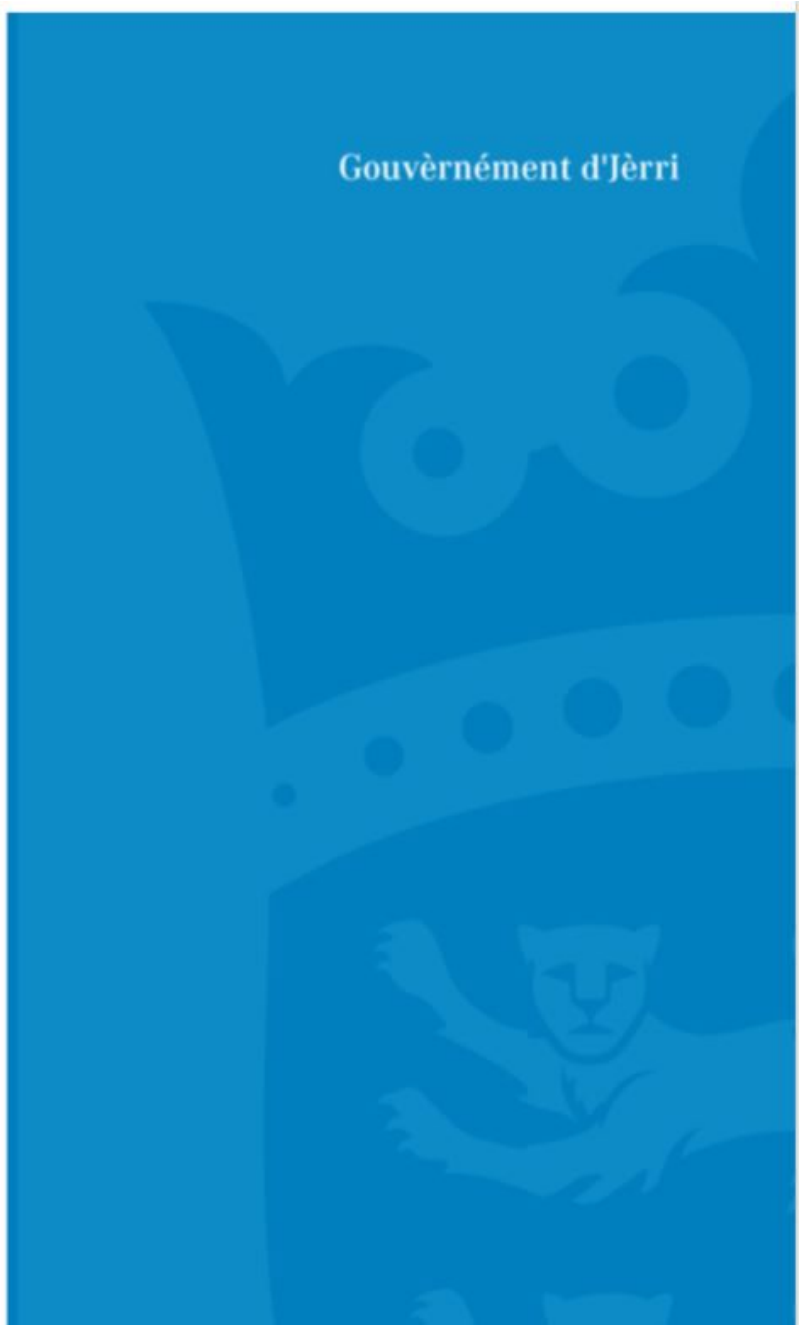
Health and Community Services

Quality and Performance Report
January 2024



Health and Community Services

INTRODUCTION

The Quality and Performance Report (QPR) is the reporting tool providing assurance and evidence that care groups are meeting quality and performance across the full range of HCS services and activities. Indicators are chosen that are considered important and robust to enable monitoring against the organisations strategic and operational objectives.

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

SPONSORS:

Interim Chief Nurse - Jessie Marshall
Medical Director - Patrick Armstrong
Chief Operating Officer - Acute Services - Claire Thompson
Director Mental Health & Adult Social Care - Andy Weir

DATA:

HCS Informatics

Health and Community Services

STATISTICAL PROCESS CONTROL (SPC) CHARTS

WHAT ARE SPC CHARTS?

A statistical process control system (SPC) is a method of controlling a production 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.
Target		In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.
Investigate		Points which fall outside the grey lines (control limits) are unusual and should be investigated. They represent variations beyond what is considered normal. This does not necessarily reflect deteriorating performance.

Elective Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

Patients waiting over 52 weeks to a first outpatient appointment

Of the 668 patients waiting over 52 weeks for a first appointment:

* Ophthalmology 181pts – long wait cataract patients waiting for treatment off Island

* Dermatology 100pts – Service review being undertaken

* Clinical Genetics 95pts – being managed through an SLA with Guys & Thomas's

All over 52-week referrals are being actively managed to ensure compliance with the 2024 QPR standards

Patients waiting over 52 weeks on elective waiting list

Of the 321 patients waiting over 52 weeks on the elective inpatient list, 248 are in the process of receiving a date for procedure or clinical review.

The current over 52 weeks are:

* General Surgery 130 with 108 requiring TCI date

* Orthopaedics 126 with 101 requiring a date

* ENT 36 with 27 requiring a date

All patients are being actively managed to ensure compliance with 2024 QPR standards.

Access to Diagnostics over 6 weeks

Access to diagnostics tests in line with the DM01 standards requires improvement as we assess performance to this new measure. Further work will be required to describe the resource implication of achieving this. However, following the success of the MRI WLI initiative and the ongoing endoscopy initiative, other schemes will be developed and implemented to support DM01 compliance. This will be undertaken in conjunction with the private patient workstream due to the intrinsic links and benefits the private patient income can support the overall public waiting list position.

New to Follow-up Ratio

As clinician job plans and review of capacity and demand commence for 2024, standardised new to follow-up ratios will be identified within specialties. This continues to be a development area.

Outpatient DNA and Was Not Bought Rates

The DNA and WNB rates are significantly above the target of 8%. A review of these metrics will be undertaken over the coming months as part of the overall outpatient improvement programme.

Operations cancelled by Hospital for Non-Clinical Reasons

There is currently a mixture of non-clinical reasons why patients are being cancelled on their day of procedure. These fall into two:

* No bed available

* Patients not adequately communicated with

The theatre improvement programme will support the reduction in on the day cancellations. Plans are in their infancy and being managed by the FRP team

Escalations

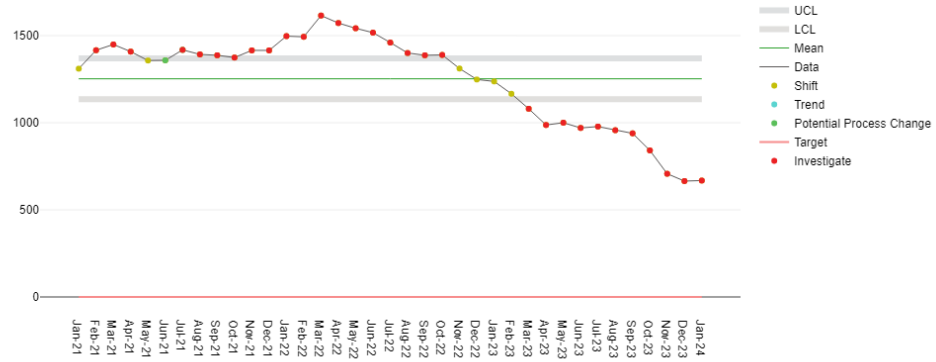
Actions to recover > 52 weeks standard described in waiting list paper.

Funding provided as part of Waiting List Initiative business to address.

Elective Care Performance - SPC Charts

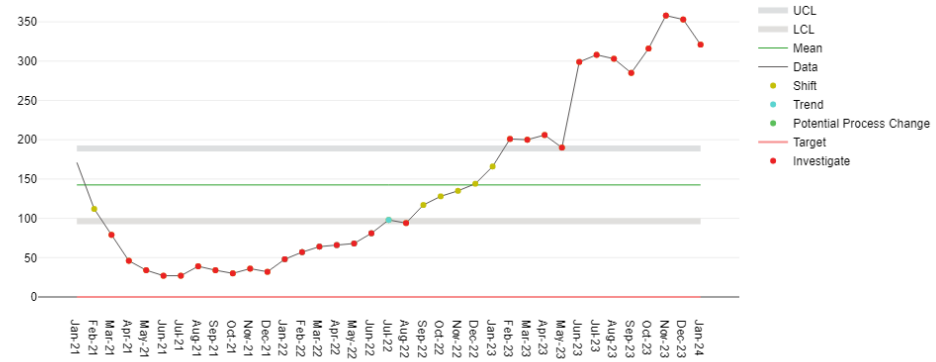
Latest value	Standard
668	<499

Patients waiting for first outpatient appointment Greater Than 52 weeks



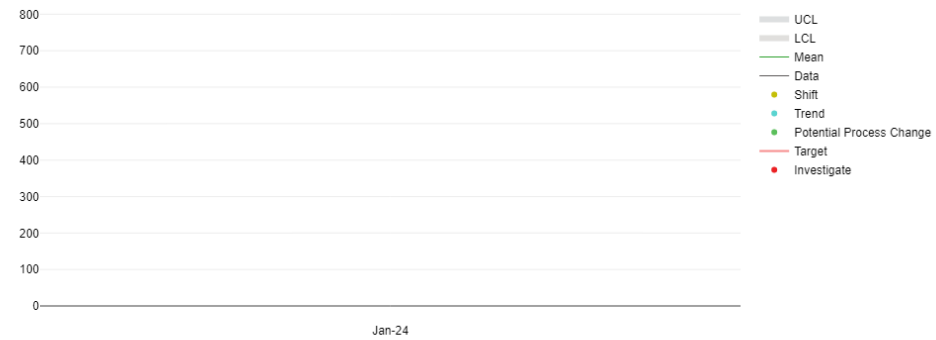
Latest value	Standard
321	<265

Patients on elective list Greater Than 52 weeks



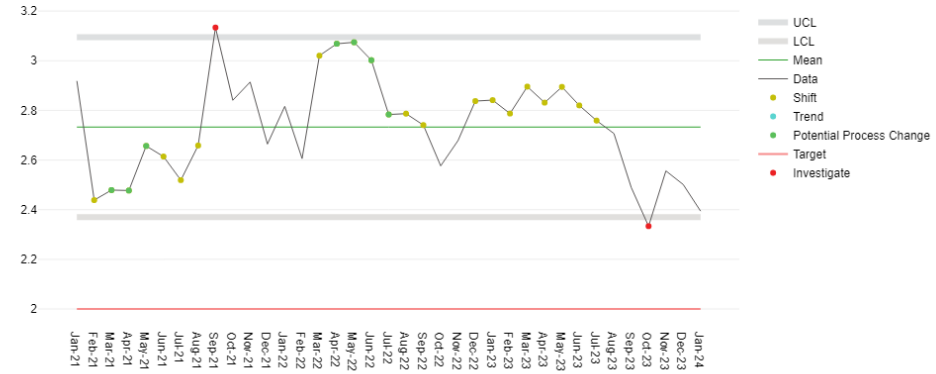
Latest value	Standard
782	<525

Access to diagnostics Greater Than 6 weeks



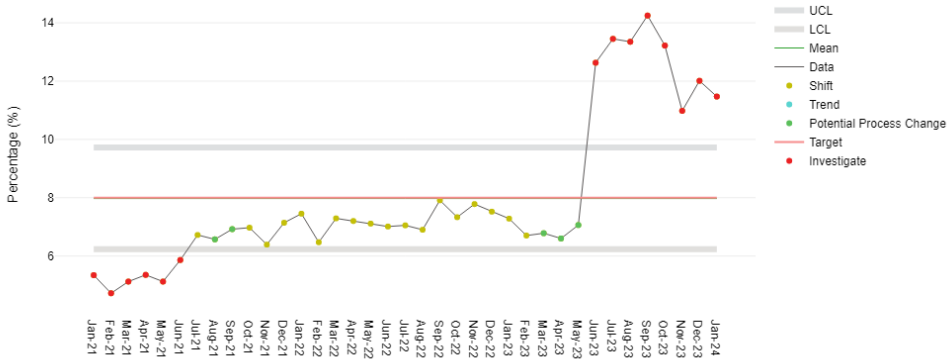
Latest value	Standard
2.39	2

New to follow-up ratio

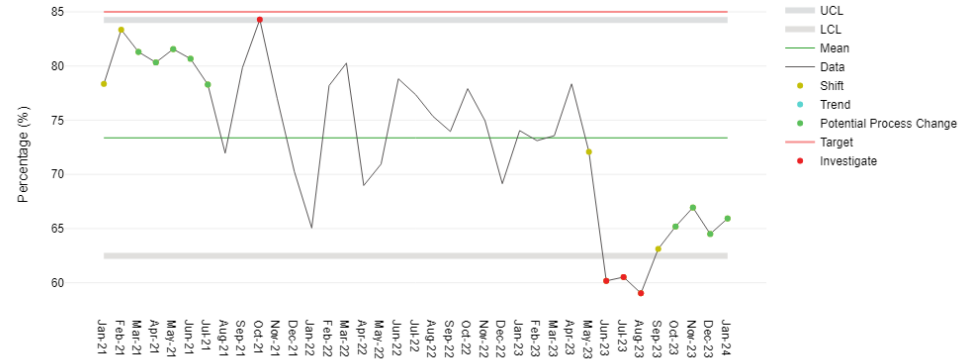


Elective Care Performance - SPC Charts

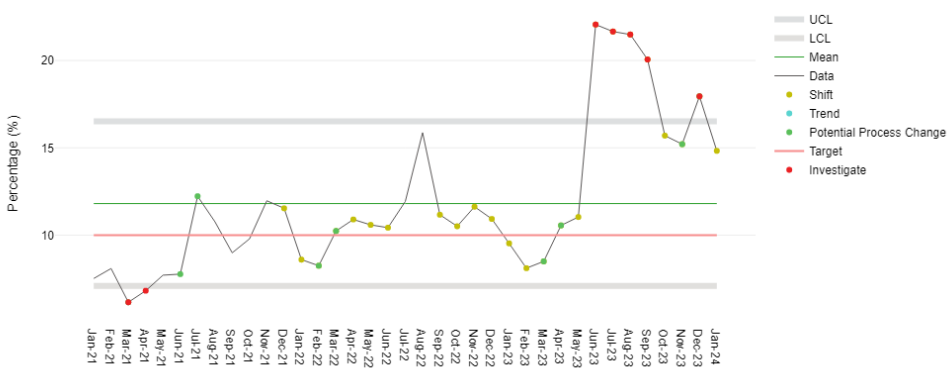
Latest value	Standard
11.5 %	<=8%



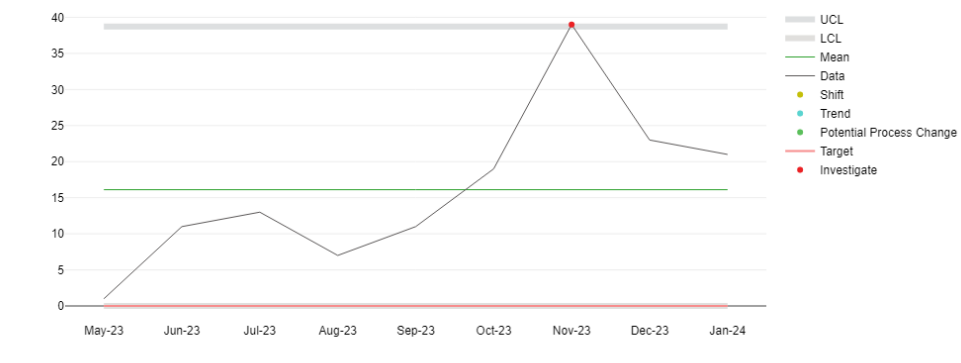
Latest value	Standard
65.9 %	>85%



Latest value	Standard
14.8 %	<=10%



Latest value	Standard
21	Not applicable



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), Cris report)	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. Diagnostic investigatations included are 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.
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))		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 based on average (mean) of previous two years' data	Percentage of JGH/Overdale public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale public outpatient appointments where the patient did not attend. Denominator: Number of all attended and unattended appointments. Under 18 year old patients only. All specialties included. 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

Health & Community Services has introduced the 4 hour Emergency Department Standard for 2024 to drive patient experience and operational improvements. We are now able to ascertain performance against this (75%) and will develop further action plans to steadily increase performance. Actions are already in place from some of the associated FRP work streams, and the additional capacity opened on February 19th and service developments in ED & AAU/SDEC are all contributing to this metric.

An increase in delayed transfer of care bed days has been noted through the winter period, there is correlation between previous years showing heightened delays occurring during the winter period. However as evidenced at the weekly DTOC meeting, a positive impact is being seen in package of care availability. A discharge to assess proposal is being developed which will see patients move into an alternative care facility to enable an appropriate assessment to take place outside of hospital.(In May 2023 is due to the change in systems with actions taken recently settling the reporting of this metric.)

Acute length of stay for January is 5.8 days remaining within the target indicator of 10 days. Introduction of the Red2Green initiative further aims to reduce length of stay through identification of delays and supporting to expedite through the HCS Operations Centre. An improvement in in readmissions has been noted for January 2024 however remains above the target threshold. A re-admissions review process is being introduced by the end of Q1 to enable themes and learning to be identified.

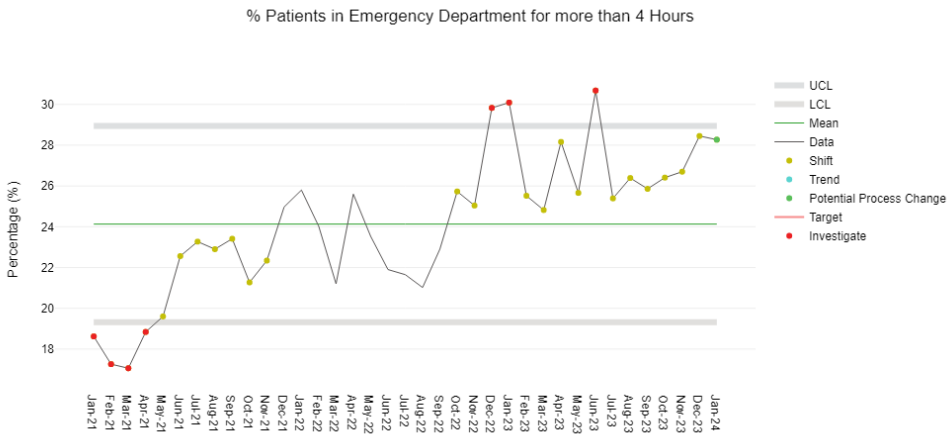
Non clinical transfers will be positively impacted by additional capacity being opened on the 19th February

Escalations

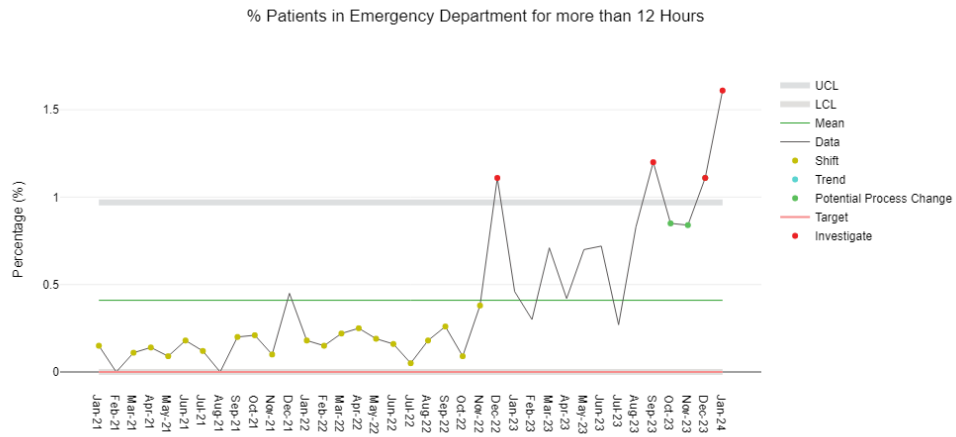
Introduction of 4-hour standard is below target indicator, to support achieving the quality indicator internal professional standards will be developed for the Emergency Department which may impact on demand and capacity within other clinical services to achieve assessment within required timescales.

Emergency Care Performance - SPC Charts

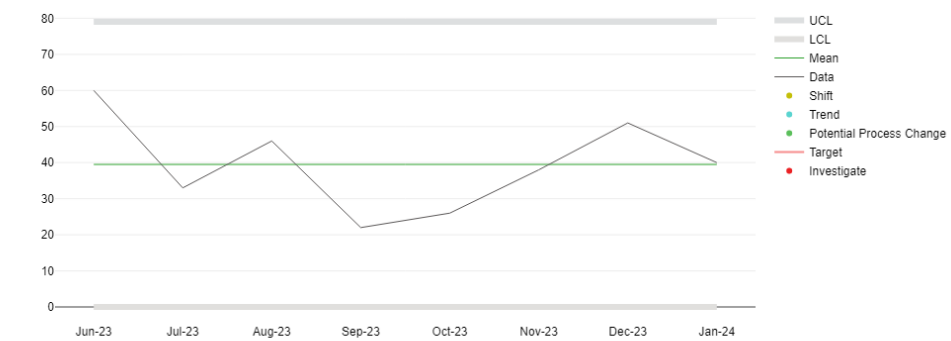
Latest value	Mean
28.3 %	24.1 %



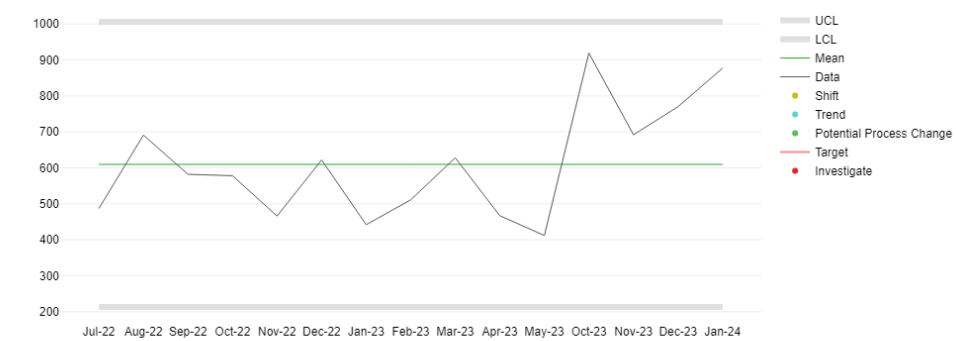
Latest value	Mean
1.6 %	0.4 %



Latest value	Mean
40	39.5



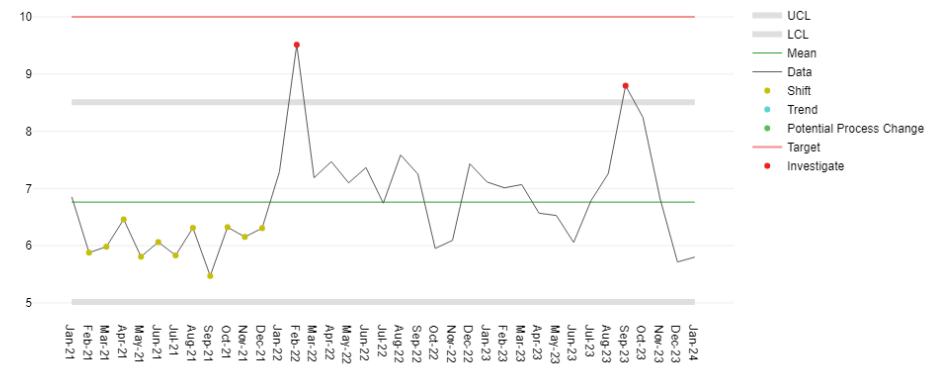
Latest value	Mean
877	609.6



Emergency Care Performance - SPC Charts

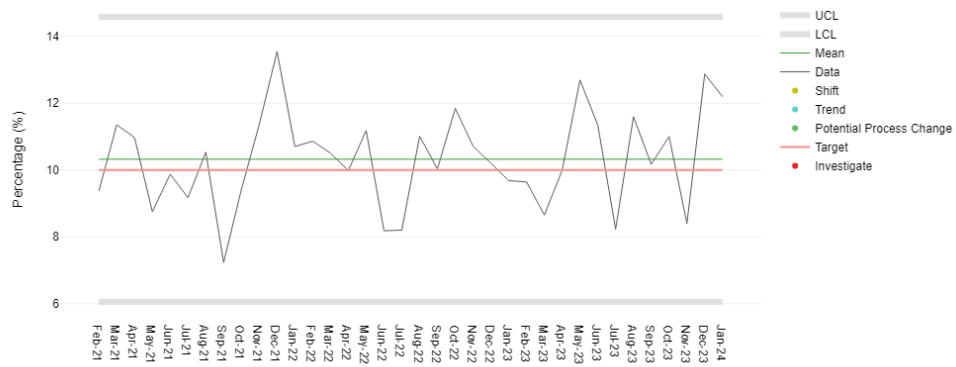
Latest value	Mean
5.8	6.76

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



Latest value	Mean
12.2 %	10.3 %

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 more than 4 Hours	Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM))		Percentage of patients in the Emergency department for more than 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))		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.
Total Bed Days Delayed Transfer Of Care (DTOC)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Not Applicable	Count of bed days where the patient is marked as Delayed Transfer Of Care (DTOC) 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. 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

Further development of the maternity dashboard has been completed to enable us to have better oversight and to monitor the implementation of principles of clinical governance 'on the ground'. It will be used to benchmark activity and monitor performance against the standards agreed locally for the maternity unit monthly.

Escalations

Support with data quality and integrated care pathways (ICP) where individuals have more than ICP. Data cleansing has commenced to ensure no duplication. Implementation of a maternity specific EPR system to enable better capturing of data; options being reviewed at present.

Maternity - Key Performance Indicators

Indicator	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	YTD
Total Births	77	60	68	59	68	53	77	71	64	60	65	59	63	63
Mothers who have given birth once (Primips)	32	25	31	36	38								19	19
Mothers who have given birth more than once (Multips)	45	35	37	23	25								6	6
Bookings ≤10+0 Weeks													7	7
% of women that have an induced labour	14.29%	26.67%	20.59%	23.73%	35.29%	22.64%	19.48%	28.17%	28.13%	18.33%	29.23%	35.59%	30.16%	30.16%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	33	30	31	20	16	21	25	23	22	20	18	11	24	24
Number of Instrumental deliveries	7	10	5	9	8	5	5	12	4	6	5	4	7	7
% deliveries by C-section (Planned & Unscheduled)	50.65%	33.33%	36.76%	44.07%	54.41%	33.96%	44.16%	45.07%	37.5%	45%	49.23%	44.07%	36.51%	36.51%
Scheduled C-section rate	27.27%	16.67%	20.59%	23.73%	26.47%	24.53%	19.48%	22.54%	21.88%	18.33%	26.15%	27.12%	23.81%	23.81%
Number of Emergency Caesarean Sections at full dilatation	5	2	1	1	1	1	0	1	1	1	2	0	2	2
Number of deliveries home birth (Planned & Unscheduled)	6	3	8	5	3	4	2	4	2	3	3	0	2	2
Transfer of Mothers from Inpatients to Overseas	0	1	2	1	1	0	0	0	0	0	2	1	0	0
Number of births in the High dependency room / isolation room						1	0	0	1	0	0	0	1	1
Number of PPH Greater Than 1500mls	4	2	3	3	10	2	3	2	3	6	6	3	2	2
Number of 3rd & 4th degree tears – all births	0	1	1	0	0	2	1	1	2	2	1	0	2	2
Number of babies that have APGAR score below 7 at 5 mins	0%	0%	100%	100%	100%	0%	0%	0%	100%	0%	100%	0%	0%	0%
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	3.23%	3.92%	3.7%	1.79%	5.45%	0%	0%	2.7%	2.7%	4.35%	4.88%	6.9%	0%	0%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation		1	4	2							2	2		
Transfer of Neonates from JNU	0	0	0	0	0	0	1	0	0	0	1	1	1	1
Preterm Births ≤36+6 Weeks	10	6	9	2	7	0	6	2	2	8	1	2	1	1

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Total Births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Not Applicable	Total number of births of any outcome. Includes live and stillbirth.
Mothers who have given birth once (Primips)	Maternity Birth Registration Details Report	Not Applicable	Total number of births of any outcome to first-time mothers. Includes live and stillbirth.
Mothers who have given birth more than once (Multips)	Maternity Birth Registration Details Report	Not Applicable	Total number of births of any outcome to mothers who have given birth at least once before. 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	Set to Not Applicable in line with the latest guidance from NHS/NICE	Number of c-sections, planned and unplanned, as a percentage of the total number of deliveries.
Scheduled C-section rate	Maternity Delivery Details Report	Not Applicable	Number of scheduled (CAT 3 & 4) c-sections divided by total number of ALL deliveries
Number of Emergency Caesarean Sections at full dilatation	Hospital Electronic Patient Record (TrakCare Deliveries Report (MAT23A) & Maxims Deliveries Report (MT005))	Not Applicable	Number of Emergency Caesarean section births (This includes all Category 1 & 2 Caesarean Sections) where the mother's cervix is fully dilated

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Number of deliveries home birth (Planned & Unscheduled)	Maternity Delivery Details Report	Not Applicable	Number of deliveries recorded as being at "Home", planned and unplanned
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))	Not Applicable	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))	Not Applicable	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
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))	NHS National Value is 1.2%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	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))	Not Applicable	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))	Not Applicable	Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility.
Preterm Births ≤36+6 Weeks	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Not Applicable	Live babies born who were born before 37 weeks (less than or equal to 36+6 gestation)

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

The service continues to achieve the improved access targets, and specifically saw 94% of all crisis referrals within 4 hours this month. The service also continues to achieve the KPI for follow up on discharge from hospital within 3 days, which is a key harm reduction target.

There has been some improvement in people waiting for psychological treatment (JTT) in month, and in the waiting list for autism assessment. However waiting times for ADHD assessment and memory assessment remain a concern.

Escalations

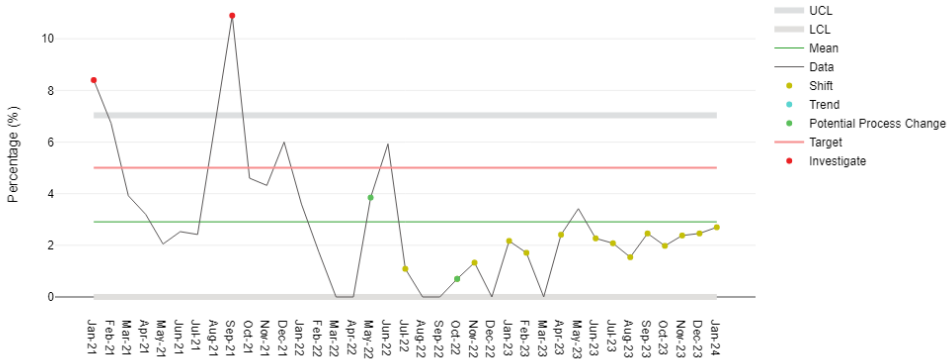
A meeting was held with the Memory Assessment Service in February and an improvement trajectory (with associated actions) has been agreed, which will reduce waiting times from April.

A similar approach is being taken with the ADHD service, although there are a number of factors outside our control (relating to prescribing limitations) which create significant limitations on our ability to impact waiting times currently.

Mental Health - SPC Charts

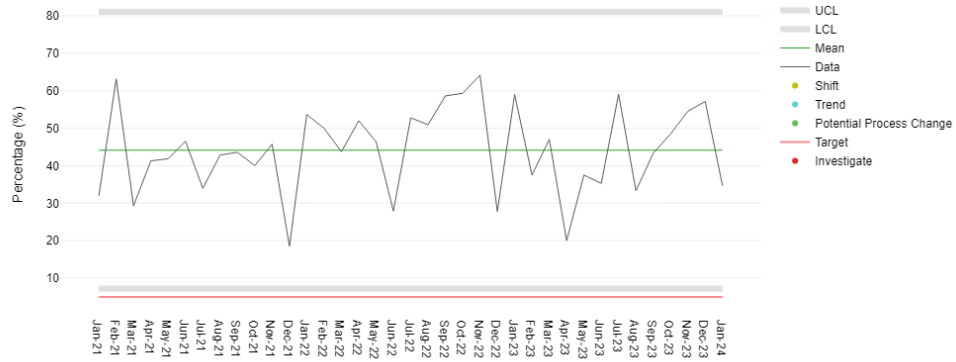
Latest value	Mean
2.7 %	2.9 %

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



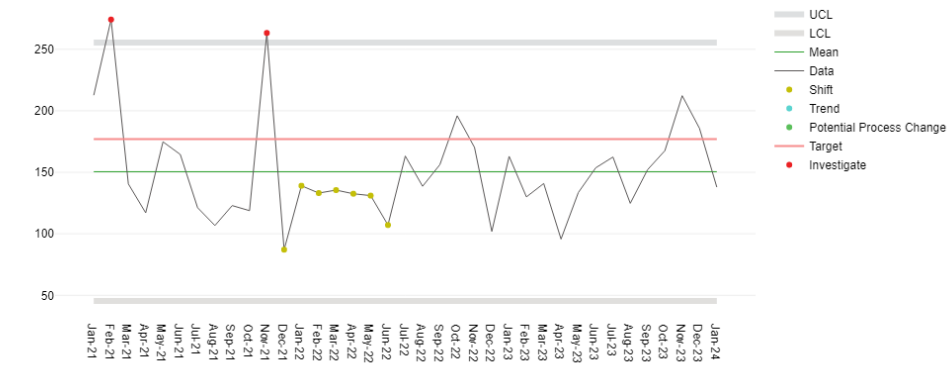
Latest value	Mean
34.6 %	44.1 %

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



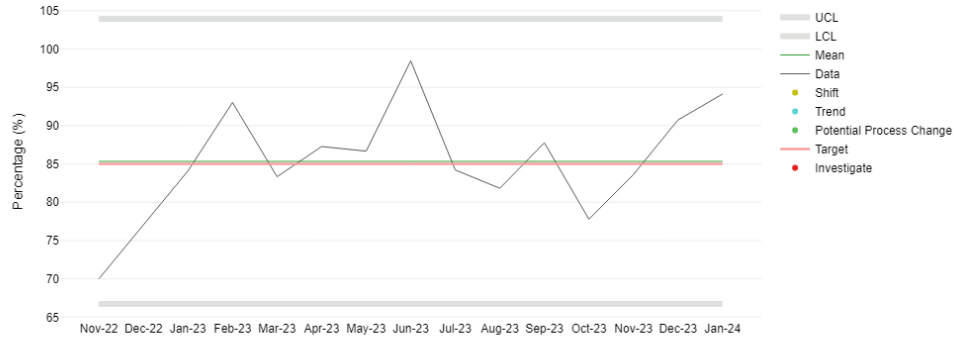
Latest value	Mean
137.94	150.48

JTT Average waiting time to treatment (Days)



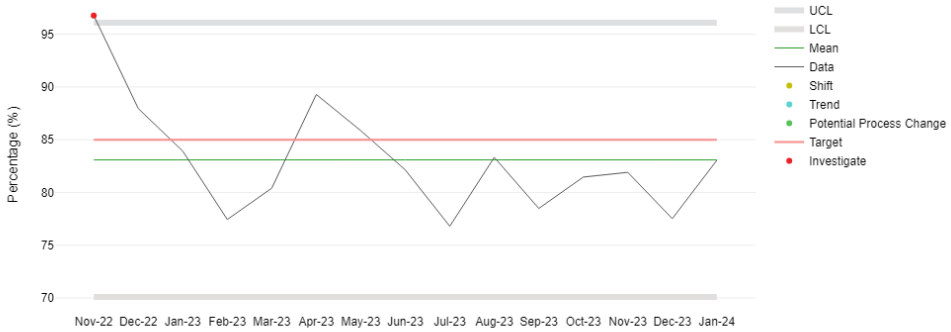
Latest value	Mean
94.1 %	85.3 %

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

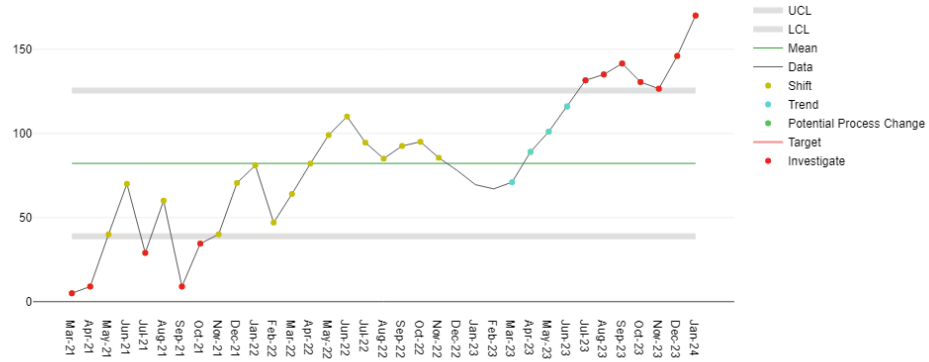


Mental Health - SPC Charts

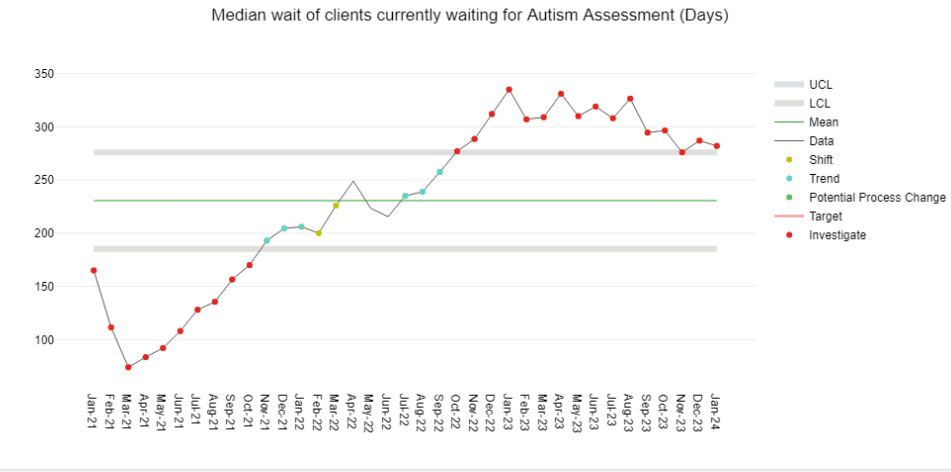
Latest value	Mean
83 %	83.1 %



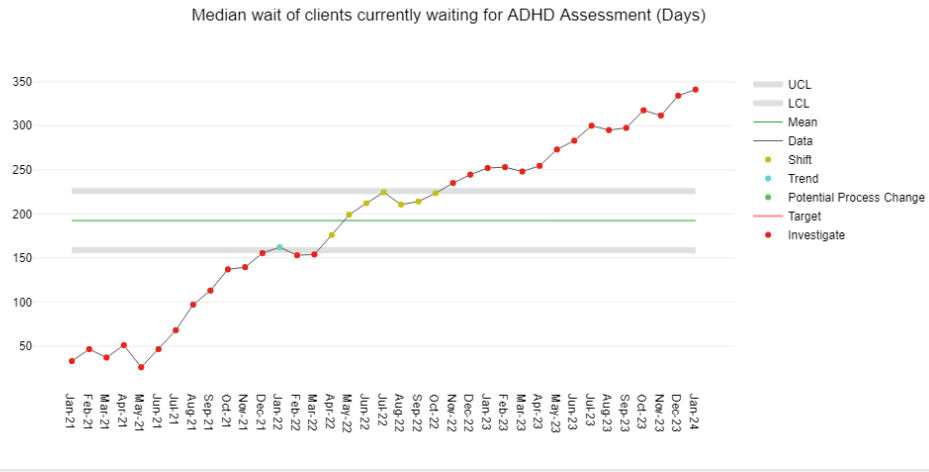
Latest value	Mean
170	82.14



Latest value	Mean
282	230.59



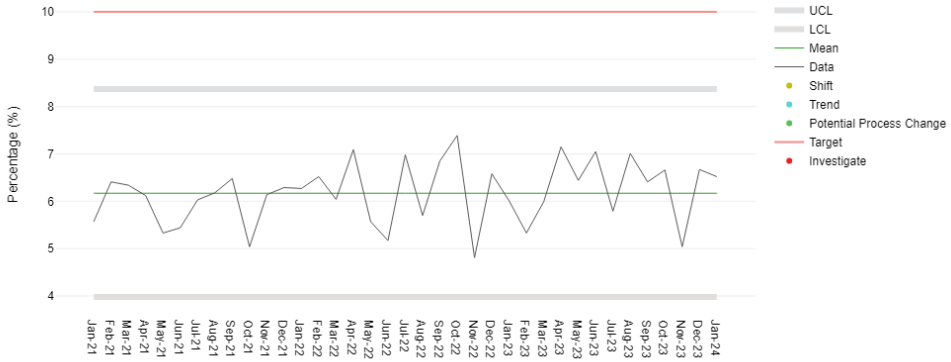
Latest value	Mean
341	192.38



Mental Health - SPC Charts

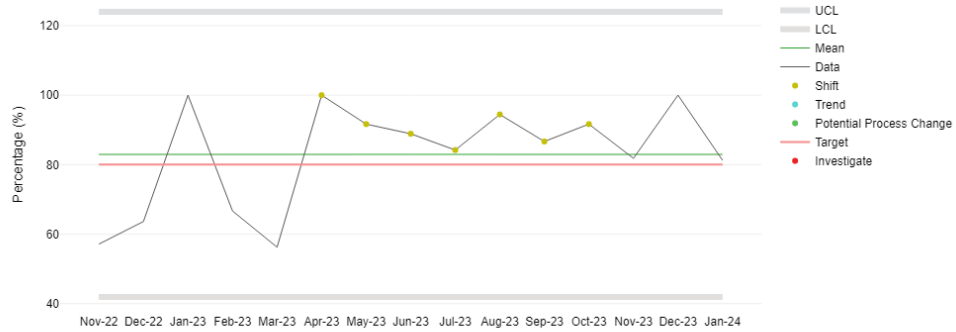
Latest value	Mean
6.5 %	6.2 %

Community Mental Health Team Did Not Attend (DNA) rate



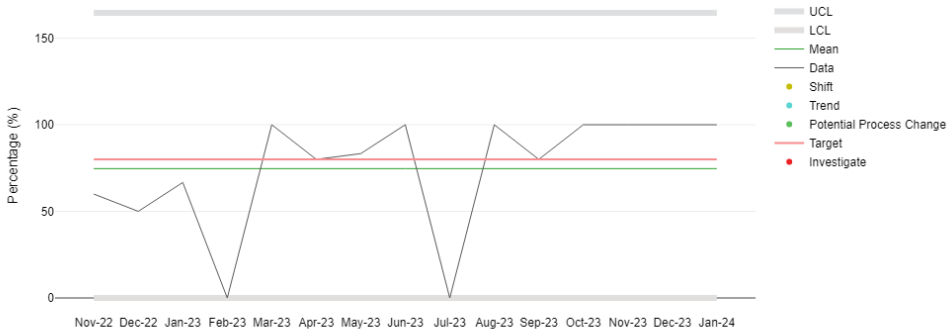
Latest value	Mean
81.3 %	83 %

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



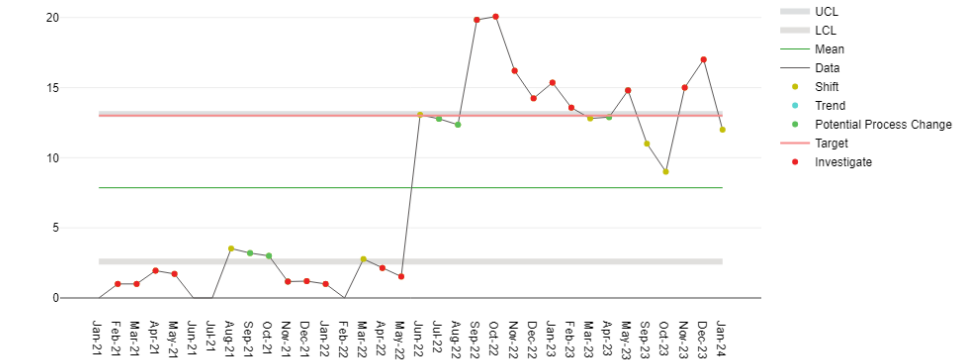
Latest value	Mean
100 %	74.7 %

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



Latest value	Mean
12	7.86

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



Mental Health - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
JTT % of clients waiting for assessment who have waited over 90 days	JTT & PATS electronic client record system	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT clients who have waited over 90 days for assessment, divided by the total number of JTT clients waiting for assessment
JTT % of clients who started treatment in period who waited over 18 weeks	JTT & PATS electronic client record system	Improving Access to Psychological Therapies (IAPT) Standard	Percentage of JTT clients commencing treatment in the perios who had waited more than 18 weeks to commence treatment. Numerator: Number of JTT clients beginning treatment who waited longer than 18 weeks from referral date. Denominator: Total number of JTT clients beginning treatment in the period
JTT Average waiting time to treatment (Days)	JTT & PATS electronic client record system	Generated based on historic percentiles	Average (mean) days waiting from JTT referral to the first attended treatment session
% of referrals to Mental Health Crisis Team assessed in period within 4 hours	Community services electronic client record system	Agreed locally by Care Group Senior Leadership Team	Number of Crisis Team referrals assesed within 4 hours divided by the total number of Crisis team referrals
% of referrals to Mental Health Assessment Team assessed in period within 10 working days	Community services electronic client record system	Agreed locally by Care Group Senior Leadership Team	Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target. Numerator: Number of Assessment Team referrals assessed within 10 working days of referral. Denominator: Total number of Mental Health Assessment Team referrals received
Median wait of clients currently waiting for Memory Service Assessment (Days)	Community services electronic client record system	Not Applicable	Memory Service Assessment Median Waiting times from date of referral to last day of reporting period

Mental Health - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Median wait of clients currently waiting for Autism Assessment (Days)	Community services electronic client record system	Not Applicable	Autism Assessment Median Waiting times from date of referral to last day of reporting period
Median wait of clients currently waiting for ADHD Assessment (Days)	Community services electronic client record system	Not Applicable	ADHD Assessment Median Waiting times from date of referral to last day of reporting period
Community Mental Health Team Did Not Attend (DNA) rate	Community services electronic client record system	Standard based on historic performance	Rate of Community Mental Health Team (CMHT) outpatient appointments not attended. Numerator: Number of Community Mental Health Team (CMHT, including Adult & Older Adult services) public outpatient appointments where the patient did not attend. Denominator: Total number of Community Mental Health Team (CMHT, including Adult & Older Adult services) appointments booked
% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from Mental Health Inpatient Unit with an Adult Mental Health Specialty' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours divided by the total number of discharges from 'Mental Health Inpatient Unit with an Adult Menatl Health Specialty'
% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Admissions Report (ATD5L), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours divided by the total number of discharges from 'Older Adult' units
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

Social Care

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Performance Narrative – Physical Health Check

Steady improvement continues. Achievement has consistently improved in the last year and has continued to exceed the 80% attainment target since November 2023. Achievement due to the concerted efforts of the Learning Disability Nurse Team.

Performance Narrative – ASCT Ax within 3 weeks

Although continuing to exceed the 80% target, noted the downturn in performance in January 2024 compared to December 2023. The cause of this drop in performance was due to temporary reduction in Authorised Registered Person (ARP) capacity. Capacity dropped because of seasonal leave: only one out of three ARPs were available.

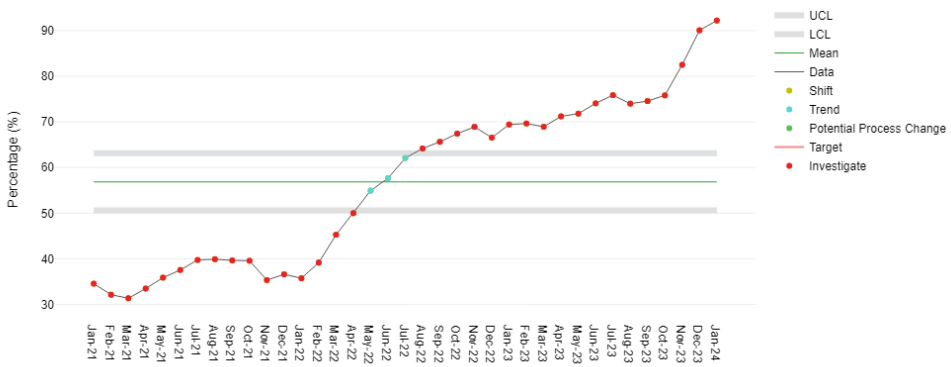
Escalations

Nothing for escalation.

Social Care - SPC Charts

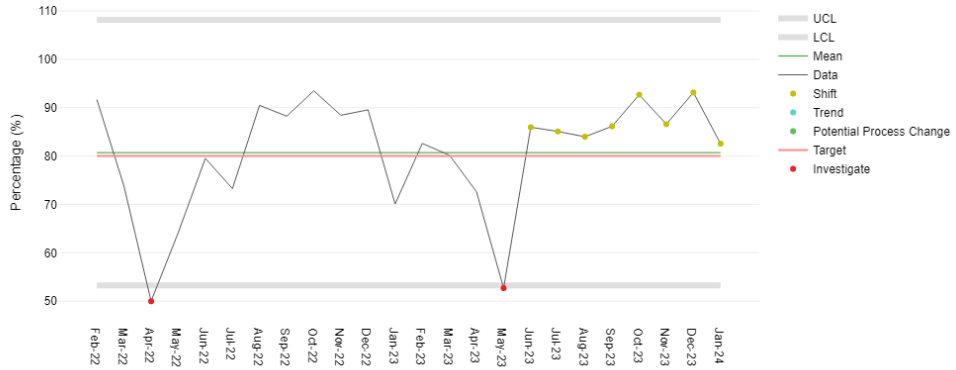
Latest value	Mean
92.2 %	56.9 %

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



Latest value	Mean
82.6 %	80.7 %

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

Pressure Ulcers

There was a reduction in hospital acquired pressure damage in January. Jersey continues to remain below the National average for pressure ulcers in the UK. The team are focused on the early detection of pressure damage to promote early healing and prevented further deterioration.

There has been an increase in the number of patients admitted with pressure damage. The HCS tissue viability team link with our community partners to ensure an island wide response.

Complaints

Whilst there was an increase in complaints in January this is consistent with seasonal trends associated with low reporting in December. The reduction in time to close complaints which has been reported to the board has both been maintained and continues to improve ensuring families achieve early resolution to their complaints.

There were a total of 64 PAL's enquiries logged in January 2024 compared to 15 in January 2023 this highlights the proactive work being undertaken to identify concerns and issues leading to early resolution for patients and families. The key theme of the enquiries related to waiting times for appointments this is raised in the performance part of this board report.

Compliments:

In January a total of 110 compliments were logged representing an increase compared to January 2023. The PALS team continue to work to ensure that all compliments are captured, and that staff receive recognition feedback.

Infection control

Whilst there remains a positive story with MRSA and E Coli, there has been four cases of C Diff reported in January they were not attributed to one clinical area. The early root cause analysis indicates that these cases were unavoidable and not as a result of cross infection

Escalations

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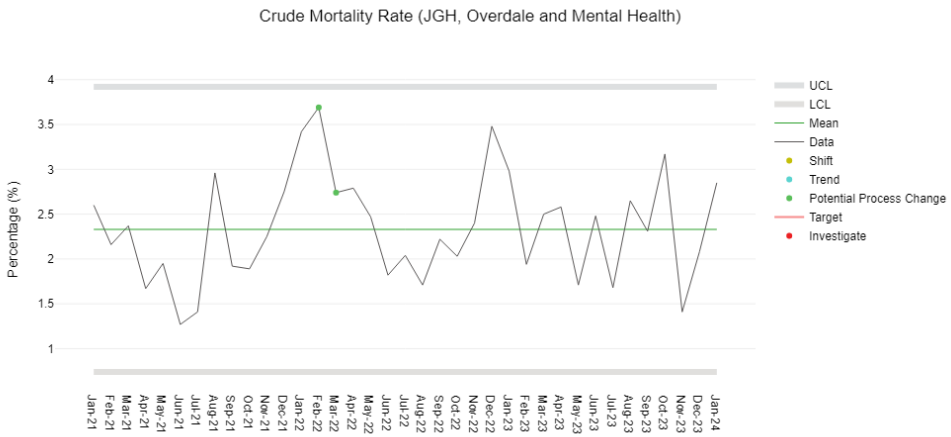
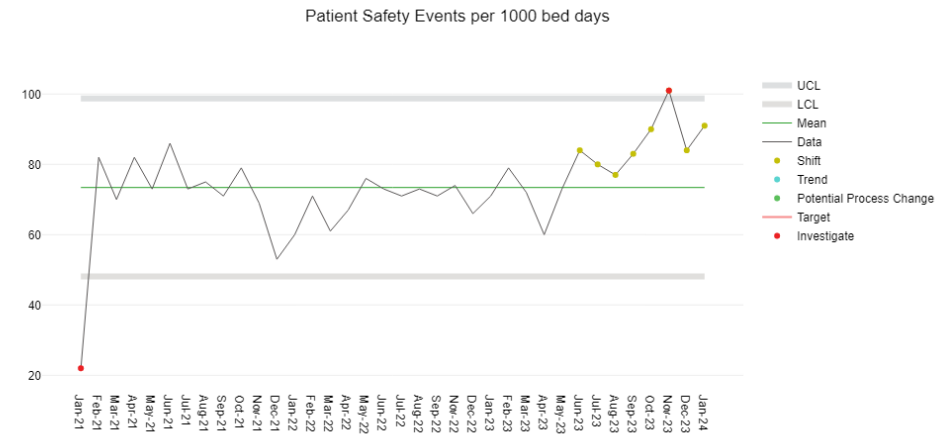
Quality & Safety - SPC Charts

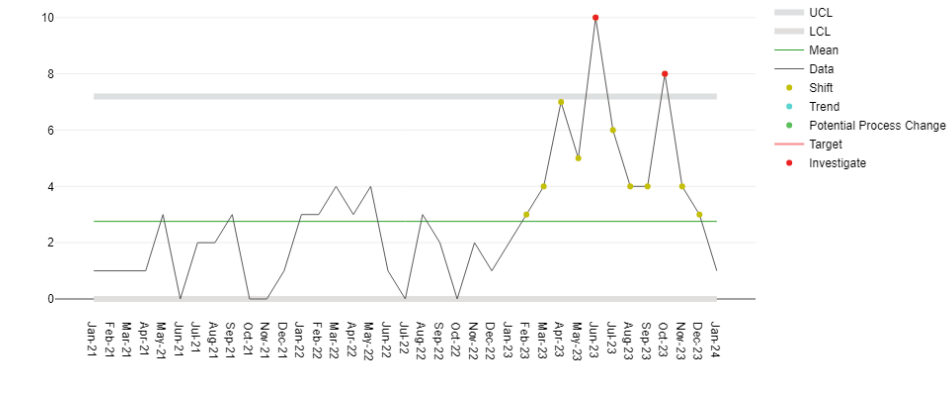
Latest value	Mean
2.9 %	2.3 %



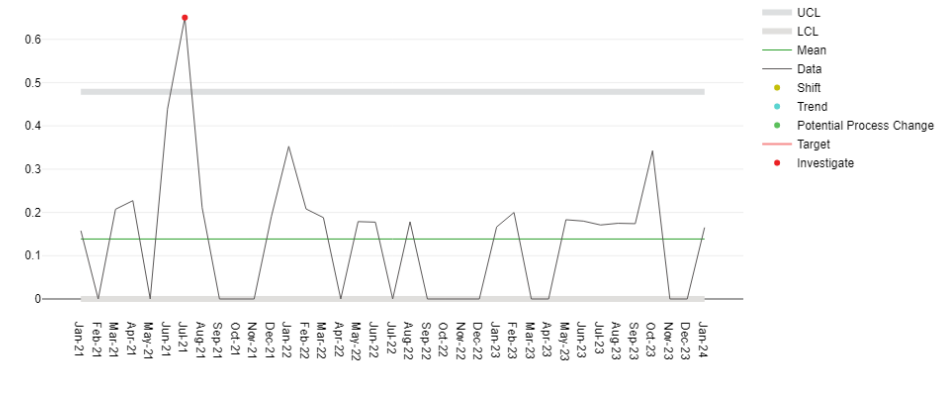
Latest value	Mean
91	73.42



Latest value	Mean
1	2.76



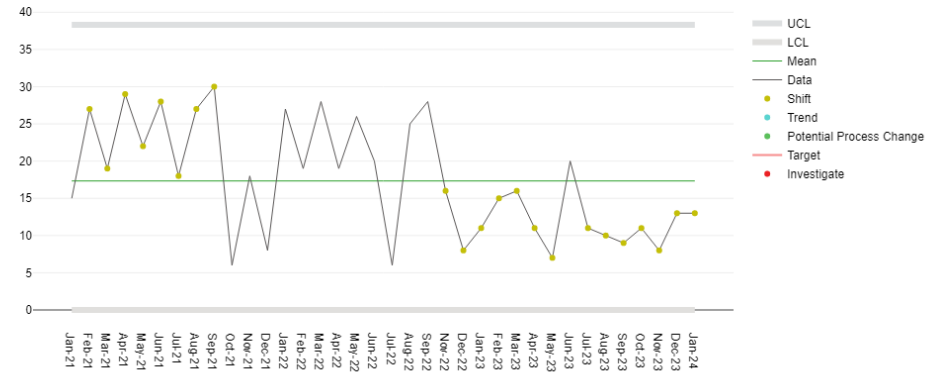
Latest value	Mean
0.17	0.14



Quality & Safety - SPC Charts

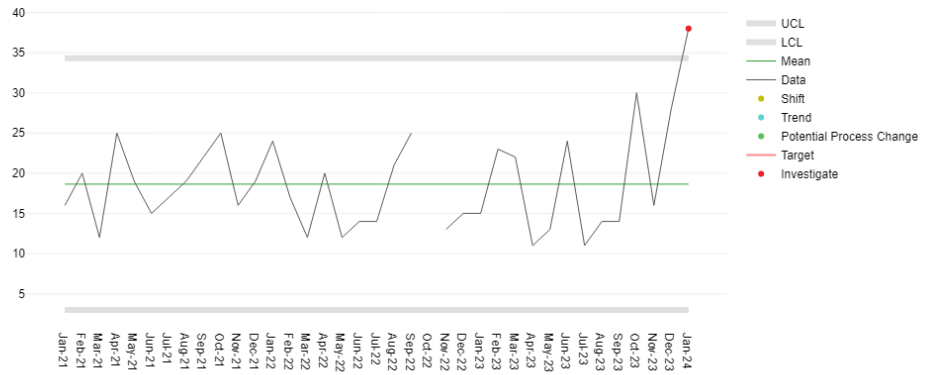
Latest value	Mean
13	17.33

Patient safety incidents with moderate/severe harm/death



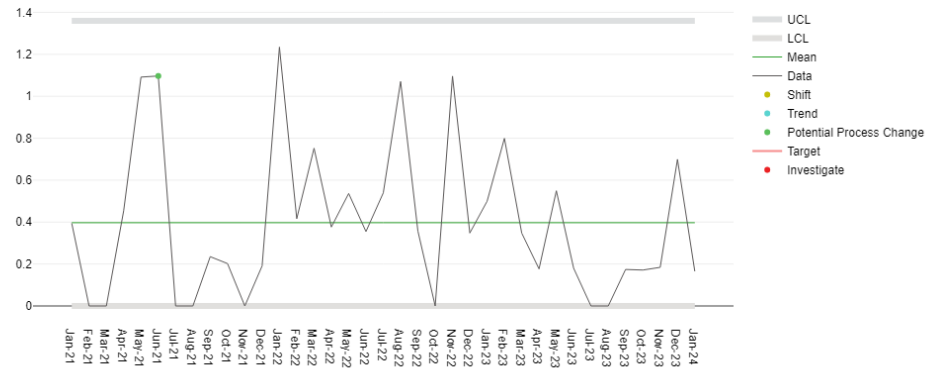
Latest value	Mean
38	18.64

Number of pressure ulcers present upon inpatient admission



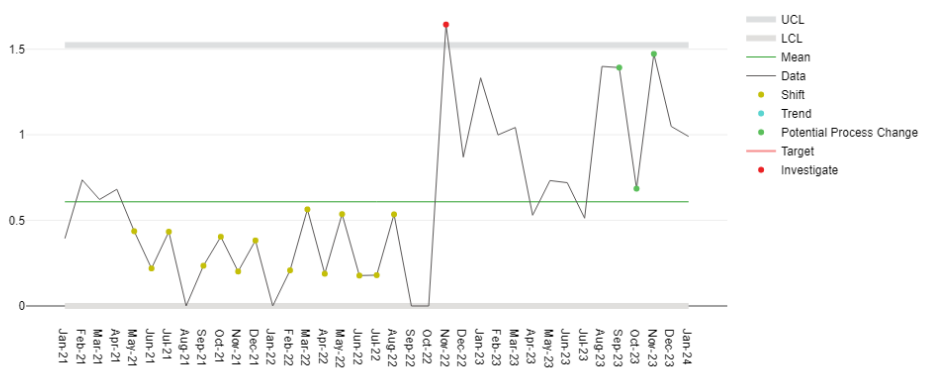
Latest value	Mean
0.17	0.4

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



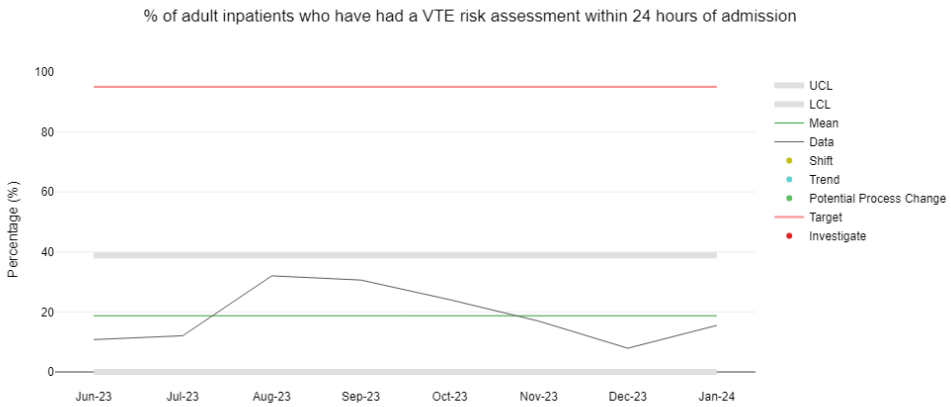
Latest value	Mean
0.99	0.61

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

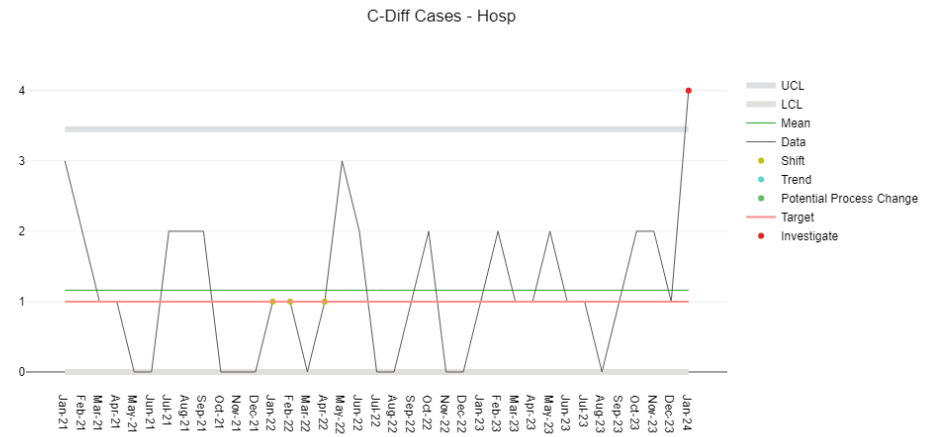


Quality & Safety - SPC Charts

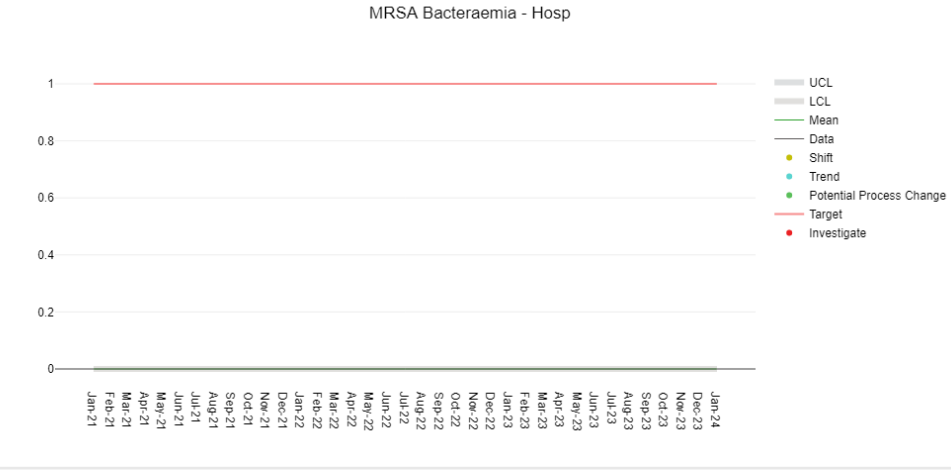
Latest value	Mean
15.5 %	18.7 %



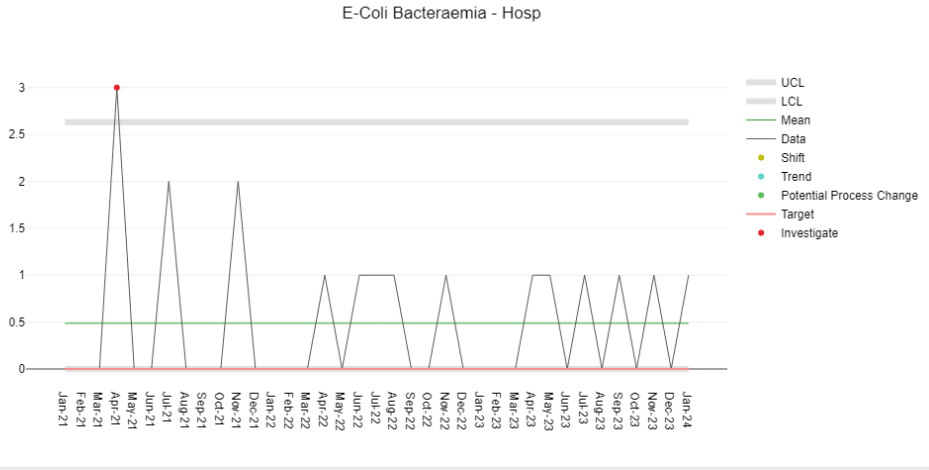
Latest value	Mean
4	1.16



Latest value	Mean
0	0

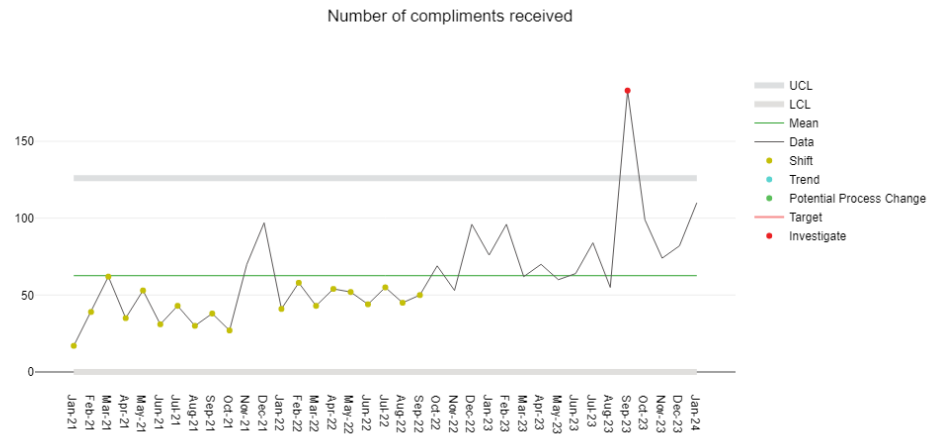


Latest value	Mean
1	0.49

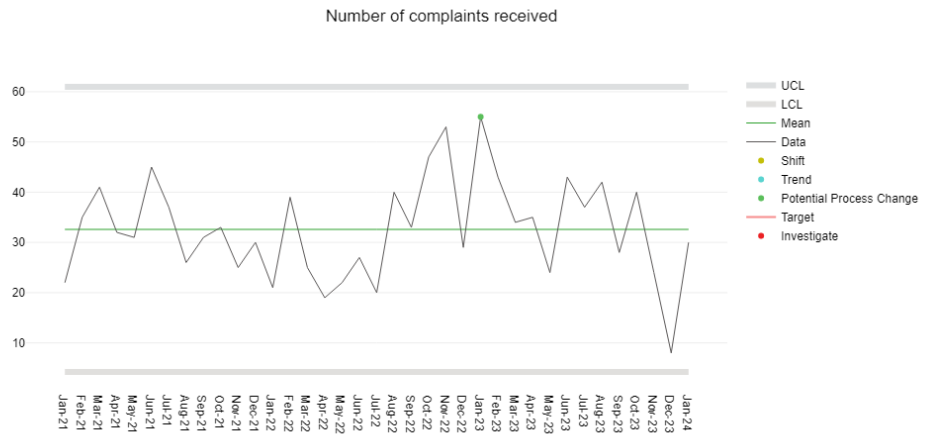


Quality & Safety - SPC Charts

Latest value	Mean
110	62.62



Latest value	Mean
30	32.59



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)	Standard removed 2022-09-28 per Q&R Committee instruction	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"