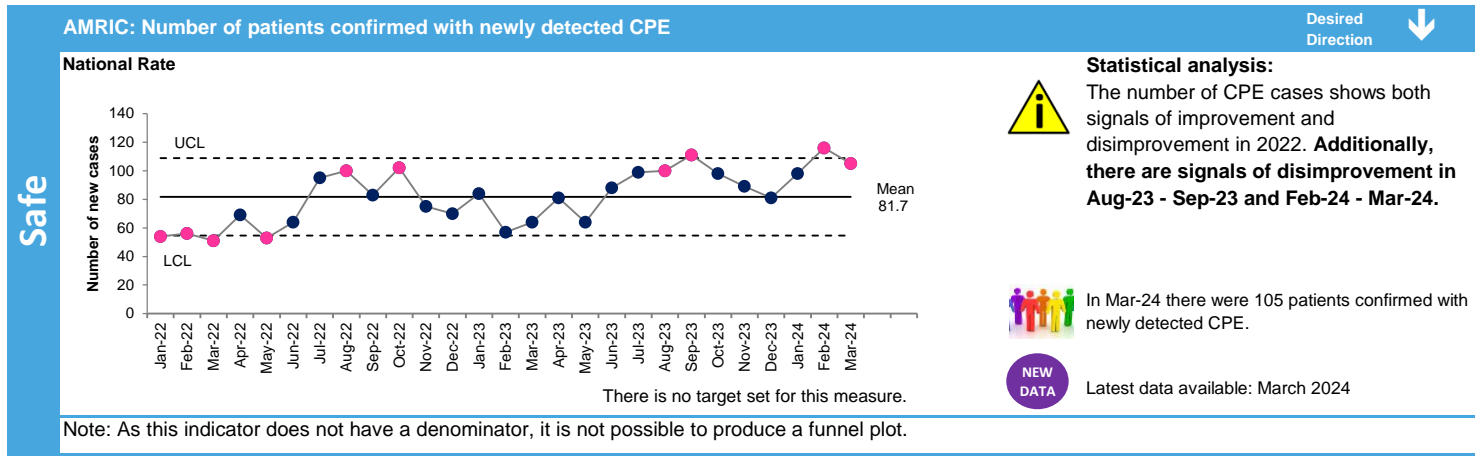The purpose of the Quality and Safety Profile is to provide statistical insights into quality and patient safety data and to support understanding of variation in performance over time. It is separate to processes supporting the performance and accountability framework under which the systems, procedures and practices for performance management and accountability are set out, monitored and reported on through the Performance Profile process up to and including the Board Strategic Scorecard. The interim performance and accountability framework covering the transition phase to August 2024 has recently been approved, pending the development of new formalised permanent arrangements.

Safe

AMRIC: Number of patients confirmed with newly detected CPE

Desired Direction ⬇

National Rate

There is no target set for this measure.

Statistical analysis:
The number of CPE cases shows both signals of improvement and disimprovement in 2022. **Additionally, there are signals of disimprovement in Aug-23 - Sep-23 and Feb-24 - Mar-24.**

In Mar-24 there were 105 patients confirmed with newly detected CPE.

NEW DATA Latest data available: March 2024

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

Service analysis (updated 25/04/2024):

• 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 newly detected CPE case numbers and screening numbers. Several hospitals have adopted a universal screening approach for CPE on admission. It is noted that there has been an upward trend in numbers of positive cases detected in Q1 2024, which is likely to be multi factorial and although detected by hospitals does not indicate that CPE was acquired in the reporting hospital. The National CPE reference laboratory service is providing ongoing support to CPE surveillance.

• 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

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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

Prepared by the Quality Patient Safety Directorate QPSI@hse.ie. **Preliminary data at 16:00 on 25th April 2024 subject to change until published.**

Page 1

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

Desired Direction ↓

Safe

National Data

No new months; updated values.
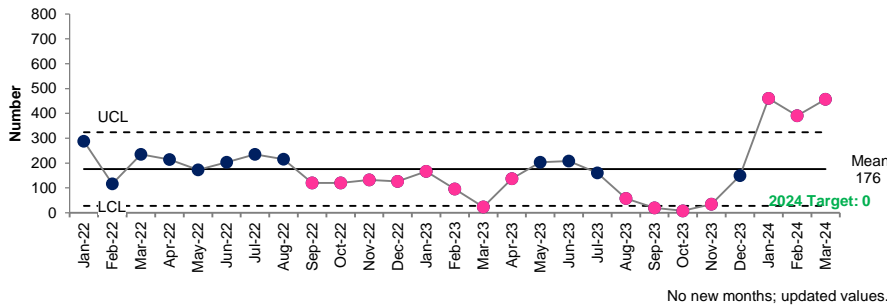
Statistical analysis:
Average national performance is above the 2024 target. There are signals of improvement Sep-22 - Apr-23 and Aug-23 - Nov-23 while for most recent 3 months there is a signal of disimprovement in Jan-24 and Mar-24.

Mar-24: there were 457 people waiting over four weeks for access to an urgent colonoscopy.

Latest data available: March 2024

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

Service analysis (updated 25/04/2024):

The NSP target is that no new patients wait greater than four weeks (28 days) for access to an urgent colonoscopy.
In March 2024 there were 457 breaches reported.

Dublin Midlands Hospital Group

No update received from hospital group.To date breaches in Portlaoise were due to demand on the service and the capacity challenges due to the unscheduled care demands within sites over the winter period. The hospital is working closely with private sites and outsourcing ongoing to facilitate patients with appointments. Capacity was also reduced due to Minor Capital works on Theatre.

There is no update on Naas breaches (n2)

RCSI Hospital Group

Breaches have occurred in the RCSI Hospitals Group as the endoscopy units in Beaumont and Connolly Hospitals have been closed/unavailable due to ED surge.

Saolta Hospital Group

There are a number of factors contributing to breaches in Roscommon UH and UH Galway.
1.Consultant staffing issues with one vacant post across both sites. Recruitment efforts are ongoing.
2.Inability to run weekend lists concurrently in both sites due to lab capacity.
3.Replacement works in the decontamination unit in RUH.
4.Reduction in capacity in UH Galway due to urgent and emergency care demand.

Mayo UH continues to breach due to ongoing loss of capacity due to urgent and emergency care demands.

All breaching patients have a TCI.

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

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Page 2

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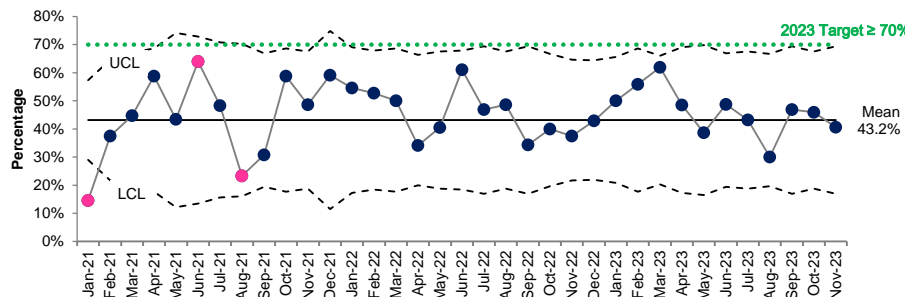
Desired Direction ⬆

National Rate

Statistical analysis:
Average national performance is below the 2023 target and stable since Sep-21.

32 category 1 incidents were notified in Nov-23 and commenced the review process. 13 of these reviews were completed within 125 days from the date the service was notified of the incident.

NEW DATA

Latest data available: November 2023

No funnel can be included for this measure at this time.

Service analysis (updated 25/04/2024):

The National Incident Management System (NIMS) is the incident management system used by HSE and HSE-funded healthcare providers to report incidents on. It is not only a legislative requirement under the NTMA (Amendment Act 2000) to report potential claims but reporting to NIMS provides an opportunity for learning locally and nationally by identifying incident trends and risks in the system.

The NIMS system is the source of the data used to calculate the system wide quality and safety KPIs. Relevance of this indicator: to assist with a responsive and timely approach to review and with building a culture of safety, reviews should be completed within the shortest possible timeframe.

This indicator captures patient related incidents only of major and extreme severity and excludes the incidents where there was a local or Serious Incident Management Team (SIMT) decision that no further review was necessary. The total number of such incidents captured for this reporting period in line with the aforementioned criteria is 450 incidents over a 12-month period nationally.

An extended turn-around-time for completion of reviews can lead to a poor experience for all those involved (patients, staff and the organisation). The NIMS system was recently updated to better improve the tracking progress with incident reviews and better understand where delays are occurring. An SOP to support staff in completing the review screen fields on the system where the data is pulled from was approved at the HSE Incident Management System Committee recently.
NQPSD will be engaging REO offices and local services concerning turn-around times and is providing training and technical assistance for local teams.

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

Desired Direction ⬇

Safe

National Rate

There is no target set for this measure.
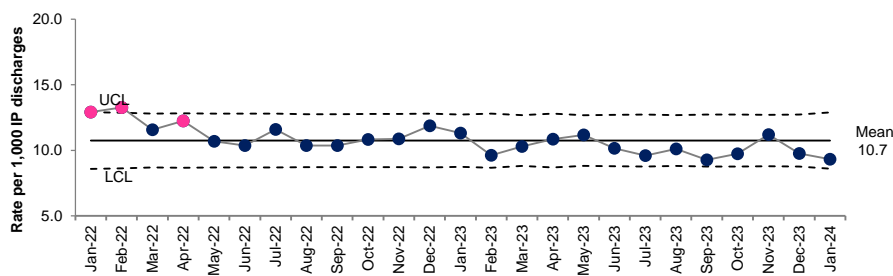
Statistical analysis:

The rates are stable since Apr-22. This KPI is based on HIPE data. Although data returns were not impacted for this KPI, HIPE data completeness for 2023 is 57.1%.

In Jan-24 there were 197 defined and suspected VTE blood clots associated with hospitalisation.

NEW DATA Latest data available: January 2024

No funnel plot is produced for this measure.

Service analysis (06/03/2024):

A VTE is a blood clot in the veins and can be fatal or have adverse long term health effects. Over half of VTE events happen in association with a hospitalization. This is called a "hospital-acquired thrombosis" or HAT. HAT is a leading cause of preventable hospital mortality and morbidity. It is therefore a crucial patient safety issue that every opportunity to prevent HAT is taken. This KPI monitors rates of suspected or confirmed hospital associated VTE which is extracted from HIPE data and can be used at local level to assess true HAT.

The NVTEP, currently a temporary patient safety national programme, works with BIU and hospitals to prevent HAT in our hospitals by encouraging local governance and monitoring cases of suspected or confirmed hospital associated VTE.

The KPI is based on HIPE data and is dependent on accurate and up to date coding. Rates are assessed in comparison to similar hospitals in terms of size and case mix. Please note that 6 to 8 hospitals' rates reported as zero in each of the last 3 months in MDR, only individual hospitals can clarify if these represent data gaps or true zeros therefore national rates should be considered in this context.

⚠	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

Prepared by the Quality Patient Safety Directorate QPSI@hse.ie. **Preliminary data at 16:00 on 25th April 2024 subject to change until published.**

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Safe

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

Desired Direction ↑

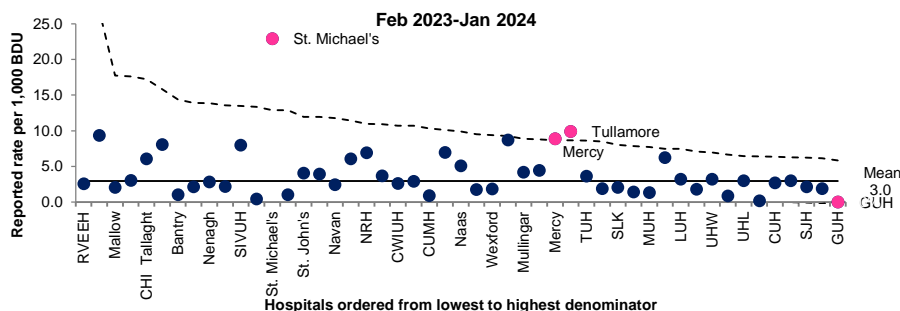**National Rate**
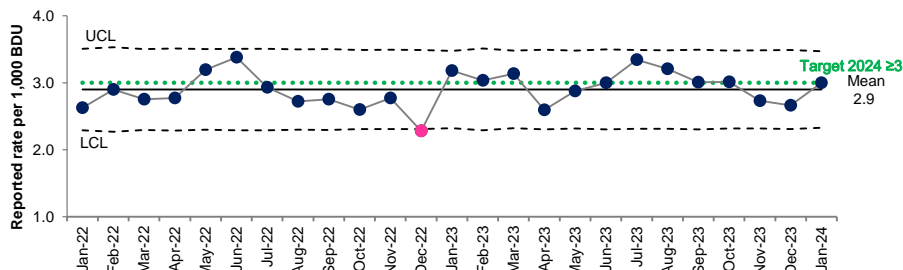
Statistical analysis:
The average reported rate is slightly lower than the 2024 target. Dec-22 shows a signal of disimprovement. No signals in the data since Jan-23.

In Jan-24 there were 1084 medication incidents reported to NIMS.

NEW DATA Latest data available: January 2024

Feb 2023-Jan 2024

Hospitals ordered from lowest to highest denominator

Statistical analysis funnel plot:
The SPC funnel plot for the last 12 months shows that the reported rates for St. Michael's (22.9), Mercy (8.9) and Tullamore (9.9) are higher (better) than expected relative to the national average while GUH (0.01) is lower. All other hospitals were within the expected range of variation.

Service analysis (updated 24/04/2024):

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

The mean reporting rate has risen to the target of 3.0 over the last 12 months, denoting slightly improved reporting associated with a positive medication safety culture.
The reporting rates in Tullamore, Mercy and St Michael's are higher (better) than expected.
Engagement with hospitals with reporting rates of less than 1.0 will proceed through the performance management system. This denotes very limited staff reporting of medication safety incidents and near misses and/or these reports not being entered to NIMS.

Note: The rate of medication safety incidents or adverse drug events cannot be determined from this measure. The incident reporting rate indicates the medication safety culture and ability of the hospital systems to support staff reporting.

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

Desired Direction ↑
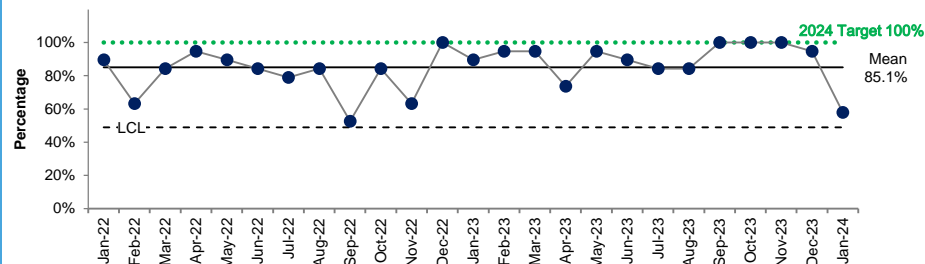
Safe

National Rate

Statistical analysis:
Average national performance is stable, and continues at an average below the 2024 target.

In Jan-24, out of the 19 maternity hospitals, there were 11 hospitals that have completed and published monthly Maternity Safety Statements.

NEW DATA Latest data available: January 2024

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

Service analysis (updated 23/04/2024):

The annual targets for the two MSS KPIs both A128 and A129 are 100%.

NWIHP has not found any resistance within the system to publishing the MSS although a small number of units have amended the pro-forma, this was established practice prior to NWIHP involvement. The MSS are published directly, two months in arrears, by the maternity hospitals and units to either their own hospital website or the dedicated HSE MSS homepage.

NWIHP continues to work with one site to encourage and offer assistance to reach timely reporting.
Two other sites had a delay due to change in governance structures, one of these hospitals has since published. The final hospital group was delayed due to the EMT requesting data be rechecked before sign off. The MSS for this hospital group were subsequently published.

⚠ 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

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

Desired Direction ↓

Safe

National Rate
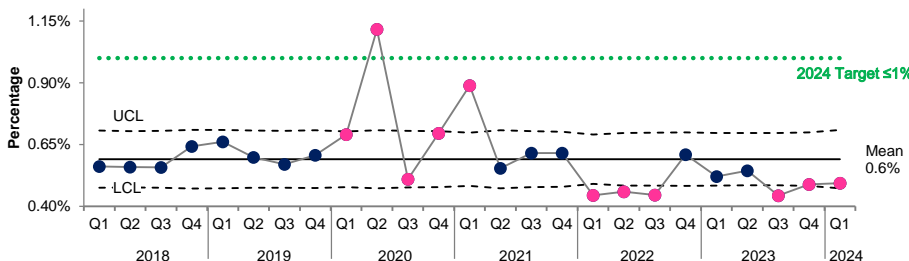
Statistical analysis:
Since 2018 the rates are below the target (better) except for Q2-20. For Q1,Q2 & Q4-20 and Q1-21 there were signals of disimprovement, while Q3-20 and Q1-Q3-22 and Q3-23 - Q1-24 show signals of improvement.
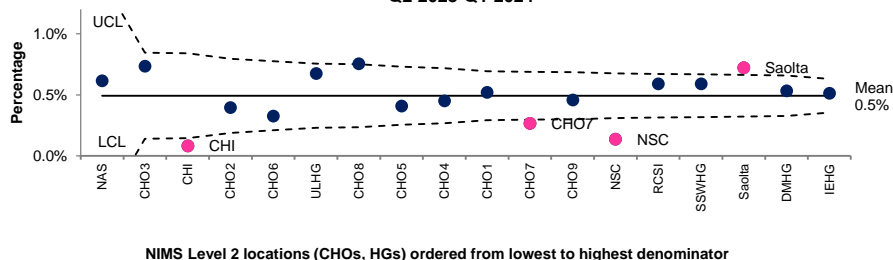
Q1-24: 37892 incidents occurred in this quarter and were recorded in NIMS until end of the quarter, of which 187 were Category 1 incidents

NEW DATA Latest data available: Q1 2024

Q2 2023-Q1 2024

NIMS Level 2 locations (CHOs, HGs) ordered from lowest to highest denominator

Statistical analysis funnel plot:
The SPC funnel plot for last 4 quarters shows Saolta(0.7%) is above the expected limits although within target, while CHO7 (0.2%), CHI (0.08%) and NSC (0.1%) are below the expected limits (better).

Service analysis (22.04.2024):

The National Incident Management System (NIMS) is the incident management system used by HSE and HSE-funded healthcare providers to report incidents on. It is not only a legislative requirement under the NTMA (Amendment Act 2000) to report potential claims but reporting to NIMS provides an opportunity for learning locally and nationally by identifying incident trends and risks in the system.
The NIMS system is the source of the data used to calculate the system wide quality and safety KPIs.
Relevance of this indicator: The percentage of extreme and major incidents of the total number of incidents reported on the system is a good proxy for a robust reporting culture.
All reported incidents must be uploaded onto NIMS. To provide assurance on comprehensive use of NIMS system, Category 1 incidents are expected to account for less than one percentage of total incidents reported. This is achievable when good reporting practices are in place and all incidents are captured.
Achieving a measure of less than 1% extreme and major incidents in the system is particularly relevant if the overall number of reported incidents is stable or increasing.
As shown in the graph below the trend for the overall number of incidents reported is positive although for the last two quarters the number of reported incidents is slightly lower than Q3 2023. Overall numbers for last two quarters may increase as services are clearing backlogs.
Although the percentage of extreme and major incidents of all incidents is well below the target, the reporting levels are not equally high across all services. The national team is continuously engaging with services to support them and improve buy-in in NIMS usage.
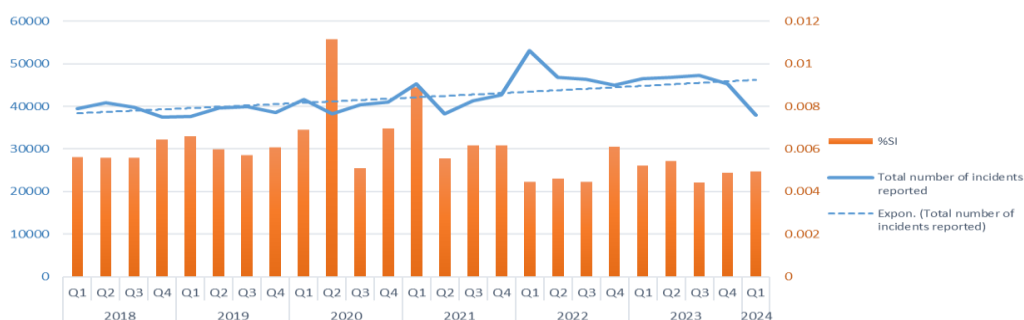
⚠️	Used to highlight a change in the assessment from last month; unexpected variation; or variance from the target.
NEW DATA	Indicates updated data for this measure this month
NO NEW DATA	Indicates no updated data available for this measure this month
NEW	Indicates a new measure this month
	Note: Special 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
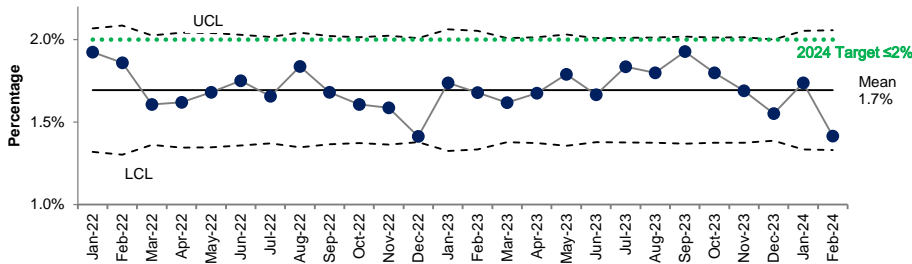
Statistical analysis:
Average national performance is stable and continues well below the 2024 target.

There were 30,175 surgical discharges in Feb-24 of whom 427 patients were re-admitted to the same hospital within 30 days of discharge.

NEW DATA Latest data available: February 2024

Mar 2023-Feb 2024

Statistical analysis funnel plot:
The SPC funnel plot for the last 12 months shows that the rate for UHL (3.8%) was higher than expected relative to the national average. All other hospitals were within the expected range of variation.
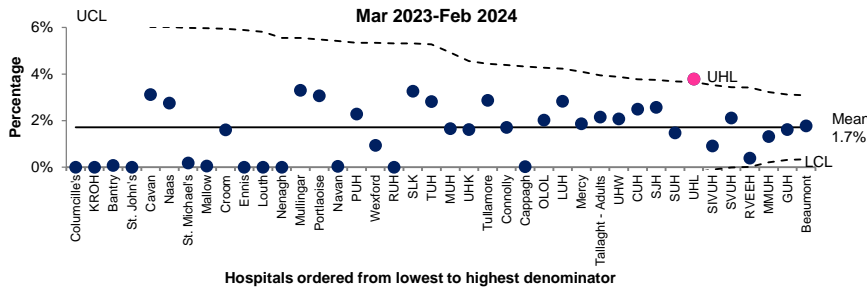
Service analysis (updated 25/04/2024):

The number of patients that were re-admitted was 427, this is down from 535 the previous month. The National Average is 1.7%.

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.

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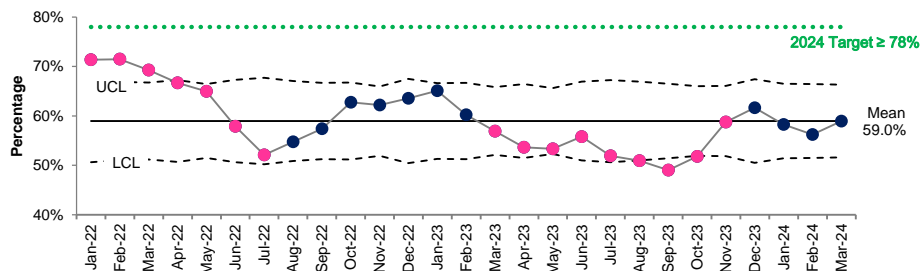
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CAMHS: Percentage of accepted referrals / re-referrals offered first appointment and seen within 12 weeks

Desired Direction ↑

Person-centred

National Rate

2024 Target ≥ 78%

Mean 59.0%

Statistical analysis:
Average national performance is below the 2024 target. There have been signals of disimprovement in Jan-22 - Jul-22. In addition the rates for Mar-23 - Nov23 show another signal of disimprovement.

There were 1,145 CAMHS appointments in Mar-24 (seen & DNA), of whom 675 were seen within 12 weeks.

Latest data available: March 2024

Mar 2024

Mean 59.0%

CHOs ordered from lowest to highest denominator

Statistical analysis funnel plot:
The SPC funnel plot for Mar-24 shows that the rates for CHO1 (79%), CHO2 (76%) and CHO3 (78%) are higher (better) than expected while rate for CHO5 (41%) is lower than expected. All other CHOs were within the expected range of variation.
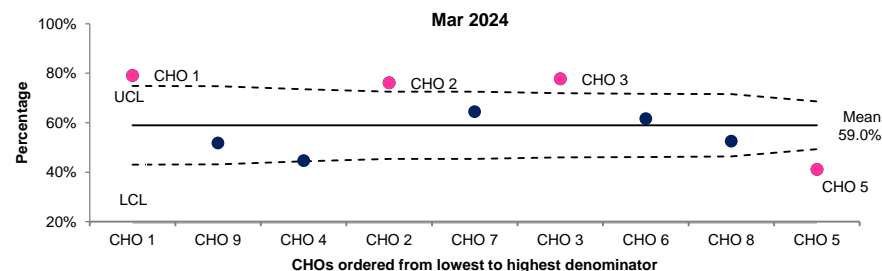
Service analysis (updated 25/04/2024):

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 2024, there was 3,798 referrals accepted to Community CAMHS which is +1.5% more than the same period in in 2023 (MH44)
3,348 new/re-referred appointments were offered which is -1.5% less than same period last year position (MH45)
Of these 3,171 were seen (MH46) and 177 (5.3%) did not attend their appointment (MH47)

As of the end of March, 57.8% of referrals accepted by child and adolescent community teams nationally were offered an appointment and seen within 12 weeks against a target of ≥78% (MH7). A detailed data analysis has been completed to establish contributory factors behind variances across CHOs. Engagement with CHO management teams', points to general trends, including increased demand for services, in part driven by population growth, recruitment and retention challenges, reduced seasonal capacity during summer months and the prioritisation of urgent referrals. In addition, CHOs have reported local issues, including long-term sick leave among key staff, which are proactively being addressed.
89.2% of new or re-referred cases were seen within 12 months in community CAMHS services YTD March 2024 (MH72).

The severity of presenting symptoms as well as an assessment of risk is always taken into account in terms of waiting times. 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.
Nationally, 94.1% of urgent referrals to CAMHS were responded to within three working days, above the ≥90% target. (MH73).
* Data return rate 100%

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	

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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

2024 Target 99%

UCL

Mean 53.4%

LCL

Note: Jan from live data.
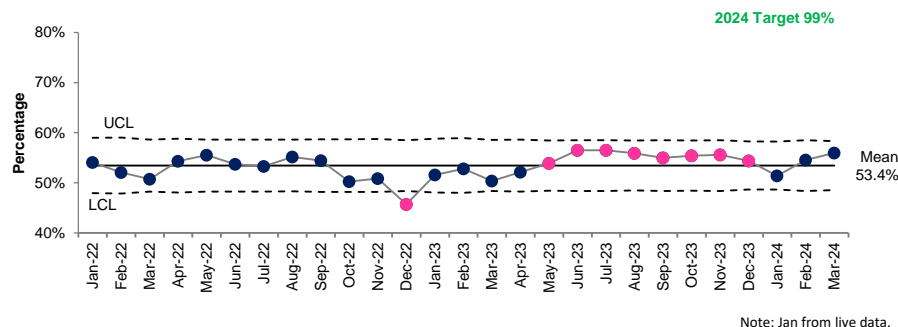
Statistical analysis:
Average national performance is below target with recent signal of improvement. The rate for Dec-22 showed a signal of disimprovement while rates for May-23 - Dec-23 show a signal of improvement.

Mar-24: 18,948 people 75+ years presented to ED, of whom 10,598 were discharged or admitted within 9 hours.

NEW DATA

Latest data available: March 2024

Apr 2023-Mar 2024

UCL

Mean 54.7%

LCL

Hospitals ordered from lowest to highest denominator

Hospitals: St. Michael's, Portlaoise, Navan, Mercy, PUH, Wexford, Mullingar, TUH, Naas, Cavan, UHK, SLK, MUH, SUH, Tallaght - Adults, Connolly, Tullamore, SJH, LUH, OLOL, GUH, UHW, MMUH, UHL, Beaumont, CUH, SVUH

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.
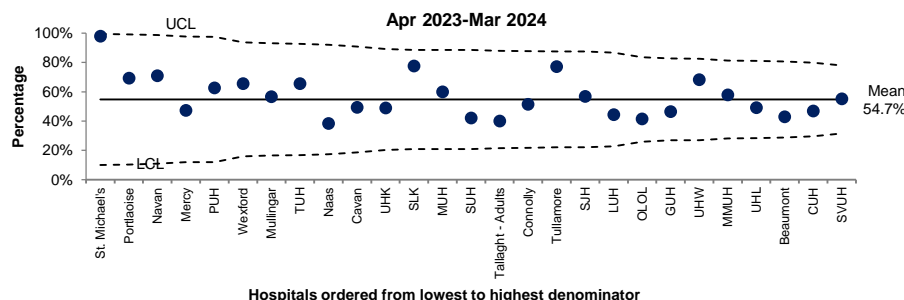
Service analysis (updated 25/04/2024):

At end of March 2024, 55.9% 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.

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. The UEC Operational Plan is to identify short-term initiatives and measures to be progressed to support UEC delivery until year end. This operational plan will lead into year one of the multi-annual UEC plan and will align with the governance structure of the overarching multi-annual UEC plan with key focus on 24 hour PET, 24 hour PET > 75, 8am trolley count, DTOC and NAS Turnaround times and Length of Stay.

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

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

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

Desired Direction ⬆

Timely

National Rate

Note: Jan from live data.
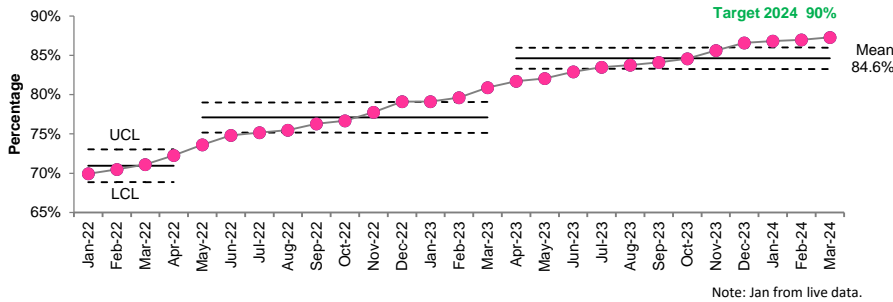
Statistical analysis:
Average national performance is below 2024 target but there are signals of improvement for the entire period. The control limits have been recalculated to reflect the new average.

Mar-24: there were 585,030 people waiting for first access to OPD services, of whom 510,707 were waiting less than 15 months.

NEW DATA

Latest data available: March 2024

Mar 2024

Hospitals ordered from lowest to highest denominator
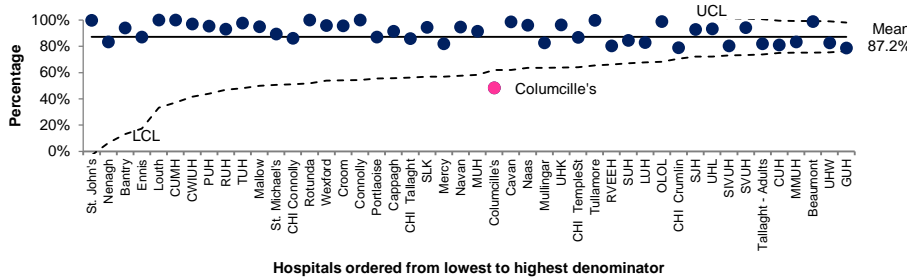
Statistical analysis funnel plot:
The SPC funnel plot for last month shows the range of variation in the rates by hospital. All hospitals are within the control limits, with the exception of Columcille's (48%) which is lower than expected.

Service analysis (updated 25/04/2024):

At the end of March 2024, 87.3% (585,030) of patients on the outpatient waiting list were waiting less than 15 months.

The 2024 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. It is an ambitious plan targeting significant additional activity to reduce waiting lists in line with Sláintecare reforms and the Government has allocated €437 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 take place with Hospital Sites to maximise waiting list improvements.

⚠ 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

Prepared by the Quality Patient Safety Directorate QPSI@hse.ie. **Preliminary data at 16:00 on 25th April 2024 subject to change until published.**

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

Desired Direction ⬆
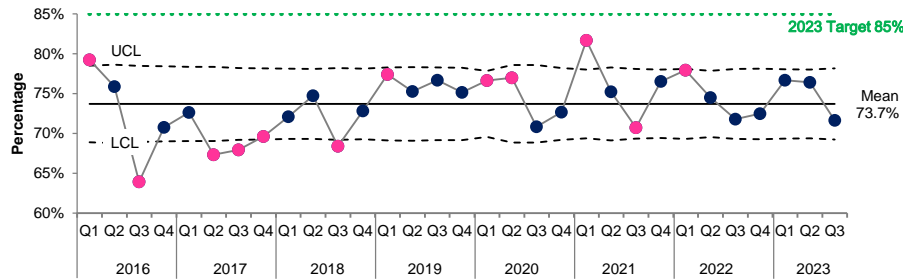
Timely

National Rate

2023 Target 85%

Mean 73.7%

Statistical analysis:
Average national performance is below the target. There were signals of improvement in Q1-21 and Q1-22 and a signal of disimprovement in Q3-21. There are no current signals in the most recent 6 quarters.

Q3-23: 878 inpatient discharges 60+ years had emergency hip fracture surgery, of which 629 were within 48h of initial assessment

Latest data available: Q3 2023

Q4 2022-Q3 2023

Hospitals ordered from lowest to highest denominator
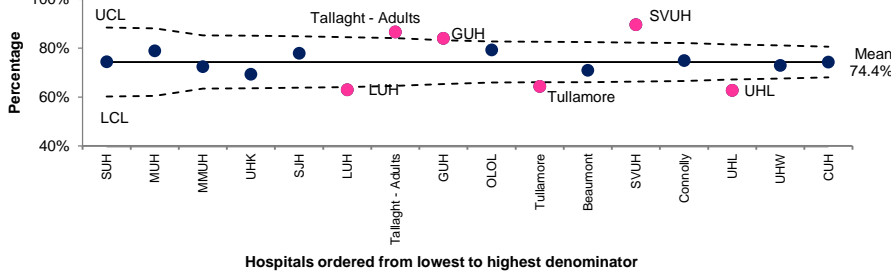
Statistical analysis funnel plot:
The SPC funnel plot for last 4 quarters shows the rates for Tallaght-Adults (87%), GUH (84%) and SVUH (90%) are above the expected limits (better) while Tullamore (64%), LUH (63%) and UHL(63%) are below the expected limits.

Service analysis (26/10/2023):

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.

•A cohort of patients are elderly with medical conditions which deem them unfit for surgery. They require medical assessment prior to surgery.

This causes delays and in a number of cases they are on medications which needs to be stopped at a minimum of 48 hrs pre surgery
•Activity
•Scheduling needs review with regard to theatre access and utilisation.

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

Prepared by the Quality Patient Safety Directorate QPSI@hse.ie. **Preliminary data at 16:00 on 25th April 2024 subject to change until published.**

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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 were signals of improvement Jan-22 - Jun-23. The last 9 months show a signal of disimprovement.

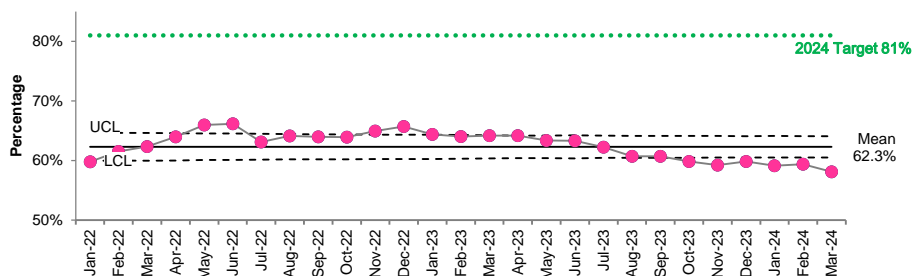Mar-24: 20,821 people were on the waiting list for Primary Care Psychology treatment, of whom 12,099 were waiting less than 52 weeks.

NEW DATA Latest data available: March 2024

Mar 2024

Statistical analysis funnel plot:
The SPC funnel plot for the last month shows the range of variation among CHOs. All CHOs are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by CHO, but there are no statistical differences between CHOs with higher or lower rates.
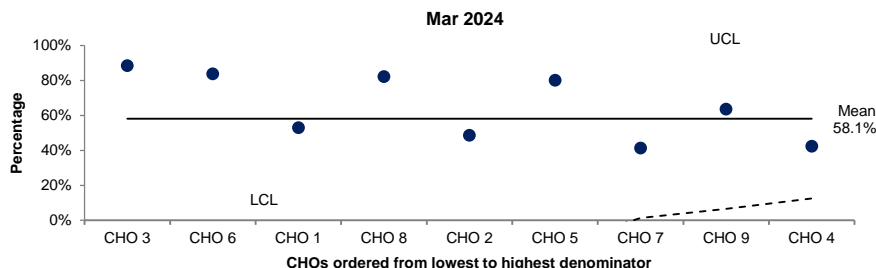
Service analysis (updated 25/04/2024):
58.1% are waiting for treatment ≤ 52 weeks at the end of March 2024, compared to the target of 81% (PC103G).
The number of Psychology patients on waiting list for treatment ≤ 52 weeks will require an additional 4,766 people to be seen to reach the target of 81%
The number of people waiting longer than 52 weeks has increased by +1.6% from 8,581 in February to 8,722 in March (PC103E).

In 2024 performance for Psychology continues to be monitored including in the monthly Primary Care engagement. The focus is on increasing numbers seen to drive improvements in waiting lists. The Heat map access trend continues to be monitored at CHO level. A new performance tool was developed in 2023 which shows numbers seen per WTE for each CHO for all therapy services – the rolling data for a 12 month period was provided to each CHO and discussed in the CHO engagements.

Numbers of referrals to date is 4,879 which represents an increase of +85.4% in expected activity (2,631) and +4.9% ahead of the same period last year (4,651) (PC38)

The number of new patients seen for first time at the end of March 2024 is 3,074 which is +0.8% ahead of same period last year position of 3,049 (PC40)
CHOs 1, 2, 4, 6 and 7 are over 10% of achieving this year's target for access

Performance data for Psychology is impacted by non-return of data from 2 LHOs in 2024.
*Data return rate 96.9%

Note on Primary Care Services
The underlying trend in numbers seen by Primary Care Therapy Services continues to improve. At March 2024 the total number of patients seen is -4.4% behind of the same period in 2023. However there are ongoing performance challenges in some therapy services that are being discussed through the engagement between Primary Care national operations in the engagement calls with heads of services in the CHOs.

One of the factors impacting on the numbers of patients seen is the complexity of people's needs.
Many patients require a multi-disciplinary approach and in a number of cases ongoing treatment is required for an extended 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 results in longer waiting times as patients are clinically prioritised.
Overall, there was 93% return rate for data across Primary Care Services in March 2024.

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

Desired Direction ↑

Timely

National Rate

2024 Target 64%

Mean 53.3%
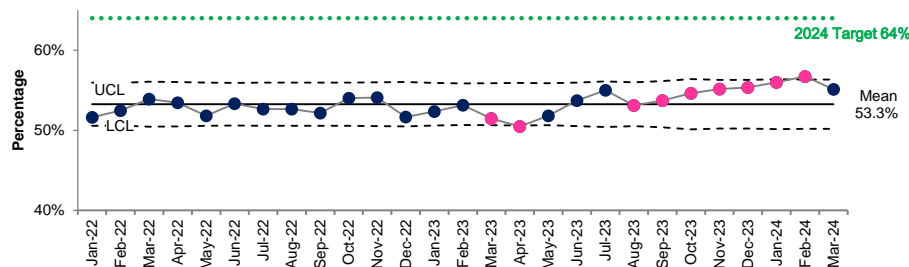
Statistical analysis:
Average national performance is below the target. There is a signal of disimprovement in Mar-23 - Apr-23 and a signal of improvement improvement in Aug-23 - Feb-24..

Mar-24: 16,881 people were on the waiting list for Primary Care Ophthalmology treatment, of whom 9,302 were waiting less than 52 weeks.
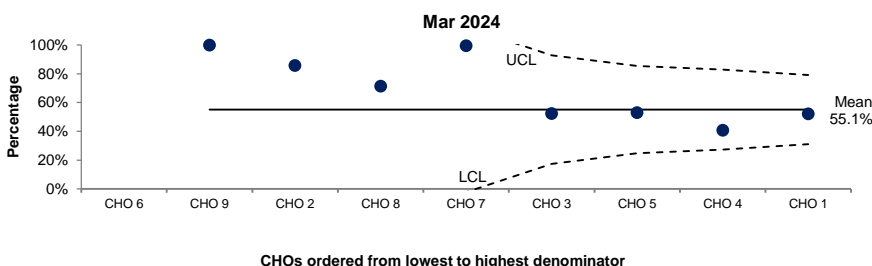
NEW DATA Latest data available: March 2024

Mar 2024

UCL

Mean 55.1%

LCL

CHOs ordered from lowest to highest denominator

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

Service analysis (updated 25/04/2024):

55.1% are waiting for treatment ≤ 52 weeks at the end of March 2024, compared to the target of 64% (PC107G).
The number of Ophthalmology patients on waiting list for treatment ≤ 52 weeks will require an additional 1,502 people to be seen to reach the target of 64%
The number of people waiting longer than 52 weeks has increased by +2.4% from 7,401 in February to 7,579 in March (PC107E).

In 2024 performance for Ophthalmology continues to be monitored including in the monthly Primary Care engagement. The focus is on increasing numbers seen to drive improvements in waiting lists. The Heat map access trend continues to be monitored at CHO level are required to submit performance improvement plans where necessary. A new performance tool was developed in 2023 which shows numbers seen per WTE for each CHO for all therapy services – the rolling data for a 12 month period was provided to each CHO and discussed in the CHO engagements.

Numbers of referrals to date is 6,381 which represents an increase of +4.6% in expected activity (6,102) and -15.6% behind the same period last year (7,564) (PC52)

The number of new patients seen for first time assessment at the end of March 2024 is 6,813 which is +3.4% ahead of same period last year position of 6,588 (PC54)

CHOs 3, 8 and 9 are over 10% of achieving this year's target for access.
Performance data for Ophthalmology is impacted by non-return of data from 5 LHOs in 2024.
*Data return rate 87%

⚠️ 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

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Efficient

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

Desired Direction ⬇

National Data
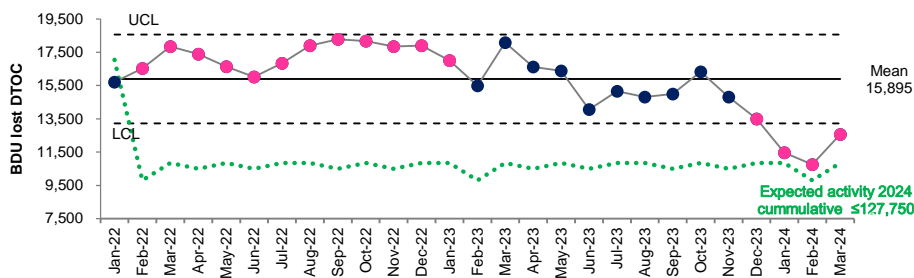
Statistical analysis:

⚠️ **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 are signals of improvement in Dec-23 - Mar-24.

Mar-24: 12,564 acute bed days were lost through delayed transfers of care. As of end of Mar-24 there were 411 beds subject to Delayed Transfer of Care.

NEW DATA Latest data available: March 2024

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

Service analysis (25/04/2024):

At the end of March 2024, there were 411 Delayed Transfers of Care;down 32% compared to March 2023 (60). 12,564 Bed Days Lost were reported due to delayed transfers of care compared to February 2023 (18,086).

|					
⚠️ 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	

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

Desired Direction ↑

Equitable

National Rate
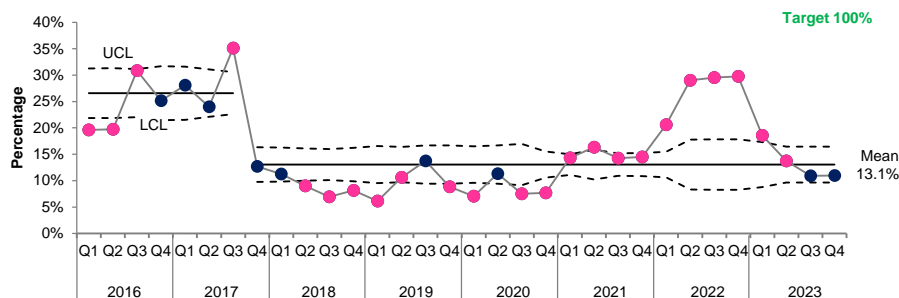
Statistical analysis:
Average national performance is below the target with a sustained reduction since Q4 2017. However the rates for Q1-21 - Q4-22 indicate signals of improvement. Rates for Q1-23 - Q2-23 are a signal of disimpovement.

Q4-23: 883 Assessments of Need were completed, of which 97 were within 3 months of their commencement or within a revised time frame negotiated as per the regulations

NEW DATA Latest data available: Q4 2023

Q1 2023-Q4 2023
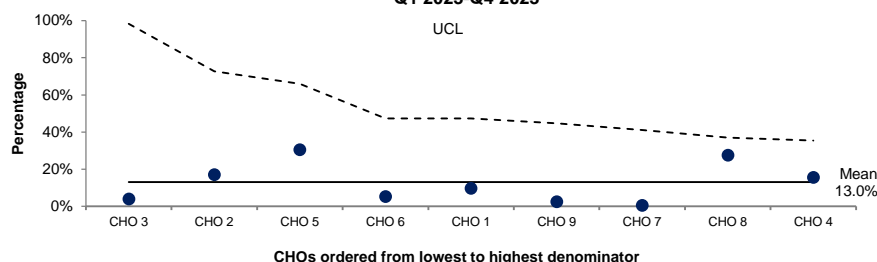
Statistical analysis funnel plot:
The SPC funnel plot for the last 4 quarters shows the range of variation among CHOs. All CHOs are within the control limits, although the control limits are very wide. This indicates that there is a lot of variation in the rates by CHO, but there are no statistical differences between CHOs with higher or lower rates.

Service analysis (25/04/2024):

The Assessment of Need process is set out in the Disability Act, 2005. The aim of an Assessment of Need under the Disability Act is to identify whether a person has a disability, the nature and extent of the disability, any health and education needs arising from that disability, as well as what services are required to meet those needs.

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 1, 2024, 11% of assessments were completed within the timeframes set out in the Disability Act 2005 and accompanying Regulations.

The numbers of applications for AON under the Act have risen steadily since its implementation in June 2007. 8,472 applications for AON were received in 2023. This was the highest number of applications received in any 12 month period since Part 2 of the Act was commenced in June 2007 and represents a 23% increase on the number of AON applications received in the previous 12 months. This growth has continued into 2024, with a further 2,603 received in Quarter 1 (470 up on same period last year).

The HSE has endeavoured to meet its legislative obligations under the Act. However, as a consequence of a High Court ruling of December 2009, the effect of which was to open eligibility to all persons born after 1st June 2002 who are suspected of having a disability, the number of children aged five and over, and in addition of school-going age, has risen steadily as a percentage of all applications received. At the end of 2011, the figure stood at 26%, while throughout 2023, this figure averaged 62%. In the first quarter of 2024, this figure has increased to 68%. This is a reflection that the AON process is an accumulative process in terms of numbers of children and young people seeking access.

The judgement of Ms Justice S Phelan in the case of CTM & JA v the HSE was delivered in March 2022. This judgment found that the Preliminary Team Assessment approach described in the HSE's Standard Operating Procedure for Assessment of Need does not meet the requirements of the Disability Act. This judgement in effect requires the HSE to deliver diagnostic assessments where necessary and appropriate as part of the Assessment of Need process. This ruling has a significant impact operationally and has resulted in a growth in the numbers of overdue Assessments of Need. The requirement for services to prioritise the statutory Assessment of Need process will also impact significantly on their capacity to provide necessary intervention / treatment for children with disabilities.

As a result of the Judgement, activity indicates that there has been an increase in the total number of applications 'overdue for completion', which now stands at 9,924 (including 369 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).

It is important to note that children do not require an Assessment of Need as defined by the Disability Act (2005) in order to access a Children's Disability Network Team (CDNT) or Primary Care service. They can be referred by a healthcare professional or parent/carer to the CDNT for children with complex needs as a result of their disability, or to Primary Care for children with non-complex needs. This direct access ensures more efficient and timely access for many families.

The increased numbers of applications for Assessment of Need, which is a legal entitlement under the Disability Act 2005, is a reflection of the increase in population and of families exploring all options for accessing services for their child.

In 2023, the HSE spent approximately €10.5m commissioning AONs from the private sector, in addition to what it was able to deliver within existing services. The HSE will continue to secure any available capacity though it is of the view that the available capacity is being maximised.

The situation in relation to AON is not the same in every area. The numbers of applications in some areas have historically been significantly lower than other areas. This reflects a service model used in those areas to engage with families as soon as practicable and support them to access services without them having to resort to the Assessment of Need legal route.

This will be explored by the HSE in the context of the Roadmap for Service Improvement actions relating to Services Access and Improvement, with the objective to spread this good practice across all teams nationally, and rebalancing the demand for AON with CDNT Service Provision, including workshops with families and with staff on how this can be achieved.

Data return rate 100%

|				
⚠ 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

Wellbeing

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

Desired Direction ↑

National Rate

Expected activity 2024 cummulative 148,000

Mean 11,523
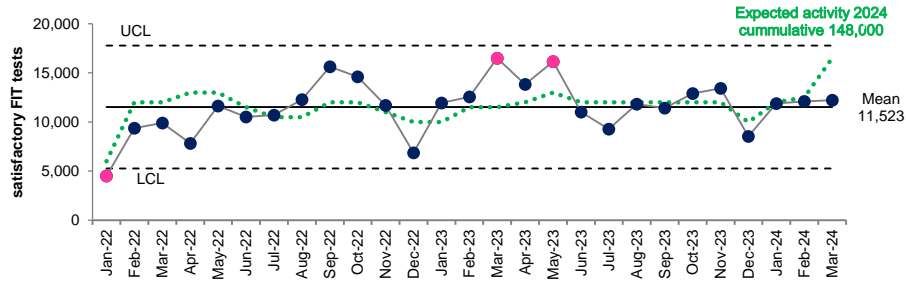
Statistical analysis:
There are signals of improvement in Mar-23 and May-23. The monthly targets are included as per metadata specifications.

Mar-24: there were 12,211 people screened by the BowelScreen programme who have completed a satisfactory FIT test.

Latest data available: March 2024

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

Service analysis (updated 23/04/2024):

Eligible BowelScreen clients are aged 59-69 years. The programme expanded to include 59 year olds from 01/10/2023. The eligible population is invited over that a 2-year period (approximately 600,000 people).

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

The number of men and women who have completed a satisfactory BowelScreen FIT test in the period (March 2024) was 12,211 which is below the target of 16,500 by 4,289 (26%). The number of men and women who have completed a satisfactory BowelScreen FIT test year to date (Jan-March 2024) was 36,204 which is below the target of 41,000 by 4,796 (11.7%).

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

The BowelScreen Patient Reported Experience Measures (PREMs) has a Net Promoter Score (NPS) of 75.6% for the period Jan-March 2024, a score considered exceptional by international standards.

Net Promoter Score Defined
Net Promoter Score (NPS) is a metric that measures customer satisfaction and loyalty by asking one key question: "How likely are you to recommend our company/product/service to a friend or colleague?". Based on their responses, customers are grouped into Promoters, Passives and Detractors, with NPS being the difference between the percentage of Promoters and Detractors.
• Promoters (9-10): Loyal enthusiasts who will most likely recommend your business to others and help attract new customers.
• Passives (7-8): Although satisfied, these customers are not devoted to your brand and may easily switch to a competitor if a better offer is on their radar.
• Detractors (0-6): Unhappy customers who may affect your business reputation and growth through negative word-of-mouth.

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

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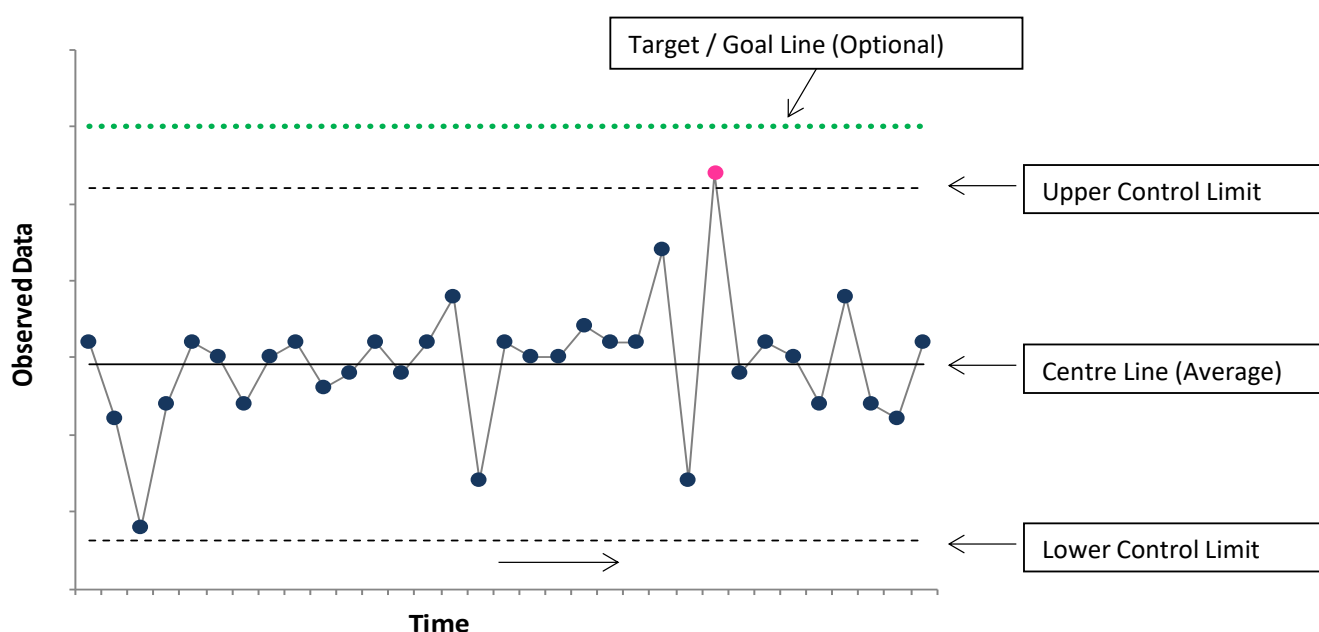
References
Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011

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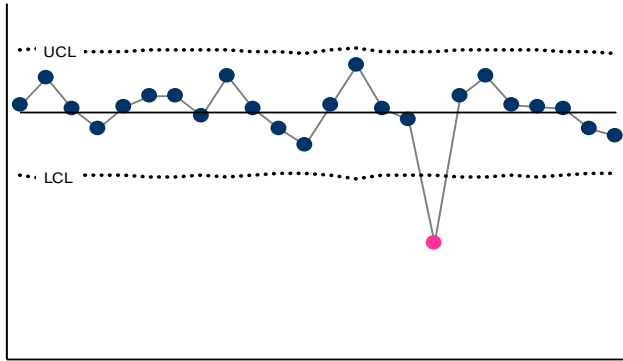
2. A run of 8 or more consecutive points above or below the centre line
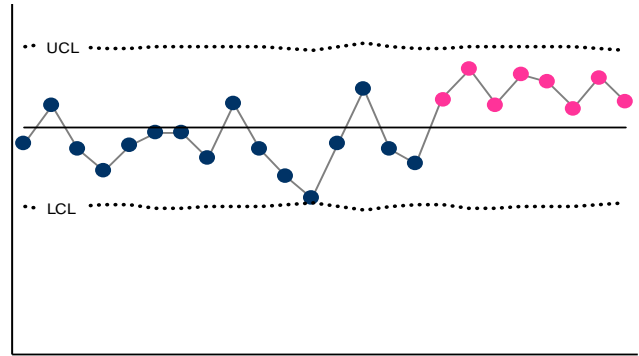
3. A trend of at least 6 consecutive points all going up or down
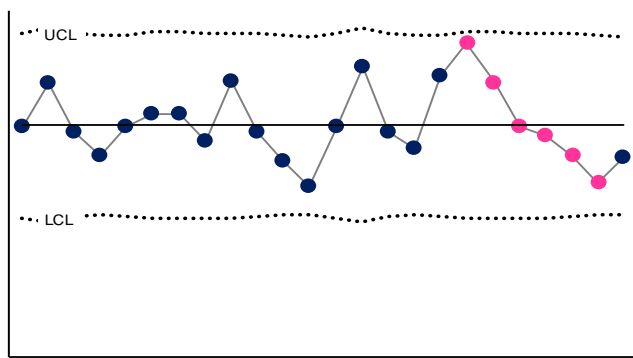
4. Two out of three consecutive points in the outer third (or beyond)
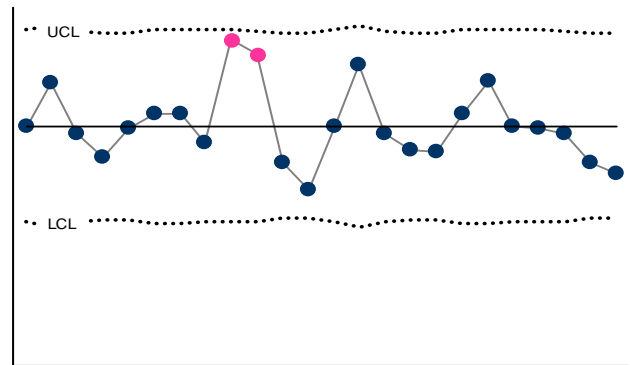
5. A series of 15 consecutive points close to the centre line (in the inner one-third)

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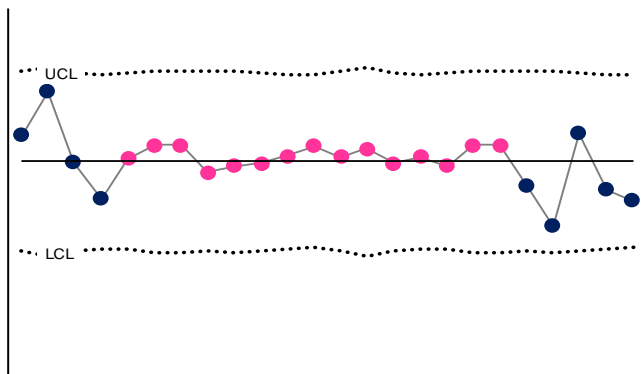
Anatomy of a Statistical Process Control Funnel Plot

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
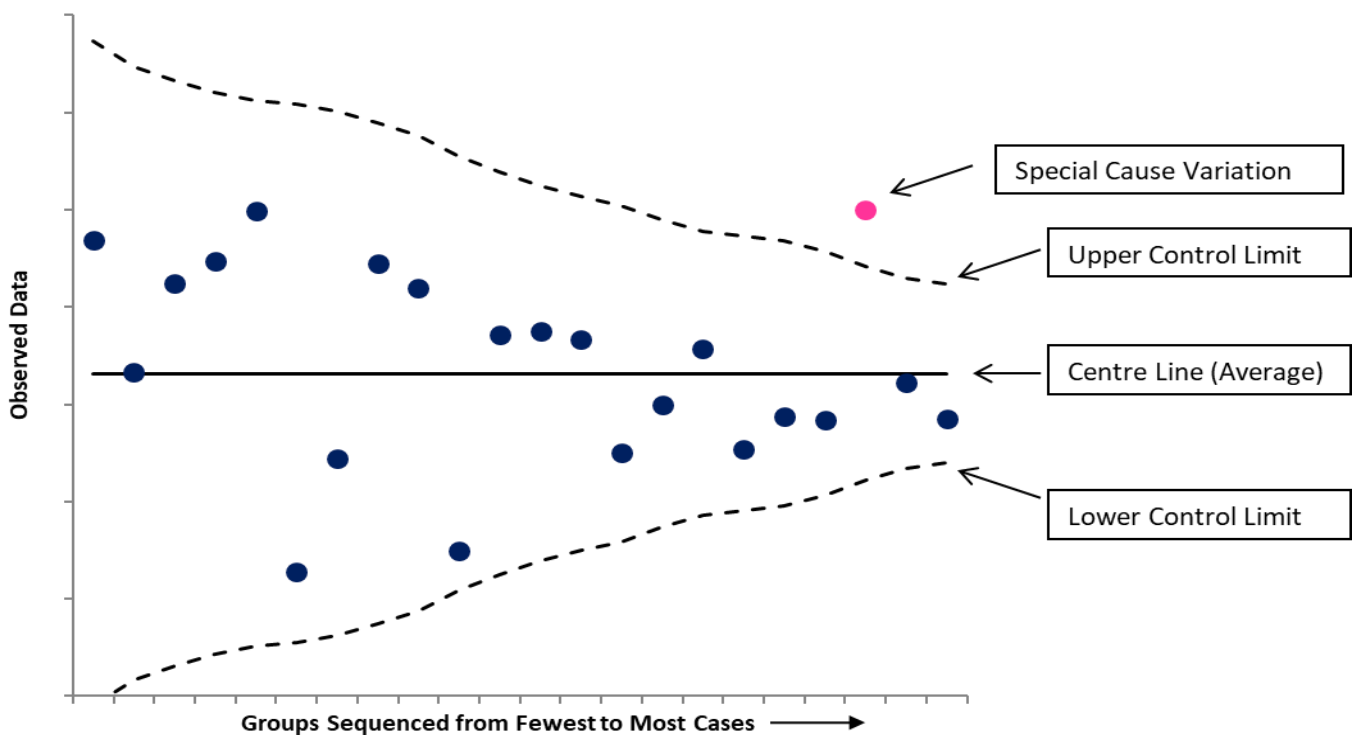
Example 1: Percentage of patients with a hip fracture undergoing surgery within 48 hours, by hospital
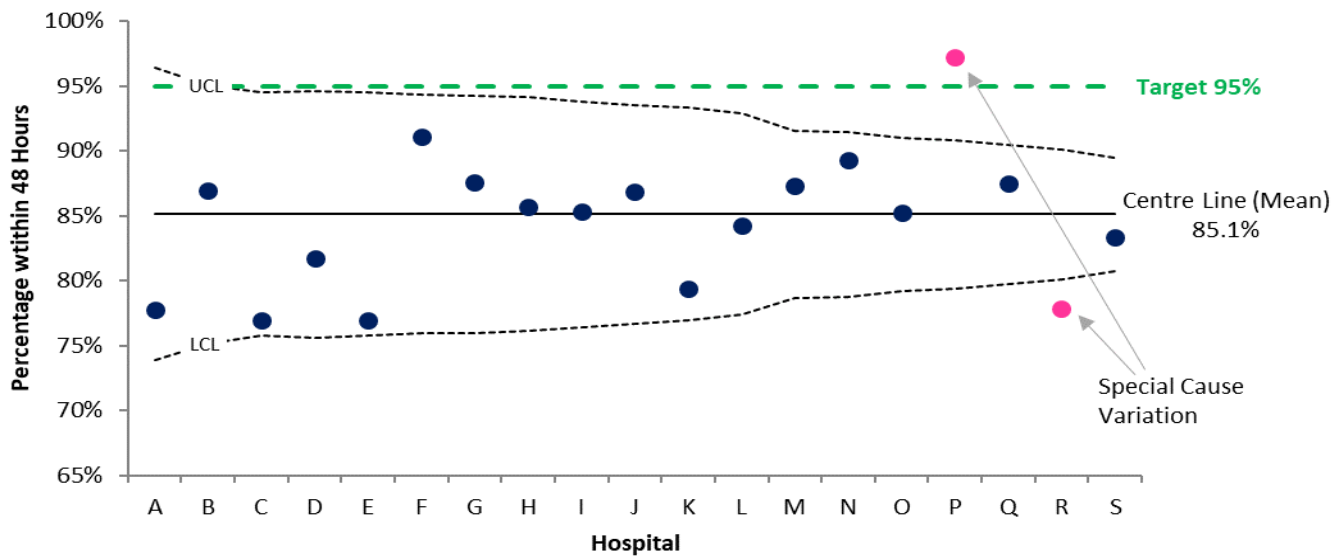
Example 2: Rate of falls per 1,000 bed days, by community nursing units

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Quality and Safety Profile Indicators Metadata

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

Safe

Calculation	Numerator: Number of new cases of hospital acquired S. *aureus* bloodstream infection.
	Denominator: Number of bed days used
	Rate is calculated as the numerator/denominator*10,000.
Details of analysis	National level data are displayed in an SPC U chart since January 2022
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	Indicator not included in this Quality and Safety Profile.
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf

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

Safe

Calculation	Numerator: Number of new cases of hospital associated C. difficile infection.
	Denominator: Number of bed days used
	Rate is calculated as the numerator/denominator*10,000.
Details of analysis	National level data are displayed in an SPC U chart since January 2021
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	Indicator not included in this Quality and Safety Profile.
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf

AMRIC: Number of patients confirmed with newly detected CPE

Safe

Calculation	Numerator: Number of patients confirmed with newly detected CPE.
Details of analysis	National level data are displayed in an SPC C chart since January 2021
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf

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

Safe

Calculation	Count: Number of New patients waiting greater than 28 days for an Urgent Colonoscopy
Details of analysis	National level data are displayed in an SPC I chart since January 2021.
Data source	Acute Management Data Report
Data frequency	Monthly
Data coverage	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf

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

Safe

Calculation	Numerator: Number of incidents included in Denominator where the review was completed in no more than 125 calendar days.
	Denominator: Number of Category 1 Incidents involving service users, where a decision that 'further review is not necessary' was not made that were notified between last day of reporting month-125days and 12 months prior
Details of analysis	National level data are displayed in an SPC P chart since January 2021.
Data source	NIMS KPIs report
Data frequency	Monthly
Data coverage	No known current data coverage issues.
Further information	https://www.hse.ie/eng/services/publications/kpis/2024-national-quality-and-patient-safety-directorate-incident-management-nsp-metadata.pdf

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Quality and Safety Profile Indicators Metadata

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

Safe		
Calculation	Numerator: Number of adult in-patient discharges with a length of stay of 2 or more days with an additional diagnosis of VTE.	
	Denominator: Number of adult in-patient discharges with a length of stay of 2 or more days	
	Rate is calculated as the numerator/denominator*1,000.	
Details of analysis	National level data are displayed in an SPC U chart since January 2021	
Data source	Acute Management Data Report	
Data frequency	Monthly	
Data coverage	Indicator based on HIPE data. HIPE data completeness YTD Dec 2023 57.7%. This KPI may be impacted.	
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf	

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

Safe		
Calculation	Numerator: number of medication-related incidents as reported on NIMS	
	Denominator: number of in-patient bed days	
	Rate is calculated as the numerator/denominator*1,000.	
Details of analysis	National level data are displayed in an SPC 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/acute-metadata-2024.pdf	

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

Safe		
Calculation	% maternity hospitals that completed and published MSS = number of maternity hospitals that completed and published MSS/ total number of maternity hospitals	
Details of analysis	National level data are displayed in an SPC I chart since January 2021.	
Data source	Acute Management Data Report	
Data frequency	Monthly	
Data coverage	No known current data coverage issues.	
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf	

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

Safe		
Calculation	Numerator: Number of Category 1 incidents that occurred in the reporting period.	
	Denominator: Number of incidents that occurred in the reporting period	
Details of analysis	National level data are displayed in an SPC P chart since Q1 2018.	
Data source	NIMS KPIs reports from Jan 2022. For 2018-2021 data was re-calculated from NIMS system using same methodology as reports issued from 2022 to ensure a consistent approach.	
Data frequency	Quarterly	
Data coverage	No known current data coverage issues.	
Further information	https://www.hse.ie/eng/services/publications/kpis/2024-national-quality-and-patient-safety-directorate-incident-management-nsp-metadata.pdf	

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

Effective		
Calculation	Numerator: Number of Surgical discharges (inpatient & daycase) in the denominator period which resulted in an emergency readmission to the same hospital within 30 days	
	Denominator: Number of Surgical discharges (elective and emergency) in the denominator period (denominator period is set 30 days in arrears)	
Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021.	
Data source	Acute Management Data Report	
Data frequency	Monthly	
Data coverage	No known current data coverage issues. This KPI is based on HIPE data and my be impacted by data HIPE completeness- YTD Dec 2023 57.7%.	
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf	

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Quality and Safety Profile Indicators Metadata

Person-centred

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

Calculation	Numerator: Number of new / re-referred cases offered an urgent or routine appointment and seen up to 13 weeks
	Denominator: Total number offered an appointment, seen and DNA
Details of analysis	National level data are displayed in an SPC P Prime chart since January 2021.
Data source	Community Healthcare Metric Report – QlikView
Data frequency	Monthly
Data coverage	Data outstanding for North Tipperary CAMHS West LHO Feb-24.
Further information	https://www.hse.ie/eng/services/publications/kpis/2024-mental-health-services-nsp-metadata.pdf

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

Calculation	Numerator - All ED patients aged >75 years of age, who are admitted to a ward or discharged in less than 9 hours from their Arrival Time.
	Denominator - All patient attendances at ED who are aged over 75 years of age who are admitted or discharged
Details of analysis	National level data are displayed in an SPC P Prime chart since January 2022.
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/acute-metadata-2024.pdf

Timely

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

Calculation	Numerator: Number of outpatient patients waiting to be seen less than 15 months
	Denominator: Total number of patients waiting to be seen in Outpatients
Details of analysis	National level data are displayed in an SPC P Prime chart since November 2022
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/acute-metadata-2024.pdf
	Acute Metadata 2024 not yet published. Target 2024 available in NSP 2024.

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

Calculation	Numerator: The number of inpatient discharges aged over 60 in the reporting period where emergency hip fracture surgery was carried out within 48 hours of initial assessment.
	Denominator: The number of inpatient discharges aged over 60 in the reporting period where emergency hip fracture surgery was carried out.
Details of analysis	National level data are displayed in an SPC P chart since Quarter 1 2016.
Data source	Irish Hip Fracture Database (IHFD)
Data frequency	Quarterly in arrears
Data coverage	Q4 2023 data has not been provided and therefore is unavailable at present.
Further information	https://www.hse.ie/eng/services/publications/kpis/acute-metadata-2024.pdf

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

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	Partial data gaps for LHOs Dublin North Jan-23 - Oct-23, South Tipperary Feb-23 - Dec-23, Wexford Jan-24 and Meath Mar-24.
Further information	https://www.hse.ie/eng/services/publications/kpis/2024-primary-care-services-nsp-metadata.pdf

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Quality and Safety Profile Indicators Metadata

Timely

PRIMARY CARE: Percentage of ophthalmology patients on waiting list for treatment ≤52 weeks	
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	Partial data gaps for LHOs Galway Jul-23 and Mar-24, Louth Sep-23 - Feb-24, North Lee Oct-23, Wexford Jan-24 and Cavan Monaghan Mar-24.
Further information	https://www.hse.ie/eng/services/publications/kpis/2024-primary-care-services-nsp-metadata.pdf

Efficient

ACUTES: Number of acute bed days lost through delayed transfers of care	
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 2022
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/acute-metadata-2024.pdf
	Acute Metadata 2024 not yet published. Target 2024 available in NSP 2024.

Equitable

SOCIAL CARE: Disability Act Compliance: percentage of child assessments of need completed within the timelines	
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/2024-disability-services-nsp-metadata.pdf

Wellbeing

NSP: No. of clients who have completed a satisfactory BowelScreen FIT test	
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 2022
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/2024-national-screening-services-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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AMRIC: Hospital acquired new cases of S. aureus bloodstream infection per 10,000 bed days used

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	37	24	29	29	31	37	35	39	24	31	30	30	21	30	26	28	28	28	29	26	35	16	30	30	33	32										
Denominator	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856	340,770	343,168	333,875	346,887	343,132	336,912	361,323	343,331										
Data point	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	1.0	0.7	0.8	0.8	0.8	0.9	0.8	1.0	0.5	0.9	0.9	0.9	0.9										

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

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

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	76	64	49	66	65	69	81	70	67	81	86	62	80	60	81	65	72	72	73	61	69	80	76	92	84	68										
Denominator	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856	340,770	343,168	333,875	350,255	346,649	336,912	361,323	343,331										
Data point	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	2.1	2.2	2.1	1.8	2.1	2.3	2.2	2.7	2.3	2.0										

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

AMRIC: Number of patients confirmed with newly detected CPE

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Data point	54	56	51	69	53	64	95	100	83	102	75	70	84	57	64	81	64	88	99	100	111	98	89	81	98	116	105									

Count: Number of patients confirmed with newly detected CPE

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

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Data point	288	116	235	214	173	203	235	215	120	120	132	126	167	96	24	137	203	208	160	58	20	8	35	150	460	391	457									

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

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

Underlying data for SAFE	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Numerator	16	18	17	20	10	16	14	7	12	20	18	13	18	19	17	14	15	22	15	18	11	16	18	21	22	19	26	16	12	19	16	12	15	17	13	
Denominator	110	48	38	34	23	25	29	30	39	34	37	22	33	36	34	41	37	36	32	37	32	40	48	49	44	34	42	33	31	39	37	40	32	37	32	
Data point	15%	38%	45%	59%	43%	64%	48%	23%	31%	59%	49%	59%	55%	53%	50%	34%	41%	61%	47%	49%	34%	40%	38%	43%	50%	56%	62%	48%	39%	49%	43%	30%	47%	46%	41%	

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.

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

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	267	283	267	273	247	239	268	246	246	253	255	274	275	218	266	251	290	258	237	258	229	239	280	240	197											
Denominator	20,681	21,325	23,104	22,315	23,123	23,089	23,112	23,748	23,729	23,348	23,452	23,067	24,297	22,688	25,855	23,157	25,935	25,387	24,679	25,537	24,697	24,577	25,018	24,595	21,140											
Data point	12.91	13.27	11.56	12.23	10.68	10.35	11.60	10.36	10.37	10.84	10.87	11.88	11.32	9.61	10.29	10.84	11.18	10.16	9.60	10.10	9.27	9.72	11.19	9.76	9.32											

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.

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

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	834	857	892	868	1038	1072	935	894	885	883	929	774	1122	958	1102	864	1007	992	1140	1101	1004	1055	946	897	1084											
Denominator	317,791	295,637	324,004	313,425	325,123	317,222	319,275	328,313	321,557	339,739	335,342	339,311	352,862	315,666	351,660	333,056	350,160	330,856	340,770	343,168	333,875	350,255	346,649	336,912	361,323											
Data point	2.62	2.90	2.75	2.77	3.19	3.38	2.93	2.72	2.75	2.60	2.77	2.28	3.18	3.03	3.13	2.59	2.88	3.00	3.35	3.21	3.01	3.01	2.73	2.66	3.00											

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.

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

Underlying data for SAFE	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Data point	89.5%	63.2%	84.2%	94.7%	89.5%	84.2%	78.9%	84.2%	52.6%	84.2%	63.2%	100.0%	89.5%	94.7%	94.7%	73.7%	94.7%	89.5%	84.2%	84.2%	100.0%	100.0%	100.0%	94.7%	57.9%											

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

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

Underlying data for SAFE	2018				2019				2020				2021				2022				2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator	222	228	222	241	249	237	228	234	288	427	206	285	403	242	215	206	274	242	255	210	221	187						
Denominator	39521	40813	39779	37482	37682	39569	39963	38579	41671	38259	40385	40984	45330	38260	41285	42740	53032	46807	46278	45000	46482	46878	47332	45213	37892			
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%	0.5%	0.4%	0.5%	0.5%			

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	544	481	579	531	555	619	631	603	616	621	576	565	506	513	644	643	621	667	722	698	725	702	655	654	535	427										
Denominator	28,288	25,870	36,048	32,768	33,035	35,341	38,078	32,827	36,671	38,636	36,313	39,999	29,103	30,567	39,787	38,372	34,693	40,019	39,321	38,818	37,628	39,016	38,744	42,136	30,782	30,175										
Data point	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%	1.7%	1.6%	1.7%	1.8%	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.6%	1.7%	1.4%										

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

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	635	704	708	601	721	518	421	515	599	642	782	541	690	621	744	592	744	546	466	496	533	645	716	530	638	623	675									
Denominator	890	985	1,022	901	1,110	895	808	940	1,043	1,023	1,257	851	1,060	1,031	1,307	1,103	1,394	978	897	974	1,087	1,245	1,219	860	1,095	1,108	1,145									
Data point	71.3%	71.5%	69.3%	66.7%	65.0%	57.9%	52.1%	54.8%	57.4%	62.8%	62.2%	63.6%	65.1%	60.2%	56.9%	53.7%	53.4%	55.8%	52.0%	50.9%	49.0%	51.8%	58.7%	61.6%	58.3%	56.2%	59.0%									

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

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	8008	7552	8499	8461	9356	8991	8903	9379	8891	8238	8281	8105	8099	7998	8788	8772	9713	9928	10030	10244	9625	10050	9818	10666	10164	9689	10598									
Denominator	14,816	14,508	16,750	15,575	16,841	16,749	16,705	17,003	16,331	16,398	16,275	17,729	15,698	15,144	17,455	16,818	18,020	17,573	17,755	18,333	17,499	18,140	17,668	19,616	19,773	17,767	18,948									
Data point	54.0%	52.1%	50.7%	54.3%	55.6%	53.7%	53.3%	55.2%	54.4%	50.2%	50.9%	45.7%	51.6%	52.8%	50.3%	52.2%	53.9%	56.5%	56.5%	55.9%	55.0%	55.4%	55.6%	54.4%	51.4%	54.5%	55.9%									

Numerator: All ED patients aged > In Jan-24 there were 0 defined and suspected VTE blood clots associated with hospitalisation.

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	437,392	441,730	444,502	451,509	459,628	466,897	472,046	475,149	477,239	470,888	468,858	462,604	466,559	474,585	481,313	487,245	492,974	496,041	501,918	503,346	502,270	498,021	496,549	486,649	493,680	503,320	510,707									
Denominator	625,513	626,658	625,056	624,773	624,444	623,903	627,856	629,447	625,673	614,225	602,832	584,626	589,670	596,099	594,858	596,265	600,888	598,228	601,140	600,819	597,081	588,813	580,055	562,039	568,691	578,595	585,030									
Data point	69.9%	70.5%	71.1%	72.3%	73.6%	74.8%	75.2%	75.5%	76.3%	76.7%	77.8%	79.1%	79.1%	79.6%	80.9%	81.7%	82.0%	82.9%	83.5%	83.8%	84.1%	84.6%	85.6%	86.6%	86.8%	87.0%	87.3%									

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

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

	2016				2017				2018				2019				2020				2021				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator	599	547	489	557	584	540	583	607	649	677	589	646	641	614	644	638	781	568	522	627	771	628	647	723	706	756	652	648	704	713	629	
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	933	878	
Data point	79.2%	75.9%	63.9%	70.8%	67.3%	67.9%	69.6%	72.1%	74.7%	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%	76.4%	71.6%	

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

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	7,442	7,707	7,752	8,145	9,000	9,035	9,041	9,630	9,856	9,931	10,476	10,546	10,596	10,879	11,465	11,955	12,093	11,469	12,206	12,052	12,203	12,164	12,277	12,641	12,117	12,551	12,099									
Denominator	12,446	12,524	12,433	12,732	13,638	13,656	14,323	15,015	15,410	15,530	16,130	16,047	16,462	16,986	17,865	18,622	19,078	18,116	19,616	19,853	20,092	20,332	20,720	21,122	20,499	21,132	20,821									
Data point	59.8%	61.5%	62.4%	64.0%	66.0%	66.2%	63.1%	64.1%	64.0%	63.9%	64.9%	65.7%	64.4%	64.0%	64.2%	64.2%	63.4%	63.3%	62.2%	60.7%	60.7%	59.8%	59.3%	59.8%	59.1%	59.4%	58.1%									

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

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Numerator	11,495	11,940	11,012	11,083	11,339	12,102	11,655	11,539	11,565	11,944	11,713	10,850	11,788	12,618	11,922	11,565	11,982	11,664	10,871	11,301	10,306	8,875	9,473	9,680	9,268	9,702	9,302									
Denominator	22,265	22,763	20,437	20,736	21,882	22,686	22,135	21,917	22,169	22,118	21,657	21,006	22,520	23,746	23,132	22,900	23,132	21,712	19,768	21,284	19,192	16,247	17,173	17,495	16,552	17,103	16,881									
Data point	51.6%	52.5%	53.9%	53.4%	51.8%	53.3%	52.7%	52.6%	52.2%	54.0%	54.1%	51.7%	52.3%	53.1%	51.5%	50.5%	51.8%	53.7%	55.0%	53.1%	53.7%	54.6%	55.2%	55.3%	56.0%	56.7%	55.1%									

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

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

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Data point	15,717	16,529	17,845	17,394	16,649	16,027	16,847	17,900	18,280	18,175	17,838	17,895	17,015	15,487	18,086	16,627	16,383	14,064	15,165	14,815	14,988	16,338	14,814	13,502	11,462	10,755	12,564									

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

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

	2016				2017				2018				2019				2020				2021				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator	157	156	261	169	194	210	392	119	111	97	83	83	51	98	108	68	60	87	50	125	386	207	320	311	354	132	133	133	104	120	97	97
Denominator	800	791	845	672	690	875	1,116	937	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	888	883
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%	10.9%	11.0%

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

Underlying data for WELLBEING — NSP: No. of clients who have completed a satisfactory BowelScreen FIT test

	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	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Data point	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	11,807	11,425	12,887	13,415	8,550	11,889	12,104	12,211									

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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