Health and Community Services

Quality and Performance Report September 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

The Outpatient Patient Tracking List (PTL) is stabilising following significant growth since the new Electronic Patient Record went live. Dermatology represents the most challenged specialty with plans to utilise a variety of options from outsourcing or insourcing from providers in the UK alongside additional temporary workforce at HCS and the use of other healthcare professionals in Jersey e.g., GPs with enhanced skills. Further options include medical photography clinics which are being explored and then procured if clinically appropriate.

Waits in Ophthalmology continue to grow, with routine waits for a first outpatient appointment at 21 months. Successful recruitment to medical vacancies allows for a ring-fenced routine cataract clinic each week to commence in November 2023 in line with the new starters second week in post (post induction).

The Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a limited time period aiming to reduce the backlog of patients in Ophthalmology.

The remaining patients waiting more than 1 year are in community dental which continues to deliver the commissioned recovery programme ahead of trajectory. The waiting list volume has now recovered to the pre-pandemic level.

The diagnostic PTL is currently being validated as reported to the Board in September 2023. This has seen an immediate decrease in the volume on the PTL from > 2716 patients to 1413. Xyla Elective Care commenced clinical activity on the 07th of October 2023 with 88 procedures completed in the first two weekends. The endoscopy PTL has decreased by 77 patients in this period with another 6 weekends planned until the end of 2023.

A specific waiting list initiative, to improve access for patients waiting for MRI scans, has been in planning in September and commenced on the 9th October which is delivering in line with projection.

September saw a 4% decrease in the number of Emergency Department attendances and although a slight increase in the proportional number of non-elective admissions, it was noted the conversion rate within the Emergency Department remains within the KPI at 15%. Longer stays within the Emergency Department have been noted with 72 patients remaining in the Department over 10 hours, this is a 148% increase from September 2022, some of these delays are attributable to trolley waits for admissions and which have been longer due to the increase in delayed discharge patients which had an average of 57.8 during September.

11% of hospital discharges were achieved before midday and to improve this indicator the Golden Patient Initiative has been commenced, whereby inpatient areas are proactively identifying next day discharges to be discharged before 10am. In addition, the relaunch of the Red to Green initiative has been planned for October 2023 which will enable the identification of delays and enable the Operations Centre to reduce blockages within the system.

Winter Planning continues to be undertaken with care group schemes being identified, the schemes specifically target inpatient flow or admission prevention to maximise efficiency of the hospital over the winter period. This includes reviewing winter arrangements for testing of COVID-19, Influenza and RSV to ensure appropriate and timely management of non-elective admissions and to reduce the risk of outbreaks and nosocomial transmission.

Delayed discharges continue to be high, prior to Covid the number of delayed discharges averaged between 10 and 15. Over the previous 4 years the number of delayed discharges as increased year on year. The current trend of delayed discharges waivers between 38 to 47 daily. These reductions were identified through operating efficiencies however external factors such as EU Exit and COVID-19 has impacted on the care sector.

Mental Health and Adult Social Care

Access remains significantly improved as a result of the new comunity model, with 93% of all crisis referrals being seen within 4 hours and 80% of all routine referrals being seen within 10 days. Whilst this is below the 85% target, review of all cases who were not seen within the timeframe indicates that service user choice is a reason for many of these. Waiting times for the memory assessment service and psychological therapies remain a concern. This is being addressed in part through recruitment and the temporary redeployment of some resources. However, the service are also currently exploring other potential solutions, through the development of an improvement trajectory.

Social care continue to significantly focus on developing the discharge service and maintaining flow through the hospital. This has impacted consistently on the target to review all support plans within 6 weeks (60% achieved in month); the service have current plans to address this.

Quality and Safety

September has seen a decrease in complaints received from 44 to 28. Temporary additional support has been put into the patient experience team to investigate complaints that are outside of the required timescale which has resulted in 57 complaints being closed in the month of September. Work is ongoing to reduce the number of open complaints and improve response times. Pharmacy has seen a rise in complaints particularly around opening times and length of wait, they are now reviewing the current model in line with the feedback. Lessons learned from completed investigations were analysed and shared across care groups. Work is ongoing to reduce the number of open complaints, improve response times and move toward local resolution.

There has been an increase in the number of pressure damage acquired in care from 1.32 in August to 2.95 per 1000 bed days in September. The tissue viability team continue to provide regular training and education to staff, patients and relatives. There has been an increase in the number of pressure relieving devices provided to the wards in the past month to support the management of pressure area care.

Falls have shown a decrease in numbers this month from 68 (3 guided to floor / assisted by staff) to 54, (2 guided to floor / assisted by staff), the level of harm to patients; 1 resulting in moderate harm and 1 resulting in severe harm. There is no one ward or clinical area experiencing recurrent falls. The rate of falls in hospital will be impacted by the number of delayed transfer of care patients.

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	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	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3440	3586	4104	3332	3837	3622	4812	3731	3797	4512	4204	4100	4173		36788	2%	21%
General and Acute Outpatient Referrals - Under 18	301	302	365	411	348	432	414	308	305	439	384	321	400		3351	25%	33%
Additions to Inpatient Waiting List	434	535	581	451	455	495	571	468	430	297	303	264	490		3773	86%	13%
Referrals to Mental Health Crisis Team	ND	ND	52	91	87	83	90	91	93	113	104	102	93		856	-9%	NA
Referrals to Mental Health Assessment Team	ND	ND	139	201	237	215	272	187	229	249	234	319	221		2163	-31%	NA
Referrals to Memory Service	33	21	33	30	57	43	56	43	29	27	27	39	5		326	-87%	-85%
Referrals to Jersey Talking Therapies	98	112	113	74	104	98	134	109	94	105	90	110	120		964	9%	22%

ACTIVITY

Measure	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	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	17344	19057	21502	16596	19916	19315	21533	16712	17425	16875	15572	16046	16695		160089	4%	-4%
Elective Admissions	221	240	230	163	213	233	335	315	265	166	155	132	138		1952	5%	-38%
Elective Day Cases	592	685	700	532	629	615	701	428	583	549	513	545	529		5092	-3%	-11%
Elective Regular Day Admissions	919	908	923	903	952	884	1064	932	1087	1072	1029	1046	1002		9068	-4%	9%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	292	274	277	268	316	240	245	180	162	160	150	147	144		1744	-2%	-51%
Emergency Department Attendances	3515	3479	3394	3325	3270	2982	3501	3345	3547	3762	3671	3713	3569		31360	-4%	2%
Emergency Admissions	529	583	588	571	579	502	571	555	627	591	553	544	542		5064	0%	2%
Admissions to Adult Mental Health unit (Orchard House)	16	14	11	8	16	13	15	10	9	12	15	14	14		118	0%	-13%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	5	3	11	7	5	4	4	5	6	6	11	5	10		56	100%	100%
Maternity Deliveries	71	63	70	63	77	60	68	59	69	54	81	71	65		604	-8%	-8%

WAITING LISTS

Measure	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	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9815	9394	9049	9245	9036	8571	9044	9296	9814	10917	12668	13077	13398		13398	2%	37%
Outpatient 1st Appointment Waiting List - Acute	7652	7265	7069	7247	7232	6807	7413	7860	8399	9875	11388	11793	12099		12099	3%	58%
Outpatient 1st Appointment Waiting List - Community	2163	2129	1980	1998	1804	1764	1631	1436	1415	1042	1280	1284	1299		1299	1%	-40%
Diagnostics Waiting List	1055	1022	1027	992	955	908	1030	1025	1027	971	2400	2489	2548		2548	2%	142%
Elective Waiting List	2230	2157	2186	2293	2409	2424	2385	2434	2375	2699	2730	2651	2724		2724	3%	22%
Elective Waiting List - Under 18	110	100	84	87	90	106	101	91	93	100	86	71	79		79	11%	-28%
Jersey Talking Therapies Assessment Waiting List	133	143	150	145	138	117	159	167	147	133	97	68	124		124	82%	-7%

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	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	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	47.2%	46.2%	44.0%	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%	41.8%	42.5%	45.8%		45.8%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	37.6%	35.2%	33.0%	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%	39.4%	40.8%	44.9%		44.9%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	81.0%	83.6%	83.1%	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	81.7%	63.0%	58.3%	54.0%		54.0%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	48.6%	48.1%	49.8%	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%	70.8%	70.2%	69.2%		69.2%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	57.4%	53.3%	49.6%	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%	56.4%	58.1%	59.0%		59.0%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	2.7	2.6	2.7	2.8	2.8	2.8	2.9	2.8	2.9	2.9	2.9	2.7	2.6		2.8	2.0
	Outpatient Did Not Attend (DNA) Rate	8.2%	7.6%	8.2%	7.8%	7.5%	6.8%	6.9%	7.0%	7.3%	11.7%	12.6%	12.3%	12.9%		9.3%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	1.9	2.5	2.6	2.3	1.8	1.7	2.1	2.3	2.2	2.5	3.1	3.6	2.8		2.4	<3
	% of all elective admissions that were day cases	81%	79%	76%	81%	80%	79%	78%	75%	76%	76%	75%	79%	75%		77.0%	>80%
	% of all elective admissions that were private	29%	25%	25%	30%	30%	24%	29%	28%	30%	31%	27%	24%	28%		27.9%	>32% and <34%
Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	74.0%	77.9%	75.0%	69.1%	74.0%	73.1%	73.6%	78.4%	72.9%	63.4%	64.3%	63.4%	64.2%		68.7%	>85%
	Turnaround time as % of total session time	14.0%	13.1%	14.9%	14.7%	18.3%	19.0%	16.9%	14.7%	14.3%	10.4%	12.1%	10.7%	12.8%		14.1%	<15%

CATEGORY	INDICATOR	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	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	11	9	10	10	11	11	10	12	14	26	17	16	17		15	<11
	% Triaged within Target - Minor	51%	59%	53%	51%	51%	52%	54%	49%	43%	26%	43%	46%	44%		45%	>=90%
	% Triaged within Target - Major	64%	67%	63%	61%	60%	60%	64%	58%	56%	31%	42%	44%	46%		51%	>=90%
	Median Time from Arrival to commencing Treatment	44	43	39	40	38	41	38	44	41	60	40	37	33		41	<75
	% Commenced Treatment within Target - Minor	84%	83%	86%	84%	83%	86%	85%	82%	84%	78%	89%	89%	94%		86%	>=70%
	% Commenced Treatment within Target - Major	65%	63%	61%	61%	62%	64%	66%	63%	66%	53%	71%	70%	73%		65%	>=70%
	Median Total Stay in ED (mins)	142	153	148	160	158	148	149	160	156	173	149	146	146		154	<189
	Total patients in ED > 10 hours	29	12	27	69	45	19	55	39	54	58	36	76	72		454	<1
	ED conversion rate	15%	16%	17%	17%	17%	16%	16%	16%	16%	15%	14%	14%	15%		15.3%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	7.3	6.0	6.1	7.4	7.1	7.0	7.1	6.6	6.5	6.1	6.8	7.3	8.8		7.0	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	9%	11%	8%	7%	7%	9%	8%	8%	11%	14%	12%	15%	13%		11%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	96%	95%	97%	94%	97%	90%	95%	95%	89%	87%	89%	87%	92%		91%	<85%
	% of Inpatients discharged between 8am and noon	13%	10%	11%	11%	13%	11%	12%	11%	13%	13%	11%	13%	11%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	32.4	26.2	24.0	31.1	23.2	23.9	31.1	24.2	23.2	ND	ND	ND	57.8		30.5	<30
	Total Bed Days Medically Fit For Discharge	972	811	721	932	718	669	932	702	579	ND	ND	ND	1733		5333	<910
	Total Bed Days Delayed Transfer Of Care (DTOC)	582	578	466	622	442	511	628	467	412	ND	ND	ND	ND		2460	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	10%	12%	11%	10%	10%	10%	9%	10%	13%	11%	8%	12%	10%		10%	<10%

CATEGORY	INDICATOR	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	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	0.0%	0.7%	1.3%	0.0%	2.2%	1.7%	0.0%	2.4%	4.1%	3.0%	3.1%	2.9%	3.2%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	59%	59%	64%	28%	61%	38%	47%	20%	38%	35%	59%	33%	46%		44%	<5%
	JTT Average waiting time to treatment (Days)	156	196	170	102	165	130	141	96	134	154	162	126	137		138	<=177
	% of eligible cases that have completed treatment and were moved to recovery	50%	56%	42%	62%	67%	44%	59%	64%	54%	91%	67%	43%	32%		56%	>50%
	% of eligible cases that have shown reliable improvement	75%	92%	71%	85%	78%	76%	71%	68%	77%	91%	81%	57%	77%		76%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	168	180	153	152	126	137	110	126	159	177	182	188	214		158	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	ND	ND	70.0%	77.1%	84.4%	93.0%	85.2%	87.3%	86.7%	98%	84%	85%	93%		89%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	ND	ND	96.8%	88.4%	83.9%	76.9%	80.7%	89.6%	86.0%	83%	77%	83%	80%		82%	>85%
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	ND	57%	64%	100%	67%	56%	100%	92%	89%	84%	94%	87%		85%	>80%
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	ND	60%	50%	67%	0%	100%	80%	83%	100%	0%	100%	75%		78%	>80%
	Community Mental Health Team did not attend (DNA) rate	6.9%	7.4%	4.8%	6.6%	6.0%	5.3%	6.0%	7.1%	6.4%	7.0%	5.8%	7.0%	6.3%		6%	<10%
	Adult Acute Admissions per 100,000 population - Rolling 12 month	253	241	234	224	229	226	233	229	221	219	220	209	206		206	<255
	Adult acute admissions under the Mental Health Law as a % of all admissions	50%	64%	36%	50%	25%	31%	47%	40%	11%	50%	47%	43%	64%		41%	<37%
Inpatient Mental Health	Adult acute bed occupancy at midnight (including leave)	100%	92%	93%	91%	95%	88%	94%	99%	93%	89%	84%	86%	86%		90%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	373	357	376	380	369	379	363	342	362	361	384	353	372		372	<475
	Older adult acute bed occupancy (including leave)	100%	98%	91%	98%	99%	99%	99%	96%	89%	86%	93%	88%	85%		93%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	20	19	16	14	15	14	13	13	15	ND	ND	ND	11		13.40	<13

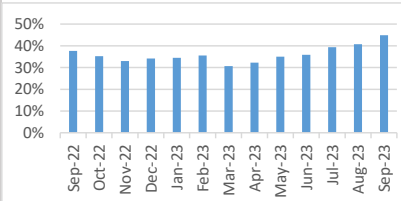
CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	62%	65%	65%	63%	66%	66%	65%	68%	68%	71%	73%	74%	74%		69%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	94%	95%	90%	91%	70%	83%	80%	73%	53%	86%	85%	84%	86%		78%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	50%	35%	62%	56%	39%	68%	73%	49%	47%	55%	64%	64%	60%		58%	>=80%

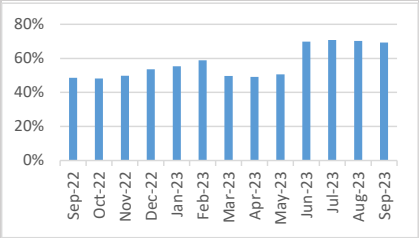
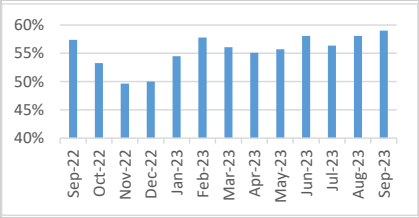
CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	11.2%	10.5%	11.6%	10.9%	9.5%	8.1%	8.5%	10.6%	10.9%	19.9%	19.8%	20.3%	19.2%		14.2%	<=10%
	Average length of stay on Robin Ward	1.07	1.62	2.21	1.85	1.35	1.56	2.93	1.73	2.74	1.50	1.38	1.39	1.44		1.8	<=1.65
	% deliveries home birth (Planned & Unscheduled)	7.0%	4.8%	14.3%	3.2%	7.8%	5.0%	11.8%	8.5%	4.3%	7.4%	2.5%	5.6%	3.1%		6.1%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	37.1%	38.7%	44.3%	28.3%	44.0%	50.0%	46.3%	33.9%	24.2%	39.6%	35.2%	32.4%	34.4%		37.7%	NA
	% Instrumental deliveries	12.7%	12.7%	4.3%	9.5%	9.1%	16.7%	7.4%	15.3%	11.6%	11.1%	7.4%	16.9%	6.2%		11.1%	NA
	% Emergency caesarean section births	17.1%	17.7%	15.7%	25.0%	25.3%	16.7%	16.4%	20.3%	27.3%	9.4%	31.0%	22.5%	15.6%		21.0%	NA
	% Elective caesarean section births	18.6%	24.2%	28.6%	26.7%	29.3%	16.7%	22.4%	23.7%	27.3%	26.4%	23.9%	22.5%	21.9%		23.9%	NA
	% of women that have an induced labour	31.0%	25.4%	20.0%	38.1%	14.3%	26.7%	20.6%	23.7%	34.8%	22.2%	19.8%	28.2%	27.7%		24.0%	=27.57%
Maternity	Number of stillbirths	0	1	0	0	0	0	0	0	0	0	0	0	0		0	
	Rate of Vaginal Birth After Caesarean (VBAC)	0.0%	0.0%	0.0%	25.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		3.7%	>15%
	% primary postpartum haemorrhage >= 1500ml	7.0%	6.3%	2.9%	4.8%	5.2%	3.3%	4.4%	5.1%	14.5%	3.7%	4.9%	2.8%	4.6%		5.5%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.9%		0.8%	<2.5%
	% of births less than 37 weeks	4.2%	7.9%	10.0%	12.7%	13.0%	10.0%	13.2%	3.4%	10.1%	0.0%	8.6%	2.8%	3.1%		7.5%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	8.5%	11.1%	8.6%	11.1%	13.0%	10.0%	17.6%	5.1%	9.0%	3.8%	18.2%	11.3%	4.7%		10.7%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	0.0%	0.0%	5.7%	1.7%	0.0%	0.0%	1.5%	1.7%	3.0%	0.0%	4.2%	1.4%	1.6%		1.5%	<=1.3%
	Average length of stay on maternity ward	2.30	2.15	2.44	2.20	1.86	2.07	2.21	2.15	2.33	1.43	1.74	1.45	1.58		1.84	<=2.28

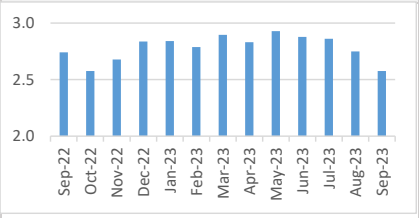
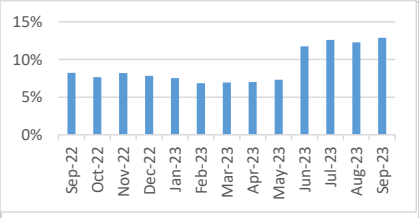
CATEGORY	INDICATOR		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
	MSSA Bacteraemia	Hosp	0	0	1	1	0	0	1	1	1	0	0	0	0		3	
	E-Coli Bacteraemia	Hosp	0	0	1	0	0	0	0	1	1	0	1	0	1		4	
	Klebsiella Bacteraemia	Hosp	0	1	0	0	0	1	1	0	0	0	0	0	0		2	
	Pseudomonas Bacteraemia	Hosp	0	0	0	1	0	0	0	0	1	1	0	0	0		2	
	C-Diff Cases	Hosp	1	2	0	0	1	2	1	1	2	1	1	0	1		10	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		1.2	1.2	2.8	2.8	2.3	2.4	2.9	2.8	4.1	3.9	2.8	4.6	2.6		3	NA
	Number of falls per 1,000 bed days		4.3	4.5	5.5	7.6	5.9	6.0	6.2	5.6	6.9	8.0	7.1	9.4	5.9		7	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.0	0.2	1.5	0.8	1.2	0.9	1.0	0.5	0.7	0.7	0.5	1.3	1.0		0.9	<0.40
	Number of serious incidents		2	1	2	1	0	2	3	4	2	9	5	4	2		31	NA
VTE	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		ND	ND	ND	ND	ND	ND	ND	ND	ND	11%	11%	31%	16%		17%	>95%
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		3.40	3.00	2.66	1.62	2.33	2.44	1.46	1.82	1.55	2.74	1.62	1.32	2.95		2.02	<2.87
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		2.89	2.00	1.50	1.30	1.71	1.69	1.13	1.66	0.86	2.23	1.30	1.16	2.46		1.6	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.34	0.67	1.00	0.32	0.62	0.75	0.32	0.17	0.52	0.17	0.00	0.00	0.16		0.30	<0.60
Feedback	Number of comments received		27	18	29	25	15	8	17	12	27	25	35	22	35		196	NA
	Number of compliments received		50	69	53	96	76	95	60	70	57	62	83	49	180		732	NA
	Number of complaints received		34	47	53	29	55	43	34	35	24	43	36	42	27		339	NA
	% of all complaints closed in the period which were responded to within the target		ND	ND	54%	21%	31%	14%	23%	37%	21%	6%	18%	19%	20%		20.0%	>40%

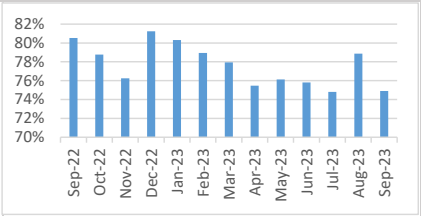
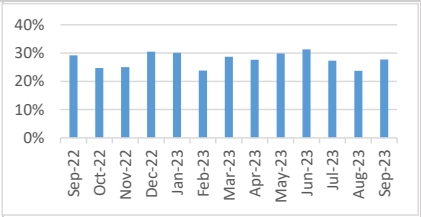
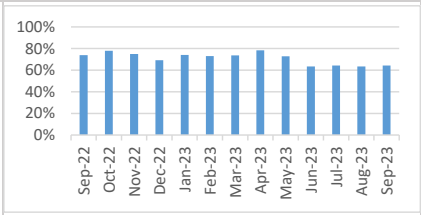
EXCEPTION REPORTS

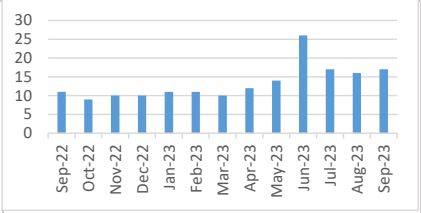
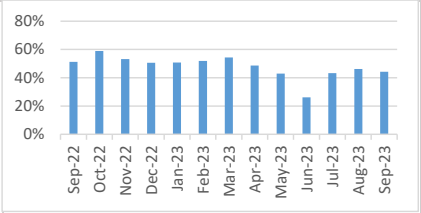
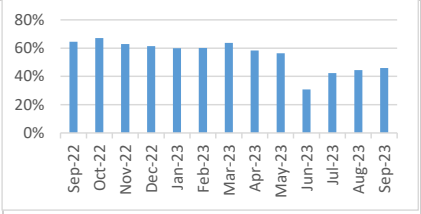
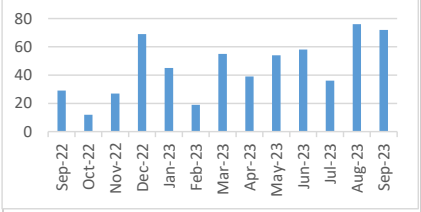
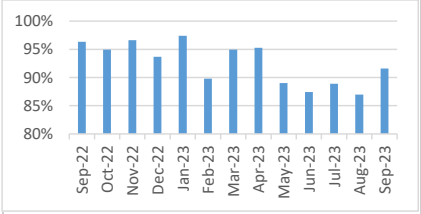
GENERAL AND ACUTE WAITING LISTS

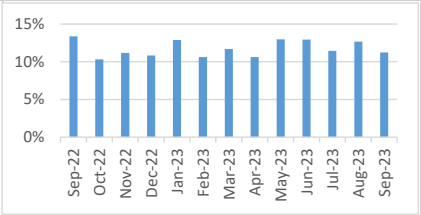
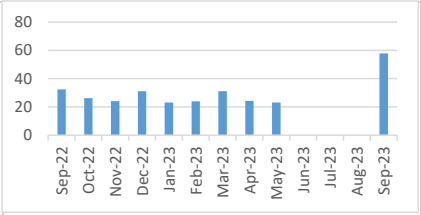
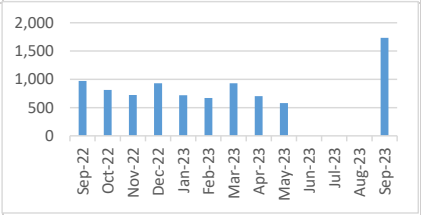
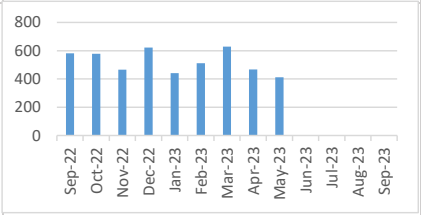
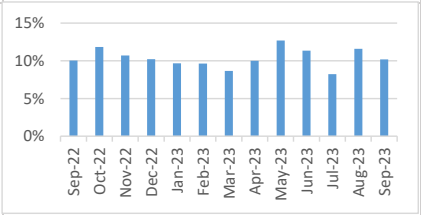
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans.	>35% Head of Access
% patients waiting over 90 days for 1st OP appointment - Acute		Ophthalmology, Clinical Genetics and Trauma and Orthopaedics remain the greatest outlier in the relation to patients waiting > 90 days. ***Ophthalmology*** : The last medical vacancy has been successfully recruited to with a start date for November. This capacity will ensure ringfenced routine cataract clinics are established for the longest waiting patients. In addition to this the Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a time limited period aiming to reduce the backlog of patients in Ophthalmology. ***Clinical Genetics:*** Proposals for a service re-design have been submitted facilitated by the purchase of clinical genetics specific software. ***Trauma and Orthopaedics:*** Waiting List Initiative clinics are commencing on the 06th October on Friday afternoons until the end of the year to ensure the outliers in relation to this metric are seen. The surgical waiting list manager is supporting to ensure chronological booking for the patient tracking lists. ***Paediatrics*** continues to recover with the PTL reducing from >400 patients to 267. The longest waiting patient without an appointment is now at 38 days. ***Dermatology*** continues to be a challenge to recruit to. Alternative solutions are being sought to reduce the number of patients waiting with a particular emphasis on the urgent acuity.	>35% Head of Access
% patients waiting over 90 days for 1st OP appointment - Community		At month end the commissioned dental scheme has reduced the total waiting volume from 1826 patients to 731 (-1095 or –60%). The remaining long waiters to be seen have either not engaged in the scheme or did not attend appointments in the scheme. These cases are being transferred back to the HCS Dental Departments care for appointments. An additional 200 patients were transferred into the scheme in August, HCS continues to receive the outcomes for this cohort as appointments are attended in the community practices. The scheme runs until the end of 2023. Discussions are on going with relevant Ministers in regards to the opportunity to continue the scheme into 2024 to reduce the risk on this list growing again post reduction. Staffing within the physiotherapy department is improving and waiting times are improving in line with this, although on boarding of new services has slowed down expected recovery.	>35% Head of Access

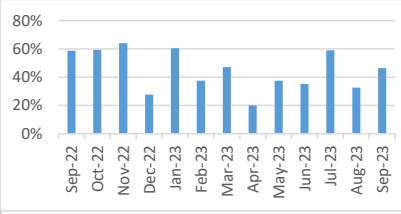
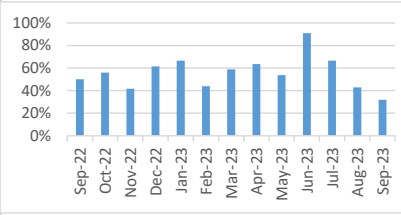
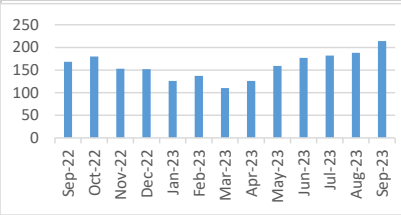
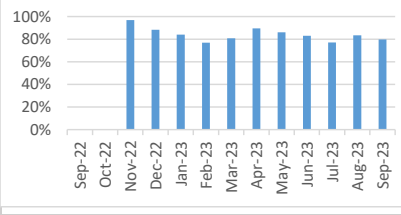
% patients waiting over 90 days for diagnostics		The diagnostic waiting list is being validated in October as post implementation of the new EPR the diagnostic PTL included a number of patients on surveillance pathway. It is expected that the October figure will return to approximately 45%. Endoscopy remains the greatest outlier in relation to this metric. Xyla Elective Care have been appointed as a quality assured provider delivering time limited additional capacity to the endoscopy unit. The mobilisation period commenced in August with the first activity on track to commence on the weekend 07th-08th October. With the impact of the WLI in endoscopy it is expected that this metric to be reaching standard by March 2024 but would be dependant on rates of referrals.	>35% Head of Access
% patients waiting over 90 days for elective admissions		HCS remains challenged across a number of specialties including Trauma and Orthopaedics, General Surgery, Ophthalmology, ENT and Gynaecology in relation to the % of patients waiting > 90 days. HCS is funded to complete additional ad-hoc activity through a variety of initiatives across all specialties. Extra sessions have taken place in Urology, General Surgery and Ophthalmology as a part of waiting list initiative. This metric would be supported to improve post the opening of additional beds in Plemont end of November into December but would be dependent on staffing and any impact of seasonal admissions as we move into the winter months and increase/decrease in MFFD in JGH.	>35% Head of Access

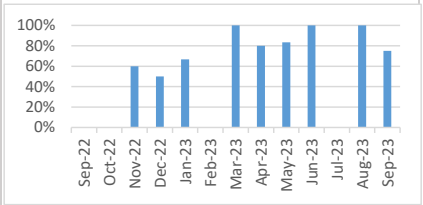
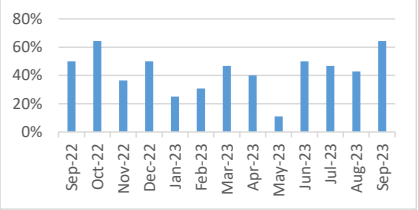
PLANNED (ELECTIVE) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
New to follow-up ratio		Detailed discussions took place at the Care Group Performance meetings this month in relation to achieving this standard. The surgical care group are taking action to focus on specific specialities pain management (2.66) although a reduction from 3.2 is noted from August, ENT & Urology although it is understood that appropriate higher follow up ratio is expected for glaucoma & some elements of ENT. General Surgery has reduced from 1.5 to 1.08 same period and T&O has reduced 6% 2.02 - 1.9. All clinical leads have been requested to consider PIFU guidance and this work will be quantified and monitored within FRP workstream. A trajectory for improvement will be forth coming next month as an outcome of this.	> 2.0 Care Group General Managers
Outpatient Did Not Attend (DNA) Rate		Since the introduction of Maxims, reminder text messages are no longer being sent to all patients for their appointments as it is now an opt in function. This is further compounded by receipt of several letters cases where appointments are changed. The opt in function is in the process of being reversed and we should see an improvement going forward once this is done (go live set 5pm 24/10/23) Work continues within therapies, community dental and screening – significant resource has been allocated to call patients before their appointment to ensure attendance. Most effected, Pain (17.23%), Ophthalmology (15.2%), Urology (15.02%), General Surgery (13.63%), T&O (12.03%), ENT (11.82%). Breast has reduced DNA rates in month so opportunities for learning is being explored.	>8% Care Group General Managers

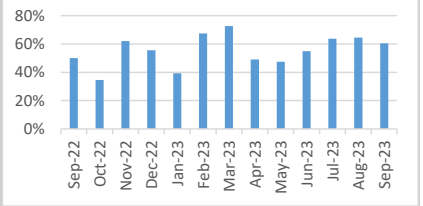
% of all elective admissions that were day cases		We continue to monitor cases that can be converted to day cases to assist with our elective bed management however more proactive benchmarking needs to be undertaken as part of clincical effectiveness agenda but current focus is on POLCV and then will be expanded. Further work needs to take into account the re provision of Sorel ward for private activity, increasing elective work generally as part of WLI, as will be impacted by increasing denominator.	<80% Surgical Services Care Group General Manager
% of all elective admissions that were private		Delivery of 27% of private patient elective activity compared to 23% in previous period. This is subjected to the limitations of separate listing, and the listing of private patients is subject to the requirement of the individual clinicians. Work is on going as part of the private patient committee to consider list utilisation & impact of opening of Plemont will drive increased bed base for private activity with associated benefits in income and patient choice.	<32% or >34% Surgical Services Care Group General Manager
Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)		Please Note: the adjusted position compared to the August QPR. The data quality for this figure has been interrogated by the Head of Access and reporting is now in line with Model Hospital Methodology. The 6-4-2 meeting continues to check and challenge the next 2/52 planned operating lists utilising historic data in relation to operating length. Data quality continues to be an issue, particularly with the adjustment to the new EPR and missing time stamps in theatre. The Head of Access and Lead Nurse are 'cashing' up each day to ensure all lists are representative of the work completed and that the October figure is a true representation of capped theatre utilisation. With data quality addressed, key actions taking place to add to under utilised planned lists and start of the day activity will be monitored in FRP work stream. The metric is expected to improve to 70-75% in November.	<85% Surgical Services Care Group General Manager

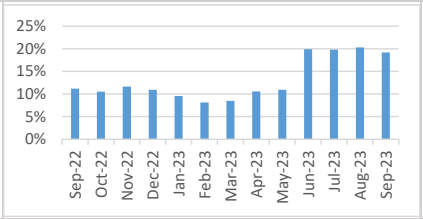
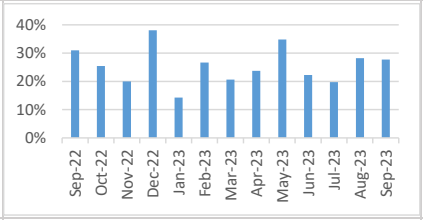
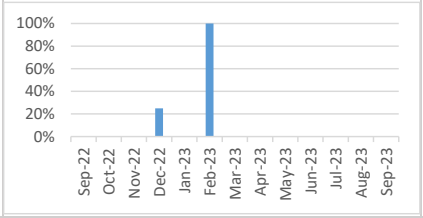
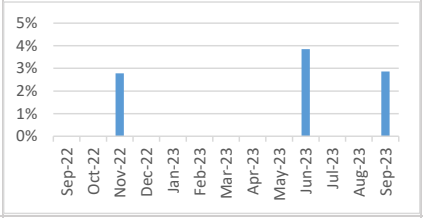
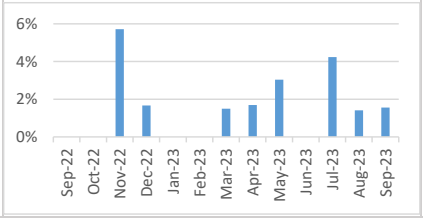
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Median Time from Arrival to Triage		Triage is an ongoing issue due to training and staffing, we have now recruited a Practice Development Nurse who will be addressing the improvements. 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 last year which recommended a 50% increase in Grade 4s and same for HCAs. Sustained improvment will be difficult without staffing increase but will be considered as part of the unfunded pressures. The new lead nurse is focusing on the quality of care in this area to provide assurance and actions to mitigate any risk but is not current feature of complaints or incident reporting.	90% Medical Services Care Group General Manager
% Triaged within Target - Major		Majors patients are seen on arrival or within 10 minutes as part of SOP 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. An audit of the SOP is going to be conducted to build assurance. An Ambo triage area to mitigate any impact of winter pressures is under consideration and would likely improve data capture for P2's & P'3s. Therefore the data has not been recorded correctly, to mitigate this we are looking at developing a more accurate quality indicators to reflect current patient care in the department at a granular level.	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 or to discharge from ED, 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
Acute bed occupancy at midnight (Elective & Non-Elective)		The metric has been reviewed in keeping with KH03 metric standards which removed ICU, paediatric in patients activity to allow benchmarking going forward and also historic in standard achievement did not sense check with daily operational pressures & observations.	>85% Medical Services Care Group General Manager

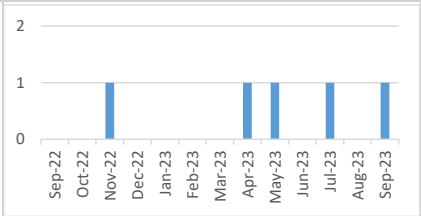
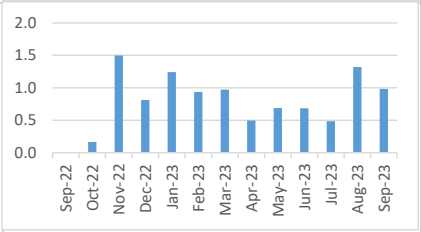
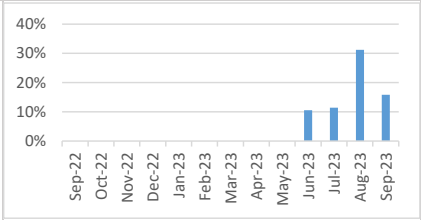
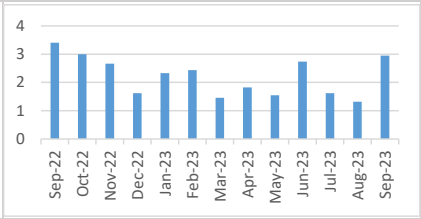
% of Inpatients discharged between 8am and noon		Implementation of the Red2Green initiative in October will support identification of delays and enable teams to troubleshoot how patient flow can be improved. As part of winter planning the golden patient initiative will be restarted and monitored through the operations meetings.	15% Medical Services Care Group General Manager
Average daily number of patients Medically Fit For Discharge (MFFD)		The average numbers of medically fit patients significantly increased in September thus increasing hospital occupancy and patients awaiting over 10 hours for a bed. A ministerial paper has been produced highlighting concerns with the available capacity across community sector and the subsequent impact on the General Hospital. A discharge taskforce has been established to implement improvements on internal aspects relating to medically fit for discharge patients.	>30 Care Group General Managers
Total Bed Days Medically Fit For Discharge		The total bed days for medically fit patients significantly increased in September thus increasing hospital occupancy and patients awaiting over 10 hours for a bed. A ministerial paper has been produced highlighting concerns with the available capacity across community sector and the subsequent impact on the General Hospital. A discharge taskforce has been established to implement improvements on internal aspects relating to medically fit for discharge patients	>910 Care Group General Managers
Total Bed Days Delayed Transfer Of Care (DTOC)		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. When this was first implemented in early August it worked for MFFD patients but failed for DTOC patients. This has been subsequently resolved, however we are unable to calculte a full month until October.	NA 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. Recent deep dive work has shown however we benchmark good against the UK.	>10% Medical Services Care Group General Manager

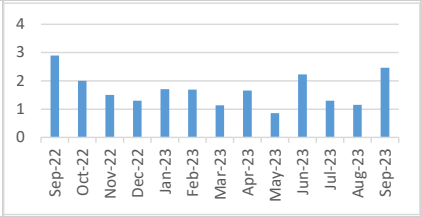
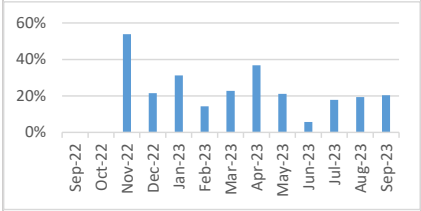
MENTAL HEALTH			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% of clients who started treatment in period who waited over 18 weeks		Jersey Talking Therapies received 120 referrals in September, which was an increase from the previous month in which 110 referrals were received in August. The average waiting time for treatment is 137 days. Our waiting times from assessment to treatment remain above our KPI. We have a new Senior Psychological Therapist starting in post, which will have a positive impact on waiting times for treatment and we are recruiting a new step 2 Psychological wellbeing practitioner, and two Psychological practitioners to work at step 3.	>5% Lead Allied Health Professional Mental Health
% of eligible cases that have completed treatment and were moved to recovery		This indicator requires clients to show recovery on both GAD (Anxiety) and PHQ (Depression) measures. The outcome measure for this month shows that the clients who have completed their intervention with JTT have shown improvements that have tended to be in either GAD or PHQ but not both.	<50% Lead Allied Health Professional Mental Health
Memory Service - Average Time to assessment (Days)		Greatly reduced team over this period due to sickness and maternity leave and reduced availability of medical staff. Meeting arranged to develop improvement trajectory with team.	>138 Lead Nurse - Mental Health
% of referrals to Mental Health Assessment Team assessed in period within 10 working days		The service continues to review all referrals that are not seen within the 10 day target in orer to understand the reasons for this and address where possible. Service user choice remains a key component.	<85% Mental Health Care Group Manager

% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days		The 75% achievement represents 3 of 4 people who were seen within the 3 day target on discharge. The circumstances of the 1 person that was not seen are being reviewed.	<80% Mental Health Inpatient Lead Nurse
Adult acute admissions under the Mental Health Law as a % of all admissions		This indicator reflects the complexities of the admissions that cannot be cared for by home treatment and require MHL admission	>37% 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		Percentage of clients with a physical health check in the past year is currently 74%. This was previously progressing towards the target of 80% over the last few months. Challenges relate to a lack of specific clinic space to carry out the health appointments (currently being reviewed for its own space to hold a clinic) and DNAs relating to service users who do not wish to have a health check.	>=80% Social Care Care Group General Manager
Percentage of new Support Plans reviewed within 6 weeks (ASCT)		Review metric had improved but regressed when the hospital discharge service were unable to complete any initial reviews in August/September. This task was brought back under the Adult Social Care team in late September. Service continues to monitor and has plans in place to bolster the HDS and move hospital reviews to that centre of care (currently subject to staff consultation).	>=80% Social Care Care Group General Manager

WOMEN'S AND CHILDREN'S SERVICES			
Was Not Brought Rate		Appointment reminder text messages are not being sent to patients as it has become an opt-in function. The care group expect an improvement once the system has been upgraded. Actions currently in place are telephone calls by clinical teams at time of appointments if a DNA has occurred and a follow-up letter/appointment sent as required. Clinic outcomes are monitored weekly to cross-check any missed outcomes.	>9.8% General Manager Womens, Childrens & Family Care Group
% of women that have an induced labour		Induction of labour is required where condition of the mother or foetus would deteriorate should the pregnancy continue. Also maternal request for the same is also one of the issues to consider when reviewing the IOL rate. Nationally the IOL rate is approx 30% with range nationally being 17.5% to 40% (2022)	>25% Lead Midwife
Rate of Vaginal Birth After Caesarean (VBAC)		No requests this month for VBAC	< 25% Lead Midwife
% 3rd & 4th degree tears – normal birth		Each case is reported on Datix and once identified repaired by experienced Obstetrician and then followed up at 6 weeks post-natal	>2.5% Lead Midwife
% of babies that have APGAR score below 7 at 5 mins		Small number of deliveries, this number equates to two babies who are reviewed by a consultant.	>0.6% Lead Midwife

QUALITY AND SAFETY			
E-Coli Bacteraemia - Hosp		RCA being completed. No learning outcomes identified currently	0 Director of Infection Prevention and Control
Number of medication errors across HCS resulting in harm per 1000 bed days		These have improved in month although have not fallen back to previous levels. The implementation of electronic prescribing has allowed more accurate determination of errors. It has also allowed redress with focussed training and mediation where required.	> 0.40 Medical Director
% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		This was previously a mandated review in TrakCare which was driving higher levels of performance before MAXIMS was implemented in MAy. This is not feasible as a mandatory field in MAXIMS however a repeated pop up feature is being implemented which will continually flag until VTE assessment is complete. This should go live in October. Snap shot audits is showing performance averaging 65% with outliers identified for action. Additional work needs to occur to develop options paper for ITU as the Critical Care module is implemented for EPR/link to MAXIMS.	>97% Medical Director
Number of pressure ulcers acquired as an inpatient per 1,000 bed days		There has been an increase in the number of pressure damage acquired in care from 1.32 in August to 2.95 per 1000 bed days in September. This equates to 22 instances of pressure damage of which 19 were category 2 there were 2 x unstageable and I x category 3. The category 3 pressure damage was reviewed by tissue viability team has been recategorized as category 2. There were instances where patients have been informed of the risks of pressure damage but have declined pressure relieving devices . The tissue viability team continue to provide regular training and education to staff, patients and relatives. There has been an increase in the number of pressure relieving devices onto the wards in the past month to support the management of pressure area care.	> 2.87 Interim Chief Nurse

Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		Further analysis of the data shows an increase in category 2 pressure damage from 1.16 in August to 2.46 per 1000 bed days in September. Further analysis of the data does not show that there is any one ward with a high incidence of pressure damage. All wards have been provided with additional mattress pumps and pressure relieving cushions to support delivery of patient care.	> 1.96 Interim Chief Nurse
% of all complaints closed in the period which were responded to within the target		September has seen a decrease in complaints received from 44 to 28, with care being referenced having received the most complaints (14) Further analysis of complaints classified as care has been undertaken; it includes administration / disposal of medication, coordination of medical treatment and delay in diagnosis. Pharmacy has seen a rise in complaints particularly around opening times and length of wait, they are now reviewing the current model in line with the feedback. Lessons learned from completed investigations were analysed and shared across care groups. Temporary additional support has been put into the patient experience team to investigate complaints that are outside of the required timescale which has resulted in 57 complaints being closed in the month of September. Work is ongoing to reduce the number of open complaints and improve response times.	<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 (DTOC), only snapshot data are currently available directly from new Patient Administration System. Informatics continue to work 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 able to be calculated was September (month 9). Unfortunately the fix did not fully work for DTOC indicator, so this will be reported from October (month 10).

Community Mental Health Services indicators in relation to follow up within 3 days of discharge have been reviewed. This has resulted in a name change on the indicator to better reflect the service provided. These are now labelled:

% of Adult Acure discharges with a face to face contact from an appropriate Mental Health professional within 3 days

% of Older Adult Acure discharges with a face to face contact from an appropriate Mental Health professional within 3 days

Theatre Utilisation Rate has now been fully reviewed following the implementation of Maxims and the indicator updated to reflect the improved data availability. In addition the standard has been revised based on NHS GIRFT Benchmarks.

Acute Bed Occupancy has been reviewed to ensure it aligns with the NHS definition used for the standard KH03 return.

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 - ACTIVITY		
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
	% 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

Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding 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	The rate of emergency readmission. This being the number of eligible emergency admissions to Jersey General Hospital occurring within 30 days (0-29 days inclusive) of the last, previous eligible discharge from hospital as a percentage of all eligible discharges from JGH and Overdale. Exclusions apply see detailed definition at: https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf

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 Acute discharges with a face to face contact from an appropriate Mental Health professional 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'

	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional 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 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 Health Team (CMHT, including Adult & Older Adult services) appointments booked
Inpatient Mental Health	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
	% 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

Maternity	% 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		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		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		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		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		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		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	Interim 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	Interim 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)	Interim 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'
VTE	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		Hospital Electronic Patient Record (Maxims Report IP026DM)	Medical Director	>95%	NHS Operational Standard	Percentage of all inpatients (17 and over), (excluding paediatrics, maternity, mental health, and ICU) that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Numerator: Number of eligible inpatients that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Denominators: Number of all inpatients that are eligible for a VTE assessment.

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	Interim 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	Interim 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	Interim 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.