Health and Community Services

Quality and Performance Report December 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

Month 12 saw a slight in month increase but levels of activity comparable to earlier in 2023. Minimal increase in emergency admissions. The median time that patients are waiting to initial triage is 16 minutes although slightly adrift of 11 minutes standard. Work to review ED staffing, staff utilisation and processes in department are in progress. The department did see an increase of patients waiting over 10 hours in ED. A breach process has been introduced to improve our ability to recover this metric. This will be affected by bed availability but is also reflective of patients without a DTA (decision to admit) and for whom we are trying to return to their place of residence post treatment or support.

Planned care saw a slight increase overall to both the outpatient & elective waiting list as capacity reduced to the bank holiday period. This will be reversed in January through a range of measures. The main area of focus is in the acute subset (ENT, Ophthalmology & Clinical Genetics) and Audiology as the now largest sub set of the community waiting list, post recovery of Community Dental position while the impact of the waiting list recovery schemes delivered in 2023 will recommence in 2024.

Mental Health Performance

Performance across mental health and social care remains relatively stable in December, although there is a reported reduction in achievement of the access targets for both Crisis assessment (77%) and routine referrals (78%). This is being reviewed in detail by the service. Waiting pressures continue in memory assessment and psychological treatment (JTT) both due to service capacity; the Mental Health Senior Leadership Team are seeking to address this in early 2024, although success will require the availability of additional clinical capacity.

Quality & Safety

During December 2023, there was a marked decrease in the number of complaints received when compared to December 2022, many enquiries were able to be managed as PALS cases and were prevented from being escalated to formal complaints. The patient experience team continued to focus on the backlog of overdue complaint cases in month, as such, 28 complaints were closed, with nine new complaints and 54 new PALS enquiries logged during the month. As of the end of December 2023 there were 35 open complaints (Stages 1, 2, and 3) of which 47.8% remained overdue the initial five-day response rate. The focus for 2024 is to ensure that regular contact is made with complainants and that complaints are responded to within an agreed timeframe.

Regrettably December has seen an increase in the number of hospital acquired pressure damage, with 20 category 2 pressure ulcers and 2 deep tissue injuries being reported. All category 2 and above are reviewed by the tissue viability team to ensure accurate grading of pressure damage, formulation of care plans and the use of appropriate pressure relieving devices in place. All wards have recently been provided with additional mattress pumps and pressure relieving cushions to support delivery of patient care. Further analysis of the data does not show that there is any one ward with a high incidence of pressure damage. There remains a focus on staff and patient education and training in the management and prevention of pressure damage.

December saw a significant decrease in the number of falls from 49 in November to 38 in December. Of these 2 were unwitnessed falls resulting in moderate physical harm with the remainder reported as no or low physical harm. There is no one ward or clinical area experiencing recurrent falls. The rate of falls in hospital will be impacted by the number of delayed transfer of care patients.

Infection Prevention and Control (IPAC) continues to demonstrate low levels of infection with targeted work on improving vaccination uptake amongst staff.

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	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3332	3837	3622	4812	3731	3787	4197	3945	3734	3836	4413	4324	3699		47656	-14%	11%
General and Acute Outpatient Referrals - Under 18	411	348	432	414	308	307	433	369	320	386	436	425	333		4504	-22%	-19%
Additions to Inpatient Waiting List	451	455	495	571	468	642	694	636	537	622	697	672	559		7048	-17%	24%
Referrals to Mental Health Crisis Team	91	87	83	90	91	93	113	104	100	93	84	108	86		1132	-20%	-5%
Referrals to Mental Health Assessment Team	201	238	216	272	187	229	249	234	321	229	274	270	162		2881	-40%	-19%
Referrals to Memory Service	30	58	43	56	43	29	27	27	40	32	34	27	ND		416	NA	NA
Referrals to Jersey Talking Therapies	74	104	98	133	109	94	105	90	110	122	125	121	103		1314	-15%	39%

ACTIVITY

Measure	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	16596	19916	19315	21533	16712	17424	16876	15810	16242	16978	18134	17796	14128		210864	-21%	-15%
Elective Admissions	163	213	233	335	315	263	153	142	119	125	144	149	99		2290	-34%	-39%
Elective Day Cases	532	629	615	701	428	583	549	513	545	529	722	702	493		7009	-30%	-7%
Elective Regular Day Admissions	903	952	884	1064	932	1089	1085	1042	1059	1015	1062	948	601		11733	-37%	-33%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	268	316	240	245	180	162	160	150	147	144	105	131	119		2099	-9%	-56%
Emergency Department Attendances	3325	3270	2982	3501	3345	3547	3762	3671	3714	3569	3309	3210	3343		41223	4%	1%
Emergency Admissions	571	579	502	571	555	625	591	553	544	542	555	583	595		6795	2%	4%
Admissions to Adult Mental Health unit (Orchard House)	8	16	13	15	10	9	12	15	14	13	12	10	11		150	10%	38%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	7	5	4	4	5	6	6	11	5	10	9	5	7		77	40%	0%
Maternity Deliveries	63	77	60	68	59	68	53	77	71	64	60	65	59		781	-9%	-6%

WAITING LISTS

Measure	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9245	9036	8571	9044	9296	9814	10917	12668	13077	13398	13162	13563	13640		13640	1%	48%
Outpatient 1st Appointment Waiting List - Acute	7247	7232	6807	7413	7860	8399	9875	11388	11793	12099	11926	12392	12500		12500	1%	72%
Outpatient 1st Appointment Waiting List - Community	1998	1804	1764	1631	1436	1415	1042	1280	1284	1299	1236	1171	1140		1140	-3%	-43%
Diagnostics Waiting List	992	955	908	1030	1025	1027	971	2400	2489	2548	2309	2286	2359		2359	3%	138%
Elective Waiting List	2293	2409	2424	2385	2434	2375	2699	2723	2647	2720	2746	2790	2812		2812	1%	23%
Elective Waiting List - Under 18	87	90	106	101	91	93	100	86	71	79	79	88	80		80	-9%	-8%
Jersey Talking Therapies Assessment Waiting List	145	138	117	157	166	146	132	96	65	122	101	126	122		122	-3%	-16%

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	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%	41.8%	42.5%	45.8%	47.4%	45.9%	48.2%		48.2%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%	39.4%	40.8%	44.9%	47.0%	45.7%	48.1%		48.1%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	81.7%	63.0%	58.3%	54.0%	51.7%	48.1%	49.6%		49.6%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%	70.8%	70.2%	69.2%	68.9%	65.4%	66.3%		66.3%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%	56.3%	58.0%	58.9%	58.9%	54.7%	56.7%		56.7%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	2.8	2.8	2.8	2.9	2.8	2.9	2.8	2.9	2.8	2.6	2.4	2.6	2.5		2.7	2.0
	Outpatient Did Not Attend (DNA) Rate	7.8%	7.5%	6.8%	6.9%	7.0%	7.4%	13.6%	14.3%	14.2%	14.9%	13.4%	11.4%	12.5%		10.7%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	2.3	1.8	1.7	2.1	2.3	2.2	2.5	3.1	3.6	2.8	3.4	2.6	2.2		2.5	<3
	% of all elective admissions that were day cases	81%	80%	79%	78%	75%	76%	75%	74%	80%	75%	78%	75%	80%		77.2%	>80%
	% of all elective admissions that were private	30%	30%	24%	29%	28%	30%	32%	29%	25%	28%	28%	28%	29%		28.3%	>32% and <34%
Theatres	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	69.1%	74.0%	73.1%	73.6%	78.4%	72.2%	60.3%	61.5%	59.4%	63.5%	65.5%	67.8%	64.4%		66.9%	>85%
	Turnaround time as % of total session time	14.7%	18.3%	19.0%	16.9%	14.7%	14.1%	11.4%	12.3%	11.0%	13.3%	12.6%	11.1%	11.7%		13.6%	<15%

CATEGORY	INDICATOR	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	10	11	11	10	12	14	26	17	16	17	16	16	16		15	<11
	% Triaged within Target - Minor	51%	51%	52%	54%	49%	43%	26%	43%	46%	44%	46%	47%	47%		46%	>=90%
	% Triaged within Target - Major	61%	60%	60%	64%	58%	56%	31%	42%	44%	46%	43%	45%	46%		49%	>=90%
	Median Time from Arrival to commencing Treatment	40	38	41	38	44	41	60	40	37	33	32	29	32		39	<75
	% Commenced Treatment within Target - Minor	84%	83%	86%	85%	82%	84%	78%	89%	89%	94%	94%	96%	94%		88%	>=70%
	% Commenced Treatment within Target - Major	61%	62%	64%	66%	63%	66%	53%	71%	70%	73%	73%	78%	74%		68%	>=70%
	Median Total Stay in ED (mins)	160	158	148	149	160	156	173	149	146	146	153	150	153		153	<189
	Total patients in ED > 10 hours	69	45	19	55	39	54	58	36	76	72	51	46	69		620	<1
	ED conversion rate	17%	17%	16%	16%	16%	16%	15%	14%	14%	15%	16%	17%	18%		16%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	7.4	7.1	7.0	7.1	6.6	6.5	6.1	6.8	7.3	8.8	8.2	6.8	5.7		7.0	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	7%	7%	9%	8%	8%	10%	14%	12%	15%	13%	13%	13%	12%		11%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	94%	97%	90%	95%	95%	89%	87%	89%	87%	92%	89%	ND	ND		89%	<85%
	% of Inpatients discharged between 8am and noon	11%	13%	11%	12%	11%	13%	13%	11%	13%	11%	14%	10%	12%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	31.1	23.2	23.9	31.1	24.2	23.2	ND	ND	ND	57.8	47.7	32.6	39.0		33.6	<30
	Total Bed Days Medically Fit For Discharge	932	718	669	932	702	579	ND	ND	ND	1733	1480	978	1209		9000	<910
	Total Bed Days Delayed Transfer Of Care (DTOC)	622	442	511	628	467	412	ND	ND	ND	ND	919	692	771		4842	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	10%	10%	10%	9%	10%	13%	11%	8%	12%	10%	11%	8%	13%		10%	<10%

CATEGORY	INDICATOR	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	0.0%	2.2%	1.7%	0.0%	2.4%	3.4%	2.3%	2.1%	1.5%	2.5%	2.0%	2.4%	2.5%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	28%	59%	38%	47%	20%	38%	35%	59%	33%	43%	48%	55%	55%		46%	<5%
	JTT Average waiting time to treatment (Days)	102	163	130	141	96	134	154	162	125	152	167	212	185		152	<=177
	% of eligible cases that have completed treatment and were moved to recovery	62%	60%	44%	59%	61%	54%	91%	63%	44%	30%	73%	75%	57%		59%	>50%
	% of eligible cases that have shown reliable improvement	85%	70%	76%	71%	65%	77%	91%	75%	56%	78%	82%	86%	86%		76%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	142	126	137	107	126	152	177	182	188	192	194	212	236		169	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	77.1%	84.1%	93.0%	83.3%	87.3%	86.7%	98.5%	84.2%	81.8%	88%	78%	84%	77%		86%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	88.2%	83.8%	77.4%	80.4%	89.6%	86.0%	82.1%	77.0%	83.5%	78%	82%	82%	78%		81%	>85%
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	64%	100%	67%	56%	100%	92%	89%	84%	94%	87%	92%	82%	100%		86%	>80%
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	50%	67%	0%	100%	80%	83%	100%	0%	100%	80%	100%	100%	100%		84%	>80%
	Community Mental Health Team did not attend (DNA) rate	6.6%	6.0%	5.3%	6.0%	7.1%	6.4%	7.0%	5.8%	7.0%	6.4%	6.7%	5.0%	6.7%		6%	<10%
Inpatient Mental Health	Adult Acute Admissions per 100,000 population - Rolling 12 month	224	229	226	233	229	221	219	220	209	205	202	201	205		205	<255
	Adult acute admissions under the Mental Health Law as a % of all admissions	50%	25%	31%	47%	40%	11%	50%	47%	43%	69%	50%	40%	36%		41%	<37%
	Adult acute bed occupancy at midnight (including leave)	91%	95%	88%	94%	99%	93%	89%	84%	86%	86%	84%	94%	ND		89%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	380	369	379	363	342	362	361	384	353	377	406	375	374		374	<475
	Older adult acute bed occupancy (including leave)	98%	99%	99%	99%	96%	89%	86%	93%	88%	85%	89%	93%	98%		93%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health	14	15	14	13	13	15	ND	ND	ND	11	9	15	17		13.49	<13

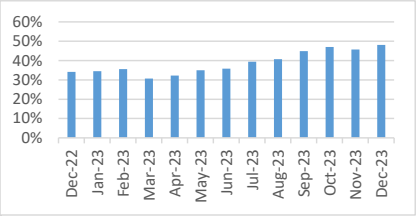
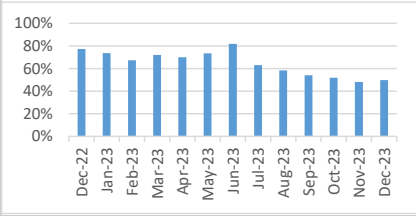
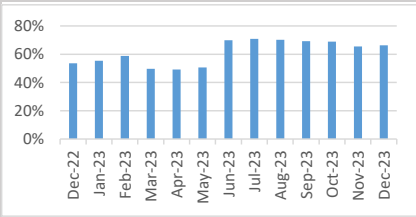
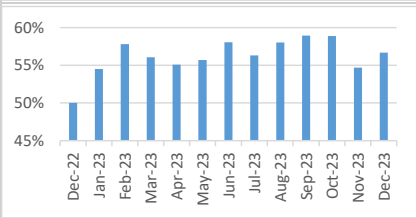
CATEGORY	INDICATOR	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	67%	69%	70%	69%	71%	72%	74%	76%	74%	75%	76%	83%	90%		75%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	90%	70%	83%	80%	73%	53%	86%	85%	84%	86%	93%	87%	93%		81%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	46%	40%	67%	71%	50%	47%	56%	63%	63%	60%	65%	56%	56%		58%	>=80%

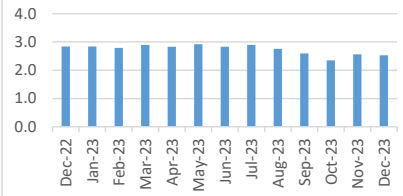
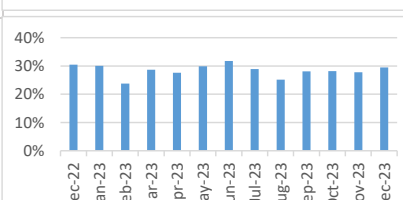
CATEGORY	INDICATOR	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	10.9%	9.5%	8.1%	8.5%	10.6%	11.0%	21.5%	21.1%	20.8%	20.5%	15.2%	14.8%	17.4%		15.1%	<=10%
	Average length of stay on Robin Ward	1.85	1.35	1.56	2.93	1.73	2.74	1.50	1.38	1.39	1.44	1.43	1.90	1.59		1.8	<=1.65
Maternity	% deliveries home birth (Planned & Unscheduled)	3.2%	7.8%	5.0%	11.8%	8.5%	4.4%	7.5%	2.6%	5.6%	3.1%	5.0%	4.6%	0.0%		5.5%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	28.3%	44.0%	50.0%	46.3%	33.9%	23.9%	40.4%	35.2%	32.4%	34.4%	36.4%	28.1%	19.0%		35.4%	NA
	% Instrumental deliveries	9.5%	9.1%	16.7%	7.4%	15.3%	11.8%	9.4%	6.5%	16.9%	6.3%	10.0%	7.7%	6.8%		10.2%	NA
	% Emergency caesarean section births	25.0%	25.3%	16.7%	16.4%	20.3%	28.4%	9.6%	31.0%	22.5%	15.6%	32.7%	23.4%	19.0%		22.0%	NA
	% Elective caesarean section births	26.7%	29.3%	16.7%	22.4%	23.7%	26.9%	26.9%	23.9%	22.5%	21.9%	23.6%	26.6%	29.3%		24.5%	NA
	% of women that have an induced labour	38.1%	14.3%	26.7%	20.6%	23.7%	35.3%	22.6%	19.5%	28.2%	28.1%	18.3%	29.2%	35.6%		25.0%	=27.57%
	Number of stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	Rate of Vaginal Birth After Caesarean (VBAC)	9.1%	5.0%	28.6%	14.3%	28.6%	16.7%	0.0%	20.0%	37.5%	25.0%	11.1%	12.5%	0.0%		14.9%	>15%
	% primary postpartum haemorrhage >= 1500ml	4.8%	5.2%	3.3%	4.4%	5.1%	14.7%	3.8%	3.9%	2.8%	4.7%	10.0%	9.2%	5.1%		6.0%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.9%	9.1%	3.7%	0.0%		1.5%	<2.5%
	% of births less than 37 weeks	12.7%	13.0%	10.0%	13.2%	3.4%	10.3%	0.0%	7.8%	2.8%	3.1%	13.3%	1.5%	3.4%		7.0%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	11.1%	13.0%	10.0%	17.6%	5.1%	8.8%	3.8%	18.2%	11.3%	4.7%	16.7%	9.2%	23.7%		12.0%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	2.0%	0.0%	0.0%	1.8%	1.8%	1.8%	0.0%	0.0%	0.0%	2.7%	0.0%	2.5%	0.0%		1.0%	<=1.3%
	Average length of stay on maternity ward	2.20	1.86	2.07	2.21	2.15	2.33	1.43	1.74	1.45	1.58	1.61	1.61	1.60		1.78	<=2.28

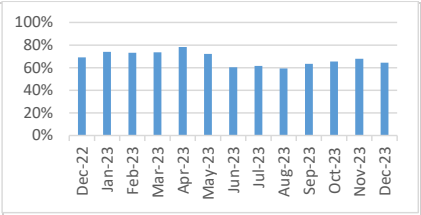
CATEGORY	INDICATOR		Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	MSSA Bacteraemia	Hosp	1	0	0	1	1	1	0	0	0	0	0	0	0		3	0
	E-Coli Bacteraemia	Hosp	0	0	0	0	1	1	0	1	0	1	0	1	0		5	0
	Klebsiella Bacteraemia	Hosp	0	0	1	1	0	0	0	0	0	0	0	0	0		2	0
	Pseudomonas Bacteraemia	Hosp	1	0	0	0	0	1	1	0	0	0	1	0	0		3	0
	C-Diff Cases	Hosp	0	1	2	1	1	2	1	1	0	1	2	2	1		15	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		3.0	2.5	2.6	3.1	3.0	4.4	4.1	2.9	4.7	2.8	3.8	2.8	2.3		3	NA
	Number of falls per 1,000 bed days		8.2	6.3	6.4	6.6	6.0	7.3	8.6	7.5	10.0	6.4	5.8	7.2	4.8		7	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.9	1.3	1.0	1.0	0.5	0.7	0.7	0.5	1.4	1.4	0.7	1.5	1.0		1.0	<0.40
	Number of serious incidents		1	2	3	4	7	5	9	4	4	3	6	2	0		49	NA
VTE	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		ND	ND	ND	ND	ND	ND	11%	12%	32%	31%	24%	17%	8%		19%	>95%
Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		1.74	2.50	2.60	1.39	1.94	1.65	2.70	1.71	1.40	2.96	2.40	1.29	3.48		2.17	<2.87
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		1.39	1.83	1.80	1.04	1.77	0.92	2.34	1.37	1.22	2.44	1.54	0.74	2.26		1.6	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.35	0.50	0.80	0.35	0.18	0.55	0.18	0.00	0.00	0.17	0.17	0.18	0.70		0.31	<0.60
Feedback	Number of comments received		25	15	8	17	12	27	25	34	22	33	48	51	54		346	NA
	Number of compliments received		96	76	95	60	70	58	63	83	49	182	97	69	63		965	NA
	Number of complaints received		29	55	43	34	35	24	43	37	43	28	40	22	9		413	NA
	% of all complaints closed in the period which were responded to within the target		21%	31%	14%	21%	37%	21%	6%	18%	20%	20%	21%	0%	7%		18.0%	>40%

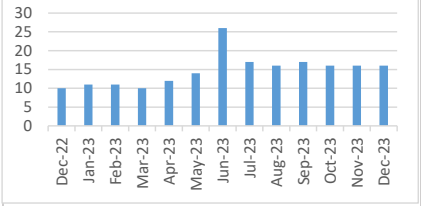
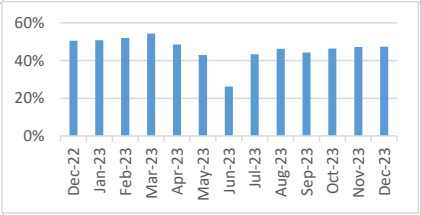
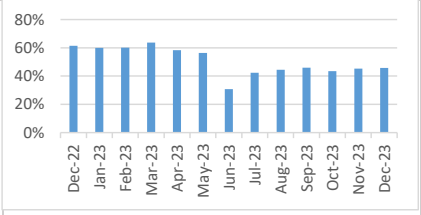
EXCEPTION REPORTS

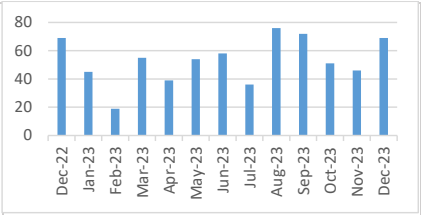
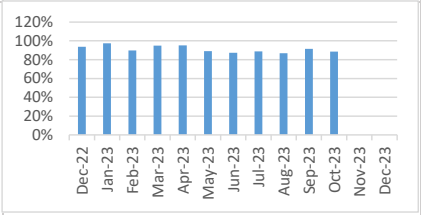
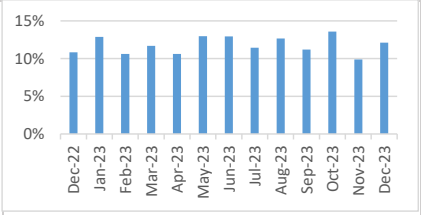
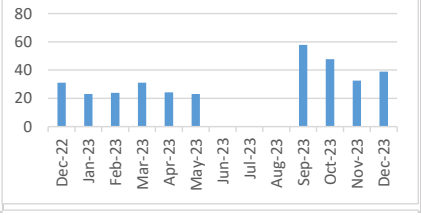
GENERAL AND ACUTE WAITING LISTS

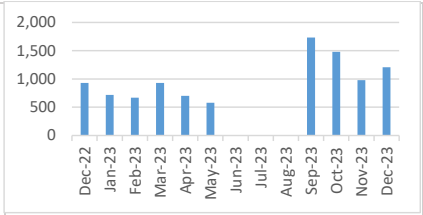
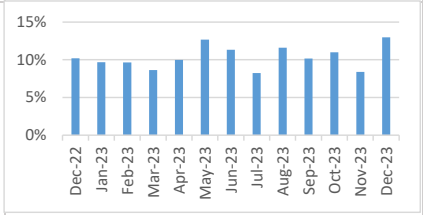
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for 1st OP appointment - Acute		An increase of 288 patients in month awaiting over 90 days for a first outpatient appointment across all acute care groups. A focus for Q1 2024 is a review and validation of the waiting lists due to a known number of admin errors impacting on the actual number of patients waiting. Additionally, the increase in over 90 day waits can be attributed to the process of 'awaiting results', due to the change over to the new PAS. A process will be defined on how to manage these patients who have been seen, but can't be outcomed until test results have been received. Within the Surgical Care Group a focus on urgent & soon patients has resulted an increase in routine patients waiting over 90 days. A reduction in elective activity due to the festive priod, has also contributed to lower activity levels and thus an increase in the waiting list position .	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for 1st OP appointment - Community		An inmonth increase of 17 patients waiting over 90 days. The overall reduction on over 90 days continues, but the impact of reduced activity over the festive period has meant this slight increase.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for diagnostics		An inmonth increase of 23 patients waiting over 90 days for a diagnostic test Patient waiting diagnostic tests remain high at 1564. A process of validation of the waiting list will commence in Q1 2024 to ascertain the true position of the diagnostic waiting list as errors may be causing an inflated figure.	>35% Chief Operating Officer - Acute Services
% patients waiting over 90 days for elective admissions		The reduced activity during the month of December contributed to an increase of patients waiting over 90 days for elective admissions. HCS remains challenged with procedures being postponed last minute by both patients and on occasion by the hospital. We continue to focus on those patients that have waited the longest. The elective recovery plan should start to make in roads into the elective waiting list numbers during 2024 ensuring our longest waiting patients revieve list procedures.	>35% Chief Operating Officer - Acute Services

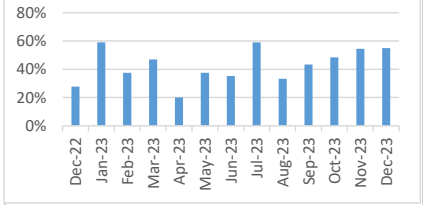
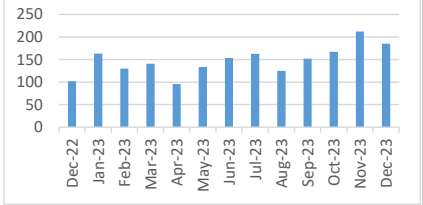
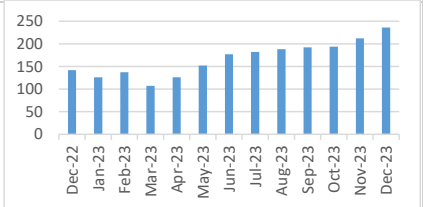
PLANNED (ELECTIVE) CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
New to follow-up ratio		The two specialties within the surgical care group that are above the metric of 2 are ophthalmology and pain management. Ophthalmology have lifelong patients and this is normal for this specialty. Pain management fluctuate on this metric as there is an opt in programme in place.	> 2.0 Chief Operating Officer - Acute Services
Outpatient Did Not Attend (DNA) Rate		Overall the rate continues to fall but not by the amount that was anticipated. We continue to assess our new processes since the implementation of Maxims to seek solutions.	>8% Chief Operating Officer - Acute Services
% of all elective admissions that were day cases		We continue to monitor cases that can be converted to day cases to assist with our elective bed management.	<80% Chief Operating Officer - Acute Services
% of all elective admissions that were private		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

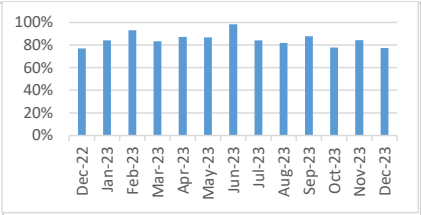
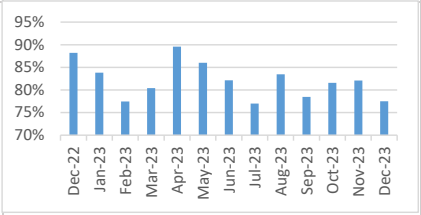
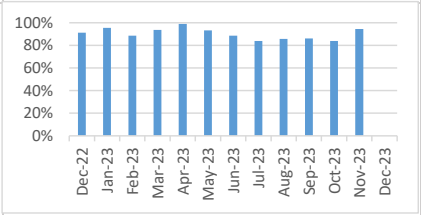
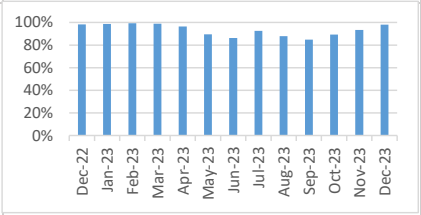
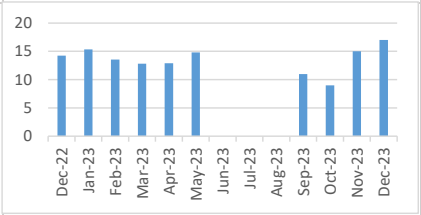
Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)		Key metric of focus as part of clinical productivity FRP workstream. December performance affected by Bank Holidays however momentum continues to drive towards 85%. A modified 6-4-2 that will deliver the Golden Patient process and support the reduction of late or on the day cancellations. Additional areas of focus which will support the theatre productivity FRP: - Late Start Rate - Turnaround Time Rate - Early Finish Rate	<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 remains static. Work continues to address the training and staffing issue to triage. Lead Nurse, Clinical lead and practice development nurse are working collaboratively surrounding to address the improvements needed. The improvements will require investment. A paper has been written re staffing model presented to SLT as currently ED is not working to staffing tool BEST.	>10 Chief Operating Officer - Acute Services
% Triaged within Target - Minor		This is part of the Practice Development Nurse's portfolio to continue to drive the improvements in conjunction with the clinical lead and lead nurse. The improvements will require investment. A paper has been written re staffing model presented to SLT as currently ED is not working to staffing tool BEST.	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 developing a more accurate quality indicators to reflect current patient care in the department.	90% Chief Operating Officer - Acute Services

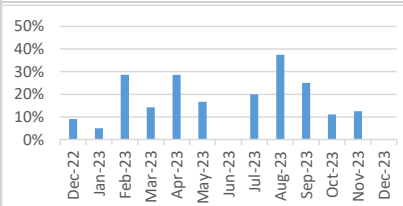
Total patients in ED > 10 hours		Data quality assessment of December identified that historic data quality issues are within this dataset, cleansing of the data results in a reduction in the number of 10hr breaches. Backdated breach validation will be undertaken in Q1 2024. For December 2023 the majority of bed breaches were attributable to patients awaiting a bed for admission. The golden patient initiative is working to improve early AM discharges to which will reduce the wait time for inpatient admission.	>0 Chief Operating Officer - Acute Services
Acute bed occupancy at midnight (Elective & Non-Elective)		There is an issue with the system that means occupancy reporting over the month is not accurate. Decision taken to suspend reporting this indicator until the system fix is applied (currently expected early in the New Year)	>85% Chief Operating Officer - Acute Services
% of Inpatients discharged between 8am and noon		An improvement in the number of patients discharged before midday has been noted. The implementation of the Golden Patient Initiative has supported this improvement. Daily tracking of early discharges is monitored through the operations centre.	15% Chief Operating Officer - Acute Services
Average daily number of patients Medically Fit For Discharge (MFFD)		An increase is noted for December 2023. It is recognised that each year a reduction in community capacity availability occurs during the festive period. Weekly delay meetings continue to be held to support with individual patient cases and unblock delays where possible.	>30 Chief Operating Officer - Acute Services

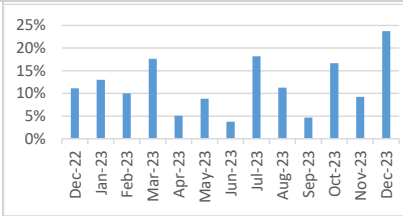
Total Bed Days Medically Fit For Discharge		An increase is noted for December 2023. It is recognised that each year a reduction in community capacity availability occurs during the festive period. Weekly delay meetings continue to be held to support with individual patient cases and unblock delays where possible.	>910 Chief Operating Officer - Acute Services
Rate of Emergency readmission within 30 days of a previous inpatient discharge		An increase in the number of readmissions for December 2023 has been noted, a review into these is planned for January 2024 to identify themes and trends	>10% Chief Operating Officer - Acute Services

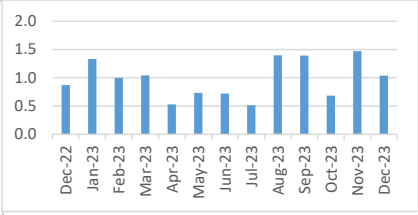
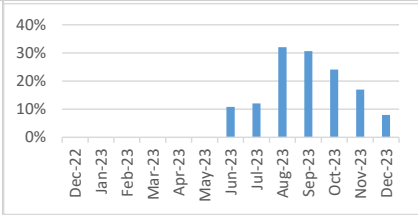
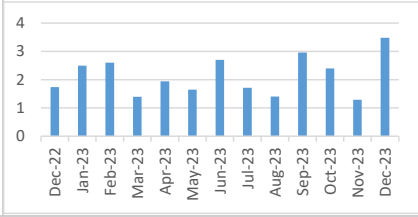
MENTAL HEALTH			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
% of clients who started treatment in period who waited over 18 weeks		There have been 96 referrals to Jersey Talking therapies in December. As previously, the service is doing well at achieving the access to initial assessment target of 90 days(97.5%) but did not achieve the target of commencing treatment within 18 weeks in 55% of cases in month. As reported previously, it anticipated that a planned increase in staffing capacity will help to address this, along with an increased offer of group work.	>5% Director Mental Health & Adult Social Care
JTT Average waiting time to treatment (Days)			>177 Director Mental Health & Adult Social Care
Memory Service - Average Time to assessment (Days)		Waiting time for memory assesment has increased again this month to 236 days, and is hindered by a lack of diagnostic capacity to currently meet demand within the service. As reported last month, this is now a priority area for the service, with the aim to agree an improvement trajectory (subject to availability of additional diagnostic capacity) within January 2024.	>138 Director Mental Health & Adult Social Care

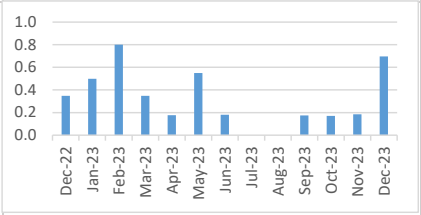
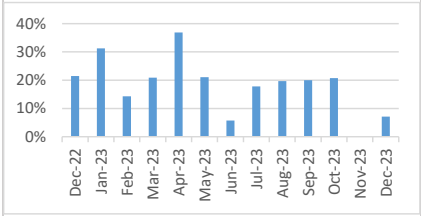
% of referrals to Mental Health Crisis Team assessed in period within 4 hours		The crisis service is reported to have seen 77% of all referals within 4 hours in December. The service is undertaking a line by line review of the data to understand where the target has not been met, and to ensure that data entry issues are not resulting in an under reporting of performance (which has been identified previously following detailed review of all cases).	<85% Mental Health Care Group Manager
% of referrals to Mental Health Assessment Team assessed in period within 10 working days		78% of all referals to adult mental health services were seen within 10 working days. As above, the service are reviewing this data in detail to understand where the KPI has not been met - previously this has related to patient choice and difficulties in contacting service users.	<85% Mental Health Care Group Manager
Adult acute bed occupancy at midnight (including leave)		There is an issue with the system that means occupancy reporting over the month is not accurate. Decision taken to suspend reporting this indicator until the system fix is applied (currently expected early in the New Year)	>88% Director Mental Health & Adult Social Care
Older adult acute bed occupancy (including leave)		Occupancy in older adult mental health services remains high, with an associated high level of Delayed Transfers of Care in December (mostly due to people waiting for community nursing home or residential placements). Work is ongoing with community providers in order to reduce this.	>85% Director Mental Health & Adult Social Care
Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards		The Medically Fit for Discharge (MFFD) patients is above the baseline. This is due to lack of placement or packages of care. The community teams across older adult and working age support the inpatient team to improve the patient flow.	>13 Director Mental Health & Adult Social Care

SOCIAL CARE			
INDICATOR	**13-MONTH GRAPH**	**COMMENTARY & ACTION PLAN**	**TRIGGER & OWNER**
Percentage of new Support Plans reviewed within 6 weeks (ASCT)		The percentage of initial reviews within 6 weeks is still lower than desired. To address this the Adult Social Care Team is in consultation with the Adult Mental Health care group, as the review function in adult social care needs to be bolstered. In addition, Hospital reviews are performed by Adult Social Care Team and the Hospital Discharge Service. The Hospital Team are struggling to meet this timescale due to high demand for assessments, affecting this measure.	>=80% Director Mental Health & Adult Social Care

WOMEN'S AND CHILDREN'S SERVICES			
Was Not Brought Rate		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. Review of the data to focus on higher rate areas for further analysis. Discussion with teams to ensure WNB policy is being followed.	>9.8% Chief Operating Officer - Acute Services
% of women that have an induced labour		Induction of labour is commonly offered where there are concerns that a problem could worsen if a pregnancy were to continue beyond a certain point. Decisions may be multifactorial.	>25% Chief Nurse
Rate of Vaginal Birth After Caesarean (VBAC)		Unable to comment due to lack of data for December however all women who have had a previous caesarean section are counselled and given appropriate information and are therefore enabled to make an informed choice.	< 25% Chief Nurse

% births requiring Jersey Neonatal Unit admission		This appears inflated this month due to the birthing numbers and reporting in a percentage equates to 11 babies that required neonatal input. Some of these babies would have been cared for under the transitional care model which is currently under review.	>5.05% Chief Nurse

QUALITY AND SAFETY			
Number of medication errors across HCS resulting in harm per 1000 bed days		Medication errors are now tracked through a care group governance reviews which occur for surgery, medicine and WACS. There is no discernible pattern and no stand out area of poor practice.	> 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 dashboard has been developed to identify in real time the VTE assessment status of current hospital inpatients, cross referenced against thromboprophylactic medications prescribed through the EPMA, allowing the identification of patients who need to be assessed, or undergo a medications review. 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
Number of pressure ulcers acquired as an inpatient per 1,000 bed days		In December there were 22 cases of hospital acquired pressure damage (compared to 6 cases in November), 20 were cat 2 pressure ulcers 2 were deep tissue injuries, 14 of the cases of pressure damage were in patients over 80 years old, 13 of the 22 were bed bound and 4 were chair bound needing assistance to reposition. 16 of the 22 patients were deemed to be high risk following pressure ulcer risk assessment. Compliance with pressure damage documentation increased 87.6% in November audits were not undertaken in December due to sickness and annual leave. Further analysis of the data will be undertaken in January to understand rationale for the increase.The tissue viability team continue to provide training and education to both staff and patients.	> 2.87 Chief Nurse

Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		See above	> 1.96 Chief Nurse
Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		See above	> 0.6 Chief Nurse
% of all complaints closed in the period which were responded to within the target		December 2023 saw a marked decrease in the number of complaints received compared to previous months, as several enquiries were able to be managed as PALS and therefore did not require escalation to the formal complaint stages. Focus has been placed on closing historically overdue complaints during the month of December, as such 28 complaint cases were closed in month. As at the time of reporting there are currently 34 open Stage 1, 2, and 3 complaint cases of which 11 historical cases are flagging as overdue and require closure. The priority for January 2024 is to get these complaints either closed, or have complainant agreed revised timelines for completion in place.	<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	Mental Health Care Group Manager	>85%	Agreed locally by Care Group Senior Leadership Team	Number of Crisis Team referrals assesed within 4 hours divided by the total number of Crisis team referrals
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	Community services electronic client record system	Mental Health Care Group Manager	>85%	Agreed locally by Care Group Senior Leadership Team	Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target. Numerator: Number of Assessment Team referrals assessed within 10 working days of referral. Denominator: Total number of Mental Health Assessment Team referrals received
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	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
	% 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 didivded 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.

Maternity	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 live births (only looking at singleton babies with a gestational length at birth between 259 and 315 days) that have an 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.