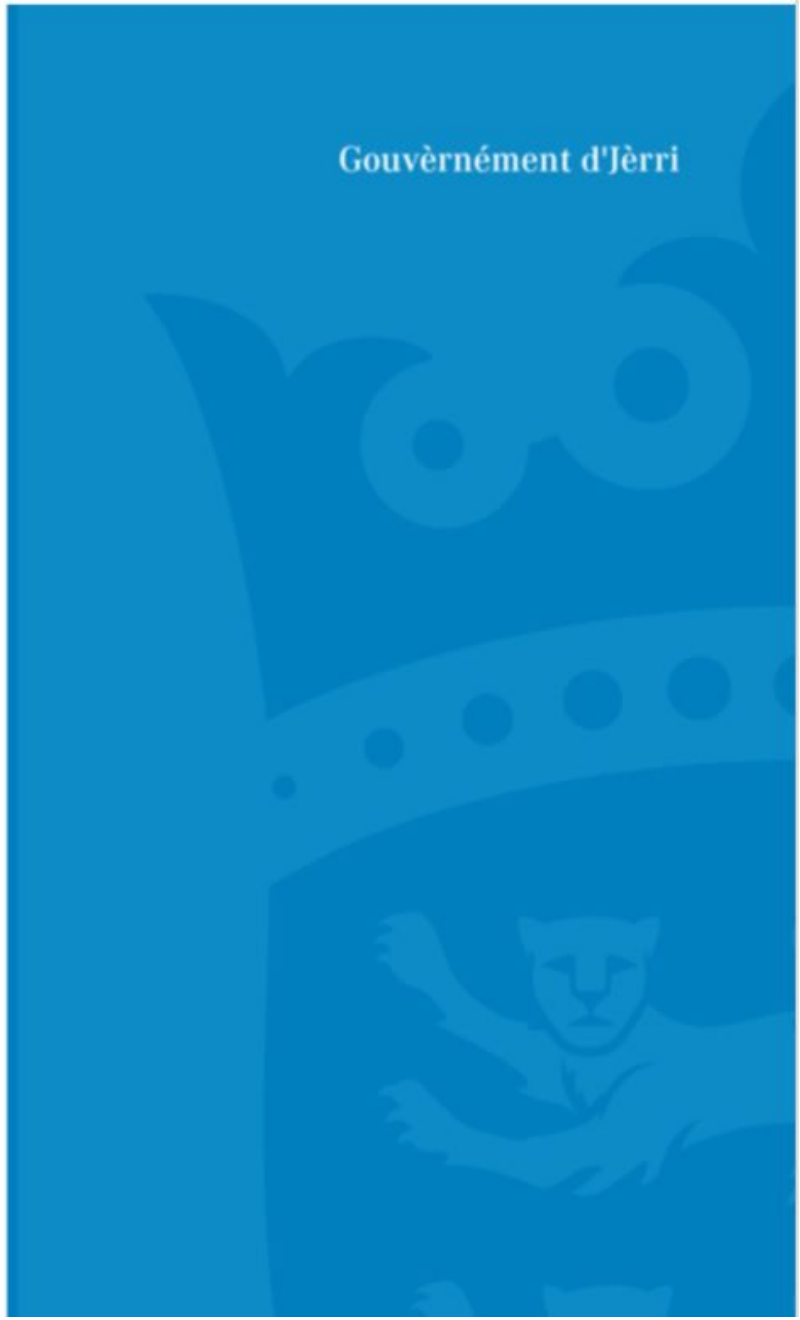
Health and Community Services

# Quality and Performance Report
# November 2024



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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
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Chief Operating Officer - Acute Services - Claire Thompson
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## 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

Outpatient waits greater than 52 weeks

The impact of the additional capacity within dermatology has significantly reduced patients waiting over 52 weeks for their first outpatient appointment. It is expected that by end of January 2025, there will be no patients waiting for their first appointment in dermatology longer than 52 weeks, other than for patient choice. Clinical Genetics (screening service) and gastroenterology are the other 2 services which have lengthy waits. As previously reported, clinical genetics have actions established to eliminate the backlog. Gastroenterology will be undertaking a focussed waiting list initiative in Q1, however there is significant capacity deficit in this service to meet the referral demand. The service is reviewing and re-designing how it will plan to deliver gastroenterology in the future to enable capacity to meet demand.

Patients waiting greater than 52 weeks for elective inpatient procedure

The elective inpatient waits have increased due to issues with theatre and equipment availability as reported previously. The increase of 42 patients waiting over 52 weeks is spread across the services and not just seen in one specialty. Specifically relating to month 11, the availability of the Opthalmic microscope, the limited availability of drills for orthopaedic procedures, and the emergency theatre needing to be reallocated to an elective theatre resulting in elective activity being suspended, together with a combination of surgeon study leave and the quarterly Inset day all contributed to a lack of capacity which saw the waiting list rise by 42 cases. Urgent and emergency cases were not affected and were given priority over routine cases. Theatre maintenance is happening over the Christmas period and further planned work at the end of January. It is expected this work will ensure theatres will be fully functional again from February onwards. Following ward refurbishment, additional physical capacity is feasible to open if winter demand was perceived to impact elective capacity in the new year. Elective capacity has been planned inpatient lighter compared to Day Surgery higher, for the initial period post New Year due to winter pressures and theatre ventilation improvements that are required.

Access to diagnostics greater that 6 weeks

The stability of the number of patients waiting diagnostic tests over the last few months indicates a significant lack of capacity to support the demand. Over 2024, the identification and confidence in the data reported has enabled a baseline for which service planning can now take place to support reduction in waiting times as we move into 2025.

New to follow-up ratio

This ratio is within acceptable range and consistent with the current service provision across all specialties.

DNA and Was Not Brought rates

In line with the continued actions to reduce these rates, a fall in numbers of those not attending their appointments is seen again this month.

# Elective Care Performance

Elective theatre utilisation

Theatre utilisation reporting remains below standard with focussed work to understand where the blocks are within the theatre flow.  This is in part due to the breakdown of equipment and theatres over the last few months. As we move into 2025, theatre utilisation and productivity will be a key action for the leadership teams across elective services.  Daily audits and action have been taken in October and November and a reduction in sessions with late starts (67 late start lists in November compared to 88 in October) has been delivered which has positively impacted theatre utilisation in month and this work continues.

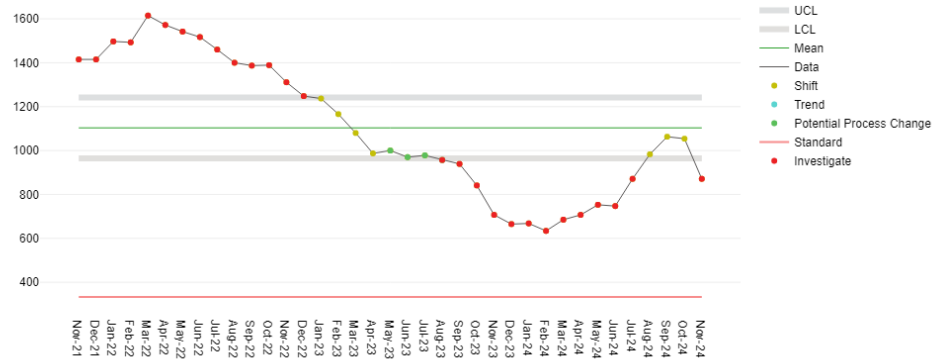
Theatre cancellations on the day of Surgery

Cancellations are directly attributable, in the main, to equipment and theatre breakdown over the course of the last few months.

# Elective Care Performance - SPC Charts

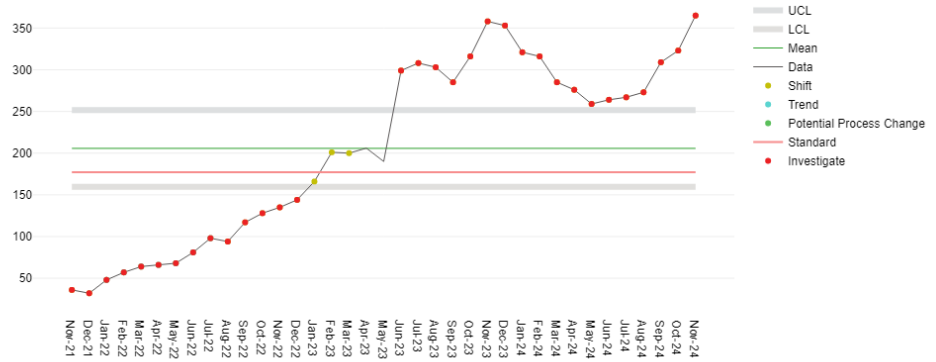
| Latest value | Standard |
|---|---|
| 871 | <333 |

Patients waiting for first outpatient appointment Greater Than 52 weeks



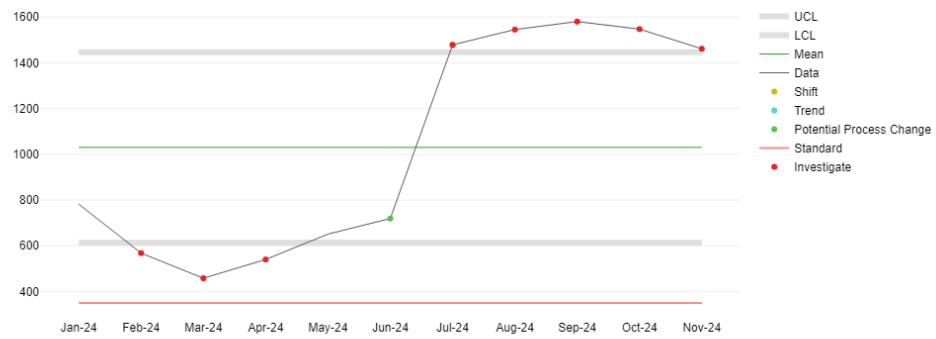

| Latest value | Standard |
|---|---|
| 365 | <177 |

Patients on elective list Greater Than 52 weeks



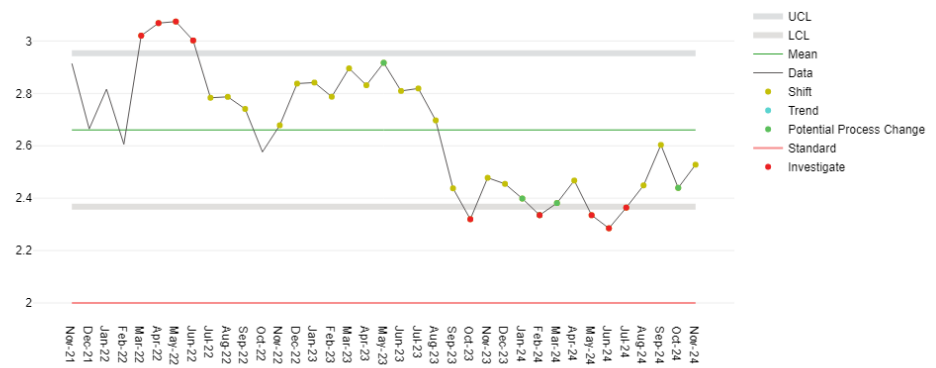

| Latest value | Standard |
|---|---|
| 1461 | <350 |

Access to diagnostics Greater Than 6 weeks



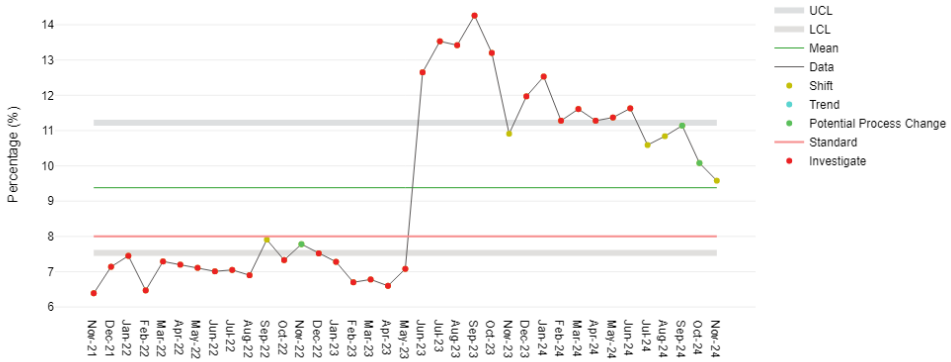

| Latest value | Standard |
|---|---|
| 2.53 | 2 |

New to follow-up ratio

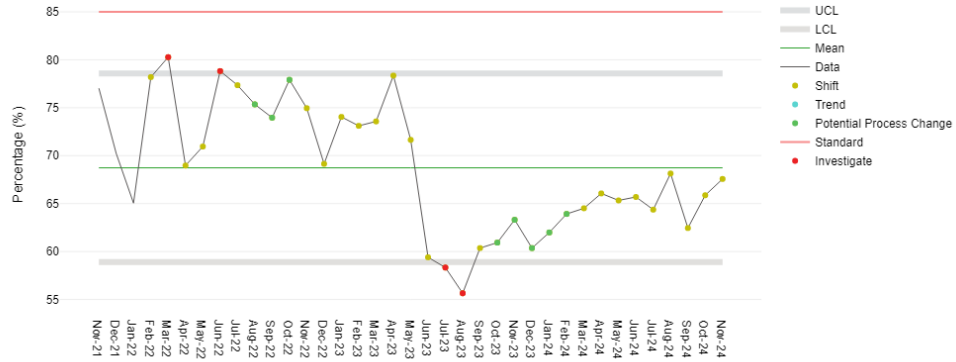


# Elective Care Performance - SPC Charts

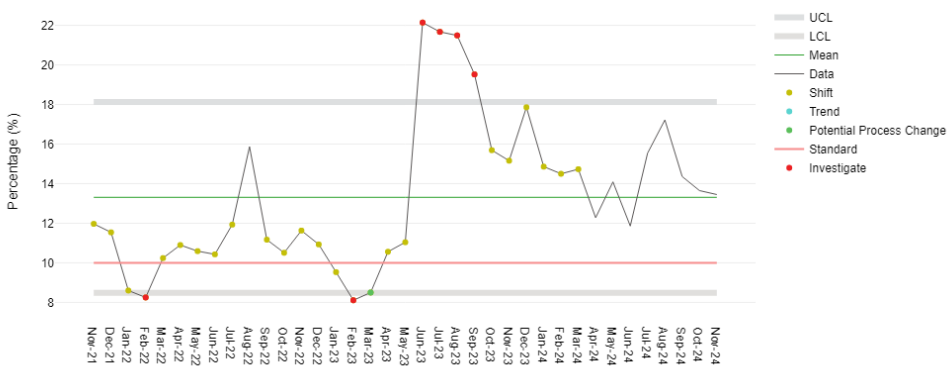
| Latest value | Standard |
|---|---|
| 9.6 % | <=8% |



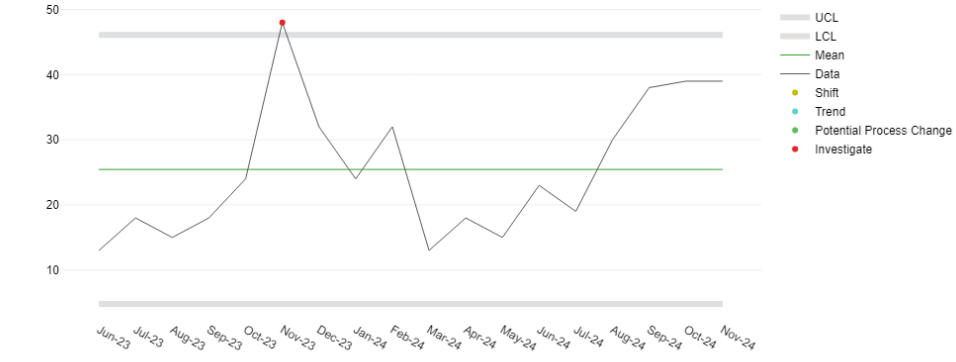

| Latest value | Standard |
|---|---|
| 67.6 % | >85% |




| Latest value | Standard |
|---|---|
| 13.5 % | <=10% |




| Latest value | Standard |
|---|---|
| 39 | 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 November, we had 3484 attendees through the Emergency Department which is slight decrease from in October. The number of patients seen within target time (<4 hours) was stable at 75%. 92% of the minor's activity was patients seen and treated within 4hrs which is a constant improvement in this area of activity. We are benchmarking higher than that reported as achieved in England currently.

There was no significant change in the number of patients who were in ED for >12 hrs (3.1%). 68% of our 12-hour breaches were those requiring admission. 14.2% of ED attendances were admitted which is the same as the previous month. It is noted that the number of emergency episodes in November 2024 is 265 patients higher, compared with November 2023 with attendances in ED sitting at 3,484.

We continue to embed Red 2 Green (R2G) principles to assist with flow and have run dedicated days of individual patient review as a process to develop this practice as a response to capacity issues and will implement these prior to Bank Holiday periods and as a recovery action.

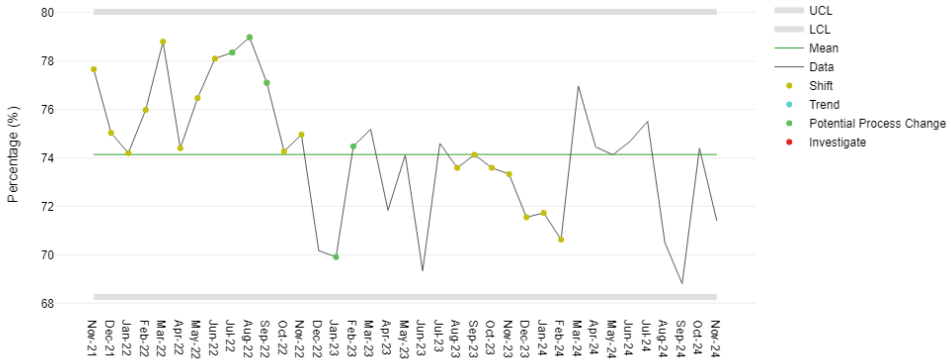
Inpatients movement out of hours for non-clinical reasons has reduced significantly and this is mainly due to specific bed requests to support continuation of clinical care. As part of embedding learning from a serious incident, consistent focus is now evident within the operational bed meetings with monitoring of all non-clinical transfers in and out of hours daily.

There is a decrease to the emergency LOS rate this month and is this 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.

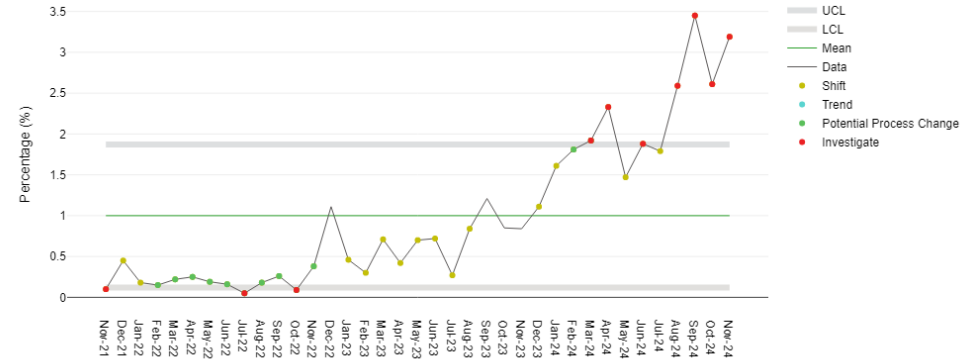
A slight decrease in the rate of readmission is noted this month at 12.4% of patients being readmitted within 30 days.

# Emergency Care Performance - SPC Charts

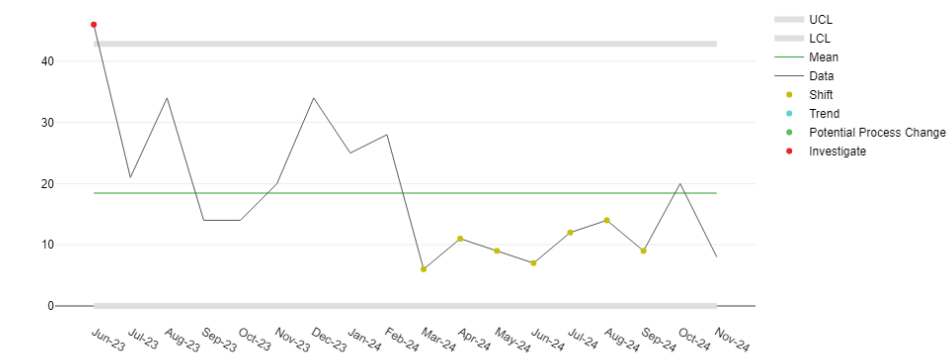
| Latest value | Mean |
|---|---|
| 71.4 % | 74.1 % |



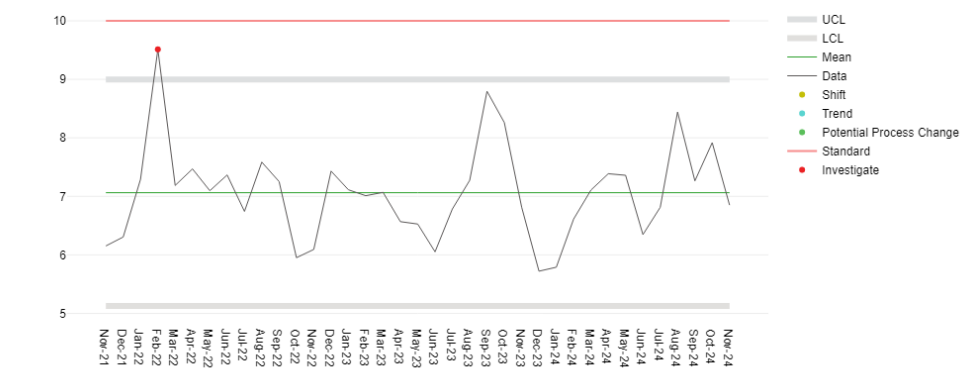

| Latest value | Mean |
|---|---|
| 3.2 % | 1 % |




| Latest value | Mean |
|---|---|
| 8 | 18.44 |

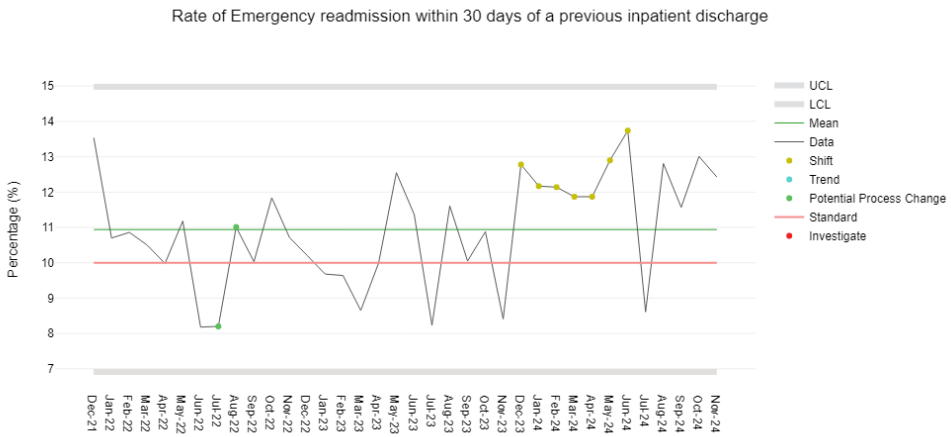



| Latest value | Mean |
|---|---|
| 6.85 | 7.06 |



# Emergency Care Performance - SPC Charts

| Latest value | Mean |
|---|---|
| 12.4 % | 10.9 % |



# 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 again seen a slight decrease to 41.67% (25/62), with 30% being elective which is a drop from the previous month. The biggest cohort this month being in relation to the Robson Criteria group 2a, women who are primigravidae (first time mothers) with single pregnancy, at least 37 weeks' gestation who had an induced labour. 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 2 (7.46%) from Robson Criteria Group 1 which are primigravida women.

Our induction rate remains consistent month on month but has seen a slight decrease in month to 33.33%, but we continue to ensure we are offering induction at the correct gestation due to the presenting clinical picture.

There were three major obstetric haemorrhages in month which was presented to SIRP and good practice identified, we continue to present and discuss all PPH/MOH at weekly risk meeting.

## Escalations

Outcome of which maternity specific EPR system was presented in month, and the process is now being undertaken to commence building the system specific to Jersey Maternity Unit requirements.

A full review of the homebirth service is presently being conducted to ensure it continues to meet the highest standards of safety and care. While the review is ongoing the home birth service will be temporarily suspended. Our maternity web pages have been updated to reflect this.

# Maternity - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Total Births | Maternity Birth Registration Details Report | Indicator is for information only | Total number of babies born (Excludes Miscarriages, Ectopic Pregnancies and Terminations of Pregnancy) |
| 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 flagged as consuming alcohol after delivery | Maternity Smoking & Drinking Details Report | Indicator is for information only | Total number of mothers who were recorded as consuming alcohol after 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

The PPH/MOH tool we now use to review has been uploaded on to our Datix system so we can ensure we are able to identify good practice and learning. This will make this an ongoing audit into 2025 as a Quality Improvement initiative, so we continue to capture themes, or any learning required.

# Mental Health

## Section Owner

Director Adult Mental Health & Social Care

## Performance Narrative

There has been a reduction in month on people waiting for JTT psychological therapy assessment (1.1% waiting more than 90 days) and number of people waiting over 18 weeks for treatment (39%). Other mental health access targets (both crisis and routine assessment) continue to be exceeded.

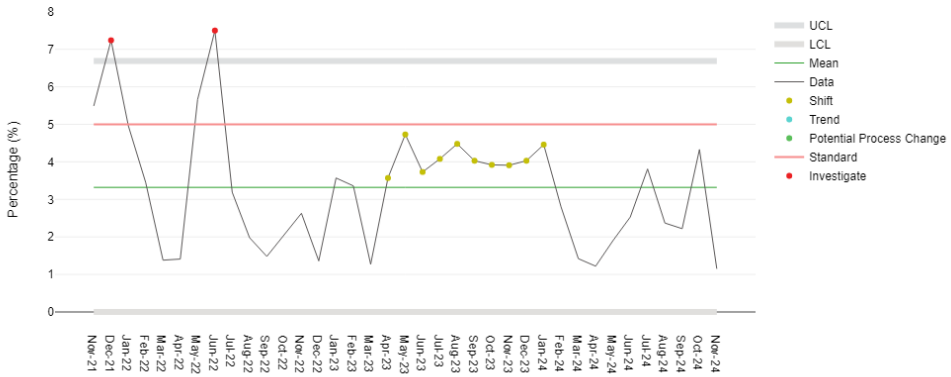
This month has seen an increase in waiting times for autism assessment (due to staffing changes in the service) and ADHD assessment

## Escalations

# Mental Health - SPC Charts

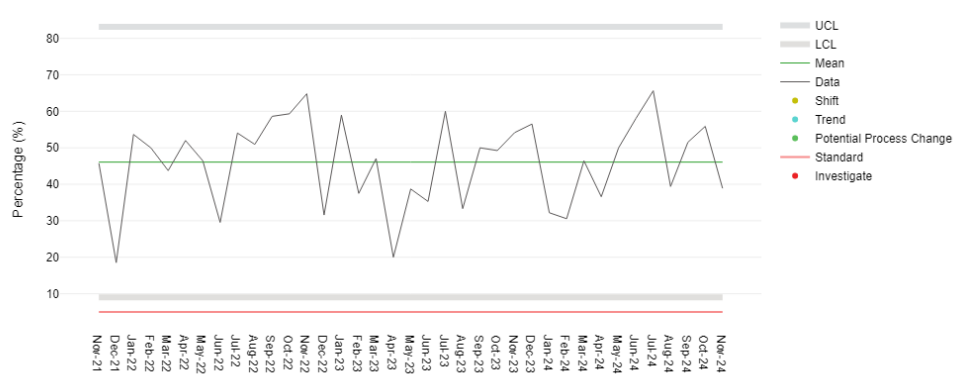
| Latest value | Mean |
|---|---|
| 1.1 % | 3.3 % |

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



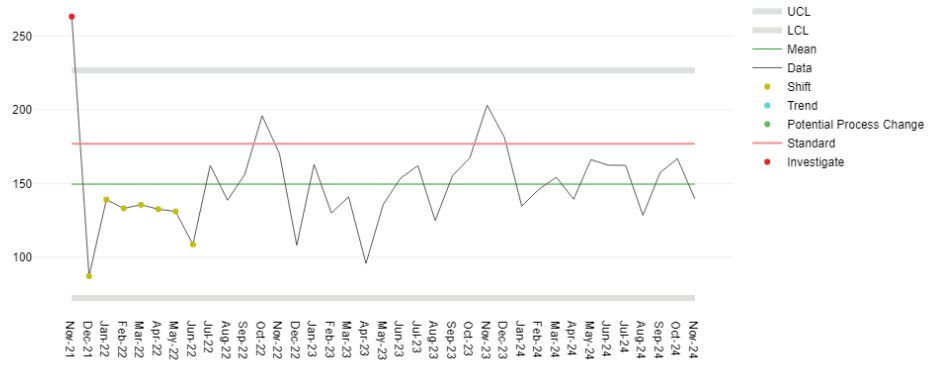

| Latest value | Mean |
|---|---|
| 38.9 % | 46.1 % |

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



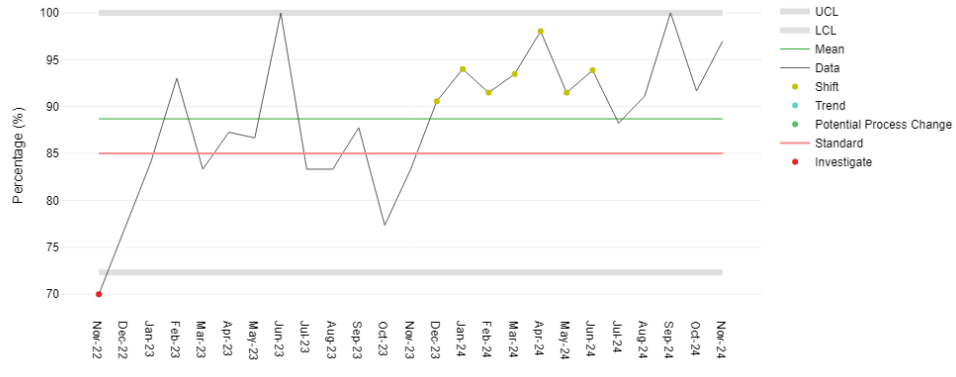

| Latest value | Mean |
|---|---|
| 139.67 | 149.51 |

JTT Average waiting time to treatment (Days)




| Latest value | Mean |
|---|---|
| 97 % | 88.7 % |

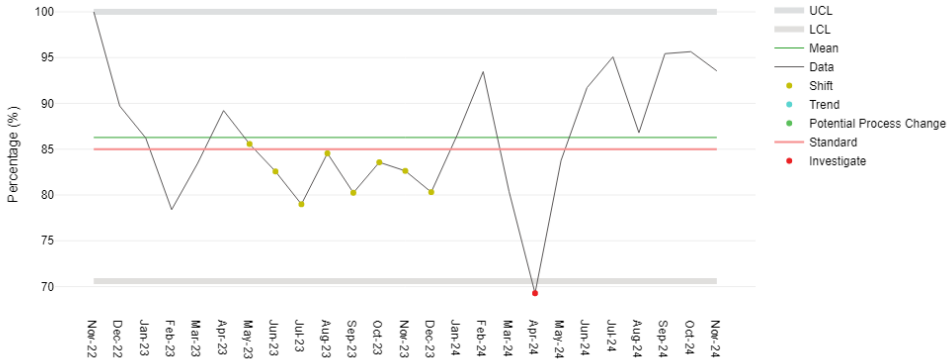
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



# Mental Health - SPC Charts

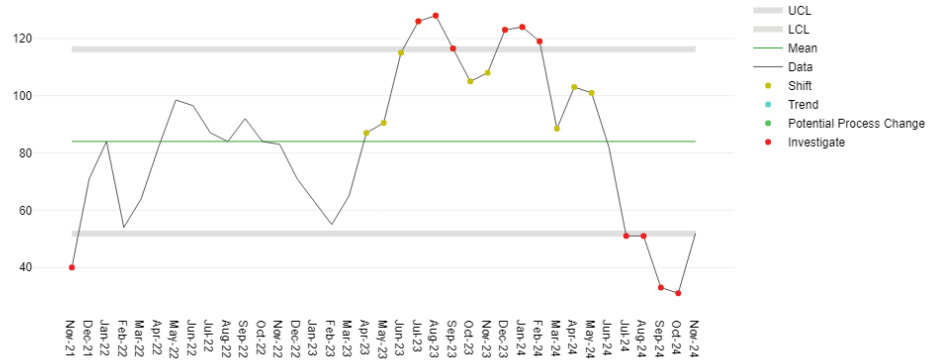
| Latest value | Mean |
|---|---|
| 93.5 % | 86.3 % |

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



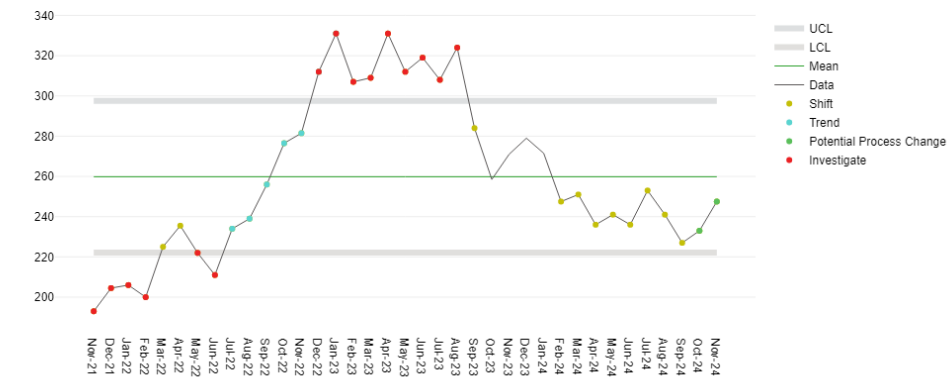

| Latest value | Mean |
|---|---|
| 52 | 84.01 |

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



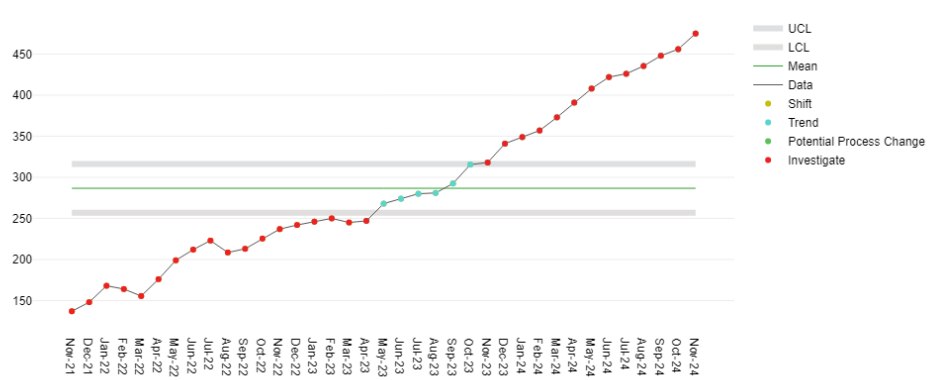

| Latest value | Mean |
|---|---|
| 247.5 | 259.84 |

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




| Latest value | Mean |
|---|---|
| 475 | 286.68 |

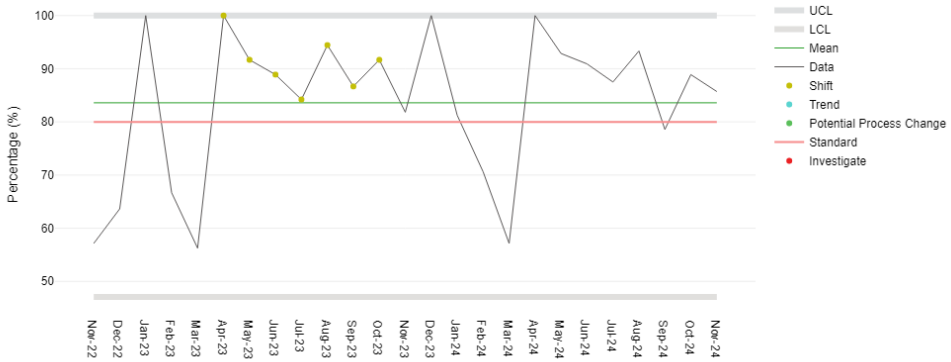
Median wait of clients currently waiting for ADHD Assessment (Days)



# Mental Health - SPC Charts

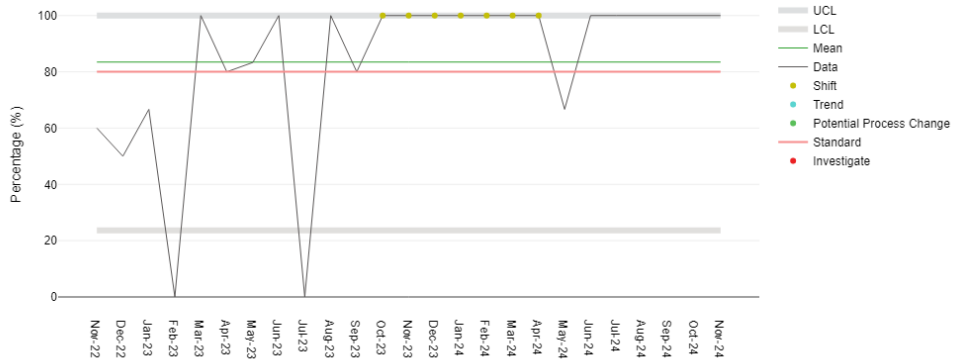
| Latest value | Mean |
|---|---|
| 85.7 % | 83.6 % |

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




| Latest value | Mean |
|---|---|
| 100 % | 83.5 % |

% 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 | PCMIS | 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 | PCMIS | 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) | PCMIS | 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 | Agreed locally by Care Group Senior Leaders | 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 |
| % of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days | Hospital Electronic Patient Record & Community services electronic client record | 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 & Community services electronic client record | 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

Percentage of Learning Disability Clients with a health check in the last 12 months has increased for a second month, and remains above target.

Percentage of assessments completed and authorised within 3 weeks (ASCT) saw a dramatic decline in earlier months. This is due to a complex set of circumstances in July, August and September which led to a shortage of available authorisers. Whilst below target this is now increasing following a deep dive and return to work of authorising staff. It is anticipated that this will continue to improve, and is being overseen by the Social Care Leadership Team

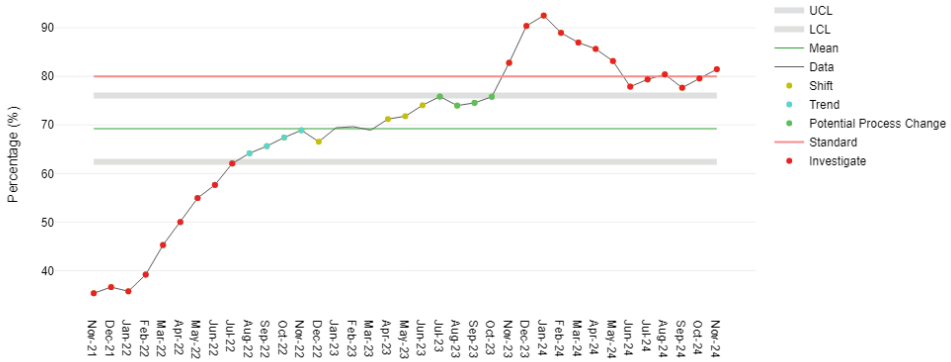
## Escalations

No escalation required

# Social Care - SPC Charts

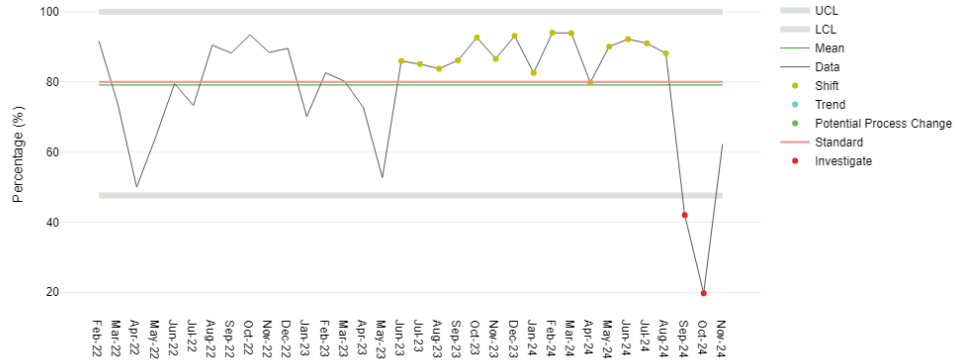
| Latest value | Mean |
|---|---|
| 81.5 % | 69.2 % |

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




| Latest value | Mean |
|---|---|
| 62.3 % | 79.1 % |

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 |

# Social Care

## Additional Commentary / Deep Dive

Deep dive completed as described above.

# Quality & Safety

## Section Owner

Medical Director / Chief Nurse

## Performance Narrative

Pressure Ulcer

In November, two category 3 pressure ulcers were reported as acquired in care:

* One progressed from a deep tissue injury.

* One developed under a plaster cast.

Both are resolving with ongoing treatment, reflecting effective clinical management.

Hospital Admission with Pre-Existing Pressure Ulcers (1): It is encouraging to note that only one patient was admitted in November with a Category 2 pre-existing pressure ulcer. With risk interventions, one ulcer resolved while the other progressed to Category 4, highlighting the complexities of managing pressure ulcers.

The tissue viability team remains committed to proactive prevention, timely intervention, and patient-centred care. All cases are reviewed at the monthly Pressure Ulcer meeting to identify learning and implement actions for continuous improvement.

Infection Prevention & Control Update

Healthcare associated Infections:

There were zero cases of MRSA/MSSA E. coli or Pseudomonas bacteraemia's during November with one case of C Diff reported. The root cause analysis (RCA) did not identify any hospital cross infection, antimicrobial prescribing being defined as the cause. In readiness for the increased seasonal activity an intensive programme of cleaning has been implemented across the clinical wards

Patient Experience Report

Complaints

In November, 18 new complaints were received across Health and Community Services. Each complaint was systematically categorised to support efficient tracking, prompt resolution, and the identification of potential trends for improvement. No consistent themes or specific areas of concern were noted. This structured approach ensures a timely response, with each complaint assigned to the relevant department for investigation and resolution, aligning with our commitment to continuous quality improvement and excellence in patient care.

# Quality & Safety

Compliments

In November 2024, 114 compliments were logged in the Datix system, a substantial increase from the 74 compliments recorded in November 2023. This positive trend reflects our teams' dedication to providing high-quality, compassionate care. Collaboration with wards and departments ensures that all patient and family compliments are documented in Datix, providing valuable feedback and well-deserved recognition for staff.

Patient Advice and Liaison Service (PALS)

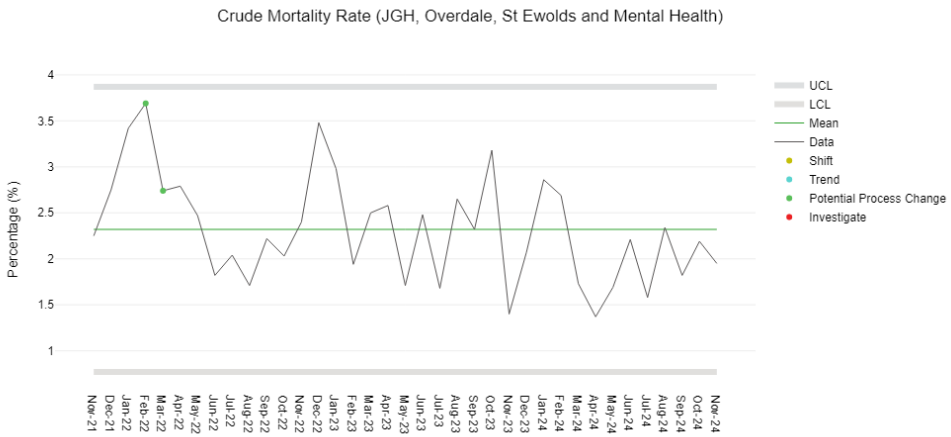
The Patient Advice and Liaison Service (PALS) saw a significant rise in engagement, with 97 logged interactions in November 2024. This growth highlights PALS' effectiveness in supporting more patients and families, promoting open communication, and addressing concerns promptly. The increased interaction levels demonstrate the team's critical role in enhancing patient experience and trust across our services.

Care Concerns - Senior Nurse Practitioner

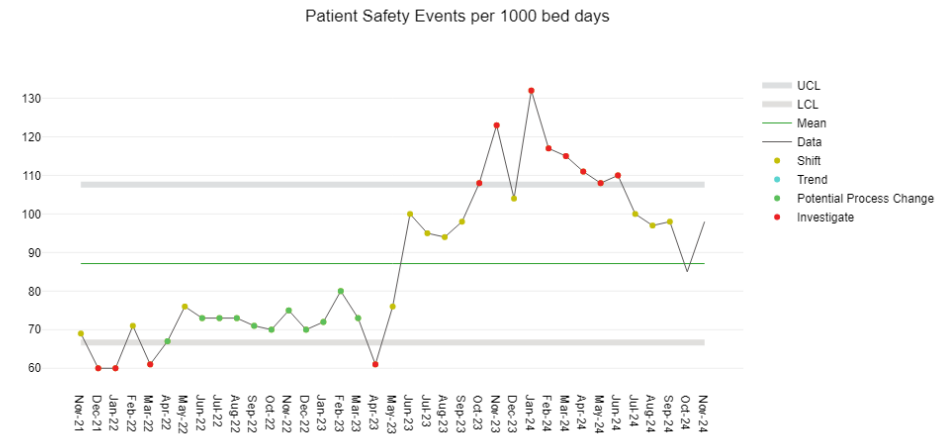
In November 2024, there were 8 new care concerns received and investigated by Patient Experience Team’s Senior Nurse Practitioner. The timely investigation and response enhance confidence and patient experience within our services.

# Quality & Safety - SPC Charts

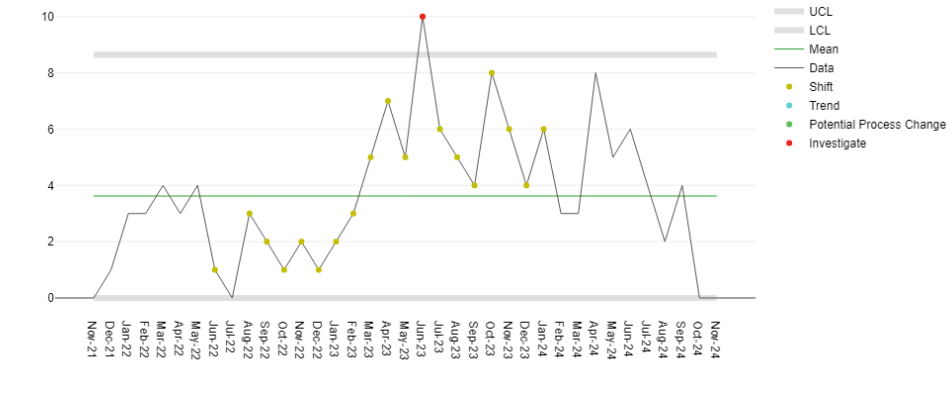
| Latest value | Mean |
|---|---|
| 2 % | 2.3 % |



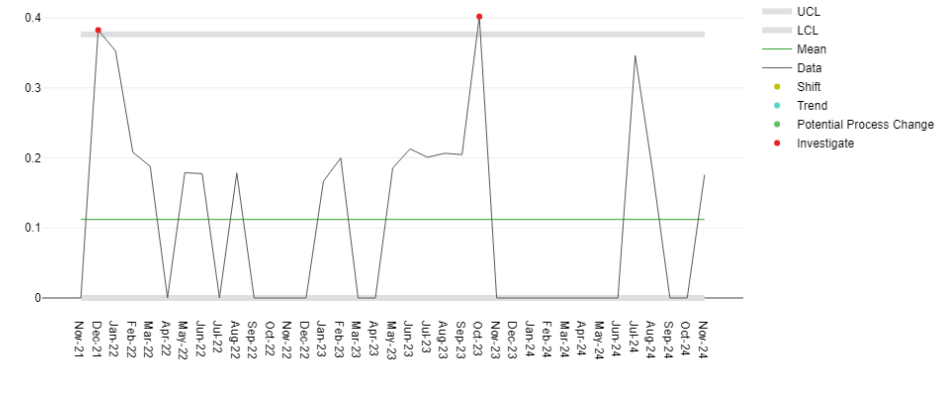

| Latest value | Mean |
|---|---|
| 98 | 87.14 |




| Latest value | Mean |
|---|---|
| 0 | 3.62 |



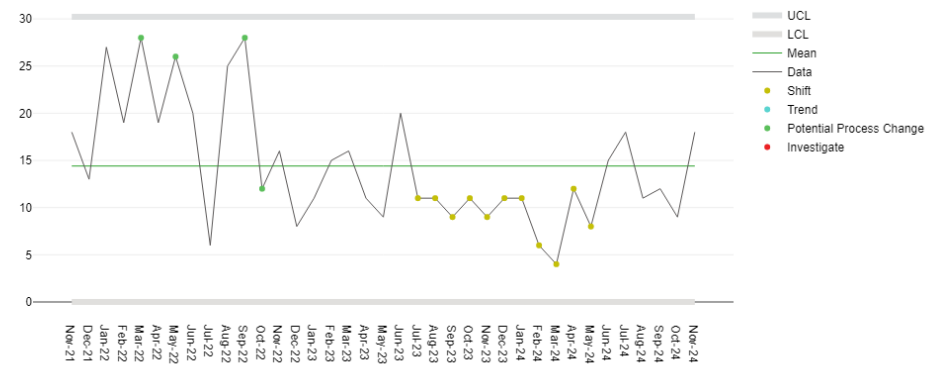

| Latest value | Mean |
|---|---|
| 0.18 | 0.11 |



# Quality & Safety - SPC Charts

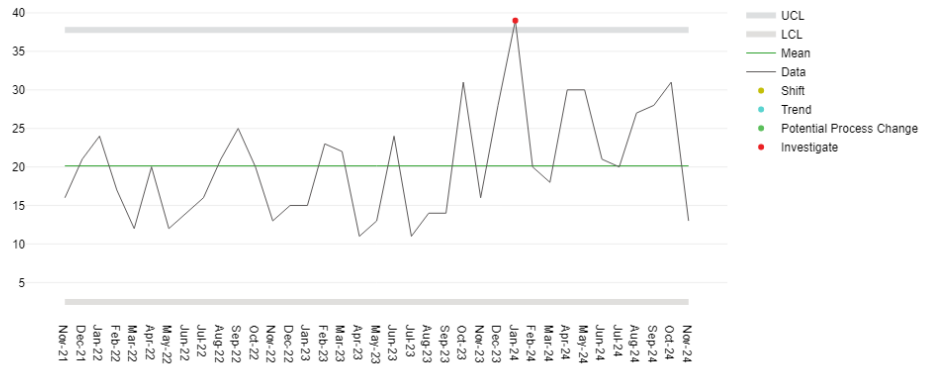
| Latest value | Mean |
|---|---|
| 18 | 14.41 |

Patient safety incidents with moderate/severe harm/death



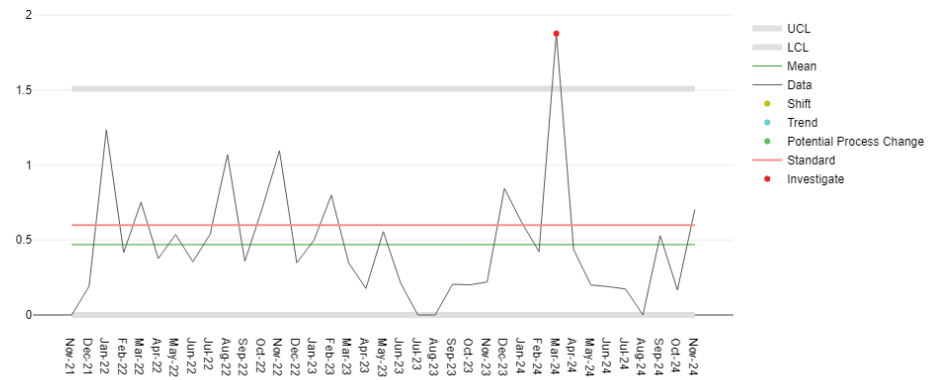

| Latest value | Mean |
|---|---|
| 13 | 20.14 |

Number of pressure ulcers present upon inpatient admission



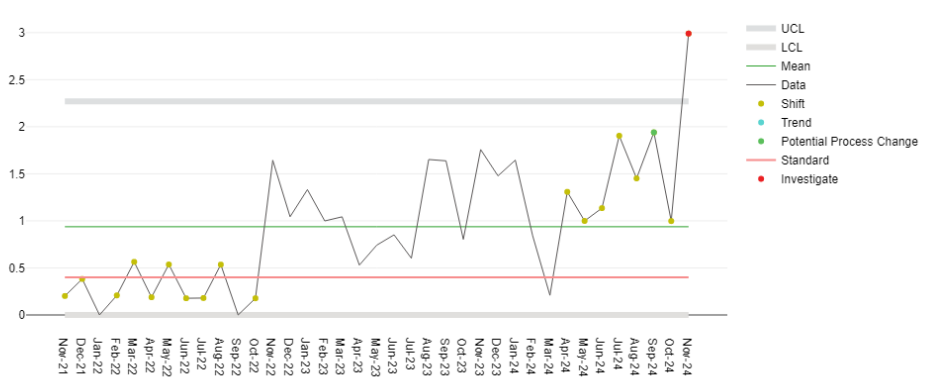

| Latest value | Mean |
|---|---|
| 0.7 | 0.47 |

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



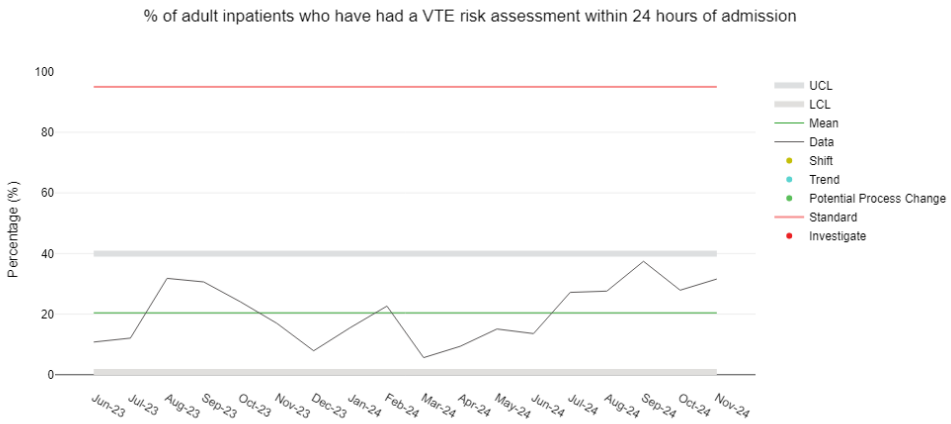

| Latest value | Mean |
|---|---|
| 2.99 | 0.94 |

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

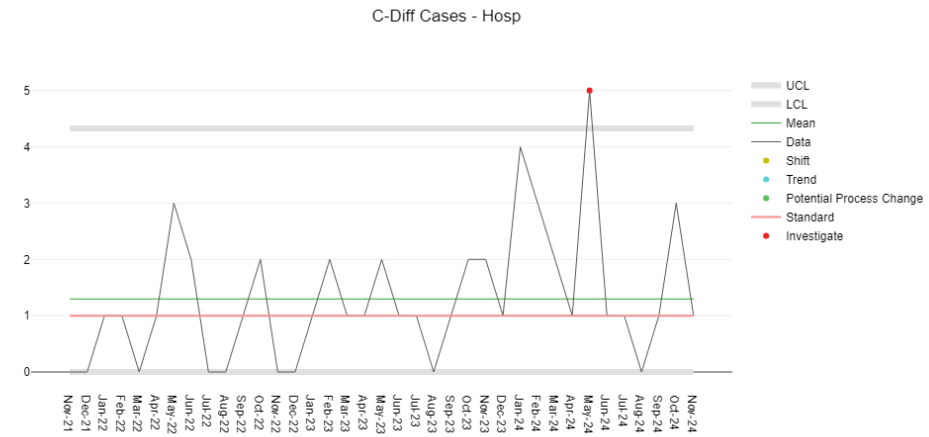


# Quality & Safety - SPC Charts

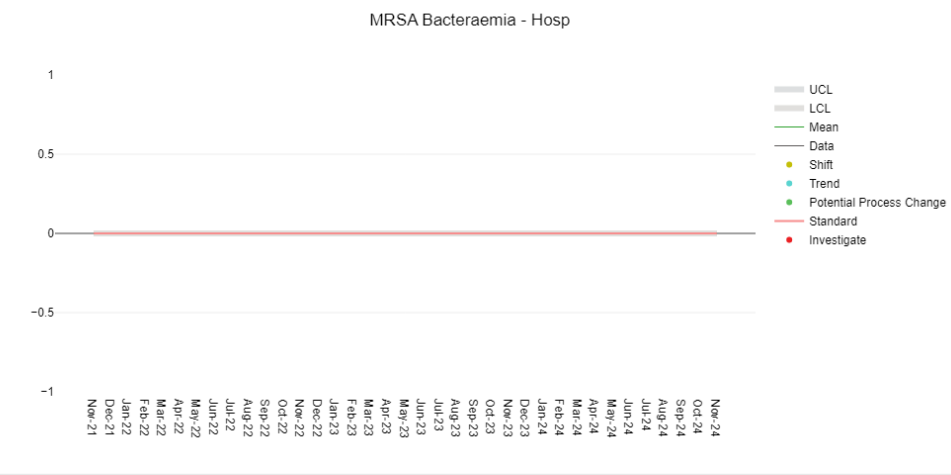
| Latest value | Mean |
|---|---|
| 31.6 % | 20.4 % |



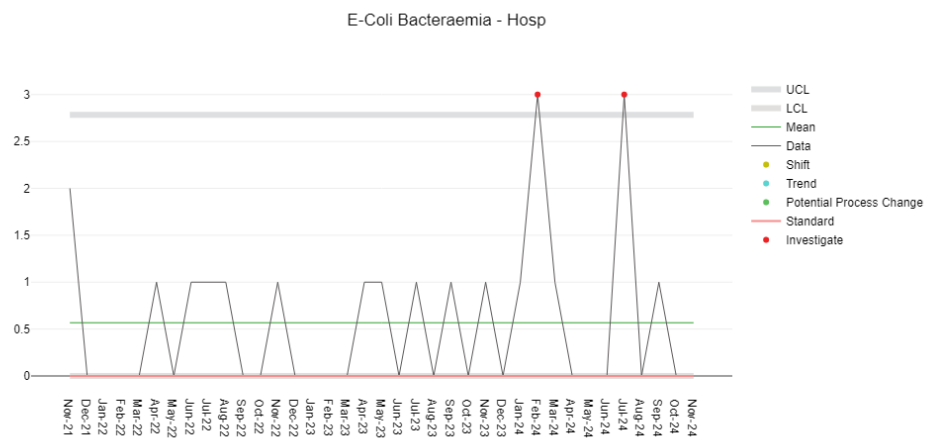

| Latest value | Mean |
|---|---|
| 1 | 1.3 |




| Latest value | Mean |
|---|---|
| 0 | 0 |

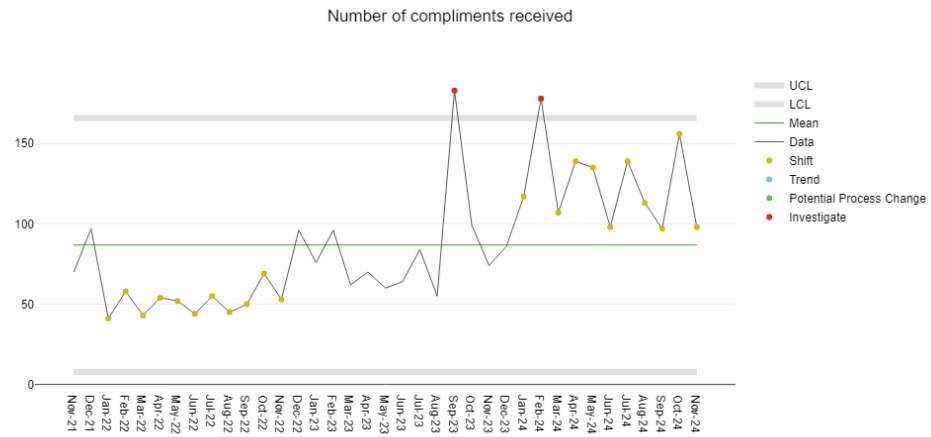



| Latest value | Mean |
|---|---|
| 0 | 0.57 |



# Quality & Safety - SPC Charts

| Latest value | Mean |
|---|---|
| 98 | 86.84 |




| Latest value | Mean |
|---|---|
| 18 | 28.22 |

# 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" |