not included in this Quality and Safety Profile.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><th colspan="3">ACUTES: Rate of medication incidents as reported to NIMS per 1,000 bed days</th></tr>
<tr><td rowspan="6">Safe</td><td>Calculation</td><td>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.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC U Prime chart since January 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
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<tr><th colspan="3">ACUTES: Percentage of maternity hospitals / units that have completed and published monthly Maternity Safety Statements</th></tr>
<tr><td rowspan="5">Safe</td><td>Calculation</td><td>% maternity hospitals that completed and published MSS = number of maternity hospitals that completed and published MSS/ total number of maternity hospitals</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC I chart since January 2021.</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>No known current data coverage issues.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><th colspan="3">System wide: Extreme and major incidents as a percentage of all incidents reported as occurring</th></tr>
<tr><td rowspan="6">Safe</td><td>Calculation</td><td>Numerator: Number of Category 1 incidents that occurred in the reporting period.

Denominator: Number of incidents that occurred in the reporting period</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P chart since Q1 2018.</td></tr>
<tr><td>Data source</td><td>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.</td></tr>
<tr><td>Data frequency</td><td>Quarterly</td></tr>
<tr><td>Data coverage</td><td>Indicator not included in current Quality and Safety Profile.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/</td></tr>
</table>

<table>
<tr><th colspan="3">ACUTES: Percentage of surgical re-admissions to the same hospital within 30 days of discharge</th></tr>
<tr><td rowspan="5">Effective</td><td>Calculation</td><td>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)</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P Prime chart since January 2021.</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>No known current data coverage issues.</td></tr>
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Quality and Safety Profile Indicators Metadata

<table>
<tr><td rowspan="7">Person-centred</td><td colspan="2">CAMHS: Percentage of accepted referrals / re-referrals offered first appointment and seen within 12 weeks</td></tr>
<tr><td rowspan="2">Calculation</td><td>Numerator: Number of new / re-referred cases offered an urgent or routine appointment and seen up to 13 weeks</td></tr>
<tr><td>Denominator: Total number offered an appointment, seen and DNA</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P Prime chart since January 2021.</td></tr>
<tr><td>Data source</td><td>Community Healthcare Metric Report – QlikView</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>Data for Jul-23 for LHO Century Court Team was outstanding at the time of production of the Quality and Safety Profile.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/2023-mental-health-services-nsp-metadata.pdf</td></tr>
</table>

<table>
<tr><td rowspan="7">Person-centred</td><td colspan="2">ACUTES: Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 9 hours</td></tr>
<tr><td rowspan="2">Calculation</td><td>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.</td></tr>
<tr><td>Denominator - All patient attendances at ED who are aged over 75 years of age who are admitted or discharged</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P Prime chart since January 2021.</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
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</table>

<table>
<tr><td rowspan="7">Timely</td><td colspan="2">ACUTES: Percentage of people waiting <15 months for first access to OPD services</td></tr>
<tr><td rowspan="2">Calculation</td><td>Numerator: Number of outpatient patients waiting to be seen less than 15 months</td></tr>
<tr><td>Denominator: Total number of patients waiting to be seen in Outpatients</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P Prime chart since November 2021</td></tr>
<tr><td>Data source</td><td>Acute Management Data Report</td></tr>
<tr><td>Data frequency</td><td>Monthly</td></tr>
<tr><td>Data coverage</td><td>No known current data coverage issues.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

<table>
<tr><td rowspan="7">Timely</td><td colspan="2">ACUTES: Percentage of hip fracture surgery carried out within 48 hours of initial assessment</td></tr>
<tr><td rowspan="2">Calculation</td><td>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.</td></tr>
<tr><td>Denominator: The number of inpatient discharges aged over 60 in the reporting period where emergency hip fracture surgery was carried out.</td></tr>
<tr><td>Details of analysis</td><td>National level data are displayed in an SPC P chart since Quarter 1 2016.</td></tr>
<tr><td>Data source</td><td>Irish Hip Fracture Database (IHFD)</td></tr>
<tr><td>Data frequency</td><td>Quarterly in arrears</td></tr>
<tr><td>Data coverage</td><td>No known current data coverage issues.</td></tr>
<tr><td>Further information</td><td>https://www.hse.ie/eng/services/publications/kpis/final-acute-metadata-2023.pdf</td></tr>
</table>

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Quality and Safety Profile Indicators Metadata

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 - Jul-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 for LHO Galway and data for Jul-23 for LHOs Galway, Mayo, Roscommon, Clare and Waterford 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
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	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/2023-disability-services-nsp-metadata.pdf

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Quality and Safety Profile Indicators Metadata

	PRIMARY CARE: Percentage of child health & development assessments completed on time or before 12 months of age	
Wellbeing	**Calculation**	Numerator: The number of babies having a health and development assessment completed by 12 months of age in the reporting period
		Denominator: The number of babies reaching **Statistical**
	Details of analysis	National level data are displayed in an SPC P Prime chart since January 2020
	Data source	Community Healthcare Metric Report – QlikView
	Data frequency	Monthly in arrears
	Note	Data for 2019 and 2020 refers to child health & development assessments completed on time or before 10 months of age. Following a recommendation by the Developmental Surveillance Subgroup of the National Steering Group for the Revised Child Health Programme and based on the latest evidence on developmental surveillance, the timeframe for the provision of this child health contact was changed from 7 to 9 months to 9 to 11 months, and so from 2021 the KPI is reported based on assessments on time or before 12 months of age.
	Data coverage	No known current data coverage issues.
	Further information	https://www.hse.ie/eng/services/publications/kpis/2023-primary-care-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

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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
Portiuncula 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

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

	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	28					
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	295,609	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,859	315,959	351,659	333,475	349,889	330,770	339,527					
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	0.9	0.6	0.9	0.7	0.8	0.8	0.8	0.8					

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

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

	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	80	66	71	72	67					
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	295,609	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,859	315,959	351,659	333,475	349,889	330,770	339,527					
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	2.0	2.2	2.0					

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

SAFE — AMRIC: Number of patients confirmed with newly detected CPE

	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

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

	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					

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

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

	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	16	18	14	13	22									
Denominator	110	48	38	34	23	25	29	30	39	34	37	22	33	36	34	41	37	34	33	38	35	41	51	52	48	38	45									
Data point	15%	38%	45%	59%	43%	64%	48%	23%	31%	59%	49%	59%	55%	53%	50%	34%	41%	65%	45%	47%	31%	41%	31%	35%	29%	34%	49%									

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.

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

	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	278	204	249	233	247							
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	23,788	20,966	23,975	21,331	22,033							
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	11.69	9.73	10.39	10.92	11.21							

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 occuring during hospitalisation per 1,000 discharges.

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

	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	893	884	882	929	766	978	913	1077	837	926							
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	295,609	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,859	315,959	351,659	333,475	349,889							
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	2.26	2.77	2.89	3.06	2.51	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.

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

	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%	63.2%							

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

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

	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
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 occuring in the reporting period

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

Underlying data for	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	479	578	575	517	494						
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	29,101	29,952	37,718	36,237	31,992	33,918						
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%	1.6%	1.7%	1.8%	1.7%	1.8%	1.7%	1.6%	1.6%	1.4%	1.7%	1.6%	1.5%	1.6%	1.6%	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

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

Underlying data for	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	453					
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	877					
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%	51.7%					

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

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

Underlying data for	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	9420	8934	8272	8322	8170	8147	8040	8880	8855	9816	10006	10163					
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	17,024	16,370	16,426	16,305	17,789	15,676	15,101	17,442	16,814	18,123	17,653	17,901					
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%	50.9%	52.7%	54.2%	56.7%	56.8%					

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

TIMELY — ACUTES: Percentage of people waiting <15 months for first access to opd15m services

Underlying data for	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					
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					
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%					

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

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

Underlying data for	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

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

Underlying data for	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	12,194					
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	19,603					
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%					

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

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

Underlying data for	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	11,741	12,619	11,907	11,499	11,850	10,683	9,606					
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	22,478	23,747	23,146	22,894	23,090	19,447	17,799					
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%	52.2%	53.1%	51.4%	50.2%	51.3%	54.9%	54.0%					

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

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

Underlying data for	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					

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

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

Underlying data for	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	983	1,078	1,199	1,021	833	923	785	771	848	770	666	1,627	2,693	1,268	2,243	2,149	1,719	455	450	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%	10.6%	13.8%	8.8%	7.1%	11.3%	7.5%	7.7%	14.3%	16.3%	14.3%	14.5%	20.6%	29.0%	29.6%	29.8%	18.6%	13.7%		

Numerator: Number of Assessments of Need completed within time frame as per regulations // Denominator: The total number of Assessments of Need completed // Data points: % child assessments completed within regulations timelines

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Underlying data for	WELLBEING			PRIMARY CARE: Percentage of child health & development assessments completed on time or before 12 months of age																																	
	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	1,762	1,954	2,270	2,379	2,338	2,468	2,793	2,829	3,241	3,372	3,201	2,967	3,360	3,519	3,779	3,769	4,001	3,884	4,013	4,097	4,284	4,286	4,316	4,130	4,146	3,722	3,813	3,747	3,906	3,937						
Denominator	4,238	4,295	4,727	4,338	4,182	4,353	4,591	4,578	4,656	4,511	4,264	4,024	4,525	4,360	4,566	4,504	4,560	4,631	4,921	4,806	4,994	4,994	4,874	4,835	4,767	4,158	4,457	4,328	4,518	4,352						
Data point	41.6%	45.5%	48.0%	54.8%	55.9%	56.7%	60.8%	61.8%	69.6%	74.8%	75.1%	73.7%	74.3%	80.7%	82.8%	83.7%	87.7%	83.9%	81.5%	85.2%	85.8%	85.8%	88.6%	85.4%	87.0%	89.5%	85.6%	86.6%	86.5%	90.5%						

Numerator: The number of babies having a health and development assessment completed by 12 months of age // Denominator: The number of babies reaching 12 months of age in the reporting period // Data points: % assessments completed in time or before 12months of age

Underlying data for	WELLBEING			PRIMARY CARE: Percentage of child health & development assessments completed on time or before 12 months of age																																	
	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	8,219	4,273	7,458	11,240	10,644	8,469	8,629	6,822	11,570	6,374	7,331	6,285	4,502	9,383	9,885	7,817	11,627	10,517	10,714	12,279	15,630	14,613	11,701	6,861	11,956	12,567	16,493	13,846	16,150	11,011	9,278					

Numerator: The number of babies having a health and development assessment completed by 12 months of age // Denominator: The number of babies reaching 12 months of age in the reporting period // Data points: % assessments completed in time or before 12months of age

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