Health and Community Services

Quality and Performance Report October 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

Chief Operating Officer – Acute 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

Acute Hospital Services: no significant change in ED attendances in October or emergency admissions. Improvement is noted on the commenced treatment metric across minor & major areas of ED care. Planned care saw increases both in outpatient and inpatient activity due to elements of waiting list recovery plans and increased scheduling especially to day case activity. Consequently, all areas of the new outpatient waiting list reduced (community, acute & diagnostic) specifically due to waiting list recovery plans delivering change in month. The TCI waiting list increased slightly due to conversion to surgery post outpatient appointment.

Mental Health & Social Care Performance

Performance against our KPIs within mental health and adult social care remain relatively consistent this month. The key issues continue to relate to waiting times for specialist diagnostic assessment services and treatment within psychological therapies, and the care group continues to seek to address this through additional capacity to meet need. It is positive to see the sustained achievement of the face to face contact within 72 hours of discharge KPI, as this is a key patient safety metric within mental health services. Whilst the Crisis & Assessment Team are not quite achieving the 85% access targets each month, much of this relates to patient choice and the significantly improved position overall following the introduction of the new community model from November 2022 (with a year to date position of 86% of crisis assessments and 82% of routine assessments being completed within the target time frames).

Quality & Safety

October saw an improvement in several quality metrics with none triggering an alert and all within expected measures.

Whilst the number of complaints has increased from 29 received in September to 42 received in October, October has seen a significant improvement, with an overall reduction of 18% of the number of open complaints that's have not been resolved in the required response time reducing from 85% to 67%.

There has been a decrease in the numbers of patients suffering from category 2 pressure damage from 2.25 to 1.54

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	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3586	4104	3332	3837	3622	4812	3731	3789	4297	4018	3881	3982	4489		40458	13%	25%
General and Acute Outpatient Referrals - Under 18	302	365	411	348	432	414	308	305	435	371	313	387	428		3741	11%	42%
Additions to Inpatient Waiting List	535	581	451	455	495	571	468	427	273	262	222	367	513		4053	40%	-4%
Referrals to Mental Health Crisis Team	ND	52	91	87	83	90	91	93	113	104	100	93	83		937	-11%	NA
Referrals to Mental Health Assessment Team	ND	139	201	237	215	272	187	229	249	234	321	229	251		2424	10%	NA
Referrals to Memory Service	21	33	30	57	43	56	43	29	27	27	40	28	7		357	-75%	-67%
Referrals to Jersey Talking Therapies	112	113	74	104	98	134	109	94	105	90	110	120	125		1089	4%	12%

ACTIVITY

Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	19057	21502	16596	19916	19315	21533	16712	17425	16893	15592	16171	16961	18388		178906	8%	-4%
Elective Admissions	240	230	163	213	233	335	315	265	166	155	132	138	160		2112	16%	-33%
Elective Day Cases	685	700	532	629	615	701	428	583	549	513	545	529	719		5811	36%	5%
Elective Regular Day Admissions	908	923	903	952	884	1064	932	1087	1072	1029	1046	1002	1050		10118	5%	16%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	274	277	268	316	240	245	180	162	160	150	147	144	105		1849	-27%	-62%
Emergency Department Attendances	3479	3394	3325	3270	2982	3501	3345	3547	3762	3671	3714	3569	3309		34670	-7%	-5%
Emergency Admissions	583	588	571	579	502	571	555	625	591	553	544	542	556		5618	3%	-5%
Admissions to Adult Mental Health unit (Orchard House)	14	11	8	16	13	15	10	9	12	15	14	13	12		129	-8%	-14%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	1	0	1	1	2	1	2	1	0	3	3	2	1		16	-50%	0%
Maternity Deliveries	63	70	63	77	60	68	59	68	53	77	71	64	60		657	-6%	-5%

WAITING LISTS

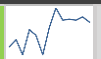
Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9394	9049	9245	9036	8571	9044	9296	9814	10917	12668	13077	13398	13162		13162	-2%	40%
Outpatient 1st Appointment Waiting List - Acute	7265	7069	7247	7232	6807	7413	7860	8399	9875	11388	11793	12099	11926		11926	-1%	64%
Outpatient 1st Appointment Waiting List - Community	2129	1980	1998	1804	1764	1631	1436	1415	1042	1280	1284	1299	1236		1236	-5%	-42%
Diagnostics Waiting List	1022	1027	992	955	908	1030	1025	1027	971	2400	2489	2548	2309		2309	-9%	126%
Elective Waiting List	2157	2186	2293	2409	2424	2385	2434	2375	2699	2730	2651	2724	2749		2749	1%	27%
Elective Waiting List - Under 18	100	84	87	90	106	101	91	93	100	86	71	79	79		79	0%	-21%
Jersey Talking Therapies Assessment Waiting List	143	150	145	138	117	159	167	147	133	97	66	121	105		105	-13%	-27%

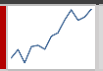
QUALITY AND PERFORMANCE SCORECARD

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	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	46.2%	44.0%	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%	41.8%	42.5%	45.8%	47.4%		47.4%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	35.2%	33.0%	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%	39.4%	40.8%	44.9%	47.0%		47.0%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	83.6%	83.1%	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	81.7%	63.0%	58.3%	54.0%	51.7%		51.7%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	48.1%	49.8%	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%	70.8%	70.2%	69.2%	68.9%		68.9%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	53.3%	49.6%	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%	56.4%	58.1%	59.0%	58.9%		58.9%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	2.6	2.7	2.8	2.8	2.8	2.9	2.8	2.9	2.9	2.9	2.8	2.6	2.5		2.8	2.0
	Outpatient Did Not Attend (DNA) Rate	7.6%	8.2%	7.8%	7.5%	6.8%	6.9%	7.0%	7.3%	11.7%	12.6%	12.3%	12.9%	11.3%		9.6%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	2.5	2.6	2.3	1.8	1.7	2.1	2.3	2.2	2.5	3.1	3.6	2.8	3.4		2.5	<3
	% of all elective admissions that were day cases	79%	76%	81%	80%	79%	78%	75%	76%	76%	75%	79%	75%	75%		76.8%	>80%
	% of all elective admissions that were private	25%	25%	30%	30%	24%	29%	28%	30%	31%	27%	24%	28%	28%		27.9%	>32% and <34%
Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	77.9%	75.0%	69.1%	74.0%	73.1%	73.6%	78.4%	72.9%	63.4%	64.3%	63.4%	64.2%	66.9%		68.5%	>85%
	Turnaround time as % of total session time	13.1%	14.9%	14.7%	18.3%	19.0%	16.9%	14.7%	14.3%	10.4%	12.1%	10.7%	12.8%	12.2%		13.8%	<15%

CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	9	10	10	11	11	10	12	14	26	17	16	17	16		15	<11
	% Triaged within Target - Minor	59%	53%	51%	51%	52%	54%	49%	43%	26%	43%	46%	44%	46%		45%	>=90%
	% Triaged within Target - Major	67%	63%	61%	60%	60%	64%	58%	56%	31%	42%	44%	46%	43%		50%	>=90%
	Median Time from Arrival to commencing Treatment	43	39	40	38	41	38	44	41	60	40	37	33	32		40	<75
	% Commenced Treatment within Target - Minor	83%	86%	84%	83%	86%	85%	82%	84%	78%	89%	89%	94%	94%		86%	>=70%
	% Commenced Treatment within Target - Major	63%	61%	61%	62%	64%	66%	63%	66%	53%	71%	70%	73%	73%		66%	>=70%
	Median Total Stay in ED (mins)	153	148	160	158	148	149	160	156	173	149	146	146	153		154	<189
	Total patients in ED > 10 hours	12	27	69	45	19	55	39	54	58	36	76	72	51		505	<1
	ED conversion rate	16%	17%	17%	17%	16%	16%	16%	16%	15%	14%	14%	15%	16%		15%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	6.0	6.1	7.4	7.1	7.0	7.1	6.6	6.5	6.1	6.8	7.3	8.8	8.2		7.1	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	11%	8%	7%	7%	9%	8%	8%	10%	14%	12%	15%	13%	13%		11%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	95%	97%	94%	97%	90%	95%	95%	89%	87%	89%	87%	92%	89%		91%	<85%
	% of Inpatients discharged between 8am and noon	10%	11%	11%	13%	11%	12%	11%	13%	13%	11%	13%	11%	14%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	27.0	24.0	31.1	23.2	23.9	31.1	24.2	23.2	ND	ND	ND	57.8	47.7		33.0	<30
	Total Bed Days Medically Fit For Discharge	811	721	932	718	669	932	702	579	ND	ND	ND	1733	1480		6813	<910
	Total Bed Days Delayed Transfer Of Care (DTOC)	578	466	622	442	511	628	467	412	ND	ND	ND	ND	919		3379	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	12%	11%	10%	10%	10%	9%	10%	13%	11%	8%	12%	10%	11%		10%	<10%

CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	0.7%	1.3%	0.0%	2.2%	1.7%	0.0%	2.4%	4.1%	3.0%	3.1%	3.0%	3.3%	2.9%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	59%	64%	28%	61%	38%	47%	20%	38%	35%	59%	32%	45%	49%		45%	<5%
	JTT Average waiting time to treatment (Days)	196	170	102	165	130	141	96	134	154	162	124	153	166		142	<=177
	% of eligible cases that have completed treatment and were moved to recovery	54%	42%	62%	67%	44%	59%	64%	54%	91%	63%	38%	32%	65%		56%	>50%
	% of eligible cases that have shown reliable improvement	92%	71%	85%	78%	76%	71%	68%	77%	91%	75%	50%	77%	76%		74%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	180	153	152	126	137	110	126	152	177	182	188	210	190		160	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	ND	70.0%	77.1%	84.1%	93.0%	83.3%	87.3%	86.7%	98.5%	84%	81%	88%	77%		86%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	ND	96.8%	88.3%	83.8%	77.4%	80.7%	89.6%	86.0%	82.3%	77%	83%	78%	82%		82%	>85%
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	57%	64%	100%	67%	56%	100%	92%	89%	84%	94%	87%	92%		85%	>80%
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	60%	50%	67%	0%	100%	80%	83%	100%	0%	100%	75%	100%		81%	>80%
	Community Mental Health Team did not attend (DNA) rate	7.4%	4.8%	6.6%	6.0%	5.3%	6.0%	7.1%	6.4%	7.0%	5.8%	7.0%	6.3%	6.6%		6%	<10%
	Adult Acute Admissions per 100,000 population - Rolling 12 month	241	234	224	229	226	233	229	221	219	220	209	205	202		202	<255
	Adult acute admissions under the Mental Health Law as a % of all admissions	64%	36%	50%	25%	31%	47%	40%	11%	50%	47%	43%	69%	25%		40%	<37%
Inpatient Mental Health	Adult acute bed occupancy at midnight (including leave)	92%	93%	91%	95%	88%	94%	99%	93%	89%	84%	86%	86%	84%		90%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	357	376	380	369	379	363	342	362	361	384	353	377	406		406	<475
	Older adult acute bed occupancy (including leave)	98%	91%	98%	99%	99%	99%	96%	89%	86%	93%	88%	85%	89%		92%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health	20	16	14	15	14	13	13	15	ND	ND	ND	11	9		12.77	<13

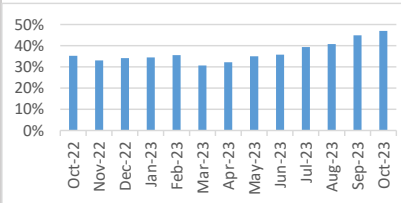
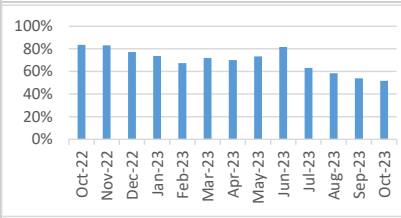
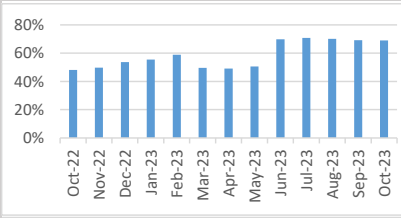
CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	67%	69%	66%	69%	69%	69%	71%	72%	74%	76%	74%	74%	76%		72%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	93%	88%	90%	70%	83%	80%	73%	53%	86%	85%	84%	86%	93%		79%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	33%	63%	45%	40%	65%	71%	50%	47%	54%	65%	66%	62%	65%		59%	>=80%

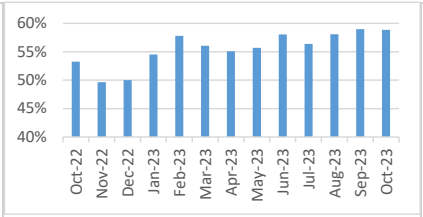
CATEGORY	INDICATOR	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	10.5%	11.6%	10.9%	9.5%	8.1%	8.5%	10.6%	10.9%	19.8%	19.7%	20.4%	19.1%	13.5%		14.2%	<=10%
	Average length of stay on Robin Ward	1.62	2.21	1.85	1.35	1.56	2.93	1.73	2.74	1.50	1.38	1.39	1.44	1.43		1.8	<=1.65
	% deliveries home birth (Planned & Unscheduled)	4.8%	14.3%	3.2%	7.8%	5.0%	11.8%	8.5%	4.4%	7.5%	2.6%	5.6%	3.1%	5.0%		6.1%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	38.7%	44.3%	28.3%	44.0%	50.0%	46.3%	33.9%	23.9%	39.6%	35.2%	32.4%	34.4%	36.4%		37.5%	NA
	% Instrumental deliveries	12.7%	4.3%	9.5%	9.1%	16.7%	7.4%	15.3%	11.8%	9.4%	6.5%	16.9%	6.3%	10.0%		10.8%	NA
	% Emergency caesarean section births	17.7%	15.7%	25.0%	25.3%	16.7%	16.4%	20.3%	28.4%	9.4%	31.0%	22.5%	15.6%	32.7%		22.1%	NA
	% Elective caesarean section births	24.2%	28.6%	26.7%	29.3%	16.7%	22.4%	23.7%	26.9%	26.4%	23.9%	22.5%	21.9%	23.6%		23.8%	NA
Maternity	% of women that have an induced labour	25.4%	20.0%	38.1%	14.3%	26.7%	20.6%	23.7%	35.3%	22.6%	19.5%	28.2%	28.1%	18.3%		23.6%	<=27.57%
	Number of stillbirths	1	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	Rate of Vaginal Birth After Caesarean (VBAC)	11.1%	0.0%	9.1%	5.0%	28.6%	14.3%	28.6%	16.7%	0.0%	20.0%	37.5%	25.0%	11.1%		16.5%	>15%
	% primary postpartum haemorrhage >= 1500ml	6.3%	2.9%	4.8%	5.2%	3.3%	4.4%	5.1%	14.7%	3.8%	3.9%	2.8%	4.7%	6.7%		5.5%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.9%	9.1%		1.4%	<2.5%
	% of births less than 37 weeks	7.9%	10.0%	12.7%	13.0%	10.0%	13.2%	3.4%	10.3%	0.0%	7.8%	2.8%	3.1%	13.3%		7.9%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	11.1%	8.6%	11.1%	13.0%	10.0%	17.6%	5.1%	8.8%	3.8%	18.2%	11.3%	4.7%	16.7%		11.3%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	0.0%	5.7%	1.7%	0.0%	0.0%	1.5%	1.7%	3.0%	0.0%	4.2%	1.4%	1.6%	5.5%		1.9%	<=1.3%
	Average length of stay on maternity ward	2.15	2.44	2.20	1.86	2.07	2.21	2.15	2.33	1.43	1.74	1.45	1.58	1.61		1.82	<=2.28

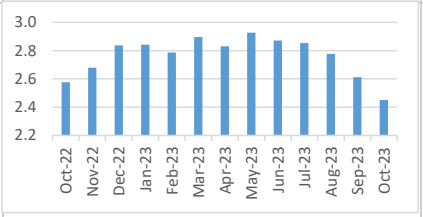
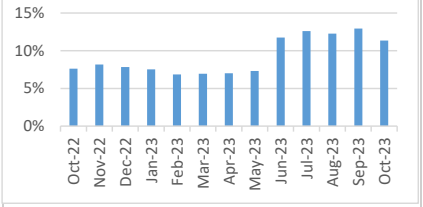
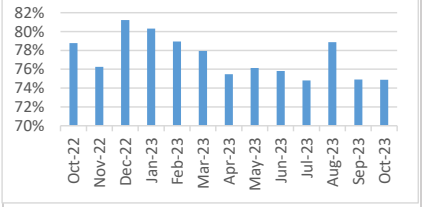
CATEGORY	INDICATOR		Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	MSSA Bacteraemia	Hosp	0	1	1	0	0	1	1	1	0	0	0	0	0		3	0
	E-Coli Bacteraemia	Hosp	0	1	0	0	0	0	1	1	0	1	0	1	0		4	0
	Klebsiella Bacteraemia	Hosp	1	0	0	0	1	1	0	0	0	0	0	0	0		2	0
	Pseudomonas Bacteraemia	Hosp	0	0	1	0	0	0	0	1	1	0	0	0	1		3	0
	C-Diff Cases	Hosp	2	0	0	1	2	1	1	2	1	1	0	1	2		12	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		1.2	3.1	3.0	2.5	2.6	3.1	3.0	4.4	4.1	2.9	4.7	2.8	3.8		3	NA
	Number of falls per 1,000 bed days		4.8	6.0	8.2	6.3	6.4	6.6	6.0	7.3	8.5	7.5	10.0	6.4	5.8		7	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.2	1.6	0.9	1.3	1.0	1.0	0.5	0.7	0.7	0.5	1.4	1.4	0.9		1.0	<0.40
	Number of serious incidents		1	2	1	0	2	3	4	2	9	5	4	2	0		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	11%	12%	32%	31%	24%		22%	>95%
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		3.19	2.74	1.74	2.50	2.60	1.39	1.94	1.65	2.70	1.71	1.40	2.96	2.40		2.12	<2.87
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		2.13	1.64	1.39	1.83	1.80	1.04	1.77	0.92	2.34	1.37	1.22	2.26	1.54		1.6	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.71	1.10	0.35	0.50	0.80	0.35	0.18	0.55	0.18	0.00	0.00	0.17	0.17		0.28	<0.60
Feedback	Number of comments received		18	29	25	15	8	17	12	27	25	35	22	33	48		242	NA
	Number of compliments received		69	53	96	76	95	60	70	58	63	83	49	182	96		832	NA
	Number of complaints received		47	53	29	55	43	34	35	24	43	36	42	28	40		380	NA
	% of all complaints closed in the period which were responded to within the target		ND	54%	21%	31%	14%	21%	37%	21%	6%	18%	20%	20%	21%		20.0%	>40%

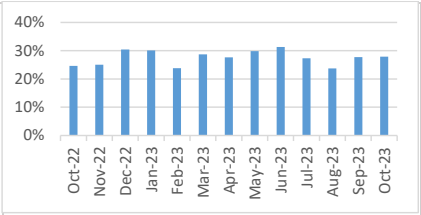
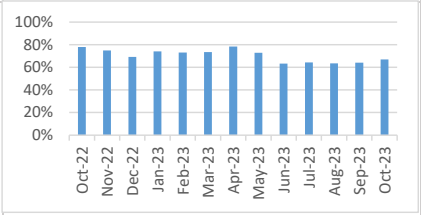
EXCEPTION REPORTS

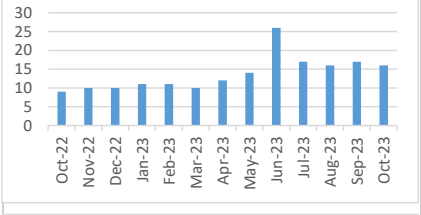
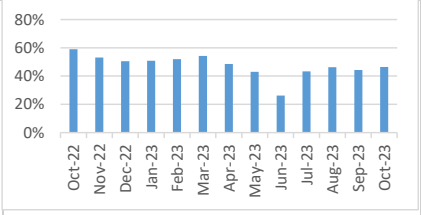
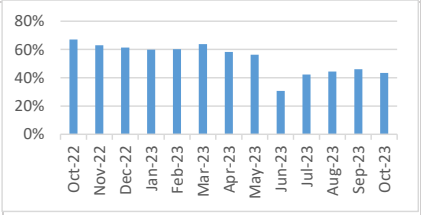
GENERAL AND ACUTE WAITING LISTS

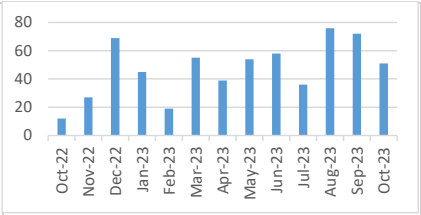
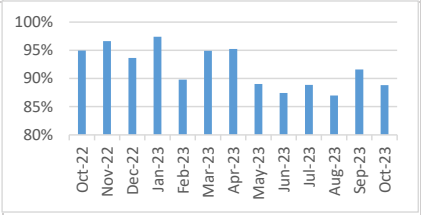
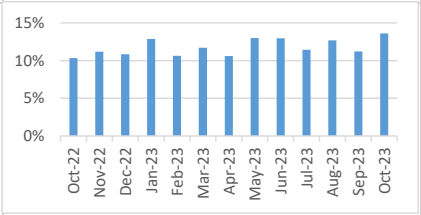
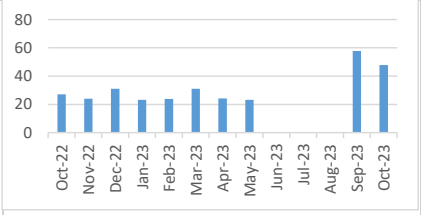
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans.	>35% Chief Operating Officer - Acute Services
% patients 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. 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: Awaiting decision from ELT if clinical genetics remains as an unfunded service and what the criteria for inclusion is. Dermatology continues to be a challenge to recruit to. There has been additional activity to support longest waiters/urgents and soon.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for 1st OP appointment - Community		Work continues to reduce the waiting times across therapies and community dental, the commissioned dental scheme has contributed to a huge drop in the community dental waiting list. Issues with recruitment of staff in therapies is accounting for a slower progression in these departments.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for diagnostics		Endoscopy remains the greatest outlier in relation to this metric. Xyla Elective Care have been appointed as a quality assured provider delivery 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. The diagnostic waiting list is continuing to be validated post implementation of the new EPR. The diagnostic PTL included a number of patients on surveillance pathway.	>35% Chief Operating Officer - Acute Services

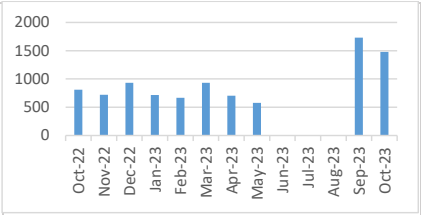
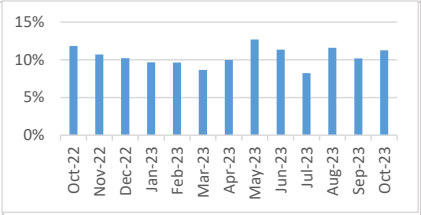
% patients waiting over 90 days for elective admissions		HCS remains challenged across a number of specialties including Trauma and Orthopaedics, General Surgery, Ophthalmology, ENT and Gynaecology in relation to the % of patients waiting > 90 days. HCS is funded to complete additional ad-hoc activity 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.	>35% Chief Operating Officer - Acute Services

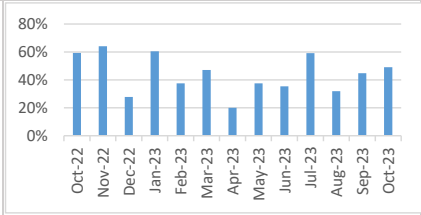
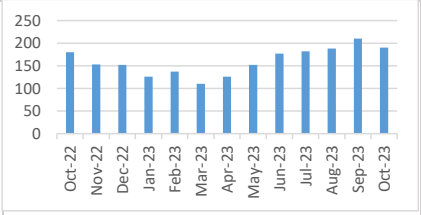
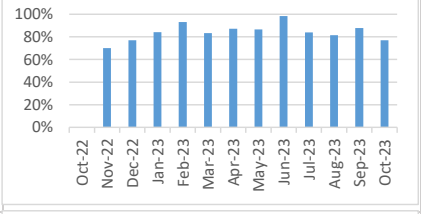
PLANNED (ELECTIVE) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
New to follow-up ratio		Improving trend is observed. Actions to address unwarranted variation in New to follow up rates is a part of the clinical productivity FRP workstream.	> 2.0 Chief Operating Officer - Acute Services
Outpatient Did Not Attend (DNA) Rate		The DNA rate has continued to grow since the implementation of IMS Maxims and the move to Enid Quenault Healthcare Facilities. Text message reminders have been restarted and many islanders are now aware of the EQ Health centre, a reduciton in DNA's is noted and will continue to be observed as part of the clinical productivity OPA FRP workstream.	>8% Chief Operating Officer - Acute Services
% of all elective admissions that were day cases		Cases that can be converted to day cases to assist with our elective bed management is part of elective planning, 642 process and also a systematic review of day case activity is inlcuded in the 2024 clinical productivity workstream. An increase in month is noted but the % metric requires review also to ensure is driving efficiency and clinical effectiveness.	<80% Chief Operating Officer - Acute Services

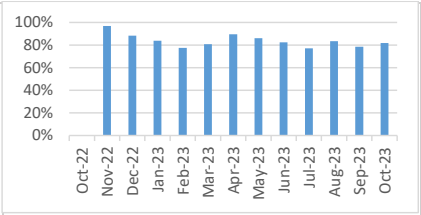
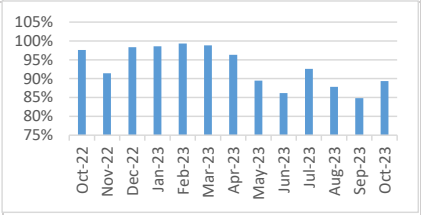
% of all elective admissions that were private		Delivery of 28% of private patient elective activity compared to 27% in previous period. This is subjected to the limitations of separate listing, and the listing of private patients is subject to the requirement of the individual clinicians.	<32% or >34% Chief Operating Officer - Acute Services
Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)		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 . Time stamps are now working really well and the information being filled. The report is being used by the theatre leadership to support. A breakdown of private and public theatre utilisation is being prepared to inform actions.	<85% Chief Operating Officer - Acute Services

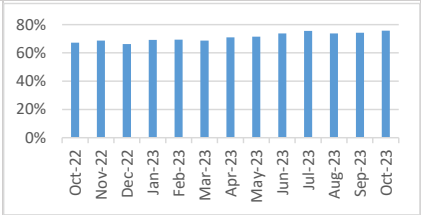
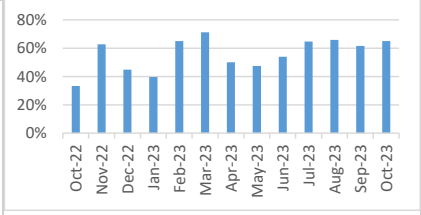
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Median Time from Arrival to Triage		Time to Triage has remained static due to staffing and training issues. Practice development nurse who has been appointed will be addressing this as part of their portfolio.	>10 Chief Operating Officer - Acute Services
% Triaged within Target - Minor		Practice development nurse who has been appointed will be addressing this as part of their portfolio.	90% Chief Operating Officer - Acute Services
% Triaged within Target - Major		Majors patients are seen on arrival or within 10 minutes however nurses completing triage also start with IV cannula and blood tests as well as doing any urgent clinical interventions that are necessary, thus entering clinical triage data on MAXIMS retrospectively. Therefore the data has not been recorded correctly, to mitigate this we are looking at developoing a more accurate quality indicators to reflect current patient care in the department	90% Chief Operating Officer - Acute Services

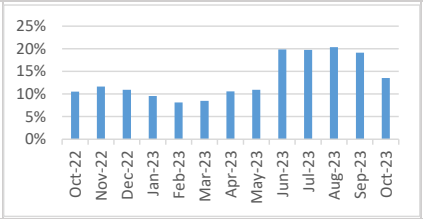
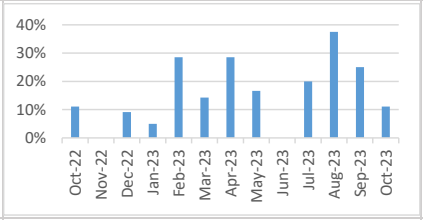
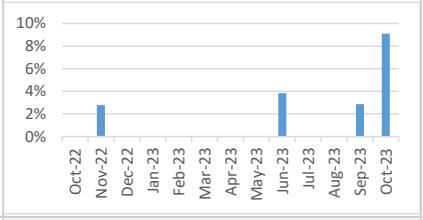
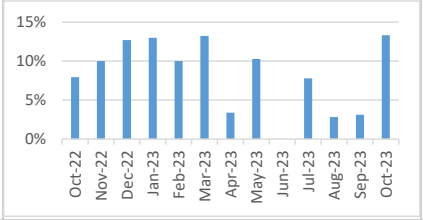
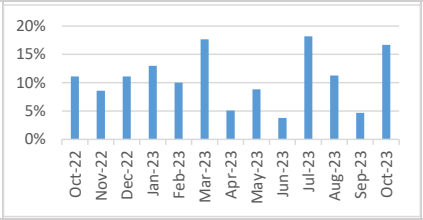
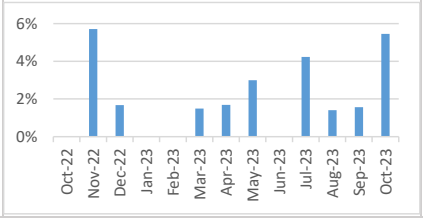
Total patients in ED > 10 hours		This data contains data quality issues as not all notes are recorded in real time. Some patient data will be accurate and are due to awaiting an inpatient bed, however this is compounded by the high number of delayed discharge patients. Discharge workstreams are looking to address the high number of delayed discharges to resolve the data quality issue we are looking at flow in the hospital as well as ensuring appropriate staffing (nursing and medical) to allow contemporaneous discharges on MAXIMs	>0 Chief Operating Officer - Acute Services
Acute bed occupancy at midnight (Elective & Non-Elective)		A reduction in hospital occupancy has been noted in October, through the patient flow improvement workstream length of stay efficiency projects continue to be implemented which improves hospital occupancy. Services such as Same Day Emergency Care (SDEC) previously known as Ambulatory Emergency Care enable patients to be treated same day rather than requiring an inpatient stay.	>85% Chief Operating Officer - Acute Services
% of Inpatients discharged between 8am and noon		An improvement in the discharges before midday has been noted, the golden patient initiative has been relaunched to increase discharges before midday aligned to the SAFER care bundle	15% Chief Operating Officer - Acute Services
Average daily number of patients Medically Fit For Discharge (MFFD)		An improvement in the number of medically fit for discharge patients is noted however MFFD patients remain considerably higher than pre-pandemic. It should be noted that a significant increase is noted in comparison to Q1 & Q2 due to a change in system functionality as the hospital moved to a new IT system. Work is ongoing to reflect an accurate position in the Quality Performance Report.	>30 Chief Operating Officer - Acute Services

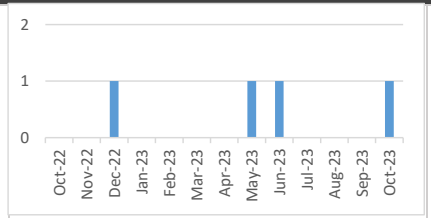
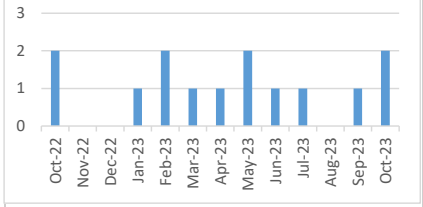
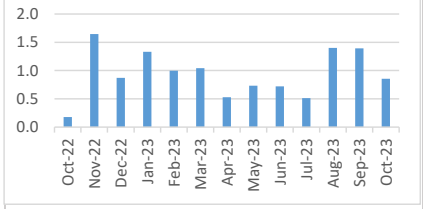
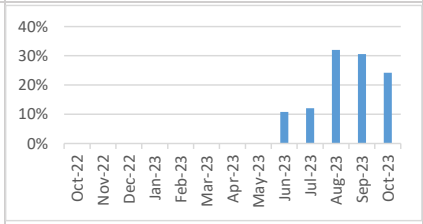
Total Bed Days Medically Fit For Discharge		An improvement in the number of medically fit for discharge bed days is noted however MFFD patients remain considerably higher than pre-pandemic. It should be noted that a significant increase is noted in comparison to Q1 & Q2 due to a change in system functionality as the hospital moved to a new IT system. Work is ongoing to reflect an accurate position in the Quality Performance Report.	>910 Chief Operating Officer - Acute Services
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. Recent deep dive work has shown however we benchmark good against the UK.	>10% Chief Operating Officer - Acute Services

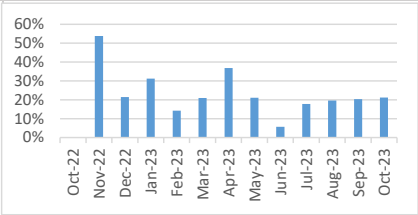
MENTAL HEALTH			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% of clients who started treatment in period who waited over 18 weeks		The trend of an increase in the referrals to Jersey Talking therapies continues from July this year. In October the number of referrals to JTT was 125. We remain well within our KPI for waiting time for assessment, however we remain above our KPI for waiting times to start treatment. We have an increase in the number of people starting treatment from the previous month to 58 in October and an increase in contacts in October to 437 contacts. We have a new Senior Psychological therapist who has joined the team and we are in the process of recruiting additional step 2 practitioners, which will have a positive impact on waiting times for treatment. Treatment outcome measures have now returned to both being within the KPI range (for completed treatment and reliable improvement)	>5% Director Mental Health & Adult Social Care
Memory Service - Average Time to assessment (Days)		Waiting time for assessment / diagnosis remains a challenge - now at 190 days from referral. Work is ongong within the care group to identify additional medical / diagnostic capacity into the team.	>138 Director Mental Health & Adult Social Care
% of referrals to Mental Health Crisis Team assessed in period within 4 hours		The crisis team have completed a face to face assessment within 4 hours in 77% of cases this month, against a KPI target of 85%. This is comparatively low in terms of the performance of the team. As previously, this is reviewed in detail each month to understand all occurrences when this is not achieved. The reasons for this can include another assessment being underway already (out of hours); patient choice; or medical treatment needs prior to assessment being possible. The team continue to aim to achieve the 85% target.	<85% Director Mental Health & Adult Social Care

% of referrals to Mental Health Assessment Team assessed in period within 10 working days		The target of assessing all referrals to mental health services was achieved in 82% of the 251 referrals to the service this month (against a KPI target of 85%). As previously explained, the key factor in not completing the assessment within 10 days tends to be patient choice; this is reviewed in detail each month by the team leader.	<85% Director Mental Health & Adult Social Care
Older adult acute bed occupancy (including leave)		Bed occupancy in older adult mental health services remains above benchmarking due to the number of medically fit for discharge / delayed transfers of care into community placements (although this has reduced in month from 11 patients to 9).	>85% Director Mental Health & Adult Social Care

SOCIAL CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Percentage of clients with a Physical Health check in the past year		Health assessments have increased slightly which is positive in terms of people receiving an annual health check. It has been noted that within reporting, this does not identify those service users who are offered but do not want to have a health assessment. The Learning Disability Services are therefore looking at revising the documentation on Care Partner to report these to ensure that these can be evidenced (especially when the service user or carer reports that the health check is being undertaken elsewhere).	<80% Director Mental Health & Adult Social Care
Percentage of new Support Plans reviewed within 6 weeks (ASCT)		The % of reviews within 6 weeks KPI is recovering from the previously reported challenges in capacity to complete initial reviews in August/September. This function was brought back under the Adult Social Care team in late September. Plans to further bolster the Hospital Discharge Service and move hospital reviews to that team are underway (currently subject to staff consultation). The care group leadership team will continue to monitor to ensure further improvement.	<80% Director Mental Health & Adult Social Care

WOMEN'S AND CHILDREN'S SERVICES			
Was Not Brought Rate		This is across the whole of HCS and is not reflective of just the women and children's care group. 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% Chief Operating Officer - Acute Services
Rate of Vaginal Birth After Caesarean (VBAC)		The rate is low for October. This is mother led and cannot be seen as a quality target. NICE recommend that women can chose their mode of delivery. Women are counselled and given information relating to vaginal birth after caesarean so that they are able to make an informed choice regarding the mode of delivery.	< 25% Chief Nurse
% 3rd & 4th degree tears – normal birth		Although the rate for October was higher than expected this is a recognised complication of childbirth. Reviewing the year to date it would appear the rate would be less than 2.5%. These tears are repaired by a senior obstetrician and women are reviewed postnatally.	>2.5% Chief Nurse
% of births less than 37 weeks		We are actively screening for maternal and fetal conditions that warrant early delivery.	>10% Chief Nurse
% births requiring Jersey Neonatal Unit admission		This would be reflective of babies less than 37 weeks who would require extra support and monitoring.	>5.05% Chief Nurse
% of babies that have APGAR score below 7 at 5 mins		The babies that had Apgar's below 7 made a good recovery and were discharged home. This was reflective of babies that were delivered less than 37 weeks gestation (as above).	>0.6% Chief Nurse

QUALITY AND SAFETY			
Pseudomonas Bacteraemia - Hosp		Unlikely if the 1 case of pseudomonas bacteraemia was a true infection however most likely a contaminated sample as source unknown	0 Chief Nurse
C-Diff Cases - Hosp		We had 2 cases of hospital onset C difficile infection in one ward in October, but these were different ribotype and therefore these cases were not linked	1 Chief Nurse
Number of medication errors across HCS resulting in harm per 1000 bed days		Reported medication errors have included miscounts of prescriptions, spillages of medication or wasted medication. There have been no reported errors in relation to opiate medication and no serious incidents in relation to medication errors.	> 0.40 Medical Director
% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		Medical Director's Office has investigated this trend in discussion with the Care Groups. Data on VTE assessment is pulled from Maxims and this data with respect to the recording of assessment in Maxims is correct. However, all Care Groups having reviewed and discussed this trend with the Medical workforce believe the prescribing of prophylaxis to be far better than this trend would suggest. A focussed piece of work is being undertaken to mandate the prescribing of prophylaxis within EPMA. However, a further piece of work needs to occur to educate medical colleagues in evidencing that an assessment has occurred by recording it within Maxims.	>97% Medical Director

% of all complaints closed in the period which were responded to within the target		October has seen a very slight improvement over previous months, with an overall reduction of the number of open complaints that are overdue their agreed response date (down to 63.9% as of 14/11/23). Three new complaints were received during the month of September 2023, and 13 new complaints were received in the month of October 2023. At the time of reporting, 36.1% of open Stage 1 complaints are within the 5-day timescale, 44.4% are between 6-100 days overdue, and 19.4% are over 101 days from the response due date (in total there are 36 open Stage 1 complaints, 4 Stage 2, and 3 Stage 3 complaints), the complainants of those complaints which are overdue are being contacted to update and agree new timescales to bring this metric back on track). New processes are also now being implemented to address performance; focused on increasing contact with complainants to agree revised response timescales when we are aware of delays in the investigation process (this will reduce the number of overdue complaints in line with the Feedback Policy), revising the process for care group oversight and sign-off to ensure more timely response rates across staff groups, reinforcing the distinction between PALS and complaints, with clear guidelines for escalation and closure to address the length of time complaints remain open, and changes to the Datix system to improve reporting and more accurately record the learning and actions taken as a result of patient feedback. These measures are being implemented in conjunction with the development of HCS specific guidance in the form of a complaints/feedback manual, and specific training that will be included in all staff inductions to improve the culture of complaint management, prompt patient feedback, improved narrative of performance, themes, and learning.	<40% Chief Nurse

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 can only 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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	>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))	Chief Operating Officer - Acute Services	>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))	Chief Operating Officer - Acute Services	>85%	NHS Benchmarking- Getting It Right First Time 2024/25 Target	The percentage of booked theatre sessions that are used for actively performing a procedure. This being the sum of touch time divided by the sum of booked theatre session duration (as a percentage). This is reported for all operations (Public and Private) with the exception of Minor Ops, Maternity and Endoscopy.
	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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	>=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))	Chief Operating Officer - Acute Services	>=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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	>=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))	Chief Operating Officer - Acute Services	>=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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	>=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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	<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))	Chief Operating Officer - Acute Services	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))	Chief Operating Officer - Acute Services	<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	Director Mental Health & Adult Social Care	<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	Director Mental Health & Adult Social Care	<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	Director Mental Health & Adult Social Care	<=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	Director Mental Health & Adult Social Care	>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	Director Mental Health & Adult Social Care	>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	Director Mental Health & Adult Social Care	<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	Director Mental Health & Adult Social Care	>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	Director Mental Health & Adult Social Care	>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	Director Mental Health & Adult Social Care	>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	Director of Mental Health Services	>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	Director Mental Health & Adult Social Care	<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))	Director Mental Health & Adult Social Care	<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)	Director Mental Health & Adult Social Care	<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))	Director Mental Health & Adult Social Care	<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))	Director Mental Health & Adult Social Care	<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))	Director Mental Health & Adult Social Care	<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))	Director Mental Health & Adult Social Care	<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	Director Mental Health & Adult Social Care	>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	Director Mental Health & Adult Social Care	>=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	Director Mental Health & Adult Social Care	>=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))	Chief Operating Officer - Acute Services	<=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))	Chief Operating Officer - Acute Services	<=1.65	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay in days of all patients discharged in the period from Robin Ward, including leave days
Maternity	% deliveries home birth (Planned & Unscheduled)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	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))	Chief Nurse	NA	Not Applicable	Number of spontaneous vaginal births including home births and breech vaginal deliveries dividved by total number of deliveries
	% Instrumental deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	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))	Chief Nurse	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))	Chief Nurse	NA	Not Applicable	Number of Elective Caesarean sections, divided by total number of deliveries
	% of women that have an induced labour	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	<=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))	Chief Nurse	0	Stanadard set locally based on historic performance	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
	Rate of Vaginal Birth After Caesarean (VBAC)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Chief Nurse	>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))	Chief Nurse	<=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))	Chief Nurse	<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))	Chief Nurse	<=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))	Chief Nurse	<=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))	Chief Nurse	<=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))	Chief Nurse	<=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	Chief Nurse	0	Standard based on historic performance	Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team
	MSSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases in the hospital in the period, reported by the IPAC team
	E-Coli Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team
	Klebsiella Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Klebsiella bacteraemia cases in the hospital in the period, reported by the IPAC team
	Pseudomonas Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	0	Standard based on historic performance	Number of Pseudomonas bacteraemia cases in the hospital in the period, reported by the IPAC team
	C-Diff Cases - Hosp	Hosp	Infection Prevention and Control Team Submission	Chief Nurse	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	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	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)	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	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	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	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)	Chief Nurse	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)	Chief Nurse	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)	Chief Nurse	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)	Chief Nurse	>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.