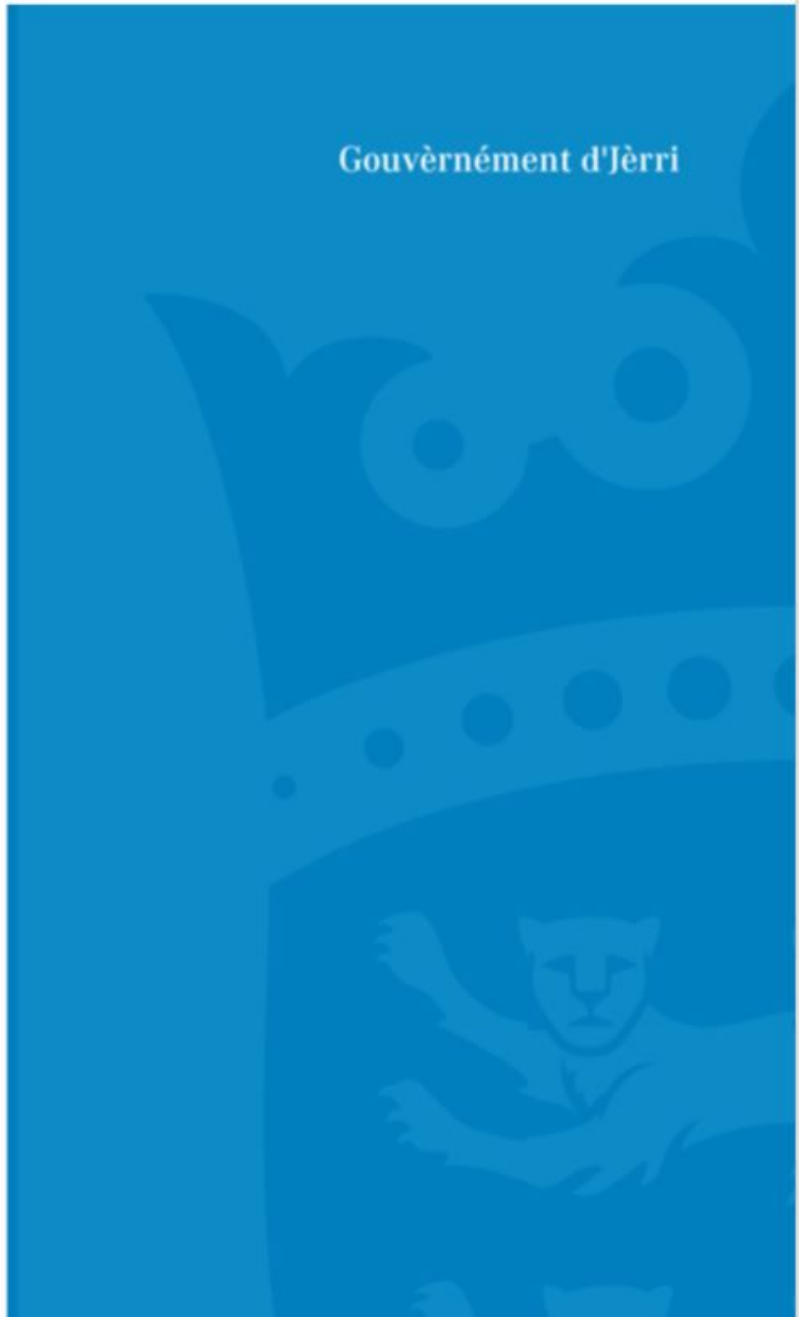
Health and Community Services

Quality and Performance Report
September 2024



Health and Community Services

INTRODUCTION

The Quality and Performance Report (QPR) is the reporting tool providing assurance and evidence 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 organisations strategic and operational objectives.

For 2024 HCS has introduced Statistical Process Control (SPC) charts for the majority of its indicators which identify trends in the data and determine when something has changed. This allows investigation of the change, if the change is unexpected, or provides supportive evidence where service improvements have been implemented with positive effect. Please note that red dots on the SPC charts only denote such a change and they do not necessarily reflect deteriorating performance.

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

Health and Community Services

STATISTICAL PROCESS CONTROL (SPC) CHARTS

WHAT ARE SPC CHARTS?

A statistical process control system (SPC) is a method of controlling a process or method utilizing statistical techniques. Monitoring process behaviour, identifying problems in internal systems, and finding solutions to production problems can all be accomplished using SPC tools and procedures. SPC charts used to monitor key performance indicators:

- Help find and understand signals in real-time allowing you to react when appropriate
- Tell you when something is changing, but you have to investigate to find out what changed by asking the right questions at the right time
- Allow you to investigate the impact of introducing new ideas aimed at improving the KPI; the SPC chart will help confirm if the changes implemented have significantly impacted performance

HOW TO READ SPC CHARTS

Legend	Visual	Description
Mean		The mean is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.
LCL		These are the Control limits (UCL = Upper Control Limit, LCL = Lower Control Limit) and are the standard deviations located above and below the centre line of an SPC chart. If the data points are within the control limits, it indicates that the variation is normal (common cause variation). If there are data points outside of these control limits then they are not within the expected 'normal variation' and indicates that a process change or one off incident may have occurred (special cause variation).
UCL		
Data		The data line connects the datapoints for the date range, allowing a visual representation of the performance of the indicator.
Shift		When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.
Trend		When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process.
Potential Process Change		On the moving range chart points which fall above the moving range process limit - grey line - are unusual and should be investigated.
Standard		In order for the standard to be achievable, it should sit within the control limits. Any standard set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.
Investigate		Points which fall outside the grey lines (control limits) are unusual and should be investigated. They represent variations beyond what is considered normal. This does not necessarily reflect deteriorating performance.

Elective Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

Patients waiting over 52 weeks for both inpatient and first outpatient appointments continue to rise with dermatology having the highest number of patients waiting for a first outpatient appointment in this category. Additional capacity in dermatology has now been secured which will deliver 740 additional outpatient appointments. This will commence in October and run through to January 2025, with a potential to extend this additional resource further into next year as required.

Additional capacity has also been secured for ophthalmology with most patients waiting over 52 weeks now in receipt of an appointment. It is anticipated therefore that as we move into Q1 2025 we will no longer have any Ophthalmology patients waiting over 52 weeks. It is pleasing to note that those patients waiting for inpatient care for an orthopaedic procedure have reduced over 2024 as we have recovered this performance metric.

Medical specialties have also seen an increase in numbers of patients waiting on their lists. This is due to clinics being cancelled throughout August and September to enable senior doctors and consultants to be released to support and maintain ward safety.

Clinical Genetic referrals are now being managed through the newly purchased software package with the ambition to ensure all referred patients who have waited extended periods to be managed by the end of the year.

The new gastroenterology consultant is now in post and is working on the over 52 weeks cohort of new patient referrals. Through some recent demand and capacity modelling, it is acknowledged that to provide sufficient capacity to meet the demand of referrals into the gastro service, an additional consultant is required. Both FIT and FCP testing have now been established, with the expectation that the service would see a reduction in referrals, however, additional resource is still required to support the service demand. The Medicine Care Group is currently reviewing the future requirements, with a case of need being presented through the usual business case route.

All waiting lists are reviewed on a weekly basis. This review focusses on clinical urgency - ensuring all urgent referrals are appointed in a timely way together with planning for additional capacity for all routine referrals.

The increase in inpatient waits has been due to equipment failure and theatre downtime. It is anticipated waits will be further increased in the coming months due to repairs required to two of the elective theatres and, as winter approaches, bed pressures could see the reduction in the availability of routine elective capacity.

Elective Care Performance

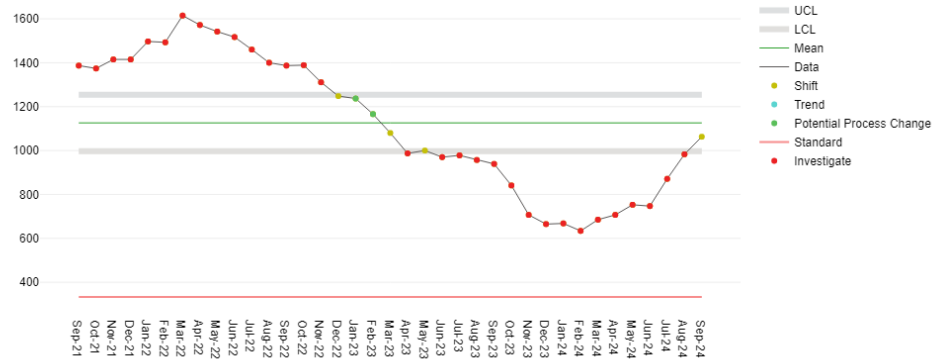
Theatre utilisation and on the day patient cancellations have seen a rise in month due to theatre equipment breakdown.

The new to follow-up ratio has increased in line with the need to start reviewing patients on follow-up waiting lists and is anticipated.

Elective Care Performance - SPC Charts

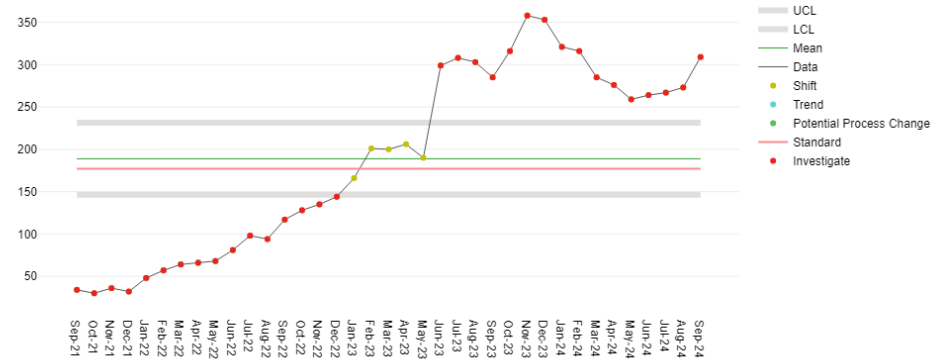
Latest value	Standard
1063	<333

Patients waiting for first outpatient appointment Greater Than 52 weeks



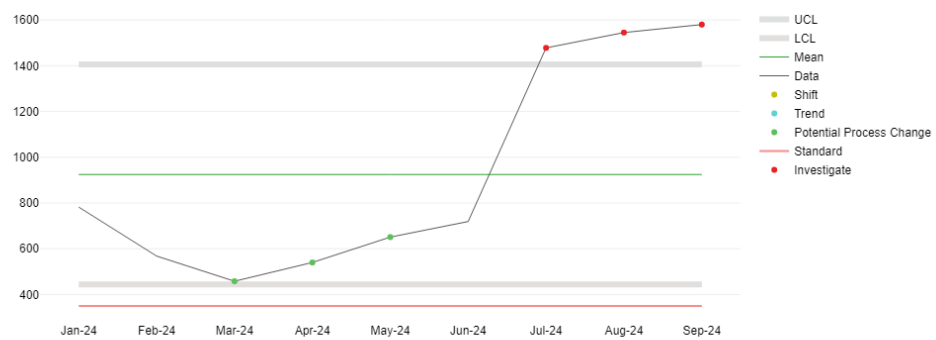
Latest value	Standard
309	<177

Patients on elective list Greater Than 52 weeks



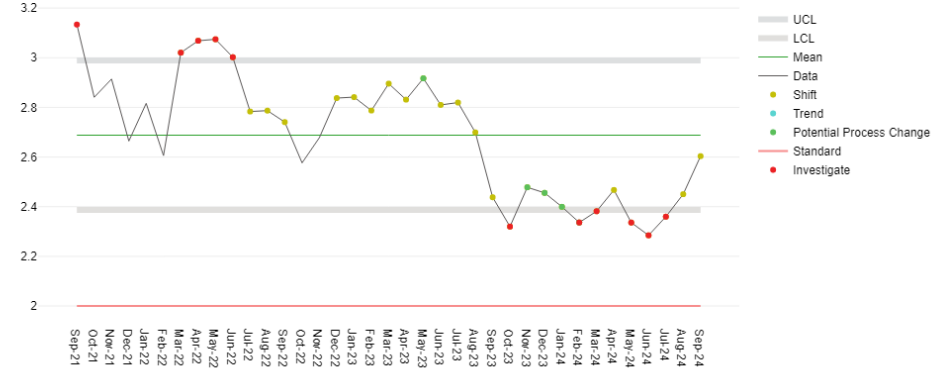
Latest value	Standard
1580	<350

Access to diagnostics Greater Than 6 weeks



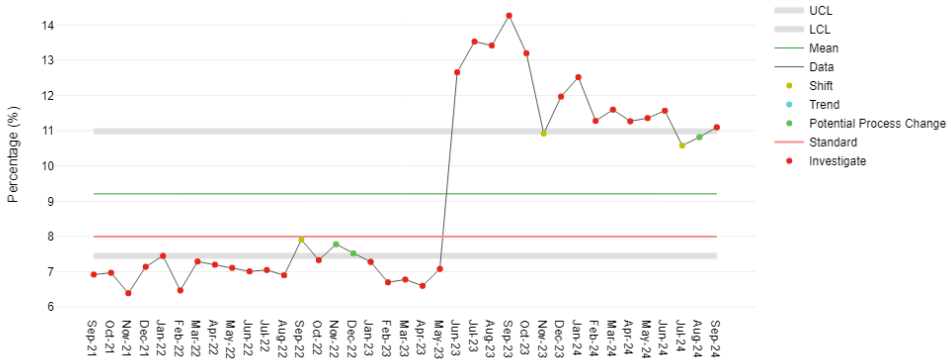
Latest value	Standard
2.6	2

New to follow-up ratio

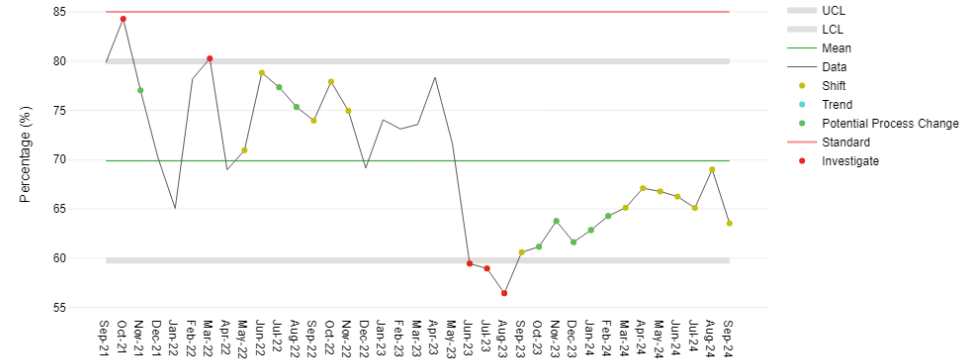


Elective Care Performance - SPC Charts

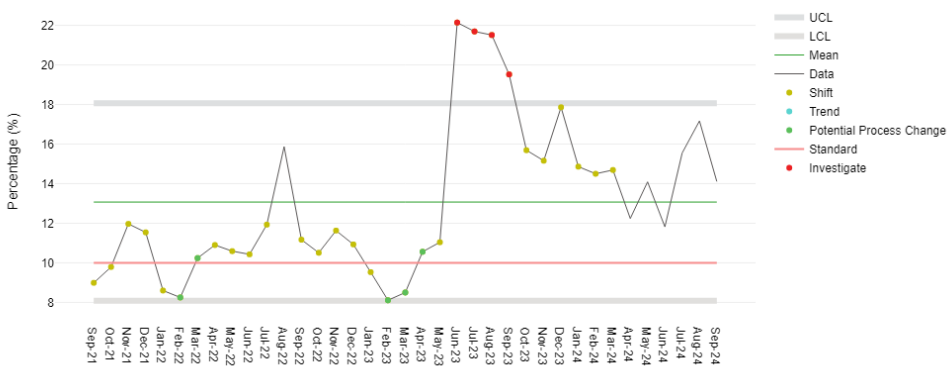
Latest value	Standard
11.1 %	<=8%



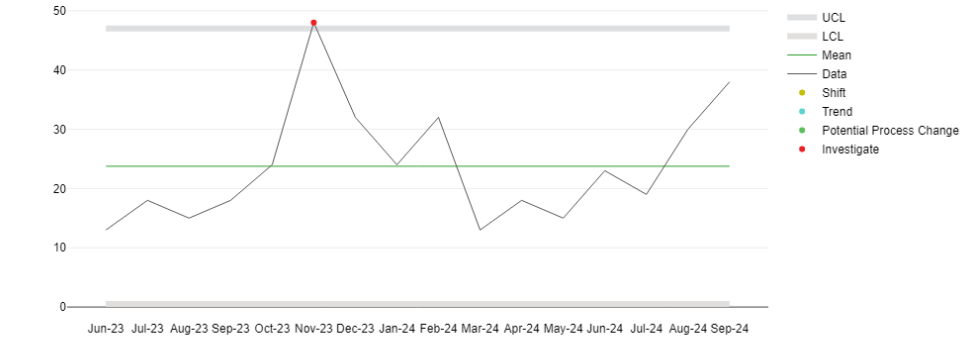
Latest value	Standard
63.5 %	>85%



Latest value	Standard
14.1 %	<=10%



Latest value	Standard
38	NA



Elective Care Performance - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Patients waiting for first outpatient appointment Greater Than 52 weeks	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4	Number of patients who have been waiting for over 52 weeks for a first Outpatient appointment at period end
Patients on elective list Greater Than 52 weeks	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4	Number of patients on the elective inpatient waiting list who have been waiting over 52 weeks at period end.
Access to diagnostics Greater Than 6 weeks	Maxims Outpatient Waiting List Reports (OP001DM and IP009DM), Radiology (CRIS) Waiting List Report (Since July 2024)	Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4	Number of patients waiting longer than 6 weeks for a first Diagnostic appointment at period end. Data only available from January 2024. Indicator is being developed to include diagnostic investigations comparable to those monitored in the NHS DM01 return. Currently HCS is unable to report on all of the diagnostic tests in DM01 due to technical system issues, but is working to include those at a future date. From July 2024, imaging tests recorded through CRIS have been included.
New to follow-up ratio	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	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 (Adults Only)	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Standard set locally	Percentage of public General & Acute outpatient (>=18 Years old) appointments where the patient did not attend and no notice was given. Numerator: Number of General & Acute public outpatient (>=18 years old) appointments where the patient did not attend. Denominator: the number of attended and unattended appointments (>=18 Years old). Excludes Private patients.
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))	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.
Was Not Brought Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP14DM))	Standard set locally	Percentage of JGH/Overdale/St Ewolds public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale/St Ewolds 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. Excludes Private patients.
Number of operations cancelled by the hospital on the day for Non-Medical Reasons	Hospital Electronic Patient Record (Maxims Theatres Cancellations report TH003DM and TCI Statuses IP0024DM)	Not Applicable	Count of the number of on the day cancellations by the hospital for non-clinical reasons in the reporting period.

Emergency Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

In the month of September, we had 3,691 attendees through the Emergency Department which is static. 69% of these patients were seen within target time (<4hrs) . 85.4% of the minor's activity was patients seen and treated within 4hrs but within the major patient cohort, it was 65.2% that met the 4 hour standard. We are benchmarking slightly higher than that reported as achieved in England currently.

3.3% (123) of the patients were in ED for >12 hours. This unfortunately is an increase on August and specific bed capacity was an issue i.e. specific need (cubicles/gender etc). 15.1% were admitted which is an increase (14.6%, approx. 64 patients more over the month) on the previous month which is being analysed but early review is describing an increase in demand. It is noted that the number of emergency admissions in September was higher than any of the Winter months in 2023/24.

We continue to embed Red 2 Green (R2G) principles to assist with flow.

Inpatients movement out of hours for non-clinical reasons continue to remain below average and decreasing at 9 compared to the average 19.67. As part of embedding learning from a serious incident, consistent focus is now evident within the operational bed meetings with monitoring of all non-clinical transfers in and out of hours.

There is a reduction to the emergency LOS rate this month and is being actioned through our response to the Royal College of Physicians' report and Operational flow work stream. It is important to note the indicator definition in that monthly performance in this metric could be representative of the in-month discharge of a patient with a significant LOS due to requiring alternative discharge arrangements e.g. a nursing or residential bed. This metric is also affected by acuity and patient management. Further work in regard to the RCP Acute Medicine and Clinical Productivity workstream is showing considerable reductions in acute LOS at a ward level specifically AAU, Corbiere and Rozel wards.

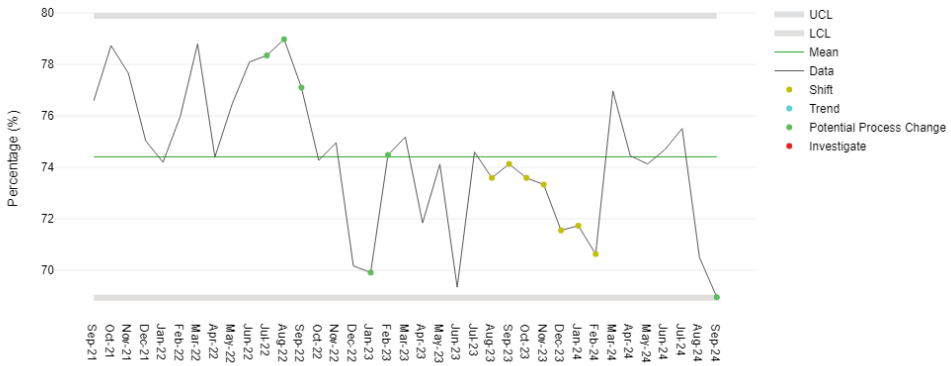
A decrease in the rate of readmission is noted this month at 11.7% of patients being readmitted within 30 days

Escalations

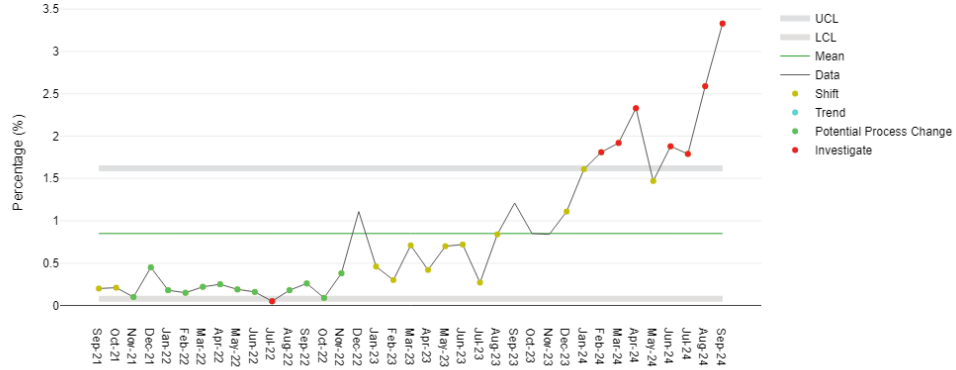
We continue to face challenges in relation to longer waits in ED with the main drivers of this including isolation, gender and general capacity. Actions being taken to address are maintaining additional capacity, R2G & length of stay activity in Clinical Productivity workstream supported by the external physician leading a clinical flow improvement strategy which will be implemented shortly.

Emergency Care Performance - SPC Charts

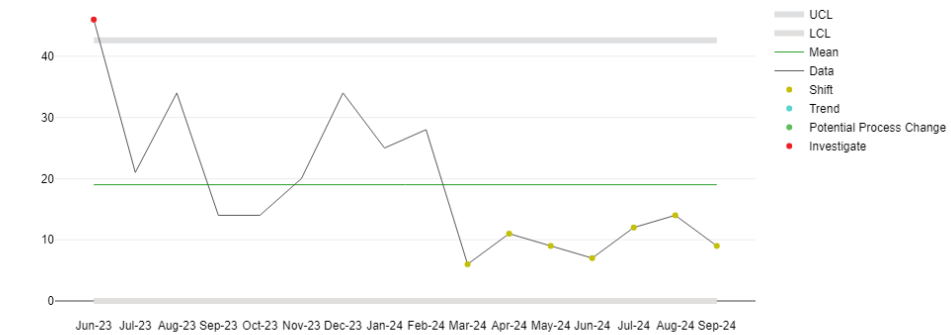
Latest value	Mean
69 %	74.4 %



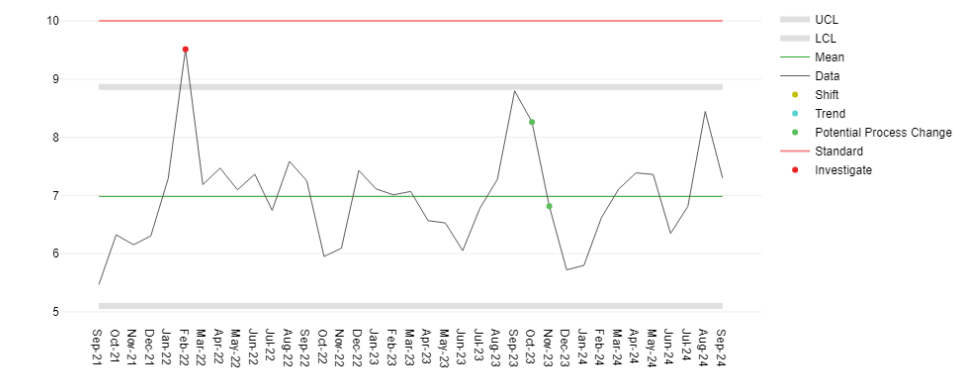
Latest value	Mean
3.3 %	0.9 %



Latest value	Mean
9	19

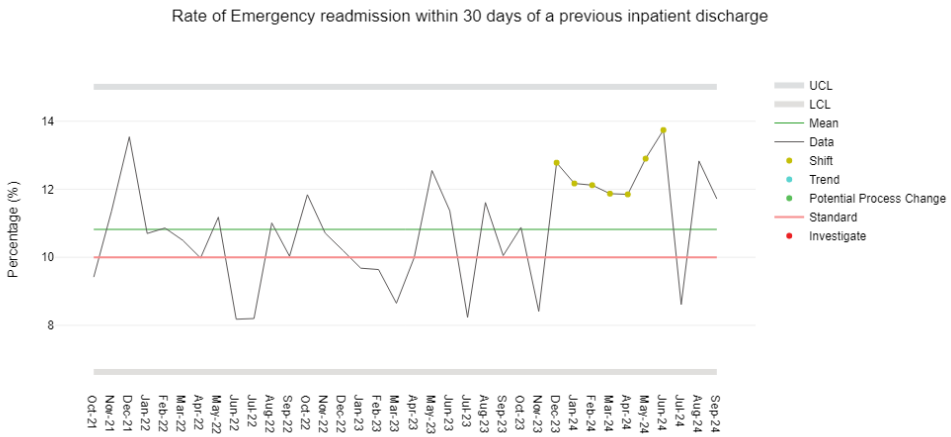


Latest value	Mean
7.3	6.98



Emergency Care Performance - SPC Charts

Latest value	Mean
11.7 %	10.8 %



Emergency Care Performance - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
% Patients in Emergency Department for less than or equal to 4 Hours	Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM))	Not Applicable	Percentage of patients in the Emergency department less than or equal to 4 hours from arrival to departure or admission
% Patients in Emergency Department for more than 12 Hours	Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM))	Not Applicable	Percentage of patients in the Emergency department for more than 12 hours from arrival to departure or admission
Inpatient movements between 22:00 and 08:00 for non-clinical reasons	Hospital Electronic Patient Record (Maxims Inpatient Ward Movements report IP001DM)	Not Applicable	Count of inpatient moves within wards or between wards, between the hours of 22:00 and 08:00 for non-clinical reasons, in the reporting period.
Non-elective acute Length of Stay (LOS) (days)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	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.
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))	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/St Ewolds. 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

Maternity

Section Owner

Chief Nurse

Performance Narrative

Our caesarean rate in month has seen a slight decrease to 48.08% (25/53), with 26.9% being elective. Biggest cohort continues to be in relation to the Robson Criteria group 5, women who had previous caesarean birth, single cephalic pregnancy and were at least 37 weeks' gestation. Patient choice continues to play a key part with our caesarean section rate which is in line with both UK national and international trends. There was 1 caesarean birth at full dilatation and 4 (2%) from Robson Criteria Group 1 which are primigravida, first pregnancy cohort.

Our induction rate remains consistent month on month and is sitting at 26.92%, but we continue to ensure we are offering induction at the correct gestation due to the presenting clinical picture.

There have been no major obstetric haemorrhages in month, all PPH discussed at weekly risk meeting and a review is undertaken using the toolkit provided to us following the NICHE review; all well managed and good practice identified.

Escalations

Outcome of which maternity specific EPR system has not been concluded yet. Awaiting date for demo to consultants and for the site visits to units in UK that use the systems so a live demo can be undertaken. This has and will cause a delay to the replacement of a maternity specific system from Maxims.

To note there has been an issue identified with the recording of Apgar scores of less than 7 at 5 minutes. It is being correctly documented, but the report is not being pulled through correctly therefore has given us incorrect numbers for August and September. A full review has been undertaken of Maxims and unfortunately it appears to be a bug or issue with Maxims rather than something within our control. This issue has been raised to Maxims to investigate.

Maternity - Key Performance Indicators

Indicator	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	YTD
Total Births	58	66	59	68	51	58	56	53	69	59	62	53	529
Mothers with no previous pregnancy (Primips)				24	15	20	16	20	34	22	27	26	204
Mothers who have had a previous pregnancy (Multips)				26	19	30	28	24	25	30	32	25	239
Mothers with unknown previous pregnancy status				18	17	8	12	9	10	7	3	2	86
Bookings ≤10+0 Weeks				6	3	7	8	8	9	7	4	9	61
% of women that have an induced labour	17.24%	30.77%	38.98%	30.16%	24%	31.58%	22.22%	16.67%	19.4%	28.07%	18.33%	26.92%	24.21%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	21	18	11	25	13	22	10	19	19	12	22	17	159
Number of Instrumental deliveries	5	5	4	7	3	5	2	3	7	4	6	4	41
% deliveries by C-section (Planned & Unscheduled)	46.55%	49.23%	45.76%	36.51%	54%	40.35%	66.67%	50%	52.24%	61.4%	51.67%	48.08%	50.98%
% Elective caesarean section births	22.41%	27.69%	28.81%	23.81%	32%	15.79%	37.04%	27.08%	29.85%	35.09%	40%	26.92%	29.72%
Number of Emergency Caesarean Sections at full dilatation	1	2	0	2	1	1	1	1	0	4	0	1	11
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)				2	3	0	8	2	7	7	0	4	33
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)				4	3	5	5	1	4	4	2	3	31
Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gesation, caesarean birth prior to onset of spontaneous labour)				3	3	2	5	3	7	4	6	2	35
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)				4	6	5	6	4	4	10	10	9	58
Number of deliveries home birth (Planned & Unscheduled)	3	3	0	2	3	1	1	1	1	3	0	1	13
Mothers who were current smokers at time of booking (SATOB)	4	3	2	7	7	3	4	6	2	3	3	4	39
Mothers who were current smokers at time of delivery (SATOD)	0	0	0	0	0	2	0	2	2	3	6	3	18

Maternity - Key Performance Indicators

Indicator	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	YTD
Number of Mothers who were consuming alcohol at time of booking	2	0	3	1	1	2	0	0	0	0	0	0	4
Number of Mothers who were consuming alcohol at time of delivery	0	1	0	0	0	4	4	3	6	4	5	4	30
Breastfeeding Initiation rates	74.1%	75.8%	72.9%	77.9%	74.5%	65.5%	73.2%	69.8%	71%	79.7%	67.7%	79.2%	73.16%
Transfer of Mothers from Inpatients to Overseas	0	2	1	0	3	1	1	0	1	0	1	2	9
Number of births in the High dependency room / isolation room	0	0	0	1	1	0	0	0	0	0	0	1	3
Number of PPH Greater Than 1500mls	6	6	3	2	2	1	6	0	1	3	1	0	16
Number of 3rd & 4th degree tears – all births	2	1	0	2	2	1	0	0	0	0	0	1	6
% of babies experiencing shoulder dystocia during delivery	1.72%	0%	1.69%	0%	0%	0%	1.79%	0%	4.35%	0%	0%	0%	0.76%
% Stillbirths Greater Than 24 Weeks Gestation				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Neonatal Deaths at Less Than 28 days old				0	0	0	0	0	0	0	0	0	0
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	9.09%	5%	6.9%	0%	3.7%	7.41%	3.85%	7.14%	2.78%	5.13%	2.56%	2.56%	3.74%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	2	2	0	1	0	0	1	2	0	1	0	5
Transfer of Neonates from JNU	0	1	1	1	0	0	1	0	1	0	1	0	4
Preterm Births ≤27 Weeks (Live & Stillbirths)	0	0	0	0	0	0	0	0	0	0	0	0	0
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	7	1	2	1	1	8	1	2	2	3	4	1	23
Neonatal Readmissions at Less Than 28 days old				11	4	4	5	5	6	4	5	9	53

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Total Births	Maternity Birth Registration Details Report	Indicator is for information only	Total number of births of any outcome. Includes live and stillbirth.
Mothers with no previous pregnancy (Primips)	Maternity Birth Registration Details Report	Indicator is for information only	Total number of births of any outcome to first-time mothers. Includes live and stillbirth.
Mothers who have had a previous pregnancy (Multips)	Maternity Birth Registration Details Report	Indicator is for information only	Total number of births of any outcome to mothers who have given birth at least once before. Includes live and stillbirth.
Mothers with unknown previous pregnancy status	Maternity Birth Registration Details Report	Indicator is for information only	Total number of births of any outcome to mothers with unknown previous pregnancy status. Includes live and stillbirth.
Bookings ≤10+0 Weeks	Maxims Deliveries Report (MT005)	Not Applicable	Number of women who attended their first pregnancy appointment where their gestation length was less than 70 days (10 weeks).
% of women that have an induced labour	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Standard set locally based on average (mean) of previous two years' data	Number of women that had an induced labour as a percentage of the total number of deliveries.
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	Maternity Delivery Details Report	Not Applicable	Number of spontaneous vaginal births including home births and breech vaginal deliveries
Number of Instrumental deliveries	Maternity Delivery Details Report	Not Applicable	Count of instrumental deliveries
% deliveries by C-section (Planned & Unscheduled)	Maternity Delivery Details Report	Indicator is for information only	Number of c-sections, planned and unplanned, as a percentage of the total number of deliveries.
% Elective caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Number of Elective Caesarean sections, divided by total number of deliveries
Number of Emergency Caesarean Sections at full dilatation	Hospital Electronic Patient Record (TrakCare Deliveries Report (MAT23A) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of Emergency Caesarean section births (This includes all Category 1 & 2 Caesarean Sections) where the mother's cervix is fully dilated
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and no labour-inducing drugs needed.

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and labour was started artificially.
Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gesation, caesarean birth prior to onset of spontaneous labour)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and baby was delivered via elective caesarean section.
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)	Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM)	Indicator is for information only	A woman who has previously given birth via caesarean section, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term.
Number of deliveries home birth (Planned & Unscheduled)	Maternity Delivery Details Report	Indicator is for information only	Number of deliveries recorded as being at "Home", planned and unplanned
Mothers who were current smokers at time of booking (SATOB)	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as being smokers at their pregnancy booking appointment.
Mothers who were current smokers at time of delivery (SATOD)	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as being smokers on their delivery date.
Number of Mothers who were consuming alcohol at time of booking	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as consuming alcohol at their pregnancy booking appointment.
Number of Mothers who were consuming alcohol at time of delivery	Maternity Smoking & Drinking Details Report	Indicator is for information only	Total number of mothers who were recorded as consuming alcohol on their delivery date.
Breastfeeding Initiation rates	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT1A) & Maxims Maternity Report (MT001))	Not Applicable	Number of babies whose first feed is from the mother's breast

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Transfer of Mothers from Inpatients to Overseas	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of mothers out of Maternity inpatient wards to an off-island Healthcare facility.
Number of births in the High dependency room / isolation room	Maxims Deliveries Report (MT005)	Not Applicable	Number of births which took place in the High Dependancy Room / Isolation Room
Number of PPH Greater Than 1500mls	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Number of deliveries that resulted in a blood loss of over 1500ml
Number of 3rd & 4th degree tears – all births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Not Applicable	Number of women who gave birth and sustained a 3rd or 4th degree perineal tear
% of babies experiencing shoulder dystocia during delivery	Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Not Applicable	Total number of babies experiencing shoulder dystocia during delivery divided by the total number of births
% Stillbirths Greater Than 24 Weeks Gestation	Hospital Electronic Patient Record (Maxims Maternity Report (MT001))	Not Applicable	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
Neonatal Deaths at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Demographics Report (MP001DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of deaths during the first 28 completed days of life
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Percentage of live births with a gestational age lower than the 3rd centile (3% of babies born at same gestational age will have a lower birth weight than them) delivered after 37 weeks and 6 days of pregnancy.
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Not Applicable	Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation
Transfer of Neonates from JNU	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility.
Preterm Births ≤27 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born at or before 27 weeks
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born before 37 weeks (less than or equal to 36+6 gestation)
Neonatal Readmissions at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Discharges Report (IP013DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of babies that were readmitted to Hospital within 28 days of their delivery date

Maternity

Additional Commentary / Deep Dive

We have commenced using the NICE tool so we can review all PPH/MOH using this to identify good practice and learning. This is fed back to staff at the weekly maternity risk meeting. This will also provide us with useful data going forward in relation to our PPH/MOH rates and we can benchmark this against National and International trends/information.

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Performance across mental health services remains stable. In month there has been a small increase in the average wait for treatment for Jersey Talking Therapies (to 159 days). This is being addressed via recruitment and a review of work allocation within the team.

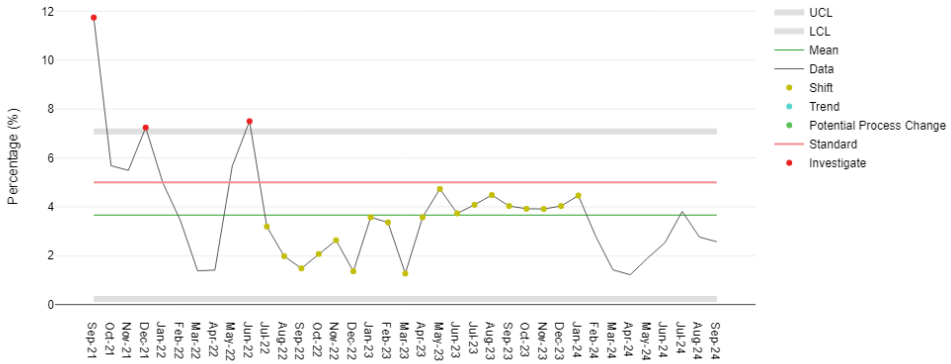
Performance against the crisis assessment and routine referral access targets remain really good (99% and 95% respectively). Waiting times for dementia assessment and autism assessment continue to reduce, whilst the ADHD average waiting time - at point of assessment - has flattened in month (although the waiting list figure continue to grow, to a current figure of 873).

Escalations

Mental Health - SPC Charts

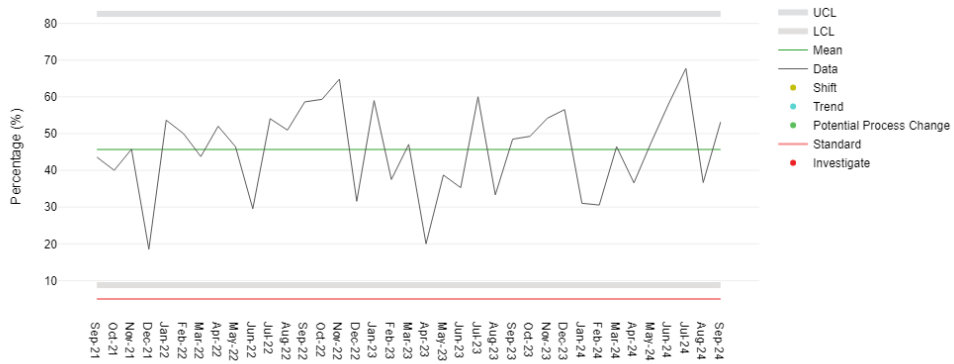
Latest value	Mean
2.6 %	3.7 %

JTT % of clients waiting for assessment who have waited over 90 days



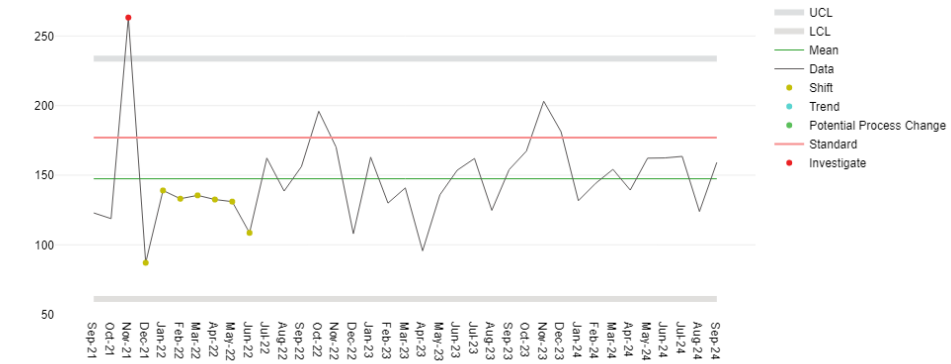
Latest value	Mean
53.1 %	45.7 %

JTT % of clients who started treatment in period who waited over 18 weeks



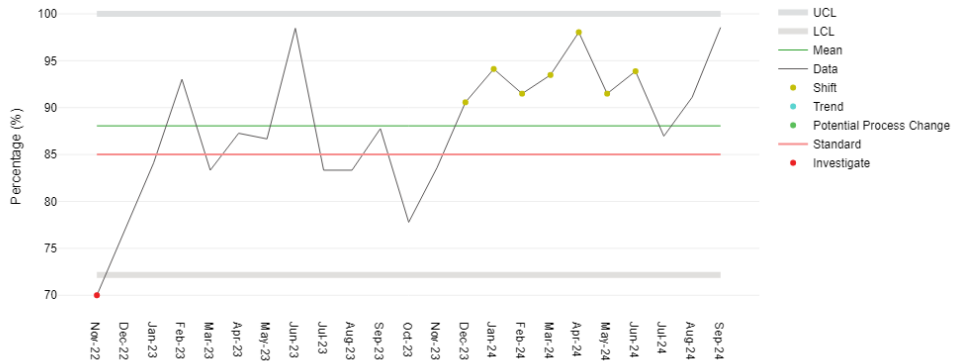
Latest value	Mean
159.19	147.45

JTT Average waiting time to treatment (Days)



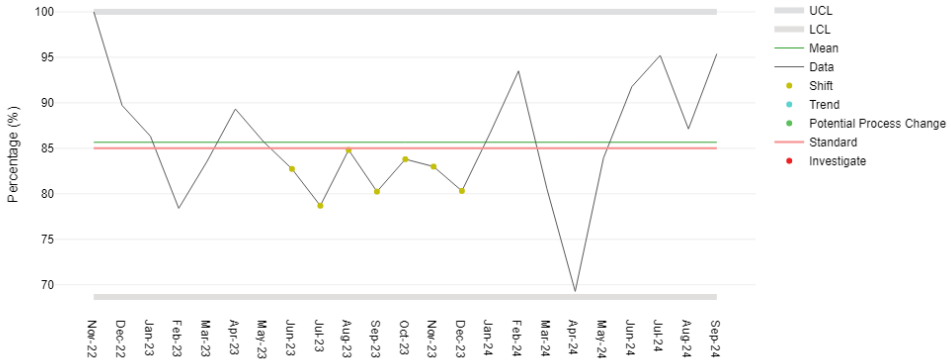
Latest value	Mean
98.6 %	88.1 %

% of referrals to Mental Health Crisis Team assessed in period within 4 hours

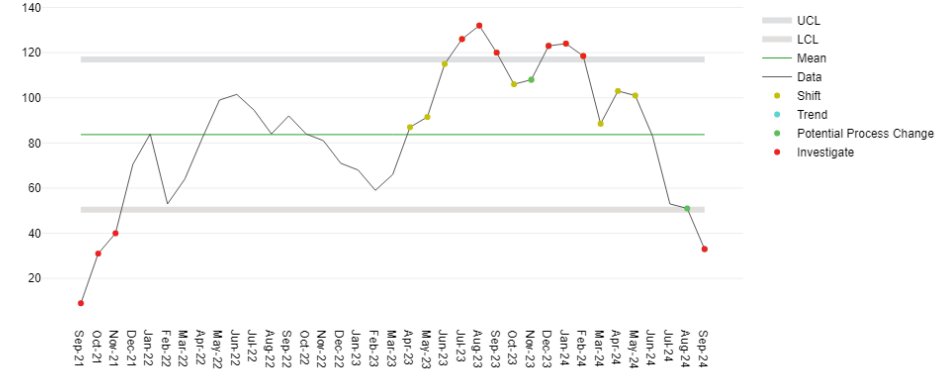


Mental Health - SPC Charts

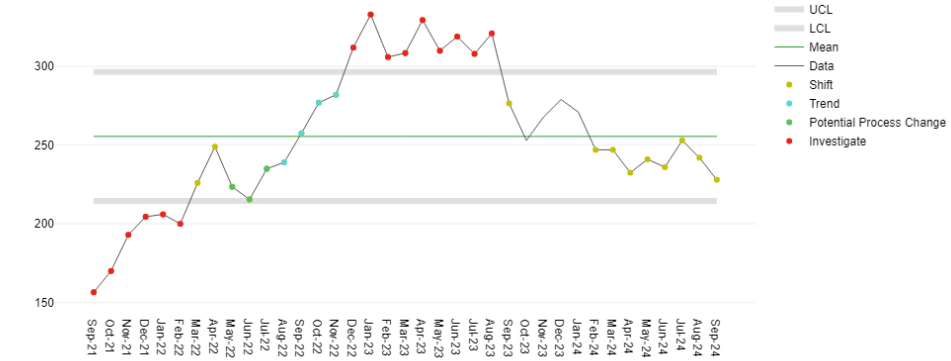
Latest value	Mean
95.4 %	85.7 %



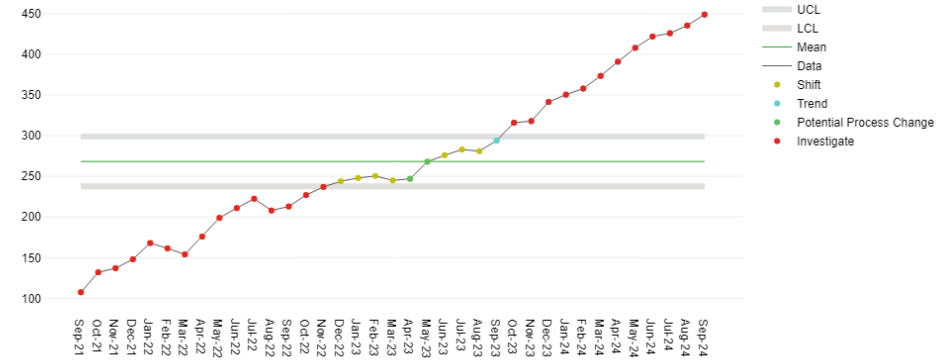
Latest value	Mean
33	83.7



Latest value	Mean
228	255.55



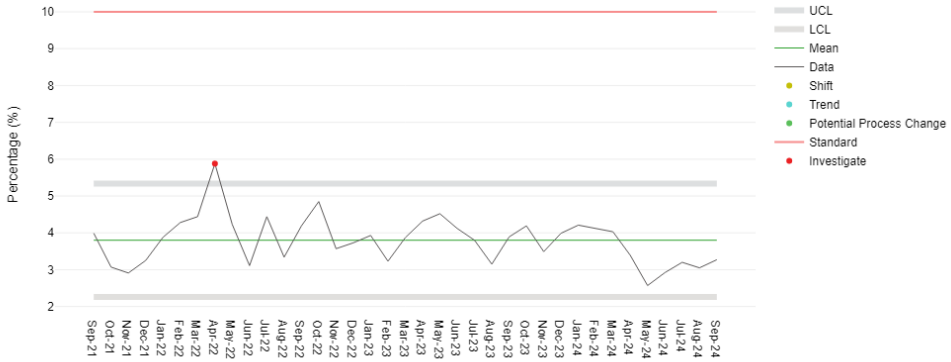
Latest value	Mean
449	268.3



Mental Health - SPC Charts

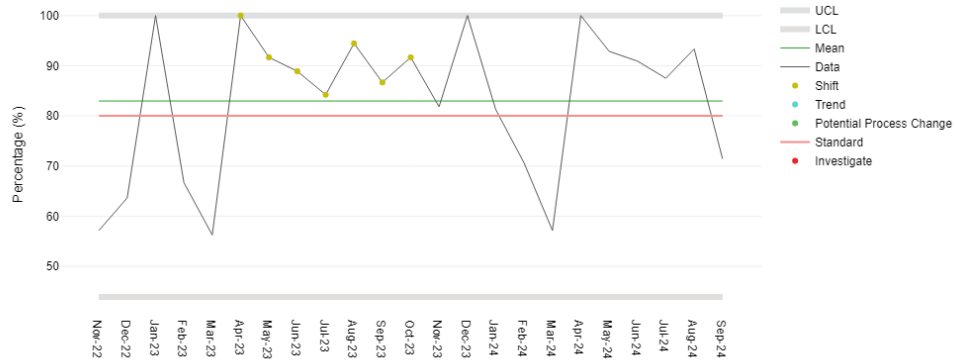
Latest value	Mean
3.3 %	3.8 %

Community Mental Health Team Did Not Attend (DNA) rate



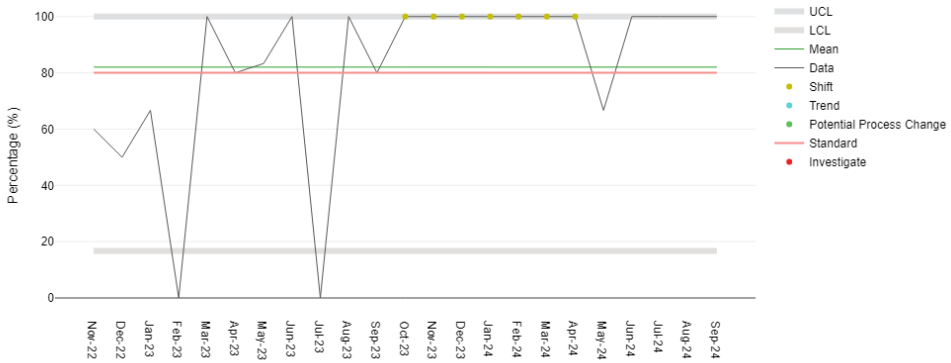
Latest value	Mean
71.4 %	83 %

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



Latest value	Mean
100 %	82 %

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



Mental Health - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
JTT % of clients waiting for assessment who have waited over 90 days	JTT & PATS electronic client record system	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
JTT % of clients who started treatment in period who waited over 18 weeks	JTT & PATS electronic client record system	Improving Access to Psychological Therapies (IAPT) Standard	Percentage of JTT clients commencing treatment in the perios who had waited 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	Generated based on historic percentiles	Average (mean) days waiting from JTT referral to the first attended treatment session
% of referrals to Mental Health Crisis Team assessed in period within 4 hours	Community services electronic client record system	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	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
Median wait of clients currently waiting for Memory Service Assessment (Days)	Community services electronic client record system	Not Applicable	Memory Service Assessment Median Waiting times from date of referral to last day of reporting period

Mental Health - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Median wait of clients currently waiting for Autism Assessment (Days)	Community services electronic client record system	Not Applicable	Autism Assessment Median Waiting times from date of referral to last day of reporting period
Median wait of clients currently waiting for ADHD Assessment (Days)	Community services electronic client record system	Not Applicable	ADHD Assessment Median Waiting times from date of referral to last day of reporting period
Community Mental Health Team Did Not Attend (DNA) rate	Community services electronic client record system	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
% 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	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from Mental Health Inpatient Unit with an Adult Mental Health Specialty' 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 'Mental Health Inpatient Unit with an Adult Menatl Health Specialty'
% 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	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

Social Care

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

The percentage of Learning Disability Service clients with a physical health check within the last year currently stands at 77.7% which has dropped below the expected 80% target. This seems to relate to a level of absence within the LD community service; as this is resolved, we expect this would resolve to within the target rate or above in the oncoming months.

Regarding Percentage of assessments completed and authorised within 3 weeks (ASCT) there is a sharp decline in performance noted. Whilst this decline was anticipated - due to significant staffing issues within the social care team arising from vacancies, unplanned sick leave, annual leave and bereavement - the decline is larger than anticipated. This is therefore now being reviewed in detail by the care group leadership team.

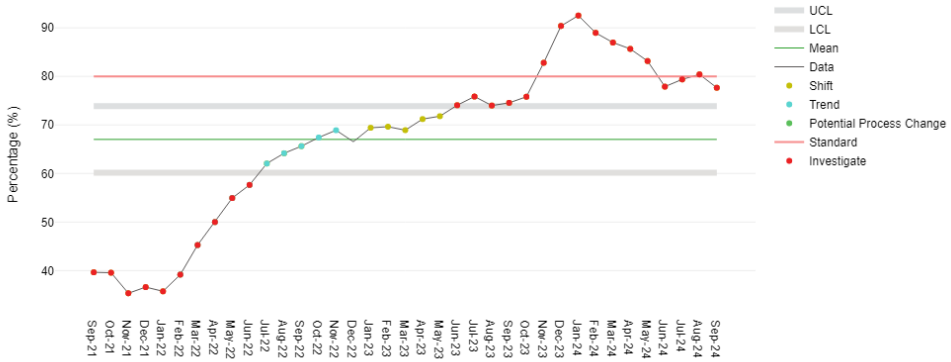
Escalations

No escalations

Social Care - SPC Charts

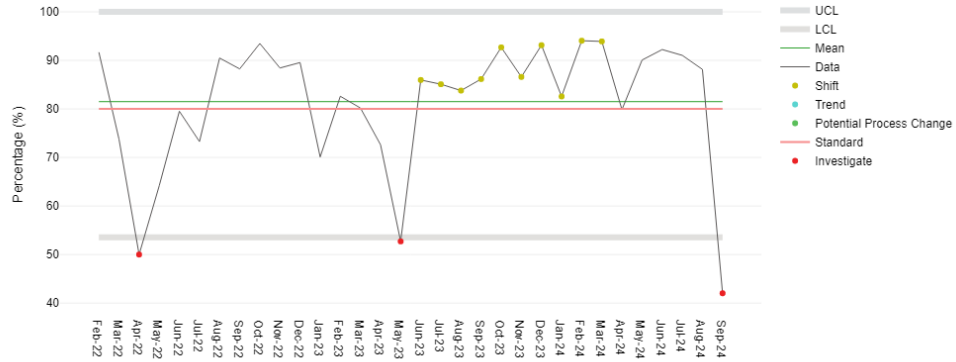
Latest value	Mean
77.7 %	67 %

Percentage of Learning Disability Service clients with a Physical Health check in the past year



Latest value	Mean
42 %	81.5 %

Percentage of Assessments completed and authorised within 3 weeks (ASCT)



Social Care - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Percentage of Learning Disability Service clients with a Physical Health check in the past year	Community services electronic client record system	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.
Percentage of Assessments completed and authorised within 3 weeks (ASCT)	Community services electronic client record system	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

Quality & Safety

Section Owner

Medical Director / Chief Nurse

Performance Narrative

In September, there were a total of 9 pressure ulcers that developed during care. Of these, 4 were categorised as Grade 2 pressure ulcers. Each received timely and appropriate care, leading to successful healing for all 4 within our care.

Among the remaining 5 pressure ulcers, 2 were classified as unavoidable due to challenges in adhering to treatment protocols, despite our proactive education efforts on associated risks (1 x Category 4 and 1 x unstageable). Additionally, 1 ulcer was assessed as meeting the safeguarding threshold (1 x deep tissue), and we implemented identified learning outcomes. The last 2 ulcers underwent thorough root cause analyses, were categorised as Grade 3, and did not meet the safeguarding threshold.

In addition, a total of 24 pressure ulcers were recorded in the Datix system for patients admitted from home or other care facilities with pre-existing conditions, with the majority (22) classified as Grade 2.

Our commitment to patient safety is reflected in the ongoing efforts of our monthly Pressure Ulcer meetings, which includes ward managers, lead nurses, and specialist nurses. We continue to foster a strong reporting culture, ensuring that pressure damage is identified at the earliest opportunity. This proactive approach not only enhances patient care but also helps prevent further deterioration.

Patient Experience:

In September 2024, a total of 14 new complaints were received. The feedback team remains focused on early de-escalation of concerns by resolving issues at the point of contact, which helps to prevent formal complaints.

Compliments: In September 2024, 96 compliments were logged. Efforts are ongoing to ensure that compliments from patients and relatives are recorded in the system, providing appropriate recognition for teams.

PALS:

PALS has seen a significant rise in interactions, with 176 cases logged in September 2024. This highlights key improvements in complaint management and PALS engagement.

Infection Prevention & Control Update Healthcare associated Infections:

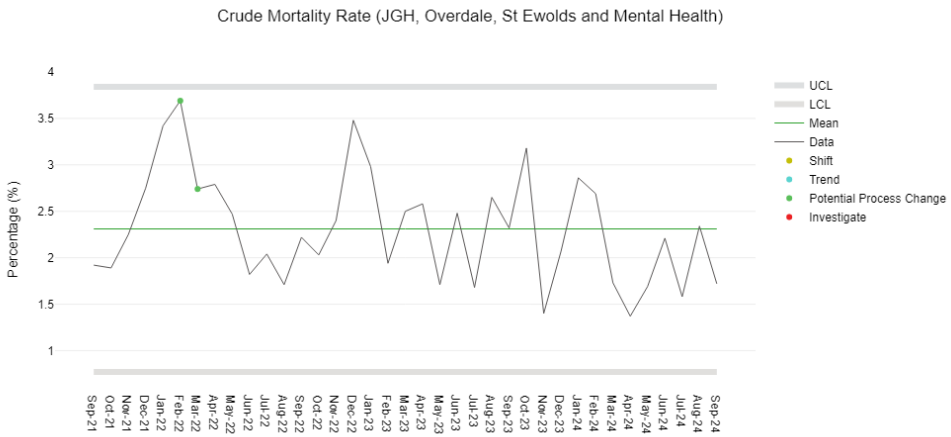
In September, one case of Clostridium difficile (C. difficile) infection was identified within the hospital. This brings the total number of cases for the year to 15, matching the number recorded during the same period last year. Enhanced infection prevention and control measures, along with thorough root cause analysis, have been implemented for each case. There have been no reported cases of MRSA bacteraemia this month. However, one case of MSSA bacteraemia and one case of E. coli bacteraemia were identified, and investigations are currently underway to determine the causes and implement appropriate corrective actions. The infection control team continues to prioritise patient safety through

Escalations

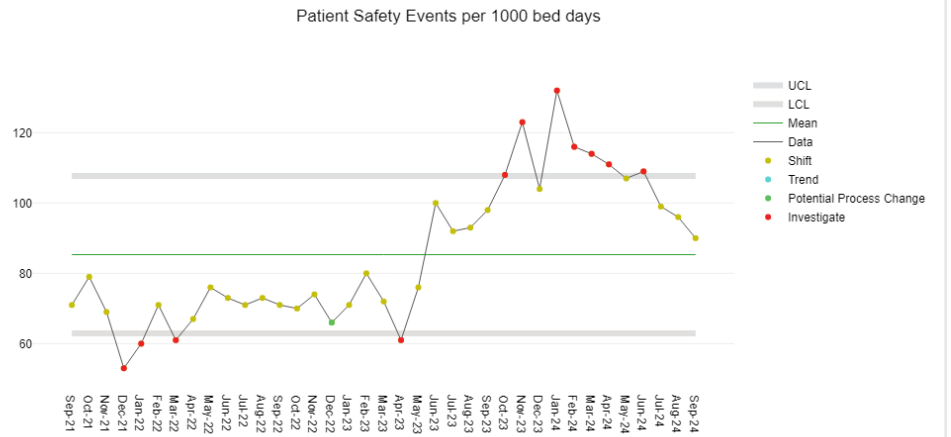
No escalations

Quality & Safety - SPC Charts

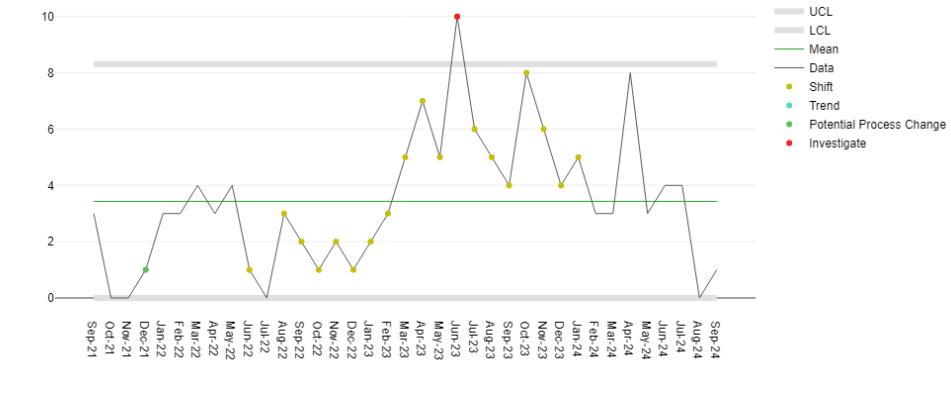
Latest value	Mean
1.7 %	2.3 %



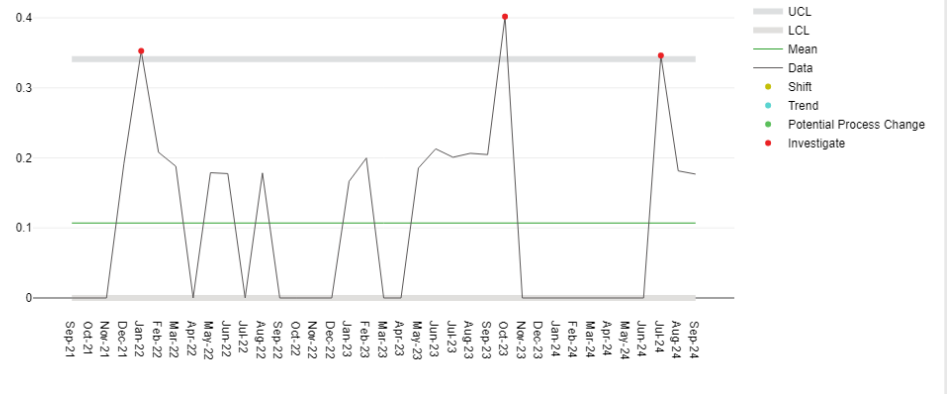
Latest value	Mean
90	85.32



Latest value	Mean
1	3.43



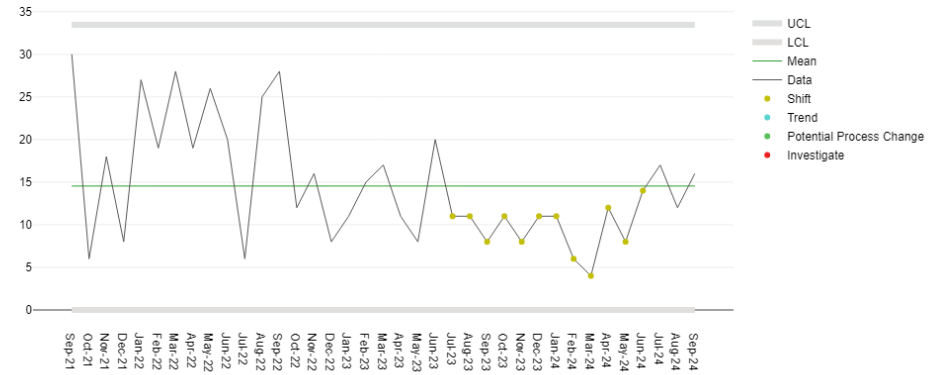
Latest value	Mean
0.18	0.11



Quality & Safety - SPC Charts

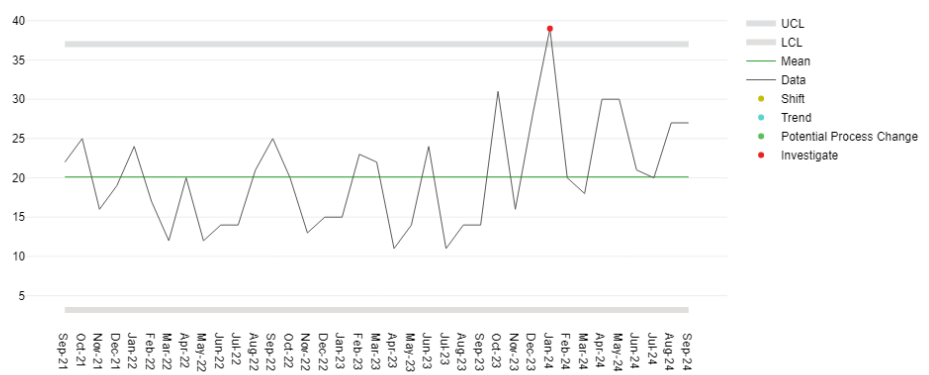
Latest value	Mean
16	14.54

Patient safety incidents with moderate/severe harm/death



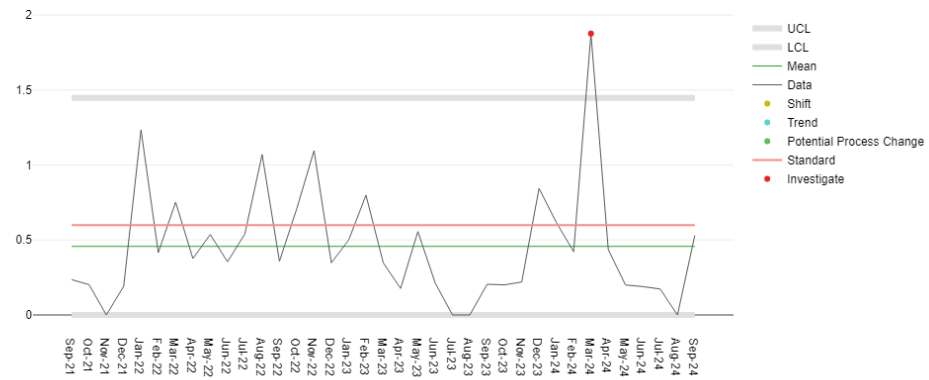
Latest value	Mean
27	20.11

Number of pressure ulcers present upon inpatient admission



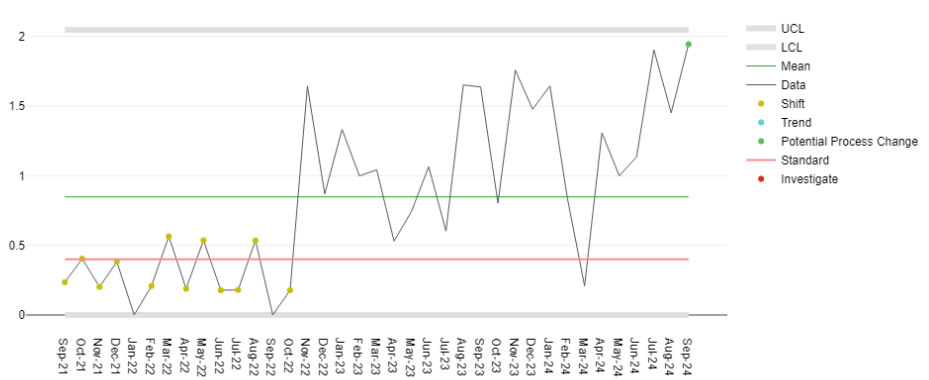
Latest value	Mean
0.53	0.46

Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days



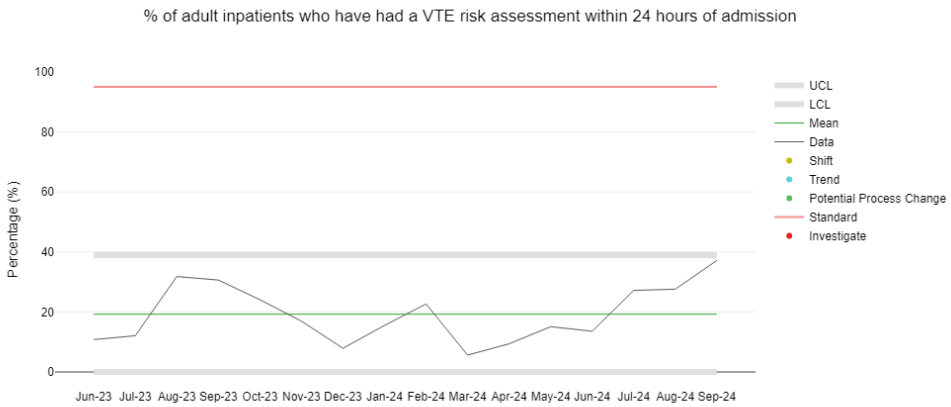
Latest value	Mean
1.94	0.85

Number of medication errors across HCS resulting in harm per 1000 bed days

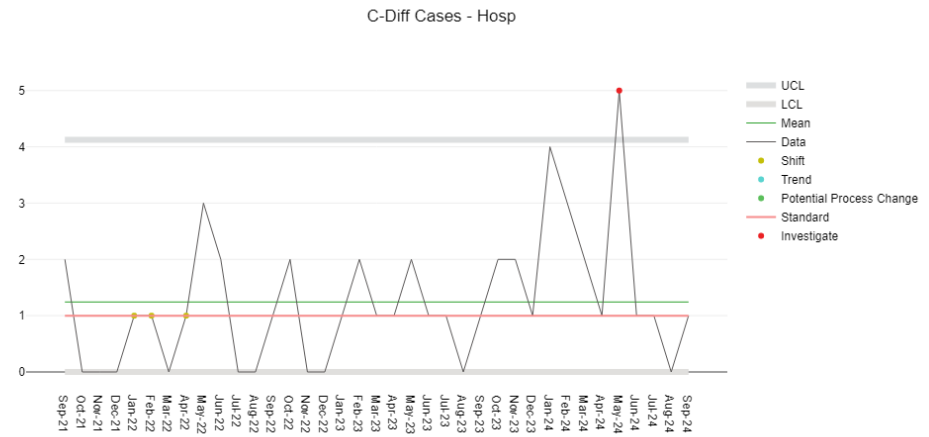


Quality & Safety - SPC Charts

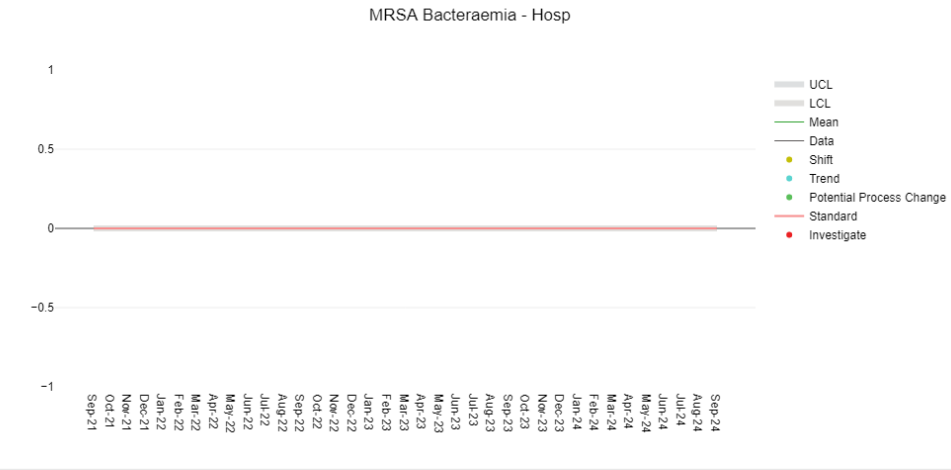
Latest value	Mean
37.1 %	19.2 %



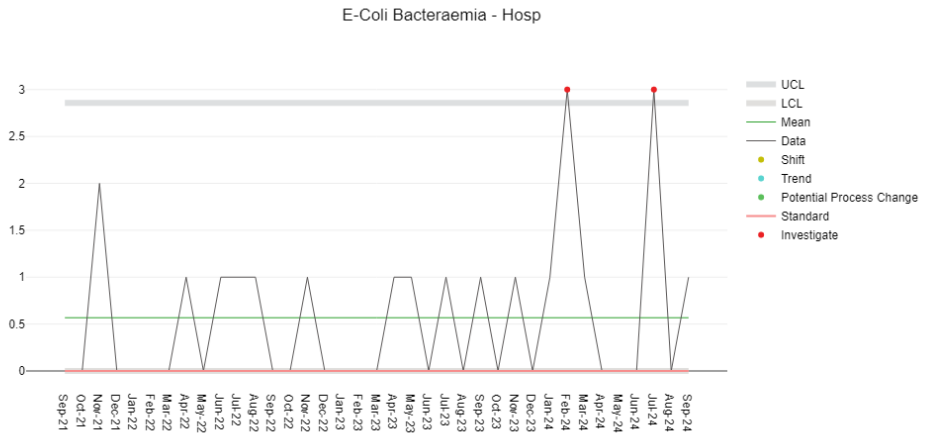
Latest value	Mean
1	1.24



Latest value	Mean
0	0

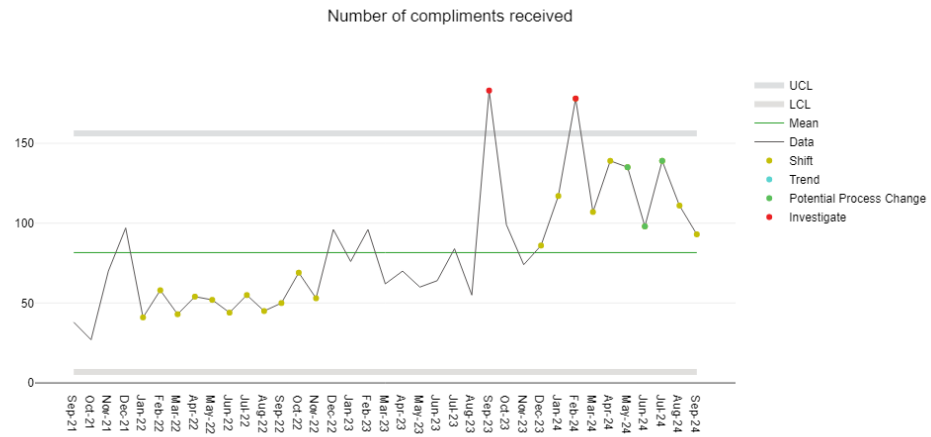


Latest value	Mean
1	0.57

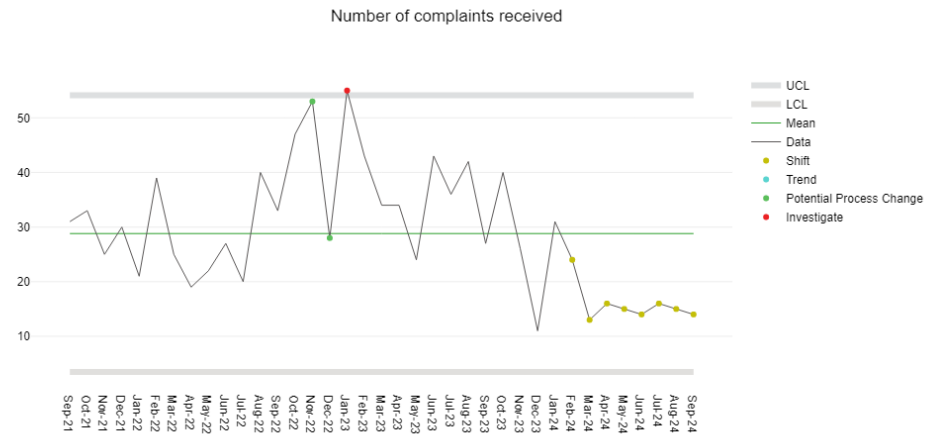


Quality & Safety - SPC Charts

Latest value	Mean
93	81.57



Latest value	Mean
14	28.81



Quality & Safety - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Crude Mortality Rate (JGH, Overdale, St Ewolds and Mental Health)	Hospital Electronic Patient Record (TrakCare Inpatient Discharges Report (ATD9P) Maxims Inpatient Discharges Report (IP013DM))	Not Applicable	A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted.
Patient Safety Events per 1000 bed days	HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Not Applicable	Number of patient safety events reported where approval status is not "Rejected" per 1,000 bed days
Number of serious incidents	HCS Incident Reporting System (Datix)	Not Applicable	Number of safety events recorded in Datix where the event is marked as a 'Serious Incident' in the period
Number of falls resulting in harm (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	Not Applicable	Number of inpatient falls with moderate or severe harm recorded where approval status is not "Rejected" per 1000 occupied bed days
Patient safety incidents with moderate/severe harm/death	HCS Incident Reporting System (Datix)	Not Applicable	Number of patient safety events recorded with moderate, severe or fatal harm recorded where approval status is not "rejected"
Number of pressure ulcers present upon inpatient admission	HCS Incident Reporting System (Datix)	Not Applicable	Datix incidents in the month recording a pressure sore upon inpatient admission. All pressure ulcers recorded as "present before admsission" but excluding those recorded as "present before admission from other ward".
Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days	HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	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

Quality & Safety - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Number of medication errors across HCS resulting in harm per 1000 bed days	HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	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.
% of adult inpatients who have had a VTE risk assessment within 24 hours of admission	Hospital Electronic Patient Record (Maxims Report IP026DM)	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.
C-Diff Cases - Hosp	Infection Prevention and Control Team Submission	Standard based on historic performance (2020)	Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team
MRSA Bacteraemia - Hosp	Infection Prevention and Control Team Submission	Standard based on historic performance	Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team
E-Coli Bacteraemia - Hosp	Infection Prevention and Control Team Submission	Standard based on historic performance	Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team
Number of compliments received	HCS Feedback Management System (Datix)	Not Applicable	Number of compliments received in the period where the approval status is not "rejected"
Number of complaints received	HCS Feedback Management System (Datix)	Not Applicable	Number of formal complaints received in the period where the approval status is not "Rejected"