



Health and  
Community Services

Quality and Performance Report  
July 2024

Gouvernement d'Jèrri



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## 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









## 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

Over 52 week waits for first outpatient appointment

The increase in those waiting over 52 weeks is associated with Dermatology and Gastroenterology capacity.

Gastro capacity has now increased with the commencement of a 2nd substantive consultant with expectation that waiting time will start to reduce. However, Dermatology capacity remains significantly compromised. Staffing resource within the dermatology service is currently only able to focus on urgent and suspected cancer referrals, with all other routine and non-urgent referrals, not appointment for many months after referral. HCS is engaging a third-party provider to support the capacity deficit in the short term with the plan in the medium to long term to redesign the service following the commencement of 2nd substantive dermatology consultant in October.

Access to Diagnostics greater than 6 weeks

The significant increase in patients waiting access to diagnostics is as a direct result of adding other diagnostic specialties to this standard. As we continue to integrate specialty digital systems into the overarching reporting programme, the impact will be larger patient numbers providing HCS with a clearer understanding as to the clinical demand placed upon the health system. A Diagnostic PTL has been built to allow modality specific monitoring. The impact on the MRI waiting list was monitored at SLT with a report describing the improving situation as routines waits fall to under 26 weeks now and a bench marking exercise has been commenced in regard to demand.

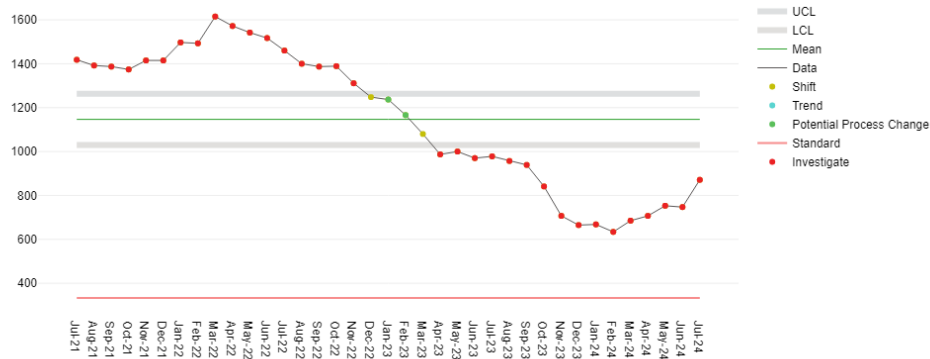
### Escalations

None

# Elective Care Performance - SPC Charts

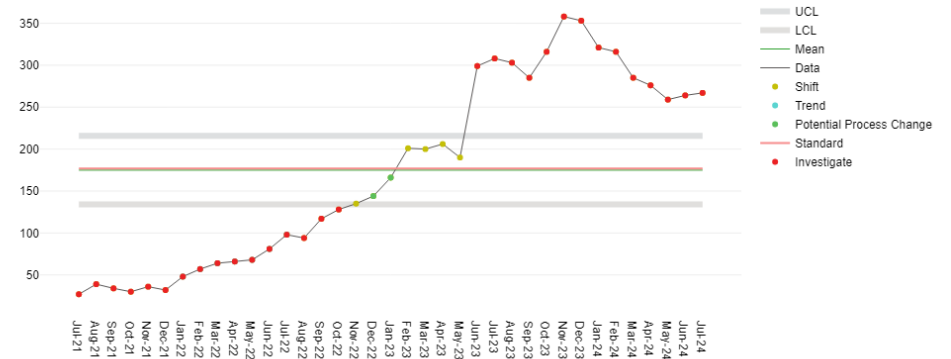
Latest value	Standard
871	<333

Patients waiting for first outpatient appointment Greater Than 52 weeks



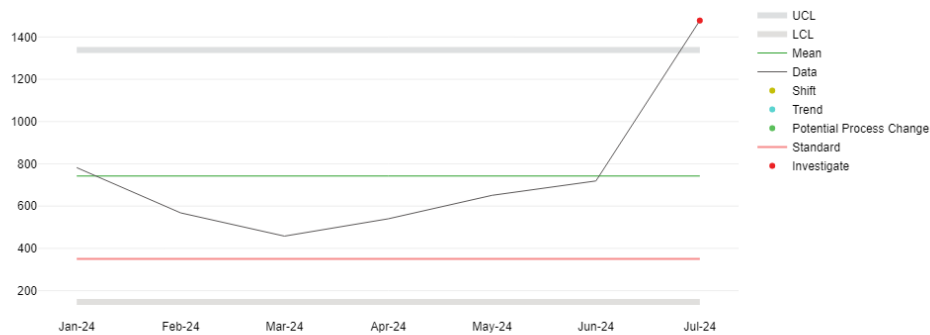
Latest value	Standard
267	<177

Patients on elective list Greater Than 52 weeks



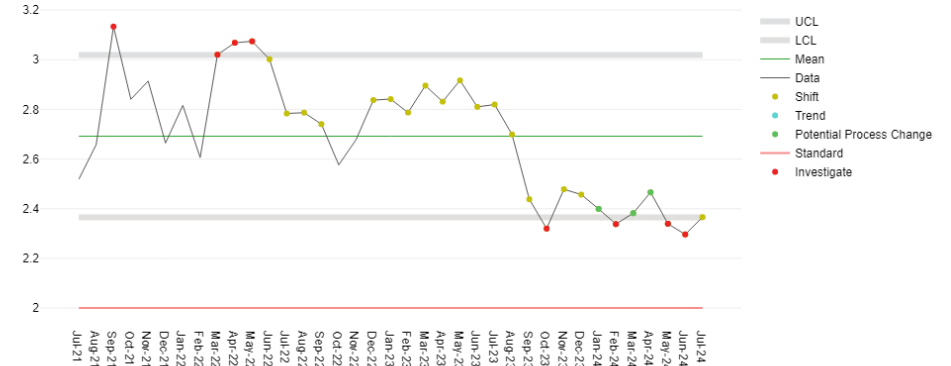
Latest value	Standard
1478	<350

Access to diagnostics Greater Than 6 weeks

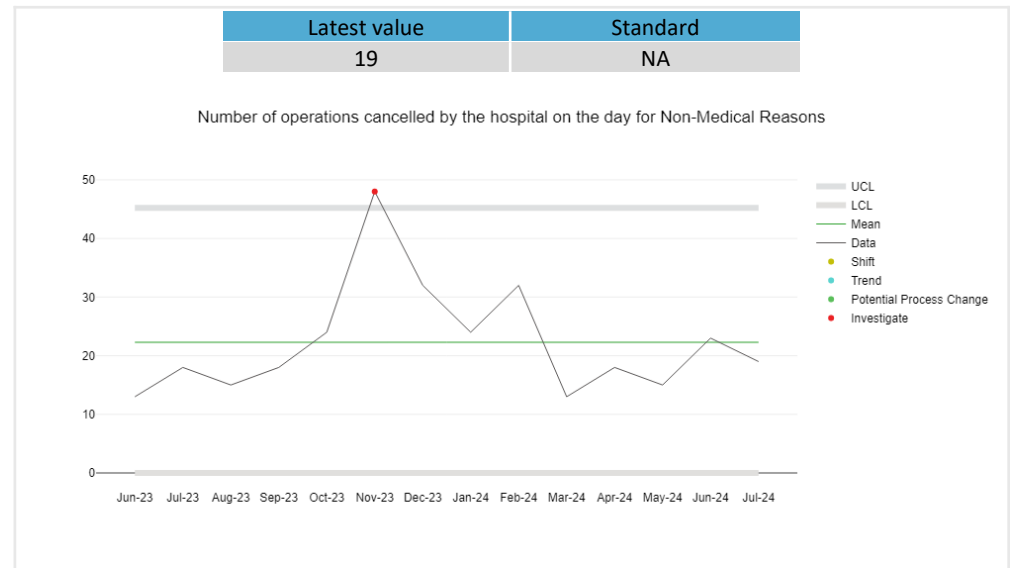
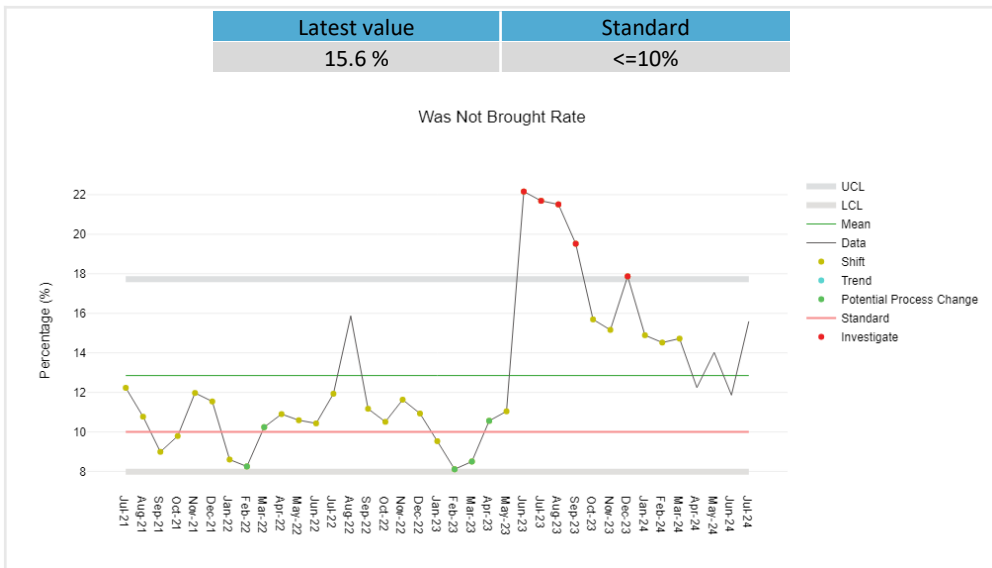
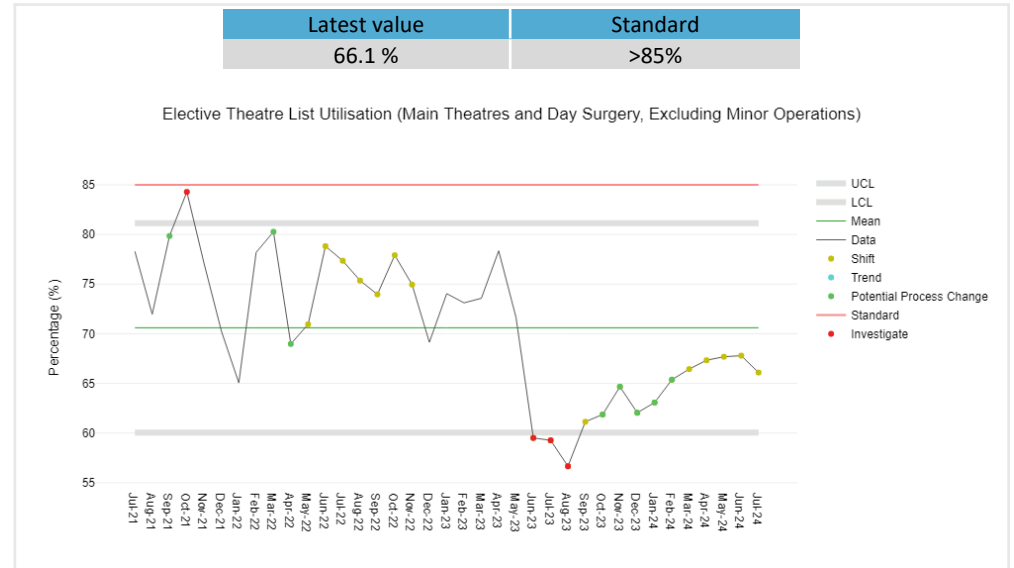
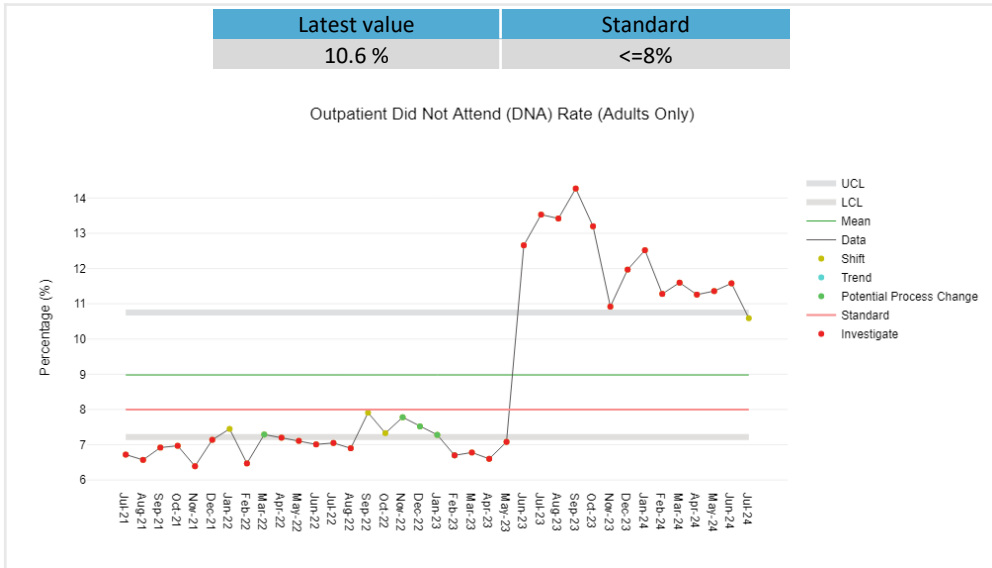


Latest value	Standard
2.37	2

New to follow-up ratio



# Elective Care Performance - SPC Charts



## 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 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. 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

Performance in the 4-hour standard was static however the overall activity in June compared to May was 35 more ED attendances overall. Our ED performance has improved since Q1. We are benchmarking slightly higher than that reported as achieved in England currently.

Of the 3992 ED attendances, 75 were in the department over 12 hours, 14.4% were admitted and 11.5% were discharged from the department direct. We continue to embed Red 2 Green (R2G) principles.

We still are seeing lower numbers of patients being moved out of hours for non-clinical reasons. However, work continues to ensure flow early to decrease this further.

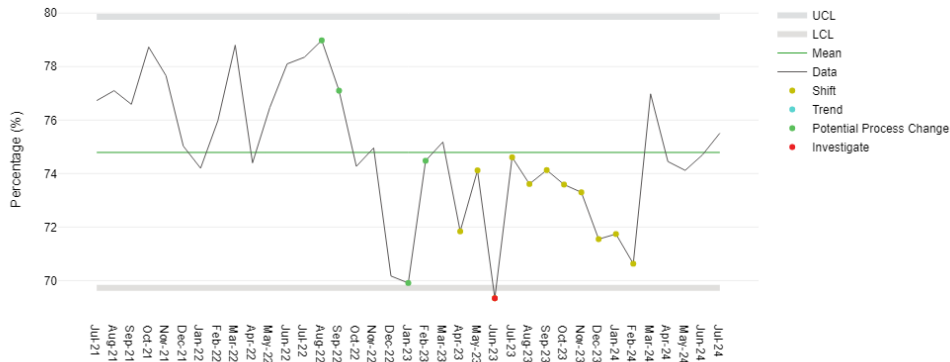
Minimal change is noted to the emergency LOS rate this month and is being addressed through our response to the Royal College of Physicians' report and Operational flow work stream.

Minimal deviation to current performance regarding rate of readmission is noted (less than 1% increase)

# Emergency Care Performance - SPC Charts

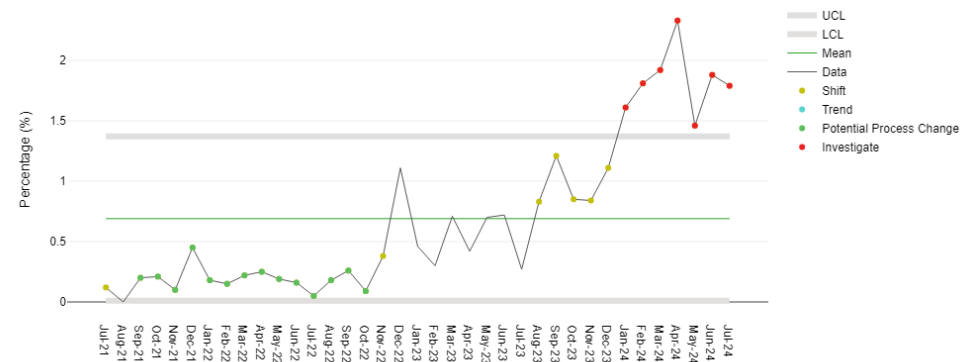
Latest value	Mean
75.5 %	74.8 %

% Patients in Emergency Department for less than or equal to 4 Hours



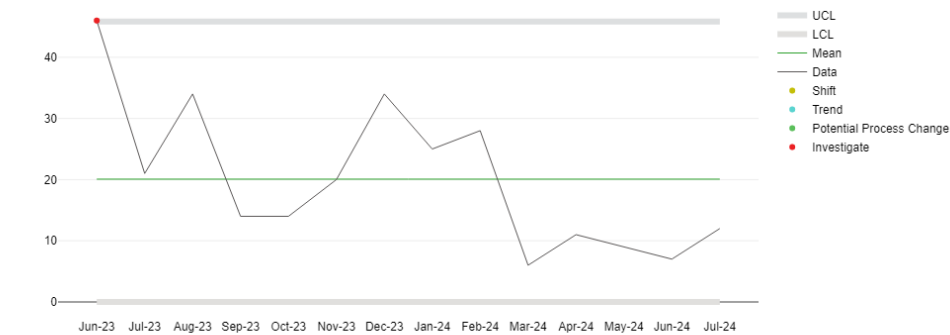
Latest value	Mean
1.8 %	0.7 %

% Patients in Emergency Department for more than 12 Hours



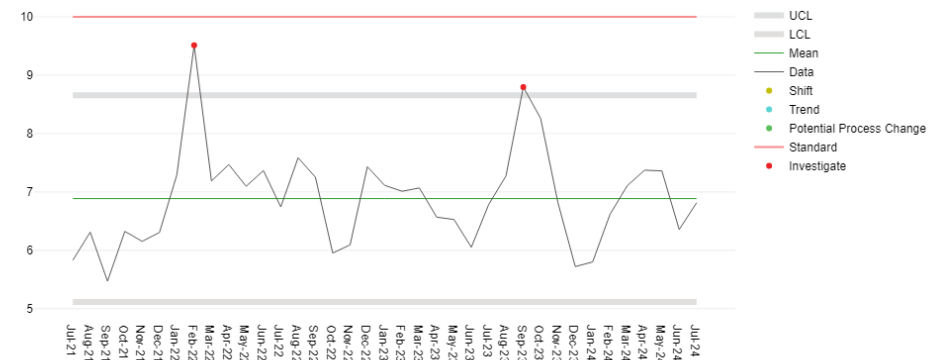
Latest value	Mean
12	20.07

Inpatient movements between 22:00 and 08:00 for non-clinical reasons



Latest value	Mean
6.81	6.89

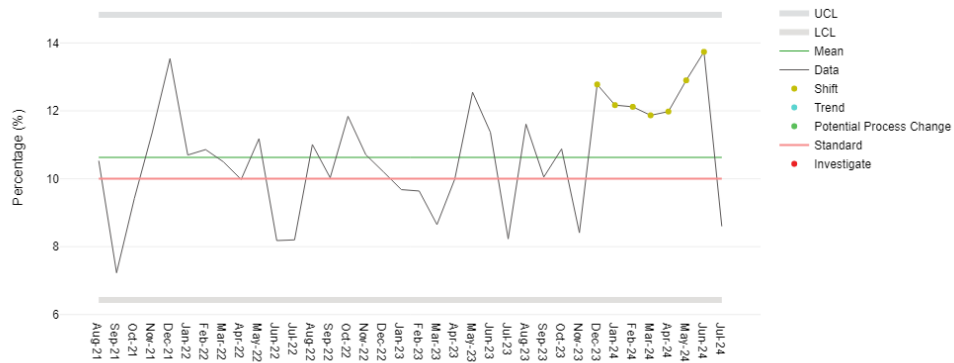
Non-elective acute Length of Stay (LOS) (days)



# Emergency Care Performance - SPC Charts

Latest value	Mean
8.6 %	10.6 %

Rate of Emergency readmission within 30 days of a previous inpatient discharge



## 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 rehabilitation 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 Admissions 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. Exclusions apply see detailed definition at: <a href="https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf">https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf</a>

# Maternity

## Section Owner

Chief Nurse

## Performance Narrative

Our caesarean rate in month was 61.4% (36 /59), with 35.09% being elective. Biggest cohort in relation to the Robson Criteria is 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 our caesarean section rate which is in line with both UK national and international trends. There were 4 caesarean births at full dilatation all of which are being reviewed by the labour ward lead.

Our induction rate remains consistent month on month at 26.32%, which is evident that we are ensuring we are offering induction at the correct gestation due to the presenting clinical picture.

Breastfeeding initiation have increases to 79.7% which is excellent with mothers choosing to breast feed. We are prepared for International Breastfeeding week on 1st-7th August 2024.

There have been three major obstetric haemorrhages in month, all were presented to the serious incident review panel (SIRP) and were well managed and good practice identified.

## Escalations

Outcome of which maternity specific EPR system we will be having is planned for Friday 16th August; choices are K2 or BadgerNet.

## Maternity - Key Performance Indicators

Indicator	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	YTD
Total Births	80	72	67	58	66	59	67	51	58	56	53	69	59	413
Mothers with no previous pregnancy (Primips)							24	15	20	16	20	34	22	151
Mothers who have had a previous pregnancy (Multips)							26	19	30	28	23	25	30	181
Mothers with unknown previous pregnancy status							17	17	8	12	10	10	7	81
Bookings ≤10+0 Weeks							6	3	7	8	8	9	7	48
% of women that have an induced labour	20.27%	27.78%	31.25%	17.24%	30.77%	38.98%	30.16%	24%	31.58%	22.22%	16.67%	19.4%	26.32%	24.49%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	26	25	23	21	18	11	25	13	22	10	19	19	12	120
Number of Instrumental deliveries	5	12	4	5	5	4	7	3	5	2	3	7	4	31
% deliveries by C-section (Planned & Unscheduled)	45.95%	44.44%	37.5%	46.55%	49.23%	45.76%	36.51%	54%	40.35%	66.67%	45.83%	52.24%	61.4%	50.76%
% Elective caesarean section births	22.97%	22.22%	21.88%	22.41%	27.69%	28.81%	23.81%	32%	15.79%	37.04%	27.08%	29.85%	35.09%	28.54%
Number of Emergency Caesarean Sections at full dilatation	0	1	1	1	2	0	2	1	1	1	1	0	4	10
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	6	28
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	26
Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, caesarean birth prior to onset of spontaneous labour)							3	3	2	5	3	7	4	27
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	39
Number of deliveries home birth (Planned & Unscheduled)	2	4	2	3	3	0	2	3	1	1	1	1	3	12
Mothers who were current smokers at time of booking (SATOB)	4	0	1	4	3	2	7	7	3	4	6	2	2	31
Mothers who were current smokers at time of delivery (SATOD)	0	0	0	1	0	0	0	1	3	0	2	2	3	11

## Maternity - Key Performance Indicators

Indicator	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	YTD
Number of Mothers who were consuming alcohol at time of booking	3	1	1	2	0	3	1	1	2	0	0	0	0	4
Number of Mothers who were consuming alcohol at time of delivery	0	0	0	0	1	0	5	4	6	4	3	6	3	31
Breastfeeding Initiation rates	73.8%	76.4%	77.6%	74.1%	75.8%	72.9%	79.1%	74.5%	65.5%	73.2%	69.8%	71%	79.7%	73.37%
Transfer of Mothers from Inpatients to Overseas	0	0	0	0	2	1	0	3	1	1	0	1	0	6
Number of births in the High dependency room / isolation room	0	0	1	0	0	0	1	1	0	0	0	0	0	2
Number of PPH Greater Than 1500mls	4	2	3	6	6	3	2	2	1	6	0	1	3	15
Number of 3rd & 4th degree tears – all births	1	1	2	2	1	0	2	2	1	0	0	0	0	5
% of babies experiencing shoulder dystocia during delivery	2.5%	2.78%	1.49%	1.72%	0%	1.69%	0%	0%	0%	1.79%	0%	4.35%	0%	0.97%
% Stillbirths Greater Than 24 Weeks Gestation							0%	0%	0%	0%	0%	0%	0%	0%
Neonatal Deaths at Less Than 28 days old							0	0	0	0	0	0	0	0
Number of babies that have APGAR score below 7 at 5 mins	0	0	1	0	1	0	0	1	0	1	1	1	2	6
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	4%	2.7%	0%	9.09%	5%	3.45%	0%	3.7%	7.41%	3.85%	7.14%	2.78%	5.26%	4.19%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	0	0	0	2	2	0	1	0	0	1	2	0	4
Transfer of Neonates from JNU	1	0	0	0	1	1	1	0	0	1	0	1	0	3
Preterm Births ≤27 Weeks (Live & Stillbirths)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	6	2	2	7	1	2	1	1	8	1	2	2	3	18
Neonatal Readmissions at Less Than 28 days old							11	4	4	5	5	5	4	38

## 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' gestation, 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 Dependency 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
Number 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))	Indicator is for information only	Number of live births (only looking at singleton babies with a gestational length at birth between 259 and 315 days) that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
% 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

The Maternity Strategy has been through all governance processes within HCS and is now business as usual for our phase two Maternity Improvement Plan.

## Mental Health

### Section Owner

Director Adult Mental Health & Social Care

### Performance Narrative

Access to mental health services remains above target, with 95% of all referrals being assessed within 10 days.

There has been a significant improvement in waiting times for memory assessment, with the wait now reduced to 61.5 days.

In terms of psychological therapies (JTT), >97% of referrals are assessed within the target 90 days, with a slight reduction in average waiting time for treatment this month but an increase in the number of people starting treatment who had waited over 18 weeks. We have recently recruited into posts within the team, and are reviewing the staffing model within the Step 3 team and increasing group use to increase capacity.

### Escalations

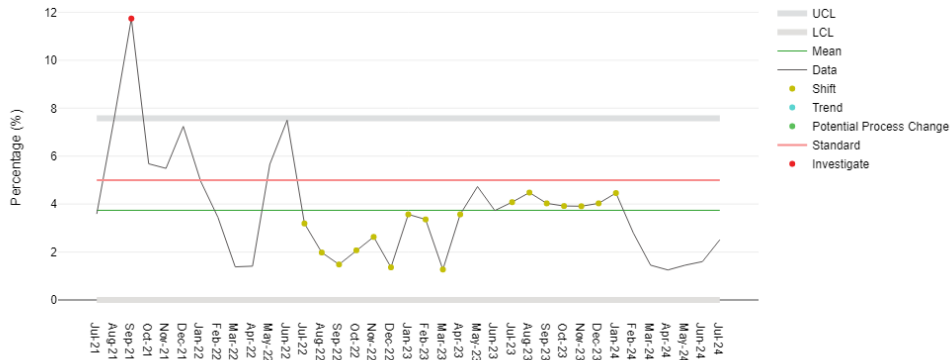
Bed occupancy and the number of patients within mental health services who no longer need to be in hospital (Medically Fit for Discharge) remain high.

This month has seen a continued increase in the length of wait for ADHD assessment, and an increase in the wait for an Autism Assessment (due to a member of staff leaving the team).

# Mental Health - SPC Charts

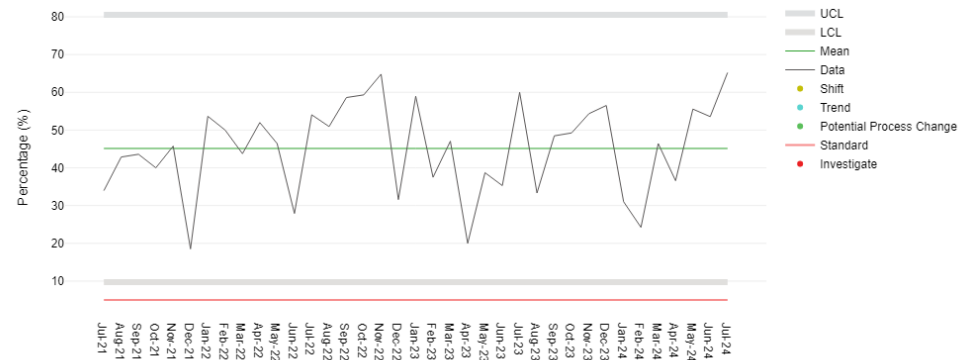
Latest value	Mean
2.5 %	3.7 %

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



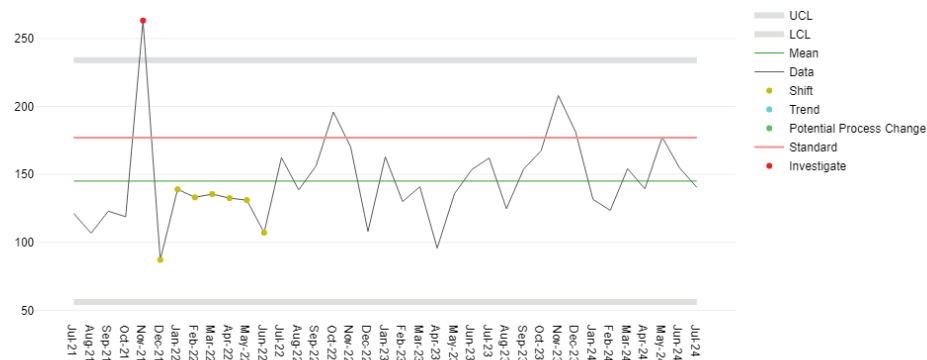
Latest value	Mean
65.2 %	45.1 %

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



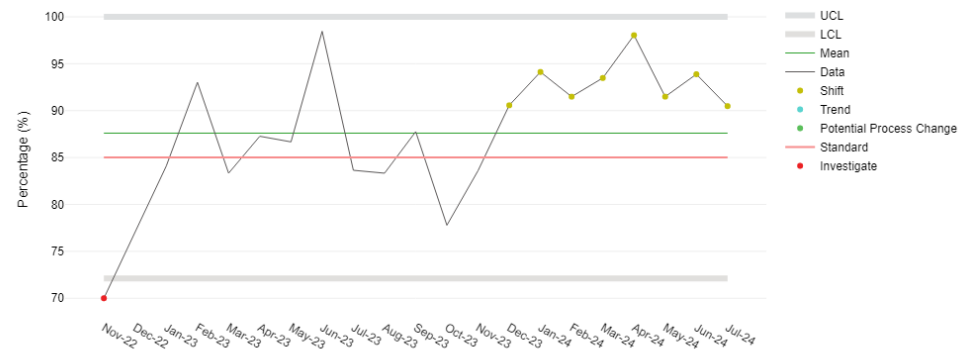
Latest value	Mean
140.45	145.07

JTT Average waiting time to treatment (Days)



Latest value	Mean
90.5 %	87.6 %

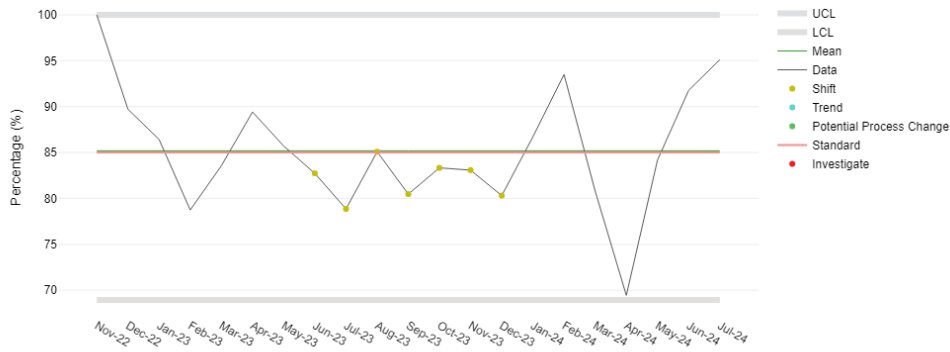
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



# Mental Health - SPC Charts

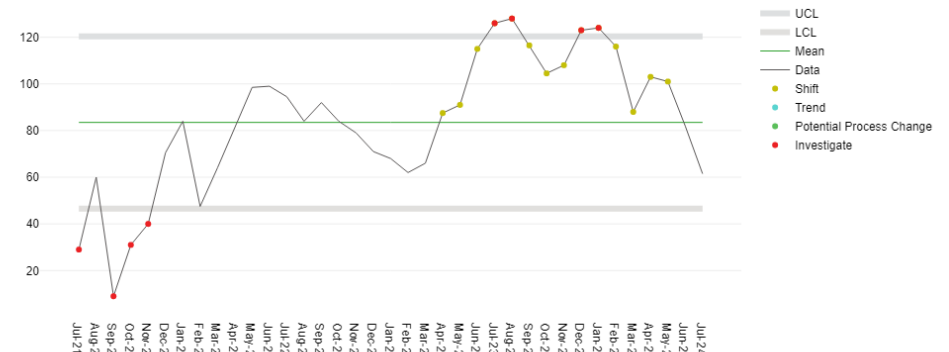
Latest value	Mean
95.1 %	85.2 %

% of referrals to Mental Health Assessment Team assessed in period within 10 working days



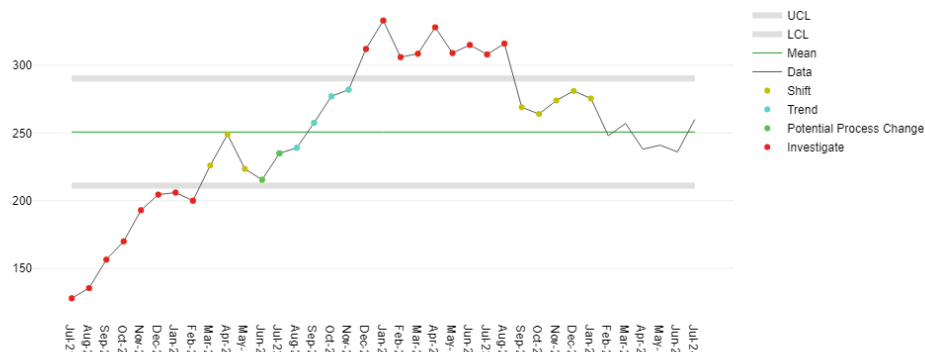
Latest value	Mean
61.5	83.49

Median wait of clients currently waiting for Memory Service Assessment (Days)



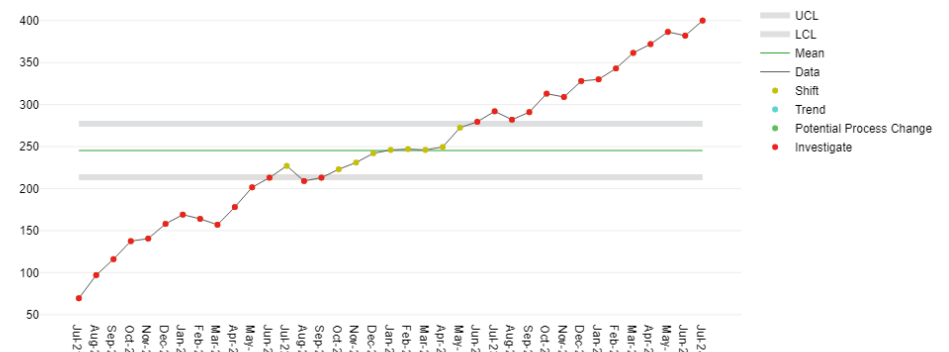
Latest value	Mean
260	250.73

Median wait of clients currently waiting for Autism Assessment (Days)



Latest value	Mean
400	245.31

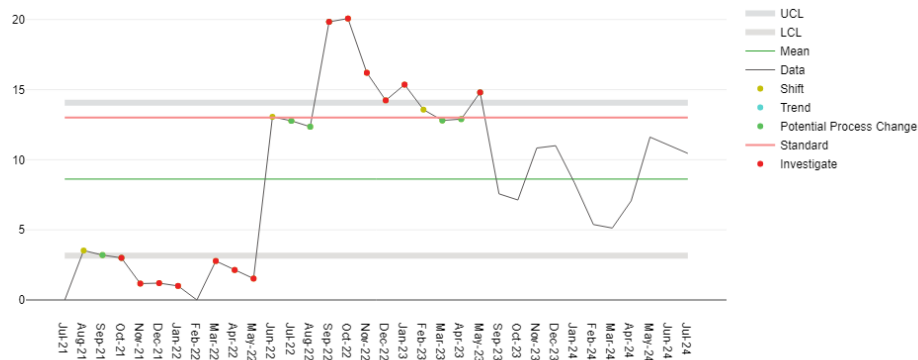
Median wait of clients currently waiting for ADHD Assessment (Days)



# Mental Health - SPC Charts

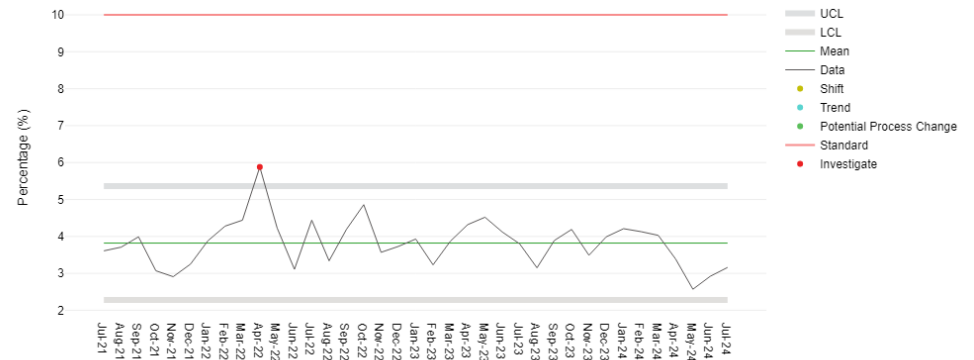
Latest value	Mean
10.45	8.62

Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards



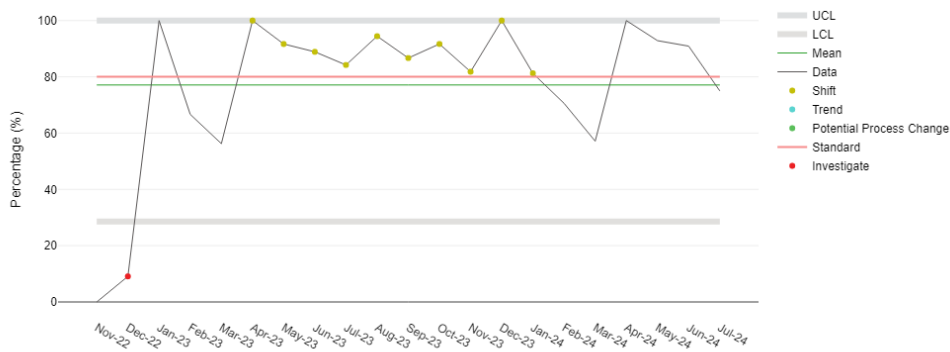
Latest value	Mean
3.2 %	3.8 %

Community Mental Health Team Did Not Attend (DNA) rate



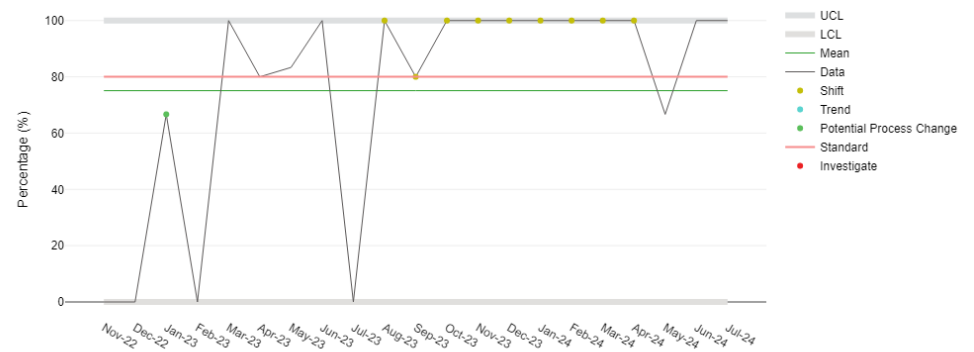
Latest value	Mean
75 %	77.1 %

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



Latest value	Mean
100 %	75.1 %

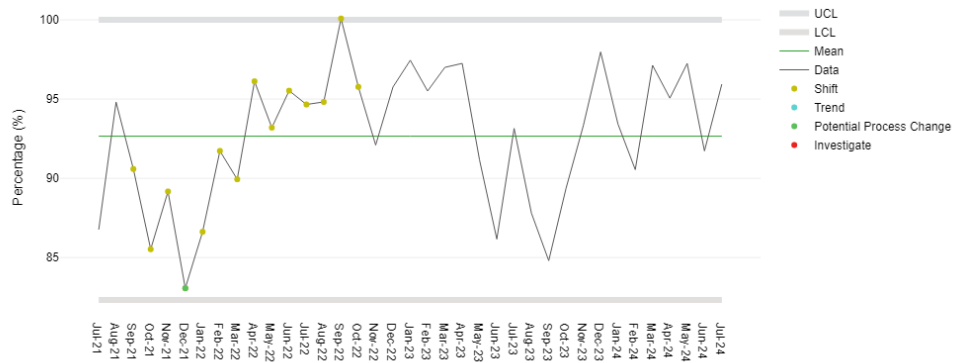
% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days



# Mental Health - SPC Charts

<b>Latest value</b>	<b>Mean</b>
95.9 %	92.7 %

Mental Health Unit Bed occupancy at midnight (Adult and Older Adult Units)





## 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 period 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 assessed 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 assessed 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
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))	Generated based on historic percentiles	Average (mean) number of Mental Health inpatients marked as Medically Fit For Discharge each day at 8am
% 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 Mental 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
Mental Health Unit Bed occupancy at midnight (Adult and Older Adult Units)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP027DM))	Not Applicable	Percentage of Mental Health inpatient beds occupied at the midnight census. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave where the bed is retained on Maxims. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census.

## Social Care

### Section Owner

Director Adult Mental Health & Social Care

### Performance Narrative

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

Achievement of 79.5% is an increase from previous month and is just short of the target of at least 80% of service users having a health check. The underlying cause relates to staff leave within the Nurse Team, who carry the assessments out due to the summer months. Activity will be reviewed continuously to ensure that the target is achieved when the Nurse Team returns to full compliment.

Percentage of Assessments Completed and Authorised within 3 weeks ASCT)

It is pleasing to see the Number of assessments completed and authorised continuing to perform strongly (91% against an 80% target), especially given the current pressures in adult social care, alongside planned and unplanned staff absences in the summer / school holiday months.

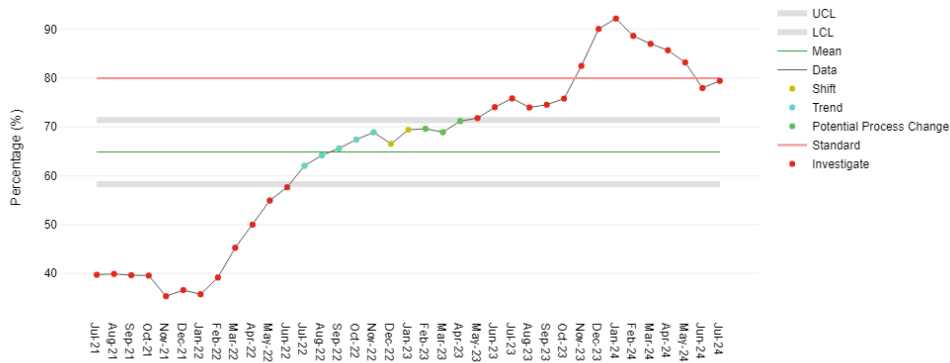
### Escalations

None

# Social Care - SPC Charts

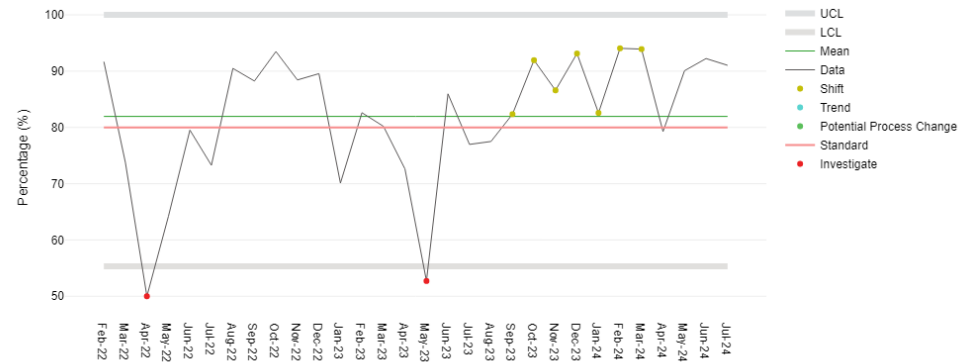
Latest value	Mean
79.5 %	64.9 %

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



Latest value	Mean
91 %	82 %

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

#### Complaints:

In July, a total of 16 new complaints were received across all care groups. This represents a decrease of 21 complaints (-57%) compared to July 2023, when 37 complaints were recorded.

The team continues to actively encourage patients and relatives to utilise the de-escalation process on wards, working directly at the point of contact to find resolutions.

#### Compliments:

In July, a total of 138 compliments were logged on the Datix system, reflecting a 64% increase compared to the same month in 2023, which saw 84 compliments recorded. The team is collaborating with wards and departments to ensure that all patient and relative compliments are captured and recorded in Datix, ensuring that the relevant individuals and teams receive appropriate feedback and recognition.

#### Infection Prevention & Control Update

There has been one *C. difficile* infection identified in the hospital in July and this is currently under review. Enhanced infection prevention and control measures have been implemented and root cause analysis investigations are underway.

There have been three *E. coli* bacteraemia's in July and these are under review.

#### Tissue Viability

In July 2024, there were 9 reported incidents of hospital-acquired pressure damage within our care. Of these, 5 were confirmed as category 2 pressure ulcers. Notably, 3 of these ulcers resolved (healed) during the same hospital admission, with no reported deterioration in the remaining 2 cases.

The other 4 incidents relate to one patient. A thorough root cause analysis revealed that these incidents were unavoidable due to the patient's complex comorbidities and non-concordance with the recommended care plans and risk reduction interventions. The patient continues to be closely monitored and supported by a multidisciplinary team.

## Quality & Safety

Key actions and observations include:

- \* The Tissue Viability Team continues to work collaboratively on both the prevention of pressure ulcers and the management of those that occur, with the goal of improving patient outcomes.
- \* Significant improvements have been noted in the Emergency Department (ED) regarding the early recognition of patients at risk of developing pressure ulcers. Early intervention measures are implemented before patient transfer to the wards.
- \* The continued enhancement of our reporting systems has allowed for the capture of more robust data, facilitating better monitoring of trends across the organisation.

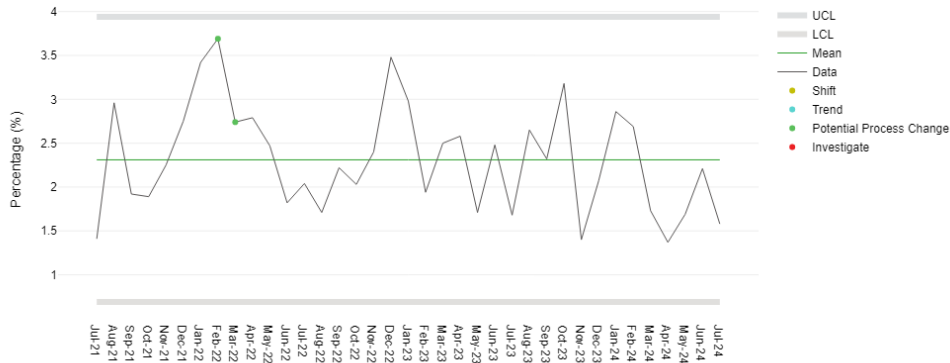
### Escalations

None

# Quality & Safety - SPC Charts

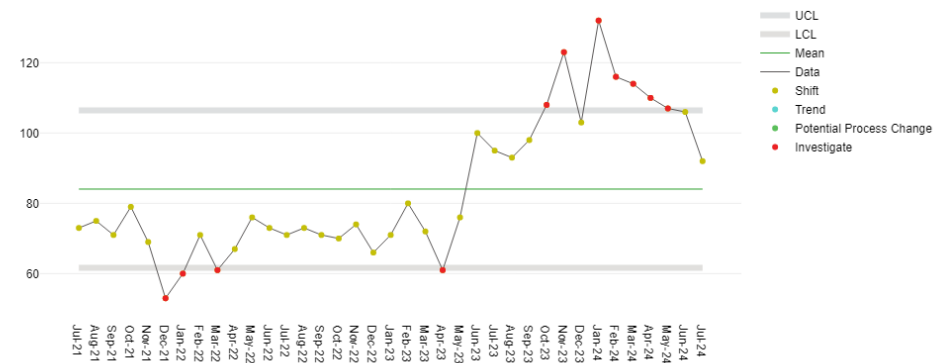
Latest value	Mean
1.6 %	2.3 %

Crude Mortality Rate (JGH, Overdale and Mental Health)



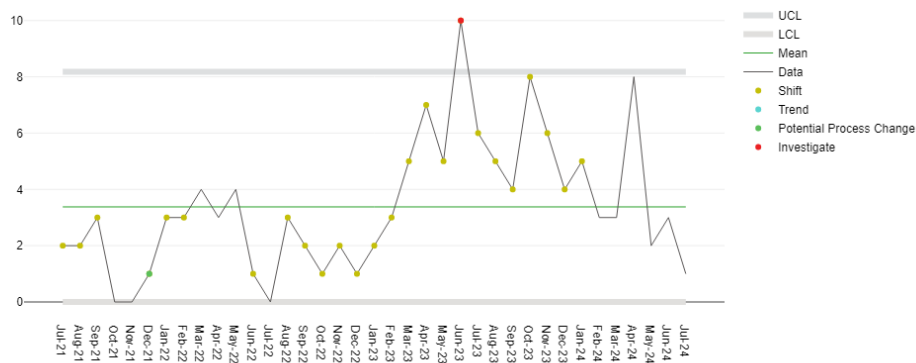
Latest value	Mean
92	84.05

Patient Safety Events per 1000 bed days



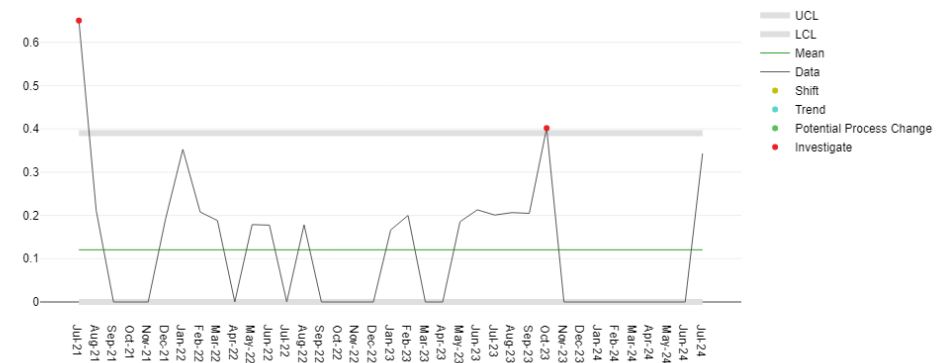
Latest value	Mean
1	3.38

Number of serious incidents



Latest value	Mean
0.34	0.12

Number of falls resulting in harm (moderate/severe) per 1,000 bed days

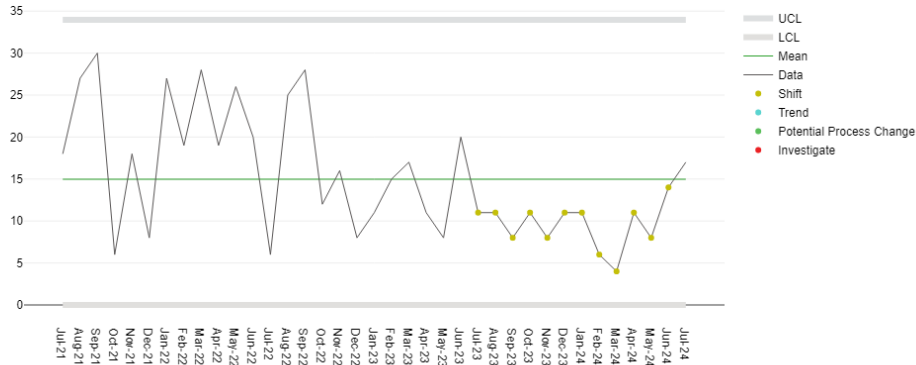




# Quality & Safety - SPC Charts

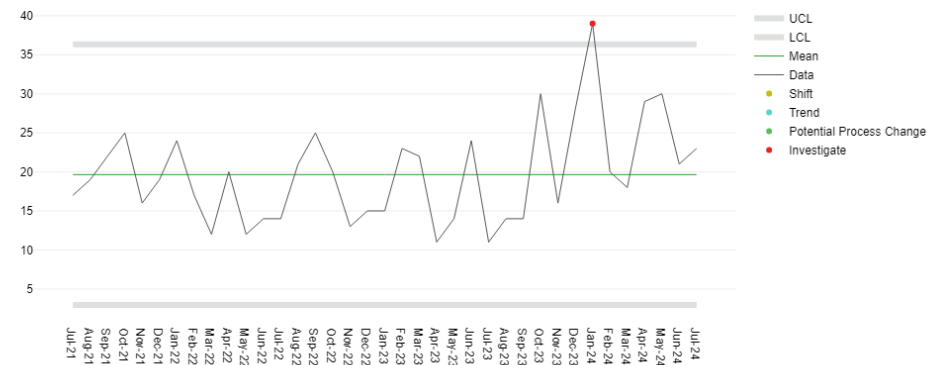
Latest value	Mean
17	14.97

Patient safety incidents with moderate/severe harm/death



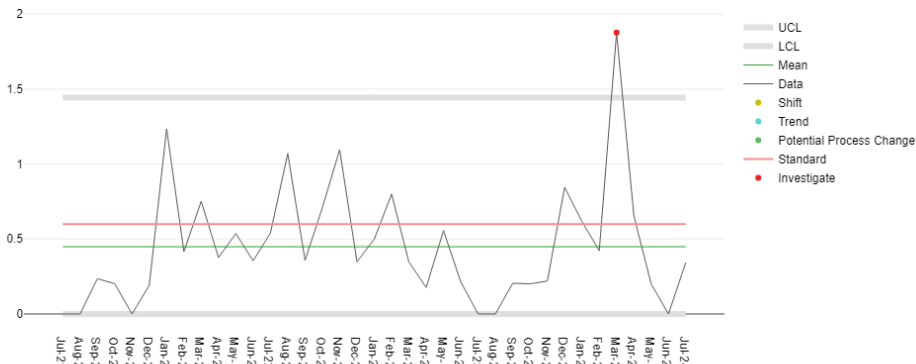
Latest value	Mean
23	19.65

Number of pressure ulcers present upon inpatient admission



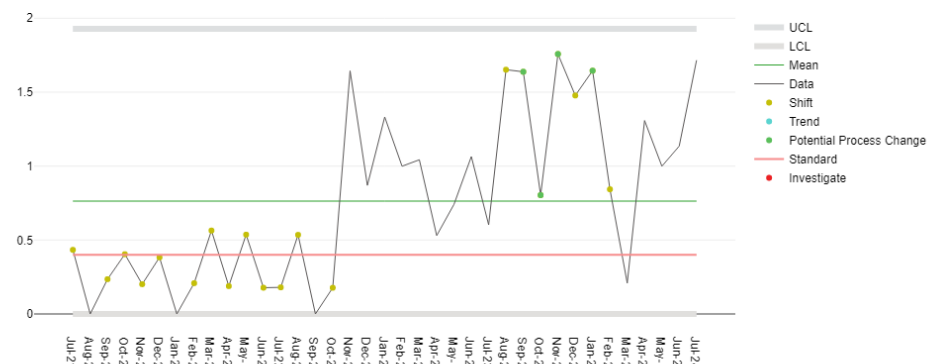
Latest value	Mean
0.34	0.45

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

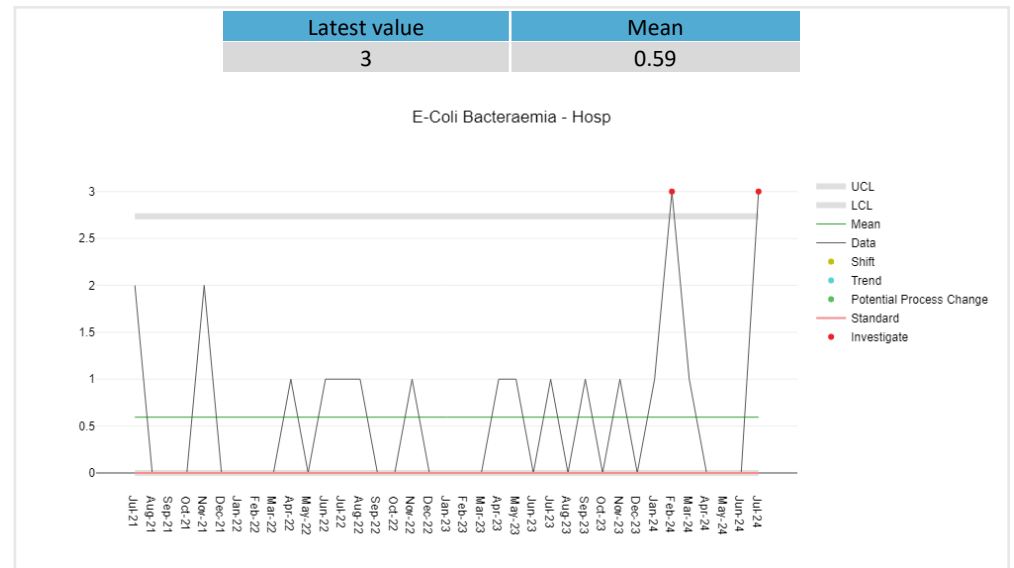
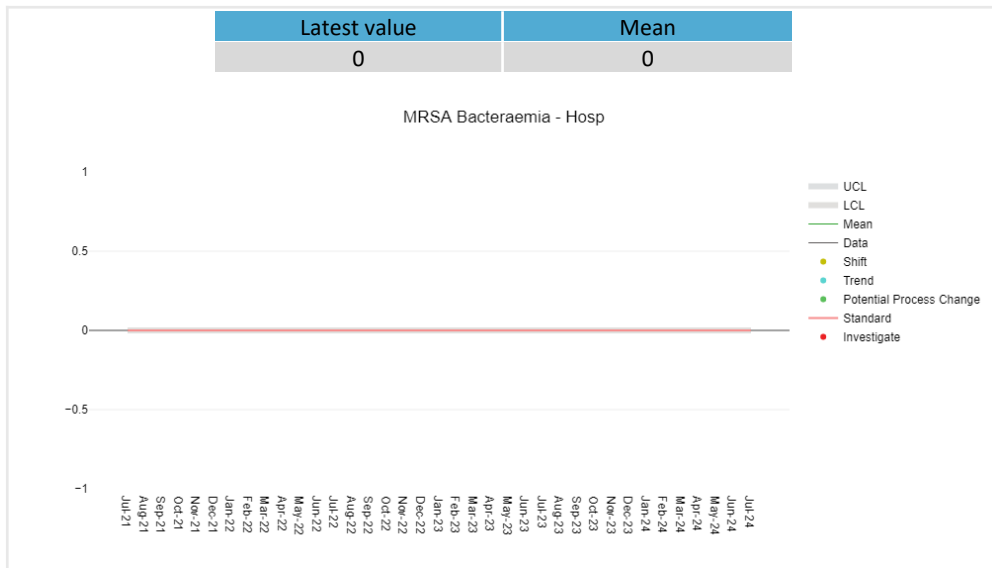
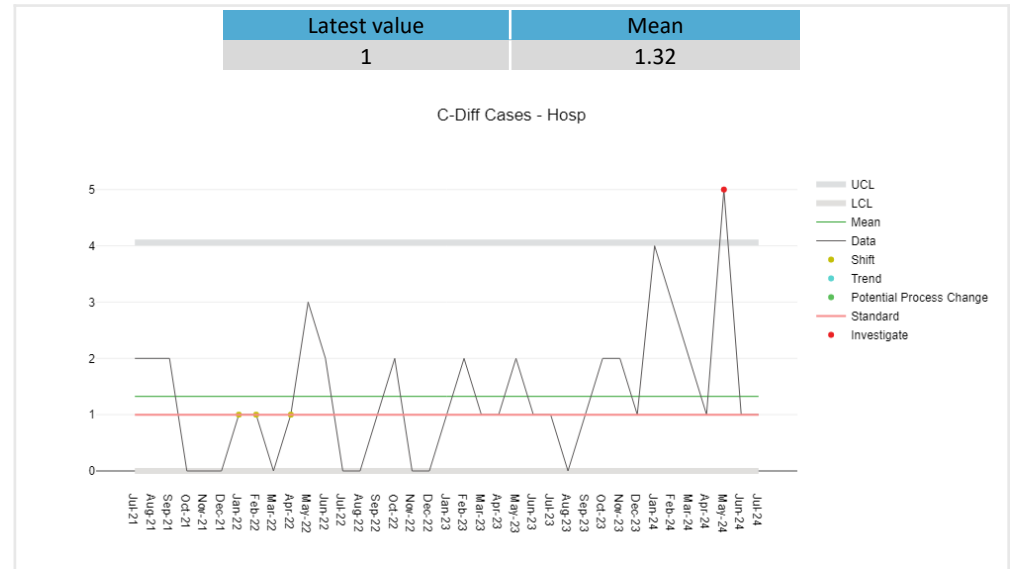
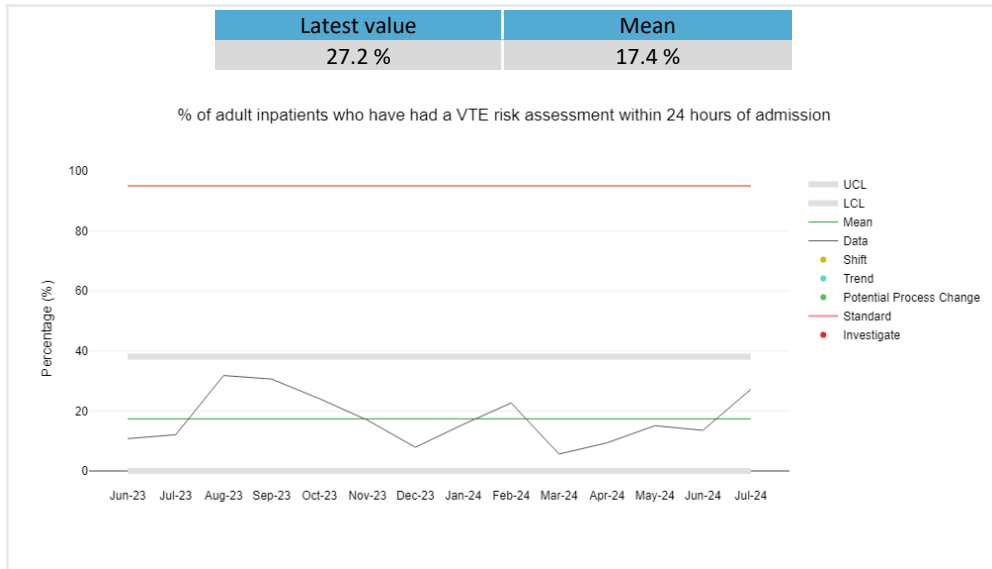


Latest value	Mean
1.72	0.76

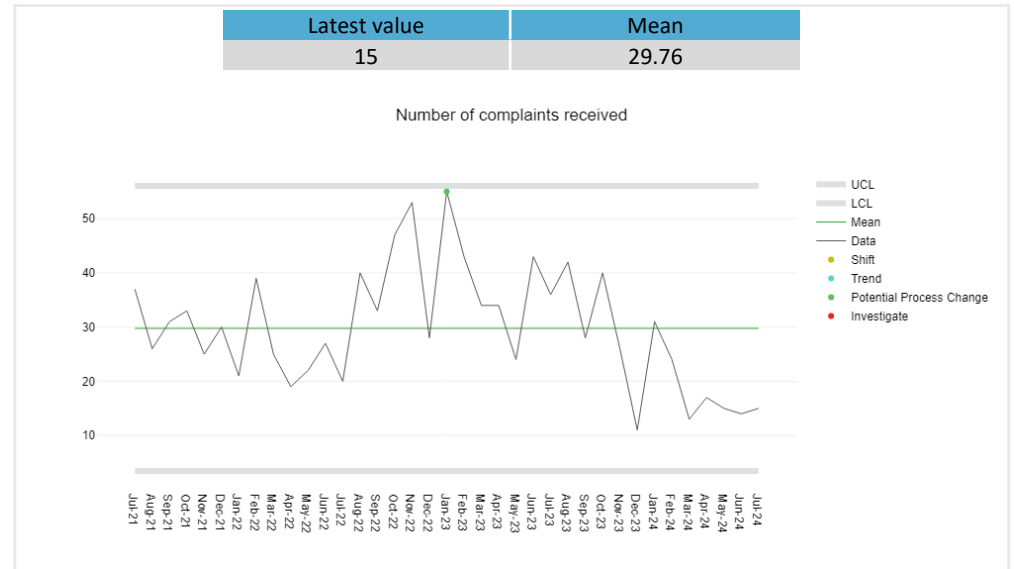
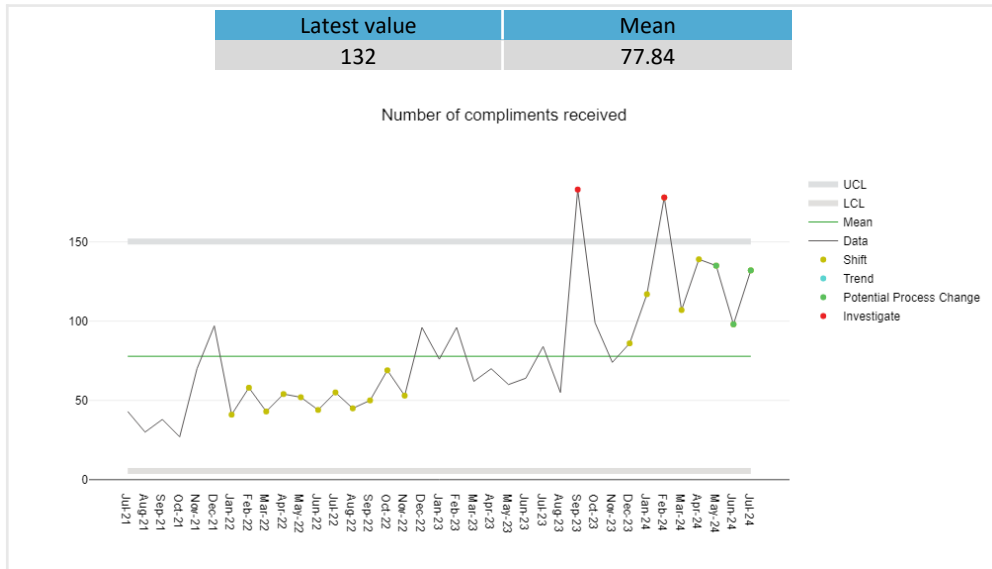
Number of medication errors across HCS resulting in harm per 1000 bed days



# Quality & Safety - SPC Charts



# Quality & Safety - SPC Charts



## Quality & Safety - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Crude Mortality Rate (JGH, Overdale 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 admission" 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"