Health and Community Services

Quality and Performance Report June 2023

Government of Jersey

INTRODUCTION

The Operations, Performance & Finance Committee obtains assurance that high standards of care are provided by Health and Community Services (HCS) and in particular, that adequate and appropriate governance structures are in place.

PURPOSE

The Quality and Performance Report (QPR) is the reporting tool providing assurance and evidence to the committee that care groups are meeting quality and performance across the full range of HCS services and activities. Indicators are chosen that are considered important and robust to enable monitoring against the organisation's objectives. Where performance is below standards, the committee will ensure that robust recovery plans are developed and implemented.

BACKGROUND

The Operations, Performance & Finance Committee has been established by the Health and Community Services Board and is authorised to investigate any activity within its terms of reference.

SPONSORS:

Interim Chief Nurse - Jessie Marshall

Medical Director - Patrick Armstrong

Director Clinical Services - Claire Thompson

Director Mental Health & Adult Social Care - Andy Weir

DATA

HCS Informatics

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EXECUTIVE SUMMARY

The Quality & Performance Report is designed to provide assurance in relation to Health and Community Services' performance. Indicators are chosen that are considered important and robust to enable monitoring against the organisation's objectives.

General & Acute Performance

June saw a slight increase in General Acute Outpatient referrals and a slightly higher than average conversion to inpatient waiting list. Outpatient appointments picked up compared to previous months due to increased Bank Holidays reducing normal capacity. This activity demonstrates good achievement as it was in the immediate post go live phase of the new patient administration system (PAS) as planned activity was reduced for elements of this month. This was delivered by some elements of waiting list recovery commencing with weekend and evening appointments. Elective admissions were lower during this time as inpatient activity (particularly high volume lists) were reduced in the immediate go live period. The outpatient & TCI waiting list grew due to the impact of the new PAS as new processes embedded and validation was affected. This is being addressed.

The Emergency Department also saw a slightly higher than average attendances in month. High numbers of medically fit for discharge remain in JGH capacity. Work is ongoing in regards to operational flow, discharge best practice, LOS and intermediate care capacity to respond to this, however the ongoing challenges of lack of capacity with the external private nursing and residential beds or ability to provide domiciliary care is recognised. The ED quality metrics are being reviewed against best practice guidance to describe areas of quality improvement.

Mental Health and Social Care Performance

Despite a high / increased level of referrals for both crisis assessment and routine referrals in June, mental health services have continued to achieve our target for face to face crisis assessment within 4 hours (97% in June) but have experienced a slight dip in achieving our target for all routine assessments within 10 days (83% in June). Examination of all cases has shown that this is predominantly due to patient choice, or to the person not being contactable or not attending an appointment. The mental health team will continue to monitor this.

Delays in accessing psychological therapies (post assessment) and diagnostic services (including the dementia memory service) remain the key pressure, and this relates to both demand and a lack of available clincial staff to address the level of need. We continue to work on this, and are about to commence a recuitment drive focussed specifically on mental health services.

Quality and Safety

Safety incidents relating to falls has increased for the second month from 6.5 to 8.6 per 1000 bed days and is now above the national average of 6.63 per 1000 bed days. That said, the level of harm caused remains low with the majority of patients sustaining no or low harm. The rate of falls in hospital will be impacted by current inpatients and would suggest that current rate of falls would be impacted by the number of medically fit for discharge patients. Hospital acquired pressure damage acquired in care has increased from 9 in May to 18 in June. All category 2 and above are reviewed by the Tissue Viability team to ensure accurate grading of pressure damage, formulation of care plans and the use of appropriate pressure relieving devices in place. The use of medical devices was associated with one of the 18 incidents. There remains a focus on staff and patient education and training in the management and prevention of pressure damage. Complaints are reported two months in arrears, however number of complaints received during May was significantly less than the previous two months but with a sharp increase in June. There has been a decrease in open complaints since the last report despite the complaints received remaining consistent. Quality indicators within Infection Prevention and Control (IPAC) demonstrate a low number of hospital acquired infection.

DEMAND

These measures monitor demand and activity in Health & Community Services. The information is used to provide contextual information when planning services and interpreting the Quality and Performance indicators in the following sections of the report.

Measure	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	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3431	3282	3597	3440	3586	4104	3332	3837	3622	4812	3731	3805	4278		22337	12%	25%
General and Acute Outpatient Referrals - Under 18	380	331	335	301	302	365	411	348	432	414	308	308	434		2068	41%	14%
Additions to Inpatient Waiting List	501	473	498	434	535	581	451	455	495	571	468	433	396		2818	-9%	-21%
Referrals to Mental Health Crisis Team	ND	ND	ND	ND	ND	52	91	87	83	90	91	94	114		559	21%	NA
Referrals to Mental Health Assessment Team	ND	ND	ND	ND	ND	139	201	237	215	271	187	229	247		1386	8%	NA
Referrals to Memory Service	25	27	31	33	21	33	30	57	43	56	43	29	27		255	-7%	8%
Referrals to Jersey Talking Therapies	97	80	91	99	111	114	74	104	98	135	109	94	105		645	12%	8%

ACTIVITY

Measure	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	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	18214	17437	18087	17344	19057	21502	16596	19916	19315	21533	16712	17488	17682		112646	1%	-3%
Elective Admissions	258	235	209	221	240	230	163	213	233	335	315	267	179		1542	-33%	-31%
Elective Day Cases	554	611	601	592	685	700	532	629	615	701	428	583	549		3505	-6%	-1%
Elective Regular Day Admissions	934	893	961	919	908	923	903	952	884	1064	932	1085	1058		5975	-2%	13%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	373	330	291	292	274	277	268	316	240	245	180	163	160		1304	-2%	-57%
Emergency Department Attendances	3707	3742	3882	3515	3479	3394	3325	3270	2982	3501	3345	3547	3762		20407	6%	1%
Emergency Admissions	550	551	566	529	583	588	571	579	502	571	555	627	591		3425	-6%	7%
Admissions to Adult Mental Health unit (Orchard House)	13	14	22	16	14	11	8	16	13	15	10	9	12		75	33%	-8%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	0	0	0	0	0	0	1	0	1	0	0	0	0		1	NA	NA
Maternity Deliveries	65	79	78	70	62	70	60	75	60	67	59	67	53		381	-21%	-18%

WAITING LISTS

Measure	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	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9825	9813	9775	9815	9394	9049	9245	9036	8571	9044	9296	9814	10917		10917	11%	11%
Outpatient 1st Appointment Waiting List - Acute	7542	7614	7625	7652	7265	7069	7247	7232	6807	7413	7860	8399	9875		9875	18%	31%
Outpatient 1st Appointment Waiting List - Community	2283	2199	2150	2163	2129	1980	1998	1804	1764	1631	1436	1415	1807		1807	28%	-21%
Diagnostics Waiting List	1151	1106	1093	1055	1022	1027	992	955	908	1030	1025	1027	971		971	-5%	-16%
Elective Waiting List	2169	2181	2220	2230	2157	2186	2293	2409	2424	2385	2434	2375	2699		2699	14%	24%
Elective Waiting List - Under 18	110	112	103	110	100	84	87	90	106	101	91	93	100		100	8%	-9%
Jersey Talking Therapies Assessment Waiting List	118	92	99	133	143	150	146	138	117	160	168	148	134		134	-9%	14%

QUALITY AND PERFORMANCE SCORECARD

The Quality and Performance Scorecard summarises HCS performance on the key indicators, chosen because they are considered important and robust to enable monitoring against the organisation's objectives. Standards are set based on appropriate benchmarks, e.g. with other jurisdictions, or past performance in Jersey. Where performance is below standards, exception reports are provided. For some indicators, a standard is not considered applicable.

CATEGORY	INDICATOR	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	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	46.3%	47.0%	46.7%	47.2%	46.2%	44.0%	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%		40.2%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	36.5%	38.2%	38.3%	37.6%	35.2%	33.0%	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%		35.8%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	78.6%	77.5%	76.3%	81.0%	83.6%	83.1%	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	52.3%		52.3%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	52.4%	43.6%	47.8%	48.6%	48.1%	49.8%	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%		69.8%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	55.2%	56.4%	54.3%	57.4%	53.3%	49.6%	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%		58.1%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	3.0	2.8	2.8	2.7	2.6	2.7	2.8	2.8	2.8	2.9	2.8	3.0	3.1		2.9	2.0
	Outpatient Did Not Attend (DNA) Rate	7.3%	7.6%	7.8%	8.2%	7.6%	8.2%	7.8%	7.5%	6.8%	6.9%	7.0%	7.3%	11.2%		7.8%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	2.7	2.5	2.2	1.9	2.5	2.6	2.3	1.8	1.7	2.1	2.3	2.2	2.5		2.1	<3
	% of all elective admissions that were day cases	82%	77%	86%	81%	79%	76%	81%	80%	79%	78%	75%	76%	74%		77.1%	>80%
	% of all elective admissions that were private	31%	26%	22%	29%	25%	25%	30%	30%	24%	29%	28%	30%	31%		28.5%	>32% and <34%
Theatres	Elective Theatre List Utilisation (Main Theatres, Day Surgery/Minor Operations)	77.1%	75.9%	72.8%	72.0%	75.3%	74.1%	66.6%	72.2%	72.2%	72.7%	77.9%	65.4%	50.8%		67.0%	>85%
	Turnaround time as % of total session time	17.8%	21.7%	15.7%	14.0%	13.1%	14.9%	14.7%	18.3%	19.0%	16.9%	14.7%	13.3%	11.2%		15.4%	<15%

CATEGORY	INDICATOR	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	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	10	10	11	11	9	10	10	11	11	10	12	14	26		14	<11
	% Triaged within Target - Minor	55%	57%	47%	51%	59%	53%	51%	51%	52%	54%	49%	43%	26%		46%	>=90%
	% Triaged within Target - Major	71%	68%	64%	64%	67%	63%	61%	60%	60%	64%	58%	56%	31%		54%	>=90%
	Median Time from Arrival to commencing Treatment	41	42	43	44	43	39	40	38	41	38	44	41	60		44	<75
	% Commenced Treatment within Target - Minor	82%	84%	80%	84%	83%	86%	84%	83%	86%	85%	82%	84%	78%		83%	>=70%
	% Commenced Treatment within Target - Major	67%	65%	64%	65%	63%	61%	61%	62%	64%	66%	63%	66%	53%		62%	>=70%
	Median Total Stay in ED (mins)	141	142	141	142	153	148	160	158	148	149	160	156	173		157	<189
	Total patients in ED > 10 hours	19	15	18	29	12	27	69	45	19	55	39	54	58		270	<1
	ED conversion rate	14%	14%	14%	15%	16%	17%	17%	17%	16%	16%	16%	16%	15%		16%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	7.4	6.7	7.6	7.3	6.0	6.1	7.4	7.1	7.0	7.1	6.6	6.5	6.1		6.7	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	9%	10%	10%	9%	11%	8%	7%	7%	9%	8%	8%	11%	14%		10%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	80%	77%	83%	87%	87%	91%	85%	89%	82%	85%	85%	79%	66%		81%	<85%
	% of Inpatients discharged between 8am and noon	15%	12%	12%	13%	10%	11%	11%	13%	11%	12%	11%	13%	13%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	33.5	38.4	34.9	32.4	26.2	24.0	31.1	23.2	23.9	31.1	24.2	ND	ND		25.6	<30
	Total Bed Days Medically Fit For Discharge	1107	1191	1081	972	811	721	932	718	669	932	702	ND	ND		3021	<910
	Total Bed Days Delayed Transfer Of Care (DTOC)	ND	487	691	582	578	466	622	442	511	628	467	ND	ND		2048	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	15%	15%	14%	17%	15%	14%	13%	15%	16%	11%	14%	16%	18%		15%	<10%

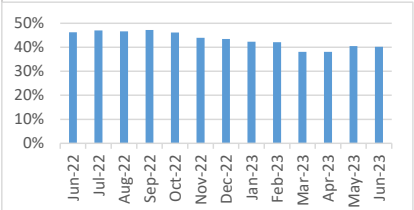
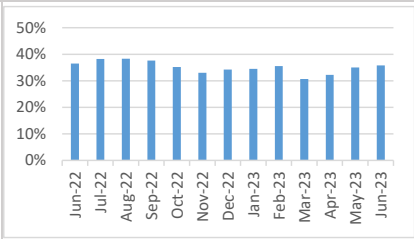
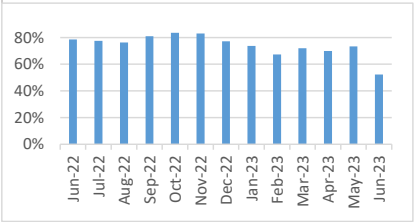
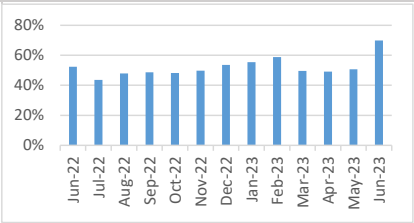
CATEGORY	INDICATOR	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	5.9%	1.1%	0.0%	0.0%	0.7%	1.3%	0.0%	2.2%	1.7%	0.0%	2.4%	4.1%	3.7%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	27%	51%	51%	59%	59%	64%	28%	61%	38%	47%	20%	36%	35%		43%	<5%
	JTT Average waiting time to treatment (Days)	105	159	139	156	196	170	102	165	130	141	96	131	154		136	<=177
	% of eligible cases that have completed treatment and were moved to recovery	60%	100%	60%	50%	56%	42%	67%	67%	44%	57%	64%	54%	91%		60%	>50%
	% of eligible cases that have shown reliable improvement	80%	100%	90%	75%	92%	71%	92%	78%	76%	64%	68%	77%	91%		74%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	150	158	214	168	162	153	152	126	137	114	126	159	177		140	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	ND	ND	ND	ND	ND	70.6%	75.5%	86.3%	88.9%	85%	87%	85%	97%		89%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	ND	ND	ND	ND	ND	96.9%	88.6%	84.4%	76.6%	81%	90%	87%	83%		83%	>85%
	% of Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days	ND	ND	ND	ND	ND	57%	55%	93%	44%	50%	83%	85%	ND		68%	>80%
	% of Older Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days	ND	ND	ND	ND	ND	60%	50%	67%	0%	100%	80%	83%	ND		78%	>20%
	Community Mental Health Team did not attend (DNA) rate	3.6%	4.7%	3.6%	4.4%	5.5%	4.0%	3.6%	4.0%	3.2%	3.8%	4.1%	4.4%	4.1%		4%	<10%
Inpatient Mental Health	Adult Acute Admissions per 100,000 population - Rolling 12 month	239	235	252	253	241	234	224	229	226	233	229	221	219		219	<255
	Adult acute admissions under the Mental Health Law as a % of all admissions	39%	43%	36%	50%	64%	36%	50%	25%	31%	47%	40%	11%	50%		35%	<37%
	Adult acute bed occupancy at midnight (including leave)	97%	98%	93%	100%	92%	93%	91%	95%	88%	94%	99%	97%	102%		96%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	412	411	399	373	357	376	380	369	379	363	342	362	361		361	<475
	Older adult acute bed occupancy (including leave)	95%	93%	96%	100%	98%	91%	98%	99%	99%	99%	96%	90%	90%		96%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	13	13	12	20	19	16	14	15	14	13	13	ND	ND		ND	<13

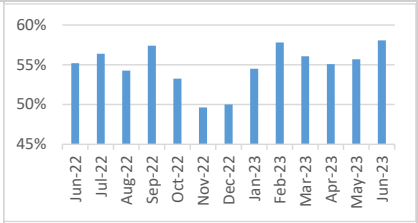
CATEGORY	INDICATOR	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	57%	62%	64%	65%	67%	69%	66%	69%	69%	69%	71%	72%	74%		71%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	80%	73%	90%	88%	93%	88%	90%	70%	83%	80%	73%	53%	86%		74%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	80%	57%	50%	77%	31%	60%	48%	38%	67%	70%	49%	45%	56%		55%	>=80%

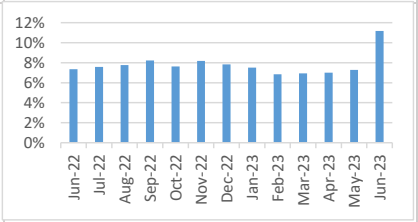
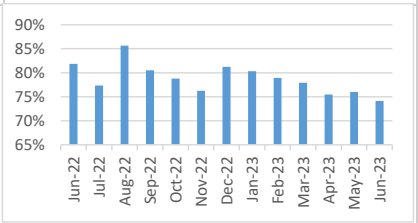
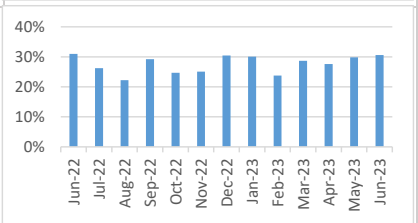
CATEGORY	INDICATOR	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	10.4%	11.9%	15.9%	11.2%	10.5%	11.6%	10.9%	9.5%	8.1%	8.5%	10.6%	10.9%	19.2%		11.2%	<=10%
	Average length of stay on Robin Ward	1.74	1.13	1.01	1.07	1.62	2.21	1.85	1.35	1.56	2.93	1.73	2.74	1.50		2.0	<=1.65
	% deliveries home birth (Planned & Unscheduled)	6.2%	5.1%	0.0%	7.1%	4.8%	14.3%	3.3%	8.0%	5.0%	11.9%	8.5%	4.5%	7.5%		7.6%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	43.1%	35.4%	38.5%	37.1%	38.7%	44.3%	28.3%	44.0%	50.0%	46.3%	33.9%	23.9%	39.6%		39.6%	NA
	% Instrumental deliveries	10.8%	8.9%	11.5%	12.9%	12.9%	4.3%	10.0%	9.3%	16.7%	7.5%	15.3%	11.9%	11.3%		11.8%	NA
	% Emergency caesarean section births	20.0%	12.7%	23.1%	17.1%	17.7%	15.7%	25.0%	25.3%	16.7%	16.4%	20.3%	31.3%	9.4%		20.5%	NA
	% Elective caesarean section births	26.2%	26.6%	23.1%	18.6%	24.2%	28.6%	26.7%	29.3%	16.7%	22.4%	23.7%	26.9%	26.4%		24.4%	NA
	% of women that have an induced labour	27.7%	26.6%	25.6%	31.4%	25.8%	20.0%	40.0%	14.7%	26.7%	20.9%	23.7%	35.8%	22.6%		23.9%	=27.57%
Maternity	Number of stillbirths	0	0	1	0	1	0	0	0	0	0	0	0	0		0	0
	Rate of Vaginal Birth After Caesarean (VBAC)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%		5.3%	>15%
	% primary postpartum haemorrhage >= 1500ml	9.2%	3.8%	6.4%	7.1%	6.5%	2.9%	5.0%	5.3%	3.3%	4.5%	5.1%	13.4%	3.8%		6.0%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	2.4%	2.9%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%		0.6%	<2.5%
	% of births less than 37 weeks	10.1%	3.8%	3.8%	4.2%	7.9%	10.0%	12.7%	13.0%	10.0%	13.2%	3.4%	10.0%	0.0%		8.8%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	14.3%	6.3%	6.3%	9.7%	6.3%	8.6%	11.1%	13.0%	10.0%	16.2%	5.0%	9.5%	1.9%		9.7%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	1.5%	1.3%	3.9%	0.0%	0.0%	5.7%	1.7%	0.0%	0.0%	1.5%	1.7%	4.5%	0.0%		1.3%	<=1.3%
	Average length of stay on maternity ward	2.25	2.02	2.17	2.30	2.15	2.44	2.20	1.86	2.07	2.21	2.15	2.33	1.43		2.01	<=2.28

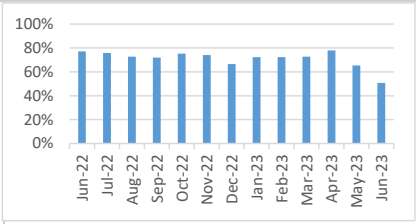
CATEGORY	INDICATOR		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	MSSA Bacteraemia	Hosp	1	1	0	0	0	1	1	0	0	1	1	1	0		3	0
	E-Coli Bacteraemia	Hosp	1	1	1	0	0	1	0	0	0	0	1	1	0		2	0
	Klebsiella Bacteraemia	Hosp	0	2	0	0	1	0	0	0	1	1	0	0	0		2	0
	Pseudomonas Bacteraemia	Hosp	0	0	0	0	0	0	1	0	0	0	0	1	1		2	0
	C-Diff Cases	Hosp	2	0	0	1	2	0	0	1	2	1	1	2	1		8	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		0.8	1.2	1.2	1.2	1.2	2.8	2.8	2.3	2.4	2.9	2.8	3.9	4.2		3	NA
	Number of falls per 1,000 bed days		4.3	6.3	6.7	4.3	4.5	5.5	7.6	5.9	6.0	6.2	5.6	6.5	8.6		6	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.2	0.2	0.5	0.0	0.2	1.5	0.8	1.2	0.9	1.0	0.5	0.7	0.7		0.8	<0.40
	Number of serious incidents		ND	0	3	2	1	2	1	0	2	3	4	2	5		16	NA
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		2.32	3.56	2.73	3.40	3.00	2.50	1.62	2.33	2.44	1.46	1.82	1.46	2.93		2.05	<2.87
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		1.66	2.54	1.54	2.89	2.00	1.50	1.30	1.71	1.69	1.13	1.66	0.81	2.38		1.5	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.33	0.51	1.02	0.34	0.67	1.00	0.32	0.62	0.75	0.32	0.17	0.49	0.18		0.42	<0.60
Feedback	Number of comments received		32	22	27	27	18	29	25	15	8	17	13	27	27		107	NA
	Number of compliments received		44	52	45	50	69	53	96	76	95	60	69	56	62		418	NA
	Number of complaints received		27	20	40	34	47	53	29	55	43	34	34	24	41		231	NA
	% of all complaints closed in the period which were responded to within the target		ND	ND	ND	ND	ND	54%	21%	31%	17%	23%	35%	21%	6%		21.2%	>40%

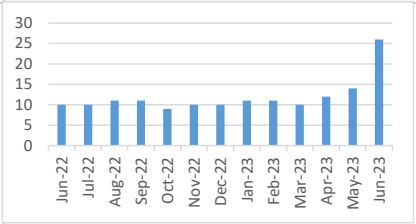
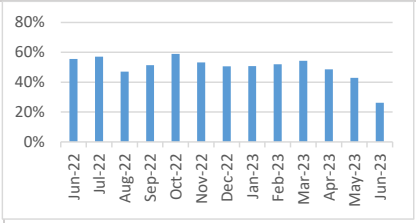
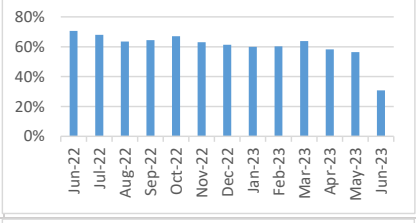
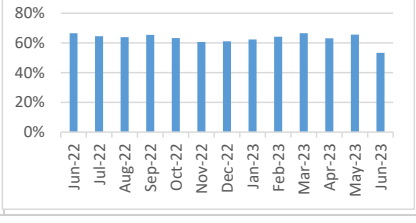
EXCEPTION REPORTS

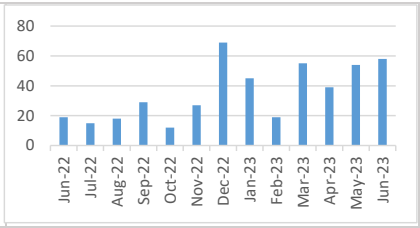
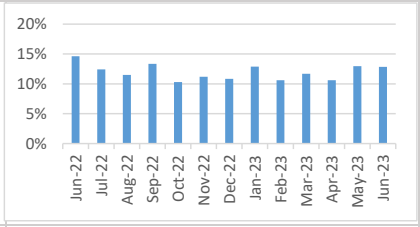
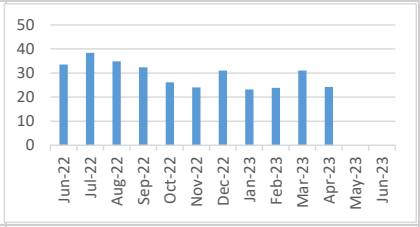
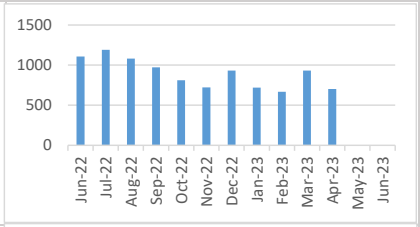
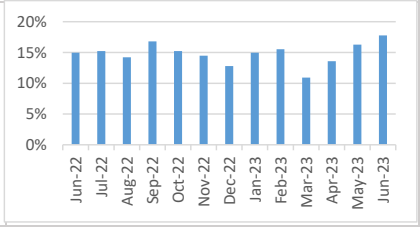
GENERAL AND ACUTE WAITING LISTS			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans below.	>35% Head of Access
% patients waiting over 90 days for 1st OP appointment - Acute		There are a number of challenges since moving to Maxims which we continue to address. However our challenges in relation to long waiters remain across the same specialties which include Ophthalmology, Clinical Genetics and Gynaecology (all of which will receive additional support via the Waiting List Initiative). From an urgent and soon perspective, dermatology is of concern. There is a 6 month locum joining the department on 8th July.	>35% Head of Access
% patients waiting over 90 days for 1st OP appointment - Community		The plan for Community Dental Health Services continues to deliver. A case has been made to extend the service to the end of the year via Commercial Services. The PTL has reduced by 1000 patients since the scheme started in October 2022 (-54.2%) The remaining long waiters over 90 days are a combination of children aged 0-2 years (who are outside of the scheme's criteria), patients who have not engaged with the providers since opting in, and patients that opted out. A WEAR has been submitted to repurpose a vacancy to provide a dental therapist who can see the 0-2 year olds in the department. All patients aged 3-11 years will continue to be transferred to the care of the dentists in the scheme until the end of the year.	>35% Head of Access
% patients waiting over 90 days for diagnostics		The majority of patients waiting over 90 days for a diagnostic procedure are awaiting colonoscopy or gastroscopy. In house the department is hindered by medium to long term sickness in addition to a diffciult transition to Maxims (Endobase and Maxims are not yet connected, leading to duplication of data entry and inefficiency) The Endoscopy Insourcing project is on track to commence in October 2023 and will provide 104 JAG points of additional activity each weekend. Eight weeks will be completed in 2023 with a further eight weeks in the first quarter of 2024.	>35% Head of Access

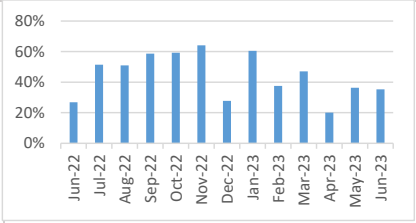
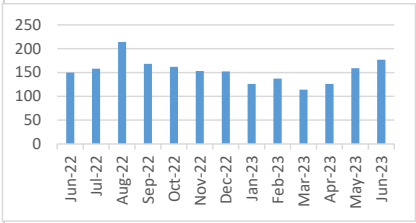
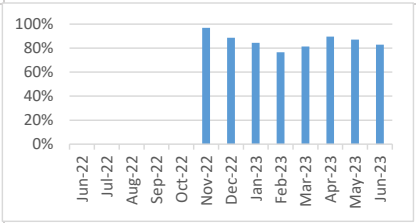
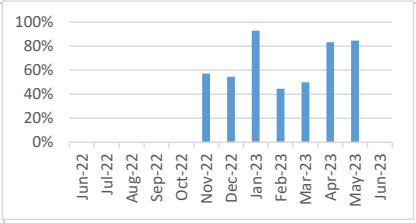
% patients waiting over 90 days for elective admissions		A planned reduction of activity was in place for the first two weeks post go live as we introduced Maxims as the new EPR. The following weeks has seen activity not return to normal levels as anticipated. The TCI process which was previosuly completed on the whole by adminstrative staff is significantly different in Maxims, and adjusting to this change is impacting productivity. At present we have removed the requirement to have completed pre-assessment prior to booking the TCI to ensure patients are listed in a timely manner. The process is under review to enable the best practice to be implemented properly. The 6-4-2 meetings are being refreshed so they are data driven regarding scheduling, utilisation and the differences between operating times per surgeon. Our key pressures remain within lower limb surgery, upper GI surgery and Ophthalmology, all of which are being supported by the waiting list initiatives project.	>35% Head of Access

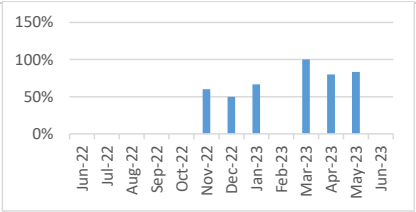
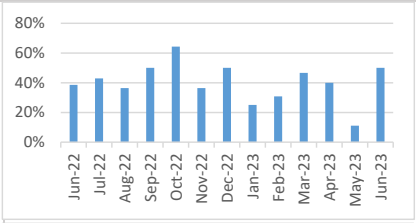
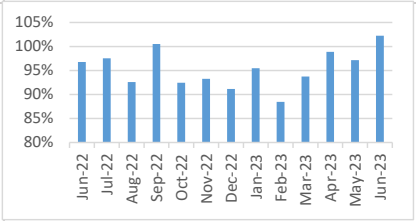
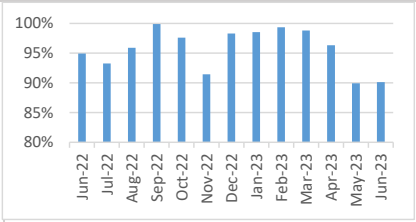
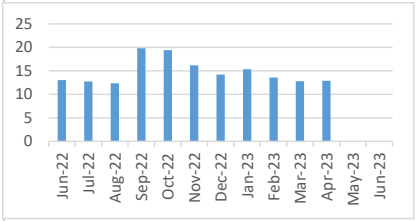
PLANNED (ELECTIVE) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
New to follow-up ratio		In relation to the New to follow up- we manage through individual departments the follow ups to see if it meets expectations of national standards/ department expectations. Specialty level new to follow-up data is reviewed at Care Group Performance Reviews.	> 2.0 Care Group General Managers
Outpatient Did Not Attend (DNA) Rate		Challenges around the data for the DNA. Admin challenges around discharge or not seen.	>8% Care Group General Managers
% of all elective admissions that were day cases		There was reduced activity because of the planned reduction in activity to support maxims cutover and the week following.	<80% Surgical Services Care Group General Manager
% of all elective admissions that were private		There was reduced activity because of the planned reduction in activity to support maxims cutover and the week following. Also reduction in available bed base for private inpatients .	<32% or >34% Surgical Services Care Group General Manager

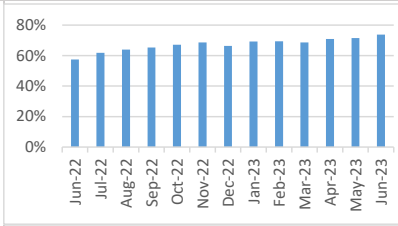
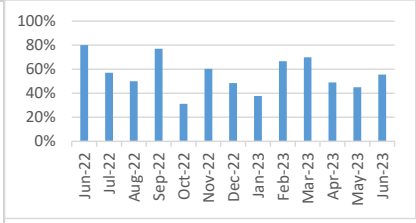
Elective Theatre List Utilisation (Main Theatres, Day Surgery/Minor Operations)		Post Maxims implementation, learning is underway to ensure full and accurate capture of data.	<85% Surgical Services Care Group General Manager

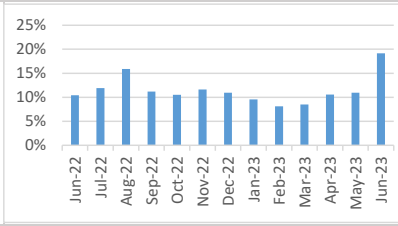
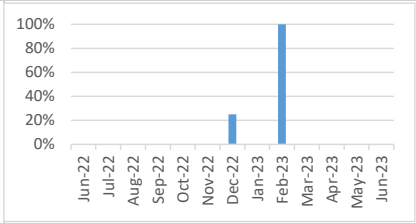
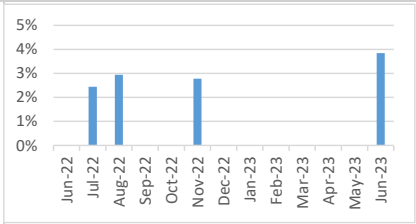
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Median Time from Arrival to Triage		Triage is an ongoing issue due to training and staffing, we have now recruited a Practice Development Nurse who will be addressing the improvements. ED nursing staff template has not been changed despite the Staffing Review done last year which recommended a 50% increase in Grade 4s and same for HCAs.	>10 Medical Services Care Group General Manager
% Triaged within Target - Minor		Triage is an ongoing issue due to training and staffing, we have now recruited a Practice Development Nurse who will be addressing the improvements. ED nursing staff template has not been changed despite the Staffing Review done last year which recommended a 50% increase in Grade 4s and same for HCAs.	90% Medical Services Care Group General Manager
% Triaged within Target - Major		Majors patients are seen on arrival or within 10 minutes however nurses completing triage also start with IV cannula and blood tests as well as doing any urgent clinical interventions that are necessary, thus entering clinical triage data on MAXIMS retrospectively. Therefore the data has not been recorded correctly, to mitigate this we are looking at developoing a more accurate quality indicators to reflect current patient care in the department	90% Medical Services Care Group General Manager
% Commenced Treatment within Target - Major		This data is incorrect for the following reasons: 1) ED does not currently use Manchester Triage, and this is what Quality Indicators are measured against; 2) Data relies on timings from MAXIMS, however if a sick (P1/P2) patient comes in, tho focus is (and should always be) on stabilising that patient rather than ensuring that the clinician first clicks on the patient on MAXIMS as been seen; 3) All P1 patients are met in Resus by the ED Consultant or a middle grade as well as nursing staff hence are seen on arrival	90% Medical Services Care Group General Manager

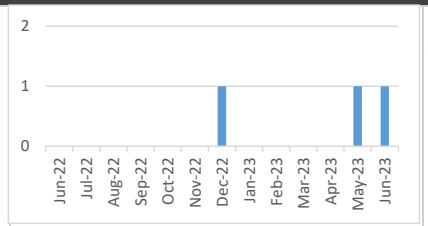
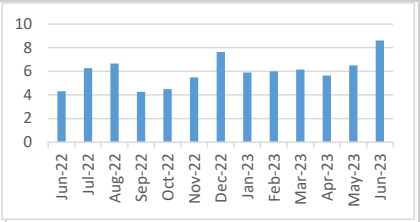
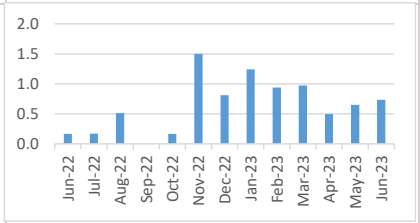
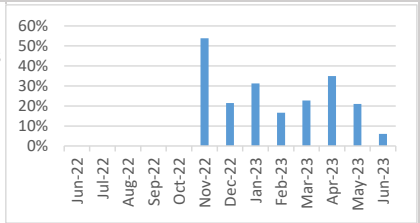
Total patients in ED > 10 hours		This data contains data quality issues as not all notes are recorded in real time. Some patient data will be accurate and are due to awaiting an inpatient bed, however this is compounded by the high number of delayed discharge patients. Discharge workstreams are looking to address the high number of delayed discharges to resolve the data quality issue we are looking at flow in the hospital as well as ensuring appropriate staffing (nursing and medical) to allow contemporaneous discharges on MAXIMs	>0 Medical Services Care Group General Manager
% of Inpatients discharged between 8am and noon		On AAU doctors now start an hour earlier to facilitate early discharges, however the % of inpatients discharged within the time range is impacted by availability within the community in both nursing and residential care home settings causing a delay in the discharging of patients that are MFFD. Discharge workstreams are looking to address the high number of delayed discharges.	15% Medical Services Care Group General Manager
Average daily number of patients Medically Fit For Discharge (MFFD)		Snapshot only data available from new Patient Administration System currently. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month that will be able to be calculated is September	>30 Care Group General Managers
Total Bed Days Medically Fit For Discharge		Snapshot only data available from new Patient Administration System currently. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month that will be able to be calculated is September	>910 Care Group General Managers
Rate of Emergency readmission within 30 days of a previous inpatient discharge		At present the re admission review process has been suspended however due to the increase this is under review. The medicine care group has added to their governance meeting for September this as a priority for discussion.	>10% Medical Services Care Group General Manager

MENTAL HEALTH			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% of clients who started treatment in period who waited over 18 weeks		Jersey Talking Therapies received 105 referrals in June, this is an increase on the previous month. The service continues to achieve our target waiting times for assessment, with only 2.9% of client waiting over 90 days for assessment. However we continue to experience a challenge with waiting times for treatment, with 35% of those who started treatment in June having waited over our target 18 weeks. This continues to relate to absence and vacancy, although the service have been interviewing this month.	>5% Lead Allied Health Professional Mental Health
Memory Service - Average Time to assessment (Days)		The waiting time for the memory service continues to be a challenge, which has been consistent since the covid period when the service was temporarily closed. This resulted in a backlog of referrals from this time, along with an increase of referrals over the last two years. The service is small and has finite diagnostic capacity - this is currently being reviewed, as to date we have been unable to find additional staffing capacity to put into the service. It is hoped that we will be able to implement a revised skill mix (and increased diagnostic capacity) in order to address the waiting times.	>138 Lead Nurse - Mental Health
% of referrals to Mental Health Assessment Team assessed in period within 10 working days		The service has reviewed all cases where the person was not seen within 10 working days of referral. In June this equates to 20 people. The main reasons for this are not being able to contact the person or patient choice or DNA / missed appointments offered. The team will continue to monitor this on a monthly basis	<85% Mental Health Care Group Manager
% of Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days		Data not currently available following new system implementation. It will be available from month 7 report (which will include the back data to month 6)	<58% Mental Health Inpatient Lead Nurse

% of Older Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days		Data not currently available following new system implementation. It will be available from month 7 report (which will include the back data to month 6)	<20% Mental Health Inpatient Lead Nurse
Adult acute admissions under the Mental Health Law as a % of all admissions		Increase in MHL detention admissions in June reflects the nature and degree of the illness and associated risks of the patients presenting during this period.	>37% Mental Health Inpatient Lead Nurse
Adult acute bed occupancy at midnight (including leave)		Bed occupancy remains above the benchmarked levels due to delayed transfers of care and sourcing suitable placements and care packages in the community.	>88% Mental Health Inpatient Lead Nurse
Older adult acute bed occupancy (including leave)		Bed occupancy remains above the benchmarked levels due to delayed transfers of care and sourcing suitable placements and care packages in the community.	>85% Mental Health Inpatient Lead Nurse
Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards		Snapshot only data available from new Patient Administration System currently. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month that will be able to be calculated is September	>13 Mental Health Inpatient Lead Nurse

SOCIAL CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Percentage of clients with a Physical Health check in the past year		Steady progress continues towards the 80% target, with a 74% attainment level achieved in June, a 3% improvement on the previous month's performance. Access to suitable clinic environment is being looked at to try and escalate attainment to target.	>=80% Social Care Care Group General Manager
Percentage of new Support Plans reviewed within 6 weeks (ASCT)		This is known to be due to a combination of legitimate reasons – for example delayed discharge from hospital, delays in service commencing and some issues of practice. The practice issues are primarily in delays completing hospital reviews and in 6 week reviews not being performed for changes of existing services. Changes to process were made in Mid June and the expected initial upturn is shown. Further monitoring required to ensure further improvement is sustained	>=80% Social Care Care Group General Manager

WOMEN'S AND CHILDREN'S SERVICES			
Was Not Brought Rate		Text message service has discontinued, and this may have impacted on the DNA rate. July to September is known months for WNB. This rate is for services that provide paediatric care across the hospital and community, dental.	>9.8% General Manager Womens, Childrens & Family Care Group
Rate of Vaginal Birth After Caesarean (VBAC)		Next birth after LSCS is associated with maternal choice, and women are counselled regarding their choice for this birth. Women may choose to opt for vaginal birth or repeat caesarean section.	< 25% Lead Midwife
% 3rd & 4th degree tears – normal birth		Of the 3rd degree tears reported, 2 had forceps deliveries which is associated wth a higher risk of third degree tears.	>2.5% Lead Midwife

QUALITY AND SAFETY			
Pseudomonas Bacteraemia - Hosp		Healthcare Associated (HCAI) awaiting confirmation of root cause, however initial findings have found patient had history of leg ulcers therefore likely carrier.	0 Director of Infection Prevention and Control
Number of falls per 1,000 bed days		In June, 48 falls were reported 25 no harm, 22 low harm and 1 moderate harm. This equates to 7.4 per 1000 bed days (national average of 6.63 per 1000 bed days). The moderate harm fall occurred on a medical ward as a result of an unwitnessed fall at the end of afternoon visiting. The relative would normally inform staff that they were leaving the ward but had failed to do so on this occassion. The patient made a full recovery following the sustained haematoma to the side of head and bruising to right knee. The patient, staff and relatives are aware that the patient will be supervised at all times when sitting out of bed. Of the 25 no harm 21 were unwitnessed falls with 3 patients having more than one fall. All incidents reviewed with no trend noted. Samares ward had the highest number of unwitnessed falls where 1 patient had 7 falls, falls care bundle completed, additional nursing support provided, falls matt and anti slip footwear in place.	6 Associate Chief Nurse
Number of medication errors across HCS resulting in harm per 1000 bed days		There has been an increase in the number of reported drug errors. Interrogation through the Medicines Optimisation Committee suggests that there has been better reporting. There is no siginificant increase in patients receiving the wrong medication, however incidents relating to the spillage or wastage of medications had increased and had been reported.	> 0.40 Medical Director
% of all complaints closed in the period which were responded to within the target		There appears to be a downward trend in complaints responded to in agreed target. It is worth noting that the target set is far outside what would be expected of a healthcare organisation. There is continued work to engage care groups with improving response time to complaints. The PALS team continue to manage the single simple complaints/comments, and these will not be shown in this report and these are responded to within 5 days in the majority of cases. There has been a new member to the patient experience team who will assist with more complex complaints management.	<40% Head of Patient Experience

CHANGES AND TECHNICAL NOTES

As part of our commitment to enhancing the quality of our services, we have developed performance indicators to track our progress and provide greater transparency into our operations. These indicators enable us to better monitor our performance towards achieving our objectives and make informed decisions about the future of our services.

However, please note these indicators may be subject to change in future versions of this report as we strive to refine our approach and respond to the changing needs of the community. We remain dedicated to providing accurate and insightful performance data and therefore use the most accurate data available at the time of publication.

The Hospital Patient Administration System was replaced at the end of May. There are significant differences between the two systems, the business processes and the data that are available to the Informatics Team. As far as possible we have attempted to ensure consistency and integrity in the indicators - and have noted where changes in the system have caused changes in the indicators.

General and Acute Outpatient Attendances - in month 6 report, the methodology has been updated following the implementation of the new system which identified some previous over-counting. The back series has therefore been revised to ensure full comparability with the recent data points.

Elective Regular Day Admissions - these are recorded differently in the new patient administration system. A different methodology is therefore in use to count these from month 6 onwards, meaning the pre/post system changeover are not wholly comparable.

For indicators related to Medically Fit for Discharge and Delayed Transfers of Care, only snapshot data are currently available from new Patient Administration System. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month that will be able to be calculated is September (month 9).

APPENDIX - DATA SOURCES

DEMAND		
INDICATOR	SOURCE	DEFINITION
General and Acute Outpatient Referrals	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of General and Acute Outpatient referrals accepted by HCS clinicians in the period. This specifically excludes Mental Health specialties
General and Acute Outpatient Referrals - Under 18	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of General and Acute Outpatient referrals accepted by HCS clinicians in the period for patients under 18 years of age (at time of referral). This specifically excludes Mental Health specialties
Referrals to Mental Health Crisis Team	Community services electronic client record system	Number of referrals into the Crisis Team Centre of Care in the reporting period
Referrals to Mental Health Assessment Team	Community services electronic client record system	Number of referrals into the Assessment Team Centre of Care in the reporting period
Referrals to Memory Service	Community services electronic client record system	Number of referrals into the Memory Assessment Service Centre of Care in the reporting period
Referrals to Jersey Talking Therapies	JTT & PATS electronic client record system	Number of referrals received by Jersey Talking Therapies in the reporting period
Additions to Inpatient Waiting List	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of new additions to the inpatient waiting list for all care groups

ACTIVITY		
INDICATOR	SOURCE	DEFINITION
General and Acute Outpatient Attendances	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Number of General & Acute public outpatient appointments attended in the period
Elective Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of General & Acute public elective inpatient admissions in the period
Elective Day Cases	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of General & Acute Elective Day Case admissions in the period
Elective Regular Day Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of JGH/Overdale Elective Regular Day Admissions in the period. A regular day admission is a planned series of admissions for broadly similar ongoing treatment, for example, chemotherapy or renal dialysis.
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Emergency Department Report (ED5A), Maxims Admissions & Discharge Report (IP13DM) & Maxims Emergency Department Report (ED1DM))	Number of Ward Attenders and non-elective AEC admissions in the period. Ward attenders includes visitors to a ward who received covid swabbing in the Emergency Department. E.g. Maternity birth partners

Emergency Department Attendances	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Number of attendances to Emergency Department in period
Emergency Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of emergency inpatient admissions to General & Acute Hospital in the period
Admissions to Adult Mental Health unit (Orchard House)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions & Discharges Report (IP013DM))	Number of admissions to Orchard House
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Number of Older Adult inpatient admissions in the period
Maternity Deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Number of on-Island maternity deliveries in the period. Note that the birth of twins/triplets would count as one delivery

WAITING LISTS		
INDICATOR	SOURCE	DEFINITION
Outpatient 1st Appointment Waiting List	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients on the Outpatient first appointment waiting list at period end
Outpatient 1st Appointment Waiting List - Acute	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Acute Outpatient appointment at period end
Outpatient 1st Appointment Waiting List - Community	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Community Outpatient appointment at period end
Elective Waiting List	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of patients on the Inpatient elective waiting list at period end
Elective Waiting List - Under 18	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of patients under 18 years of age on the elective inpatient waiting list at period end
Diagnostics Waiting List	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Diagnostic appointment at period end
Jersey Talking Therapies Assessment Waiting List	JTT & PATS electronic client record system	Number of JTT cients which match the services eligibility criteria waiting for their first assessment at the end of reporting period

GENERAL AND ACUTE WAITING LISTS						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the outpatient waiting list who have been waiting over 90 days at period end. Numerator: Number of patients on the outpatient waiting list who have been waiting over 90 days at period end. Denominator: Number of patients on the outpatient waiting list at period end.
	% patients waiting over 90 days for 1st OP appointment - Acute	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Acute Outpatient waiting list who have been waiting more than 90 days since referral for their first appointment at period end
	% patients waiting over 90 days for 1st OP appointment - Community	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Community Outpatient waiting list who have been waiting more than 90 days since referral for their first appointment at period end
Inpatients	% patients waiting over 90 days for diagnostics	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Diagnostic waiting list who have been waiting more than 90 days since referral at period end
Diagnostics	% patients waiting over 90 days for elective admissions	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the elective inpatient waiting list who have been waiting over 90 days at period end. Numerator: Number of patients on the elective inpatient waiting list who have been waiting over 90 days at period end. Denominator: Number of patients on the elective inpatient waiting list at period end.

PLANNED (ELECTIVE) CARE						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Outpatients	New to follow-up ratio	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Care Group General Managers	2.0	Standard set locally	Rate of new (first) outpatient appointments to follow-up appointments. This being the number of follow-up appointments divided by the number of new appointments in the period. Excludes Private patients.
	Outpatient Did Not Attend (DNA) Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Care Group General Managers	<8%	Standard set locally	Percentage of public General & Acute outpatient appointments where the patient did not attend and no notice was given. Numerator: Number of General & Acute public outpatient appointments where the patient did not attend. Denominator: the number of attended and unattended appointments
Elective Inpatients	Acute elective Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Surgical Services Care Group General Manager	<3	Standard set locally	Average (mean) Length of Stay (LOS) in days of all elective inpatients discharged in the period from a Jersey General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward. During the period 2020 to 2022 Samares Ward was closed and long stay rehabiliation patients were treated on Plemont Ward and therefore the data is not comparable for this period.
	% of all elective admissions that were day cases	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Surgical Services Care Group General Manager	>80%	Standard set locally	Percentage of elective admissions for surgery that are managed as day cases (with same day discharge). Numerator: Number of elective surgical day case admissions both public and private. Denominator: Total surgical elective admissions

Theatres	% of all elective admissions that were private	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Surgical Services Care Group General Manager	>32% and <34%	Based on clinical job plans	Number of private elective admissions divided by the total number of elective admissions
	Elective Theatre List Utilisation (Main Theatres, Day Surgery/Minor Operations)	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM))	Surgical Services Care Group General Manager	>85%	NHS Benchmarking- Getting It Right First Time 2024/25 Target	Sum of touch time divided by the sum of theatre session duration (as a percentage). This is reported for all operations (Public and Private) to take account of mixed lists.
	Turnaround time as % of total session time	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM))	Surgical Services Care Group General Manager	<15%	Standard set locally	Numerator: Sum of the time duration between successive patients within a single theatre session Denominator: Total theatre session duration. This is reported for all operation lists containing multiple operations (Public and Private) to take account of mixed lists.

UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Emergency Department (ED)	Median Time from Arrival to Triage	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<11	NHS England published data for Nov 2022 England Average. https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider	Median of minutes between ED arrival time and triage time
	% Triaged within Target - Minor	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=90%	Generated based on historic performance	Percentage of P4, P5 patients triaged within 15 mins
	% Triaged within Target - Major	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=90%	Generated based on historic performance	Percentage of P1, P2,P3 patients triaged within 15 mins
	Median Time from Arrival to commencing Treatment	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<75	NHS England published data for Nov 2022 England Average. https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider	Median of minutes between ED arrival time and time patient was seen
	% Commenced Treatment within Target - Minor	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=70%	Generated based on historic performance	Percentage of patients seen within targets: P4 120 mins, P5 240 mins
	% Commenced Treatment within Target - Major	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=70%	Generated based on historic performance	Percentage of patients seen within targets: P1 1 min, P2 15 mins, P3 60 mins
	Median Total Stay in ED (mins)	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<189	NHS England published data for Nov 2022 England Average. https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider	Median of minutes between ED arrival and discharge from ED

	Total patients in ED > 10 hours	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<1	Standard set locally - zero tolerance to ensure all long stays in ED are investigated	Number of ED attendances in the period where total stay in department is greater than 10 hours
	ED conversion rate	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<20%	Generated based on historic performance	Percentage of ED attendances that resulted in an inpatient admission. Numerator: Total ED attendances that resulted in an inpatient admission. Denominator: Total ED attendances.
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	<10	Generated based on historic performance	Average (mean) Length of Stay (LOS) in days of all emergency inpatients discharged in the period from a General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a Patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward. During the period 2020 to 2022 Samares Ward was closed and long stay rehabiliation patients were treated on Plemont Ward and therefore the data is not comparable for this period.
	% Emergency admissions with 0 Length of Stay (Same day discharge)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	<17%	Generated based on historic performance	Percentage of emergency (non-elective) inpatient admissions that were discharged the same day. Numerator: Total ED attendances that were discharged the same day. Denominator: Total ED attendances.
	Acute bed occupancy at midnight (Elective & Non-Elective)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Medical Services Care Group General Manager	<85%	Generated based on historic performance	Percentage of beds occupied at the midnight census, JGH and Overdale. Numerator: Number of beds occupied by a patient at midnight in the period. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	% of Inpatients discharged between 8am and noon	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	>=15%	Generated based on historic performance	% of inpatients discharged from General & Acute wards between 8am and Noon. Excluding private patients, self discharges and deceased patients. Numerator: Patients discharged between 8am and 12 noon in period. Denominator: Total patients discharged in period
	Average daily number of patients Medically Fit For Discharge (MFFD)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	<30	Generated based on historic performance	Average (mean) number of inpatients marked as Medically Fit each day at 8am, JGH/Overdale only
	Total Bed Days Medically Fit For Discharge	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	<910	Generated based on historic performance	Sum of bed days in period of patients marked as Medically Fit
	Total Bed Days Delayed Transfer Of Care (DTOC)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	NA	Not Applicable	Sum of bed days in period of patients marked as Delayed Transfer Of Care (DTOC)
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L, TrakCare Discharges Report (ATD9P), Maxims Admssions and Discharge Report (IP013DM))	Medical Services Care Group General Manager	<10%	Generated based on historic performance	Numerator: Emergency readmissions within 30 days of a previous qualifying discharge. Denominator: Total number of emergency admissions (excluding cancer, maternity and day units as per NHS definition: https://digital.nhs.uk/data-and-information/publications/statistical/ccg-outcomes-indicator-set/june-2020/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-ccg/3-2-emergency-readmissions-within-30-days-of-discharge-from-hospital)

MENTAL HEALTH						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Jersey Talking Therapies	% of clients waiting for assessment who have waited over 90 days	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	<5%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT clients who have waited over 90 days for assessment, divided by the total number of JTT clients waiting for assessment
	% of clients who started treatment in period who waited over 18 weeks	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	<5%	Improving Access to Psychological Therapies (IAPT) Standard	Percentage of JTT clients waiting more than 18 weeks to commence treatment. Numerator: Number of JTT clients beginning treatment who waited longer than 18 weeks from referral date. Denominator: Total number of JTT clients beginning treatment in the period
	JTT Average waiting time to treatment (Days)	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	<=177	Generated based on historic percentiles	Average (mean) days waiting from JTT referral to the first attended treatment session
	% of eligible cases that have completed treatment and were moved to recovery	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	>50%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that completed treatment and were moved to recovery (defined as a clinical case at the start of their treatment and are no longer defined as a clinical case at the end of their treatment), divided by the total number of JTT referrals which match the services eligibility criteria
	% of eligible cases that have shown reliable improvement	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	>75%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that showed reliable improvement (there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition), divided by the total number of JTT referrals which match the services eligibility criteria
Community Mental Health	Memory Service - Average Time to assessment (Days)	Community services electronic client record system	Lead Nurse - Mental Health	<138	Generated based on historic percentiles	Average (mean) days waiting from the date of referral to the assessment date for all those who have been referred and assessed under the Memory Assessment Service centre of care
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	Community services electronic client record system	Mental Health Care Group Manager	>85%	Agreed locally by Care Group Senior Leadership Team	Number of Crisis Team referrals assesed within 4 hours divided by the total number of Crisis team referrals
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	Community services electronic client record system	Mental Health Care Group Manager	>85%	Agreed locally by Care Group Senior Leadership Team	Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target. Numerator: Number of Assessment Team referrals assessed within 10 working days of referral. Denominator: Total number of Mental Health Assessment Team referrals received
	% of Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	Mental Health Inpatient Lead Nurse	>80%	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from 'Orchard House' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours divided by the total number of discharges from 'Orchard House'

Inpatient Mental Health	% of Older Adult discharges with a face to face contact from CMHT or Home Treatment Team within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	Mental Health Inpatient Lead Nurse	>20%	Generated based on historic percentiles	Number of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours divided by the total number of discharges from 'Older Adult' units
	Community Mental Health Team did not attend (DNA) rate	Community services electronic client record system	Lead Nurse - Mental Health	<10%	Standard based on historic performance	Rate of Community Mental Health Team (CMHT) outpatient appointments not attended. Numerator: Number of Community Mental Health Team (CMHT, including Adult & Older Adult services) public outpatient appointments where the patient did not attend. Denominator: Total number of Community Mental
	Adult Acute Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Mental Health Inpatient Lead Nurse	<255	NHS Benchmarking Network 2021/22 upper quartile. For green (<240) this reflects an improvement on GOJ 2021 performance.	Number of admissions to 'Orchard House' in the past 12 months from the reporting month for every 100,000 population
	Adult acute admissions under the Mental Health Law as a % of all admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), Maxims Admissions Report (IP013DM) & Mental Health Articles Report)	Mental Health Inpatient Lead Nurse	<37%	Jersey has a much lower rate than NHS Benchmarking Network. Standard is based on local historic benchmarking	Number of 'Orchard House' admissions under a formal Mental Health article, divided by total number of admissions to 'Orchard House'
	Adult acute bed occupancy at midnight (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Mental Health Inpatient Lead Nurse	<88%	Generated based on historic performance	Percentage of beds occupied at the midnight census, Orchard House. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	Older Adult Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Mental Health Inpatient Lead Nurse	<475	Jersey is an extreme outlier in the NHS Benchmarking Network. Standard set based on improving 2021 performance toward the NHS Benchmarking Network mean	Number of admissions to 'Older Adults' units, in the past 12 months from reporting month, for every 100,000 population
	Older adult acute bed occupancy (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Mental Health Inpatient Lead Nurse	<85%		Percentage of beds occupied at the midnight census, Beech and Cedar Wards. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	Hospital Electronic Patient Record (TrakCare Current Inpatient Report (ATD49) & Maxims Current Inpatient Report (IP020DM))	Mental Health Inpatient Lead Nurse	<13	Generated based on historic percentiles	Average (mean) number of Mental Health inpatients marked as Medically Fit each day at 8am

SOCIAL CARE						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Learning Disability	Percentage of clients with a Physical Health check in the past year	Community services electronic client record system	Social Care Care Group General Manager	>80%	Generated based on historic performance	Percentage of Learning Disability (LD) clients with an open involvement in the period who have had a physical wellbeing assessment within the past year. Numerator: Number of LD clients who have had a physical wellbeing assessment in the 12 months prior to period end. Denominator: Total number of clients with an open LD involvement within the period.
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	Community services electronic client record system	Social Care Care Group General Manager	>=80%	Generated based on historic performance	Number of FACE Support Plan and Budget Summary opened in the ASCT centre of care that are opened then closed within 3 weeks, divided by the total number of FACE Support Plan and Budget Summary opened in the ASCT centre of care more than 3 weeks ago
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	Community services electronic client record system	Social Care Care Group General Manager	>=80%	Generated based on historic performance	Percentage of Support Plan Reviews in the ASCT Centre of Care (only counting those that follow a FACE Support Plan) that were opened within 6 weeks of closing a FACE Support Plan in the ASCT Centre of Care

WOMENS AND CHILDRENS SERVICES						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Children	Was Not Brought Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	General Manager Womens, Childrens & Family Care Group	<=10%	Standard set locally based on average (mean) of previous two years' data	Percentage of JGH/Overdale public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale public outpatient appointments where the patient did not attend. Denominator: Number of all attended and unattended appointments. Under 18 year old patients only. All specialties included.
	Average length of stay on Robin Ward	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Lead Nurse for Children	<=1.65	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay in days of all patients discharged in the period from Robin Ward, including leave days

Maternity	% deliveries home birth (Planned & Unscheduled)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Percentage of deliveries home births (Planned & Unscheduled) out of the total number of deliveries in the period. Numerator: Number of deliveries recorded as being at "Home" (regardless of whether they were 'planned' or 'unplanned') in the period. Denominator: number of deliveries in the period.
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of spontaneous vaginal births including home births and breech vaginal deliveries didivded by total number of deliveries
	% Instrumental deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Instrumental deliveries divided by total number of deliveries
	% Emergency caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Emergency Caesarean sections, divided by total number of deliveries
	% Elective caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Elective Caesarean sections, divided by total number of deliveries
	% of women that have an induced labour	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=27.57%	Standard set locally based on average (mean) of previous two years' data	Percentage of women that have an induced labour in the period. Numerator: Number of women that had an induced labour. Denominator: number of deliveries.
	Number of stillbirths	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	0.0%	Stanadard set locally based on historic performance	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
	Rate of Vaginal Birth After Caesarean (VBAC)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	>15%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, standard set to match the NHS National value of 15%.	Number of Vaginal Births after Caesarean (VBAC) divided by the total number of Births after Caesarean
	% primary postpartum haemorrhage >= 1500ml	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=6.75%	NHS National Value is 3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that resulted in a blood loss of over 1500ml out of the total number of deliveries in the period. Numerator: Number of deliveries that resulted in a blood loss of over 1500ml. Denominator: number of deliveries
	% 3rd & 4th degree tears – normal birth	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<2.5%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, we have set the standard to match the NHS National value of 2.5%.	Number of women who had a vaginal birth (not instrumental) and sustained a 3rd or 4th degree perineal tear as percentage of all normal births
	% of births less than 37 weeks	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=6.85%	NHS National Value is 6.3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Number of live babies who were born before 37 weeks (less than or equal to 36 weeks + 6 days gestation) divided by total number of live births

	% births requiring Jersey Neonatal Unit admission		Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Movements Report (ATD5PA), TrakCare Deliveries Report (MAT23A), Maxims Discharges Report (IP013DM), Maxims Movements Report (IP001DM) & Maxims Deliveries Report (MT005))	Lead Midwife	<=5.05%	Standard set locally based on average (mean) of previous two years' data	Number of births requiring admission to the Jersey Neonatal Unit, divided by total number of births
	% of babies that have APGAR score below 7 at 5 mins		Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Lead Midwife	<=1.3%	NHS National Value is 1.2%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
	Average length of stay on maternity ward		Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Lead Midwife	<=2.28	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay for all patients discharged in the period from the Maternity Ward
QUALITY AND SAFETY							
INDICATOR			SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Infection Control	MRSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	0	Standard based on historic performance	Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team
	MSSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	0	Standard based on historic performance	Number of Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases in the hospital in the period, reported by the IPAC team
	E-Coli Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	0	Standard based on historic performance	Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team
	Klebsiella Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	0	Standard based on historic performance	Number of Klebsiella bacteraemia cases in the hospital in the period, reported by the IPAC team
	Pseudomonas Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	0	Standard based on historic performance	Number of Pseudomonas bacteraemia cases in the hospital in the period, reported by the IPAC team
	C-Diff Cases - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	1	Standard based on historic performance (2020)	Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Associate Chief Nurse	NA	No Standard Set	Number of inpatient falls with harm recorded where approval status is not "Rejected" per 1000 occupied bed days
	Number of falls per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Associate Chief Nurse	<6	Standard based on historic performance	Rate of recorded inpatient falls per 1000 bed days. Numerator: Number of inpatient falls recorded in the period where the approval status is not "Rejected". Denominator: Number of occupied bed days in the period in General Hospital, Overdale and Acute Mental Health wards
	Number of medication errors across HCS resulting in harm per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Medical Director	<0.40	Standard set locally based on improvement compared to historic performance	Number of medication errors across HCS (including Mental Health) resulting in harm where approval status is not "Rejected" per 1000 occupied bed days. Note that this indicator will count both inpatient and community medication errors due to recording system limitations. As reporting of community errors is infrequent and this indicator is considered valuable, this limitation is accepted.
	Number of serious incidents		HCS Incident Reporting System (Datix)	Associate Chief Nurse	NA	Standard removed 2022-09-28 per Q&R Committee instruction	Number of safety events recorded in Datix in the period where the event is marked as a 'Serious Incident'

Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Associate Chief Nurse	<2.87	Standard set locally based on improvement compared to historic performance	Number of inpatient pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days	Hosp	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Associate Chief Nurse	<1.96	Standard set locally based on improvement compared to historic performance	Number of inpatient Cat 2 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Associate Chief Nurse	<0.60	Standard set locally based on improvement compared to historic performance	Number of inpatient Cat 3 & 4 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
Feedback	Number of complaints received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of formal complaints received in the period where the approval status is not "Rejected"
	Number of compliments received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of compliments received in the period where the approval status is not "rejected"
	Number of comments received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of comments received in the period where approval status is not "Rejected"
	% of all complaints closed in the period which were responded to within the target		HCS Feedback Management System (Datix)	Head of Patient Experience	>40%	Response time standards are those in GoJ Feedback Policy which does not set achievement targets, so target set locally	Percentage of all complaints closed in the period responded to within the target time as set by GoJ Feedback Policy. Numerator: Number of all closed complaints in the period, responded to within the target. Denominator: Number of complaints closed in the period.