Health and Care Jersey

Gouvèrnément d'Jèrri

Quality and Performance Report
April 2025

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Health and Care Jersey

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 HCJ services and activities. Indicators are chosen that are considered important and robust to enable monitoring against the organisations strategic and operational objectives.

HCJ uses 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 - Simon West
Chief Operating Officer - Acute Services - Claire Thompson
Director Mental Health & Adult Social Care - Andy Weir

DATA:

HCJ Informatics

Health and Care Jersey

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

Patient waiting over 52 weeks for a first appointment

The trend continues to reduce for total patients waiting over 52 weeks for their first appointment. The main specialties where patients are experiencing longer waits continue to be gastroenterology, ENT and orthopaedics. The orthopaedic long waiting patients are all referred for ortho spinal service which has reverted to being managed by an off-island provider. Gastroenterology and ENT services both have capacity constraints, however patients requiring the most urgent appointments are being prioritised to reduce any potential patient safety risk whilst waiting for an appointment.

Patients on an elective list greater than 52 weeks

The significant upward trend, in part, can be attributed to the way patients, who have elected to have procedure for their condition and who then are unavailable for significant periods of time, are captured within the reporting system. Due to the limitations of the digital processes and the risk associated with manual removal of data prior to reporting, it has been decided by the informatics team that all patients are to be reported, regardless of status. From next month, the narrative will include the number of patients who are suspended, ie not able to receive their treatment even though there is availability for them. This will then provide a more accurate picture of those patient waiting over 52 weeks due to pure capacity.

As in previous months, the patients waiting the longest remain as General Surgery, Orthopaedics and ENT.

Access to diagnostics greater than 6 weeks

The diagnostic tests where patients are experiencing waits over 6 weeks are:

* Endoscopy
* Ultrasound
* MRI
* DEXA
* CT – mainly cardiac CT

Ultrasound has experienced reduced capacity due a vacancy within the team. This has now been recruited to, with the new member of staff starting at the end of May. It is expected that maximum wait times will reduce from 26 weeks to 12 weeks by the end of August, with a further reduction to a wait to the six week standard by the Autumn.

Cardiac CT

Overall demand for CT tests is stabilising following a significant increase last year. Cardiac CT remains as the diagnostic procedure with the longest waits due to several complex factors. A plan for eliminating the long waits is being worked up by the radiology and cardiology consultants.

Elective Care Performance

MRI

The impact of the change of service provision following the trial early last year has meant a significant reduction in patients waiting for MRI scans. The average wait for patients is currently at 41 days (6 weeks) and the current 90th percentile for patients waiting is 91days (13 weeks). These waiting times will continue to reduce over the next few months.

Endoscopy

Endoscopy waiting times continue to be the biggest area of concern for meeting the diagnostic standards. The endoscopy service's clinical and operational management team have developed an interim plan to support some short-term additional capacity to reduce the long waits pending a full review of the service provision and opportunities new technologies will have on the service.

In addition, it is anticipated a 3rd consultant will be appointed and in post by January 2026.

These short-term measures include:

* Additional capacity to see approx 100 more patients per month through a change of job plans for middle grade doctors and a monthly Saturday list.

* Review and validation of the current patients on the waiting list

* Trial of a new technique to support increased capacity within gastroscopy using sponge technology

* Potential to recruit a short term senior nurse from the UK to support capacity

* Retain the 3rd locum who had a planned leaving date of the end of May

The FIT screening programme has a significant impact on endoscopy demand. HCJ and Public Health have started discussion on mitigation and management of patients requiring endoscopy procedures following positive FIT test results as part of the screening programme.

Elective Care Performance

DEXA

Over recent months our DEXA capacity has increased to support the additional demand the service has seen. This additional capacity will support he reduction of patients experiencing longer waits over the coming weeks. It is anticipated waiting times will reduce to an average of 8-10 weeks by the end of Q3.

New to follow-up Ratio

April saw a rise in the number of follow-ups seen in outpatient clinics. Currently it is unclear whether this was a one off or a trend. A more in-depth review with May data will be undertaken. Initiatives including 'patient-initiated follow-up (PIFU), will be introduced during 2025 to ensure only patients who require a follow-up are seen thus freeing up capacity to appoint our new referrals.

Did not attend and was not brought rates

Both these indicators continue to head in a downward trend due to the improvements made in ensuring patients are aware of their appointments and are at a time when they can attend. Improvement work will continue in this respect throughout 2025.

Theatre Utilisation

The method for calculating theatre utilisation has been reviewed and updated to align with the NHS approved standard methodology used across the UK. Theatre Utilisation is now measured by dividing the total time patients spend in the theatre (from the start of anaesthetic until they are transferred to recovery) by the total available time in the theatre session. Previously, the calculation only included time up to the end of surgery; however, extending it to include the transfer to recovery provides a more accurate representation of how the theatre is used.

The table below show the difference between the two reporting methodologies over the previous 13 months; comparing previously published data against what it would have been had the approved methodology been used.

Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Old Methodology	64.5%	63.3%	63.3%	62.1%	65.6%	59.5%	63.3%	65.3%	62.4%	64.6%	69.2%	69.7%	71.9%
New Methodology	74.3%	73.1%	74.3%	71.4%	71.9%	66.5%	71.9%	72.6%	68.2%	72.1%	76.7%	76.1%	76.5%

Clearly from this data, we have made significant progress in theatre utilisation, regardless of which methodology had been used, and indicates a steady state over the last 3 months. However, we are still falling short of the 85% standard utilisation and will continue to make improvements over the coming months to move towards achieving this standard.

Theatre cancellation on the day due to non-medical reasons

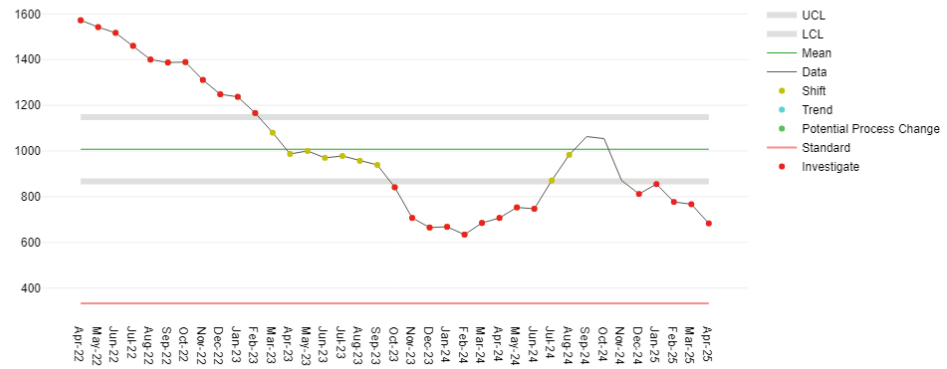
A small rise in on the day cancellations in April was due to unexpected sickness within the surgical team.

Escalations

Elective Care Performance

Patients waiting for first outpatient appointment greater than 52 weeks

Latest value	Standard
683	<333

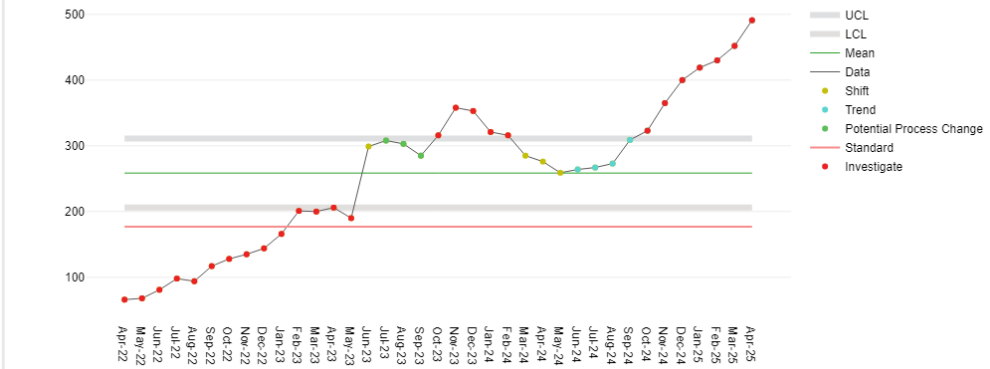


Definition
Number of patients who have been waiting for over 52 weeks for a first outpatient appointment at period end

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Standard set as per the Elective Access Policy

Patients on elective list greater than 52 weeks

Latest value	Standard
491	<177



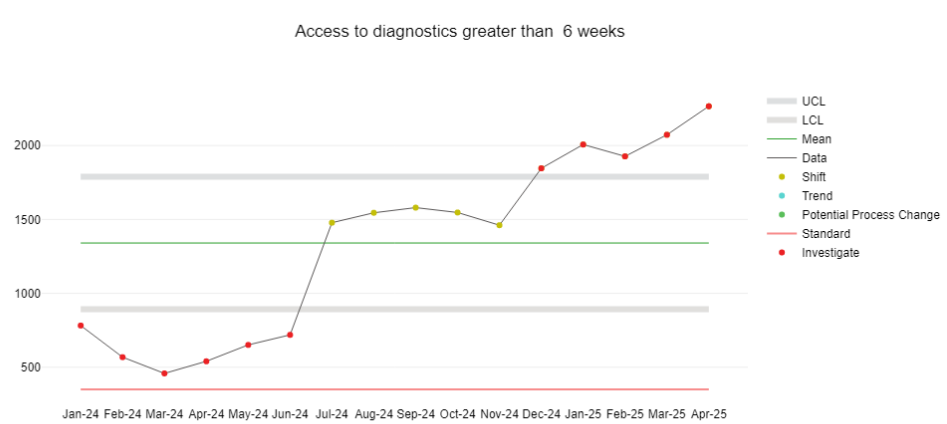
Definition
Number of patients on the elective inpatient waiting list who have been waiting over 52 weeks at period end.

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Standard set as per the Elective Access Policy

Elective Care Performance

Access to diagnostics greater than 6 weeks

Latest value	Standard
2266	<350

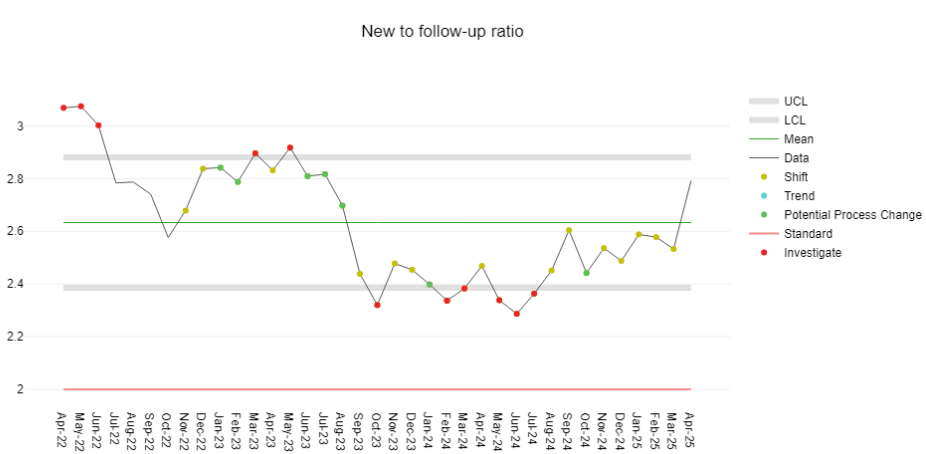


Definition
Number of patients waiting longer than 6 weeks for a first diagnostic appointment at period end. Data only available from January 2024. Indicator is being developed to include diagnostic investigations comparable to those monitored in the NHS DM01 return. Currently HCJ is unable to report 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.

Data Source	Standard Source
Maxims Outpatient Waiting List Reports (OP001DM and IP009DM), Radiology (CRIS) Waiting List Report (Since July 2024)	Standard set as per the Elective Access Policy

New to follow-up ratio

Latest value	Standard
2.79	2



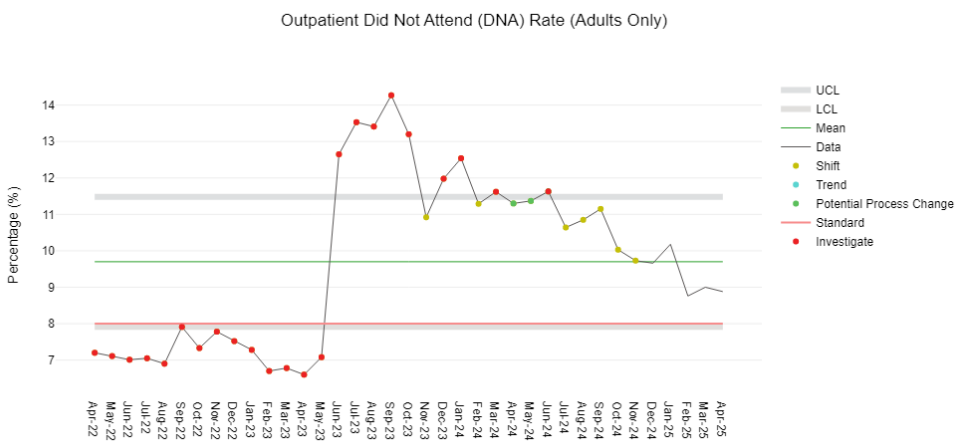
Definition
Rate of new (first) outpatient appointments to follow-up appointments, this being the number of follow-up appointments divided by the number of new appointments in the period. Excludes Private patients.

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP14DM))	Standard set locally based on historic performance

Elective Care Performance

Outpatient Did Not Attend (DNA) Rate (Adults Only)

Latest value	Standard
8.9 %	<=8%

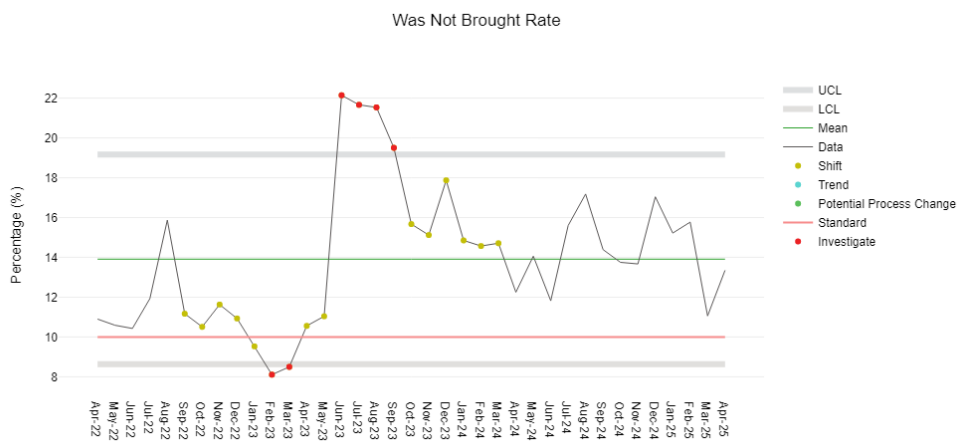


Definition
Percentage of JGH/Enid Quenault outpatient (>=18 Years old) appointments where the patient did not attend and no notice was given. Excludes Private patients.

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP14DM))	Standard set locally based on historic performance

Was Not Brought Rate

Latest value	Standard
13.4 %	<=10%



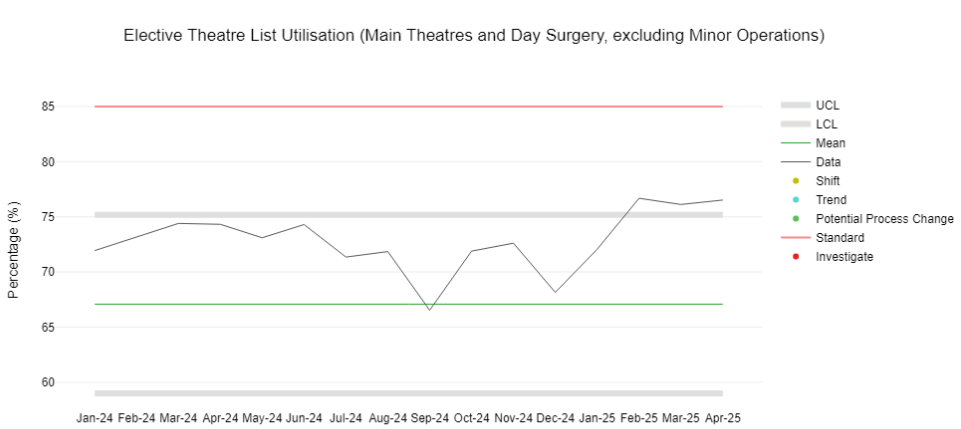
Definition
Percentage of JGH/Enid Quenault public outpatient appointments where the patient did not attend (was not brought). Under 18 year old patients only. All specialties included. Excludes Private patients.

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP14DM))	Standard set locally based on historic performance

Elective Care Performance

Elective Theatre List Utilisation (Main Theatres and Day Surgery, excluding Minor Operations)

Latest value	Standard
76.5 %	>85%

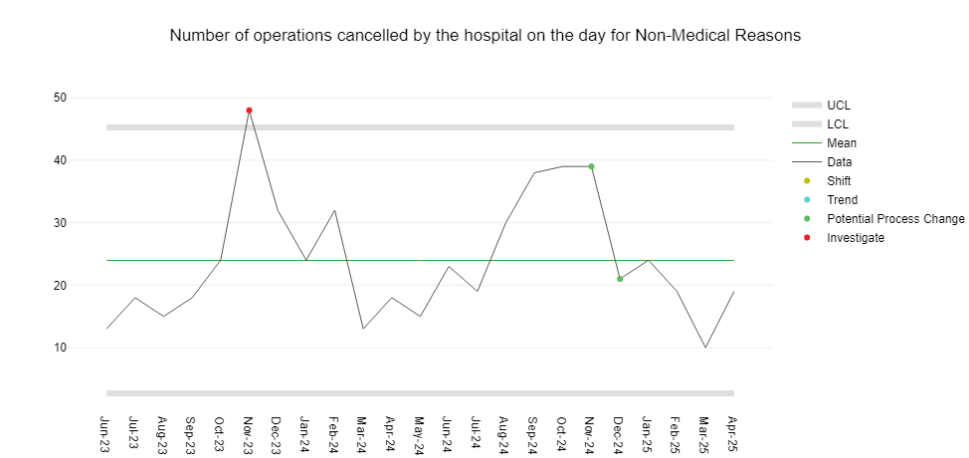


Definition
The percentage of booked theatre session time that is used for actively performing a procedure. This being the sum of touch time divided by the sum of booked theatre session duration (as a percentage). This is reported for all operations (Public and Private) with the exception of Minor Ops, Maternity and Endoscopy.

Data Source	Standard Source
Hospital Electronic Patient Record (Maxims Theatres Report (TH016DM) & Maxims Session Booking Report (TH002DM))	NHS Benchmarking - Getting It Right First Time 2024/25 Target

Number of operations cancelled by the hospital on the day for Non-Medical Reasons

Latest value	Standard
19	NA



Definition
Number of operations cancelled by the hospital on the day for non-medical reasons in the reporting period.

Data Source	Standard Source
Hospital Electronic Patient Record (Maxims Theatres Cancellations report TH003DM and TCI Statuses IP0024DM)	Not Applicable

Emergency Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

Emergency Department Attendance and Performance – April

Attendance & Admissions:

* Total Attendees: 3,428, a reduction from March by 208.
* 4-Hour Target Compliance: Maintained at 80.3%, with minors achieving 94.3%, exceeding England's current benchmarks.
* 12-Hour Breaches: Stable at 0.6%, with 9 breaches, all linked to patients requiring admission.
* Admissions Rate: 14.6%, a decrease from the previous month, moving the metric into green status.

Operational Improvements & Initiatives

Red 2 Green (R2G) Implementation:

* R2G principles continue to be embedded to support improved patient flow.
* Patient review days are now routinely scheduled ahead of Bank Holidays as part of proactive planning.

Non-Clinical Patient Transfers:

* Out-of-hours transfers have reduced significantly, supporting better continuity of care.
* All non-clinical transfers are monitored at daily operational bed meetings, aligning with learning from a recent serious incident.

Length of Stay (LOS) & Readmissions

* Emergency LOS: Currently amber, with continued progress following RCP recommendations.
* Acute Bed Occupancy at Midnight: Now at 78%, achieving green status for the first time in 2025.
* 30-Day Readmissions: Increased slightly to 11.7%; further analysis is underway to identify root causes.
* Morning Discharges (8 AM – Noon): Improved to 11.3%, though this remains in red status.

Emergency Care Performance

Escalations

* April showed significant improvement, with the number of patients in ED for over 12 hours at its lowest level in a year.
* Patients waiting over 12 hours for inpatient admission have also dropped to single figures—the first time in 12 months.

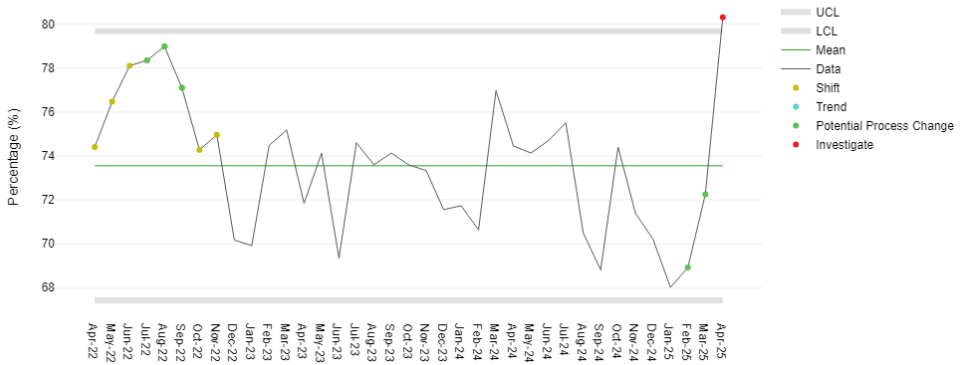
Actions Underway

* Continued use of additional capacity to support flow.
* R2G reviews remain a core strategy ahead of Bank Holidays.
* Targeted LOS reduction initiatives are underway to improve clinical productivity.
* An externally supported flow improvement programme is being implemented to optimise throughput.

Emergency Care Performance

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

Latest value	Standard	Mean
80.3 %	NA	73.6 %

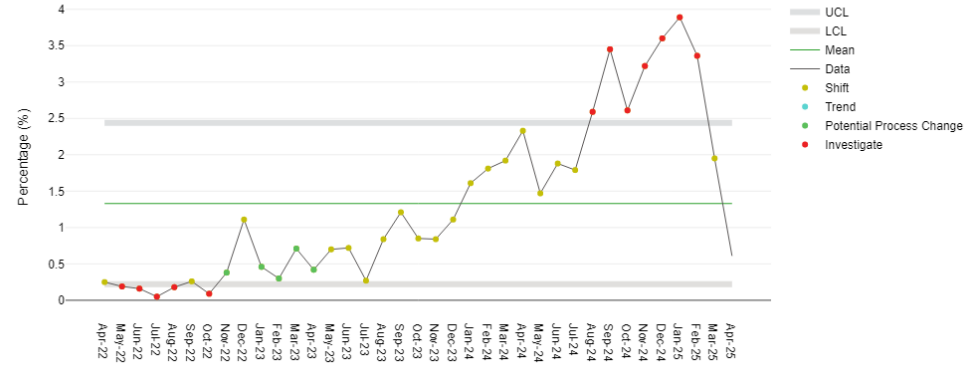


Definition
Percentage of patients in the Emergency department less than or equal to 4 hours from arrival to departure or admission

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM))	Not Applicable

% Patients in Emergency Department for more than 12 Hours

Latest value	Standard	Mean
0.6 %	NA	1.3 %



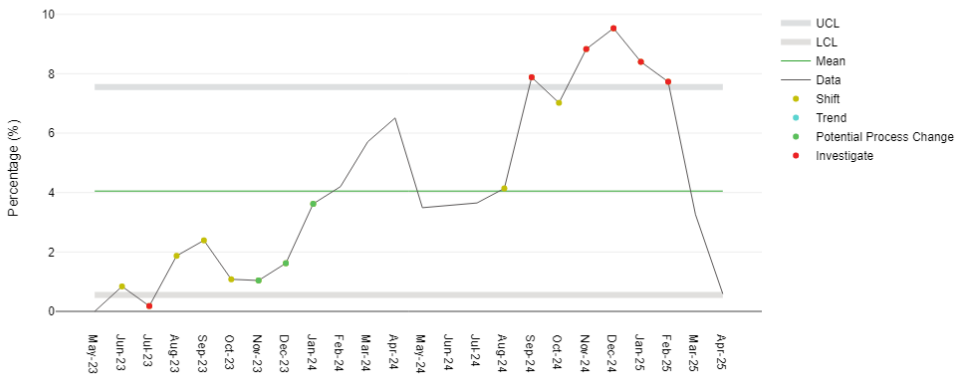
Definition
Percentage of patients in the Emergency department for more than 12 hours from arrival to departure or admission

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM))	Not Applicable

Emergency Care Performance

% of Patients in Emergency Department for more than 12 Hours from DTA

Latest value	Standard	Mean
0.6 %	NA	4 %

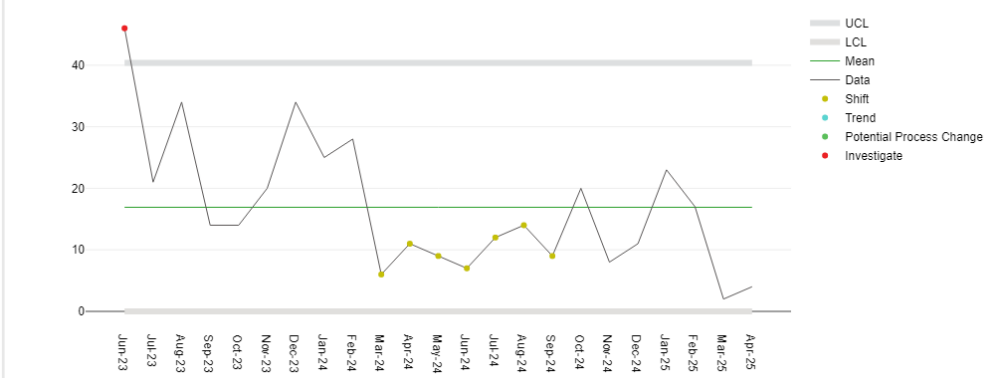


Definition
Percentage of Patients in Emergency Department for more than 12 Hours from DTA where a DTA has occurred

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Not Applicable

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

Latest value	Standard	Mean
4	NA	16.91



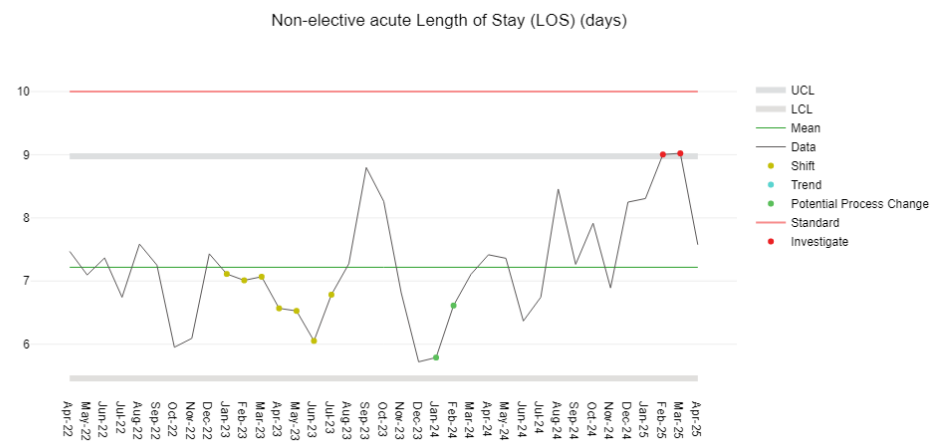
Definition
Number of inpatient moves within wards or between wards, between the hours of 22:00 and 08:00 for non-clinical reasons, in the reporting period.

Data Source	Standard Source
Hospital Electronic Patient Record (Maxims Inpatient Ward Movements report IP001DM)	Not Applicable

Emergency Care Performance

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

Latest value	Standard	Mean
7.58	<10	7.22

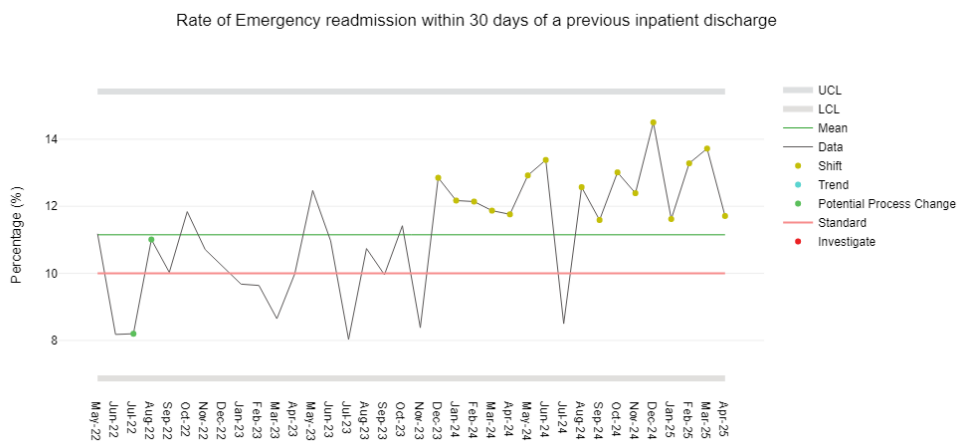


Definition
Average (mean) Length of Stay (LOS) in days of all emergency inpatients discharged in the period from a General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward & St Ewolds. 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.

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Generated based on historic performance

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

Latest value	Standard	Mean
11.7 %	<10%	11.2 %



Definition
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 applied as per NHS definition at: https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L, TrakCare Discharges Report (ATD9P), Maxims Admssions and Discharge Report (IP013DM))	Generated based on historic performance

Emergency Care Performance

Additional Commentary / Deep Dive

April has marked notable progress for the Medical Care Group, especially in ED performance. The closure of AAU Bay 1 has enabled the reintroduction of SDAC, which has positively impacted admission avoidance and flow.

The combination of R2G, focused operational interventions, and cross-departmental collaboration is forming a more sustainable framework for managing demand.

Discharge planning remains a challenge—particularly around blister packs and external community support—but this continues to improve, with delayed transfer of care (DTOC) bed days now at their lowest in a year.

Maternity

Section Owner

Chief Nurse

Performance Narrative

In the month, there were 53 births, with 64% being multigravidas (second or subsequent births).

The caesarean section (CS) rate has decreased to 33.96% (18 out of 53 births). Of these, 20.75% (11 births) were elective procedures, and 7 were emergency CS. The largest cohort, based on the Robson Criteria, continues to fall under Group 5; women with a previous caesarean birth, a single cephalic pregnancy, and a gestation of at least 37 weeks. Patient choice remains a significant factor influencing our CS rate, reflecting current national and international trends. Of note, there was one case of caesarean at full dilatation.

A five-year review of caesarean trends is underway to gain a clearer picture of our performance. Preliminary findings suggest our rates are consistent with UK and international comparators.

The induction of labour rate remains stable, with a slight decrease this month to 45.28%, highlighting our continued commitment to offering induction based on individualised clinical assessment at the appropriate gestation.

Breastfeeding initiation remains strong, though we observed a slight dip this month to 67.9% of mothers choosing to breastfeed.

There was one case of major obstetric haemorrhage reported this month. All such cases are subject to thorough review using our NICHE assessment tool to ensure learning and improvement.

We have noted an increase in the number of babies born below the 3rd centile at ?37+6 weeks. These cases have been appropriately managed and reviewed via the Datix system. This increase may be attributed to improvements in the detection of fetal growth restriction through enhanced antenatal surveillance.

Escalations

The implementation of a dedicated maternity-specific electronic patient record (EPR) system remains pending, with a confirmed date still awaited. This system is expected to significantly enhance data collection, reporting, and overall service delivery.

Maternity - Key Performance Indicators

Indicator	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	YTD
Total Births	56	53	69	59	62	53	67	62	65	51	48	52	53	204
Mothers with no previous pregnancy (Primips)	15	20	34	22	27	26	31	35	30	24	18	26	18	86
Mothers who have had a previous pregnancy (Multips)	29	25	25	31	33	25	27	23	33	26	23	23	34	106
Mothers with unknown previous pregnancy status	12	8	10	6	2	2	9	4	2	1	7	3	1	12
Bookings ≤10+0 Weeks	8	8	9	7	4	9	6	8	4	2	2	2	5	11
% of women that have an induced labour	22.22%	16.33%	19.4%	28.07%	18.33%	28.3%	38.46%	33.93%	29.51%	38%	29.55%	48%	45.28%	40.61%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	9	19	18	12	22	15	9	12	14	11	9	13	16	49
Number of Instrumental deliveries	2	3	7	4	6	4	6	7	5	4	0	3	2	9
% deliveries by C-section (Planned & Unscheduled)	66.67%	51.02%	52.24%	61.4%	51.67%	47.17%	46.15%	44.64%	52.46%	54%	61.36%	46%	33.96%	48.22%
% Elective caesarean section births	37.04%	28.57%	29.85%	35.09%	40%	26.42%	33.85%	26.79%	37.7%	42%	38.64%	24%	20.75%	30.96%
Number of Emergency Caesarean Sections at full dilatation	1	1	0	4	0	1	0	1	0	0	1	1	1	3
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)	7	2	7	7	0	4	5	2	4	1	5	0	3	9
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)	5	1	4	4	2	3	3	3	3	7	3	5	3	18
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)	5	3	7	4	6	2	7	2	6	2	5	4	0	11
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)	6	5	4	10	10	9	5	2	5	8	6	4	4	22
Number of deliveries home birth (Planned & Unscheduled)	1	1	1	3	0	1	0	0	0	0	0	1	0	1
Mothers who were current smokers at time of booking (SATOB)	5	6	2	5	3	4	6	0	2	1	3	1	4	9
Mothers who were current smokers at time of delivery (SATOD)	0	2	2	4	6	3	4	4	4	3	1	4	2	10

Maternity - Key Performance Indicators

Indicator	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	YTD
Number of Mothers who were consuming alcohol at time of booking	0	0	0	0	0	0	1	0	2	0	1	1	0	2
Number of Mothers who were flagged as consuming alcohol after delivery	4	3	6	4	5	6	5	1	2	1	0	0	0	1
Breastfeeding Initiation rates	73.2%	69.8%	71%	79.7%	67.7%	79.2%	65.7%	71%	78.5%	66.7%	70.8%	71.2%	67.9%	69.12%
Transfer of Mothers from Inpatients to Overseas	1	0	1	0	1	2	3	0	0	2	1	1	0	4
Number of births in the High dependency room / isolation room	0	0	0	0	0	1	1	0	0	0	0	1	0	1
Number of PPH greater than 1500mls	44	42	53	45	47	41	54	48	53	44	41	41	46	172
Number of 3rd & 4th degree tears – all births	0	0	0	0	0	1	1	0	0	0	0	0	0	0
% of babies experiencing shoulder dystocia during delivery	1.79%	0%	4.35%	0%	0%	0%	2.99%	1.61%	1.54%	1.96%	2.08%	0%	1.89%	1.47%
% Stillbirths greater than 24 Weeks Gestation	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Neonatal Deaths at Less Than 28 days old	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% live births Less Than 3rd centile delivered greater than 37+6 weeks (detected & undetected SGA)	3.85%	3.45%	2.78%	5.13%	2.56%	2.5%	2.22%	0%	2.33%	5.88%	9.68%	2.63%	5.41%	5.71%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	1	2	0	1	0	0	1	0	1	1	0	0	2
Transfer of Neonates from JNU to an off-island facility	1	0	1	0	1	0	0	0	0	2	0	0	0	2
Preterm Births ≤27 Weeks (Live & Stillbirths)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	1	2	2	3	4	1	4	5	8	3	4	3	2	12
Neonatal Readmissions at Less Than 28 days old	5	5	6	4	5	9	5	11	5	6	5	5	5	21

Maternity - Indicator & Standard Definitions

Indicator	Standard Source	Definition
Total Births	Indicator is for information only	Count of babies born, including those from multiple births (e.g., twins, triplets) and stillbirths. Excludes terminations, miscarriages, ectopic pregnancies, and births occurring off-island.
Mothers with no previous pregnancy (Primips)	Indicator is for information only	Number of births (live and stillbirths) to first-time mothers, excluding ectopic pregnancies, terminations, and miscarriages.
Mothers who have had a previous pregnancy (Multips)	Indicator is for information only	Number of births (live and stillbirths) excluding ectopic pregnancies, terminations, and miscarriages to mothers with a previous pregnancy.
Mothers with unknown previous pregnancy status	Indicator is for information only	Number of births (live and stillbirths) to mothers with unknown previous pregnancy status, excluding ectopic pregnancies, terminations, and miscarriages.
Bookings ≤10+0 Weeks	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	Standard set locally based on average (mean) of previous two years' data	Percentage of deliveries where labour was induced out of the total number of deliveries. (Numerator: Total induced labour deliveries / Denominator: Total deliveries).
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	Not Applicable	Count of spontaneous vaginal births, including home births and breech vaginal deliveries.
Number of Instrumental deliveries	Not Applicable	Count of deliveries assisted using instruments, including forceps or vacuum (ventouse), to aid vaginal birth.
% deliveries by C-section (Planned & Unscheduled)	Indicator is for information only	Percentage of C-section deliveries (planned and unplanned) out of the total number of deliveries. (Numerator: Total C-section deliveries / Denominator: Total deliveries).
% Elective caesarean section births	Indicator is for information only	Percentage of deliveries where birth was by planned (elective) caesarean section (Numerator: Elective C-section births / Denominator: Total deliveries).
Number of Emergency Caesarean Sections at full dilatation	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)	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.
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)	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)	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)	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)	Indicator is for information only	Count of deliveries recorded as occurring at home, including both planned and unplanned home births.

Maternity - Indicator & Standard Definitions

Indicator	Standard Source	Definition
Mothers who were current smokers at time of booking (SATOB)	Indicator is for information only	Number of mothers who were recorded as being smokers at their pregnancy booking appointment.
Mothers who were current smokers at time of delivery (SATOD)	Indicator is for information only	Number of mothers who were recorded as being smokers on their delivery date.
Number of Mothers who were consuming alcohol at time of booking	Indicator is for information only	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	Indicator is for information only	Number of mothers who were recorded as consuming alcohol after their delivery date.
Breastfeeding Initiation rates	Not Applicable	Percentage of babies born in the period whose first feed is from the mother's breast
Transfer of Mothers from Inpatients to Overseas	Indicator is for information only	Number of transfers of mothers out of the Maternity inpatient ward to an off-island Healthcare facility.
Number of births in the High dependency room / isolation room	Indicator is for information only	Number of births which took place in the High Dependancy Room / Isolation Room
Number of PPH greater than 1500mls	Indicator is for information only	Count of deliveries that resulted in a postpartum hemorrhage (PPH) with blood loss exceeding 1500ml
Number of 3rd & 4th degree tears – all births	Not Applicable	Number of women who gave birth and sustained a 3rd or 4th degree perineal tear
% of babies experiencing shoulder dystocia during delivery	Not Applicable	Number of babies experiencing shoulder dystocia during delivery divided by the total number of births
% Stillbirths greater than 24 Weeks Gestation	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	Indicator is for information only	Number of baby deaths within 28 days of their delivery date
% live births Less Than 3rd centile delivered greater than 37+ 6 weeks (detected & undetected SGA)	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	Not Applicable	Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation
Transfer of Neonates from JNU to an off-island facility	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)	Indicator is for information only	Babies born (live and stillbirths) who were born at or before 27 weeks
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	Indicator is for information only	Count of babies (live and stillbirths) born at or before 36 weeks and 6 days of gestation.
Neonatal Readmissions at Less Than 28 days old	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

A comprehensive review of the homebirth service has been completed. A full mapping of existing processes has been conducted, with identified areas for improvement. A bespoke training programme for midwives is scheduled for 3rd July. Regular updates are being provided to our Chief Officer to ensure continued oversight.

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Month 4 has seen a significant increase in patients waiting for assessment by Jersey Talking Therapies (JTT) for over 90 days, from an average of 3.6% to 11.6% in the month. We have also seen a (less significant) increase in people waiting for treatment for over 18 weeks (77%) and average waiting time for JTT treatment (184 days). This will be reviewed by the responsible service manager.

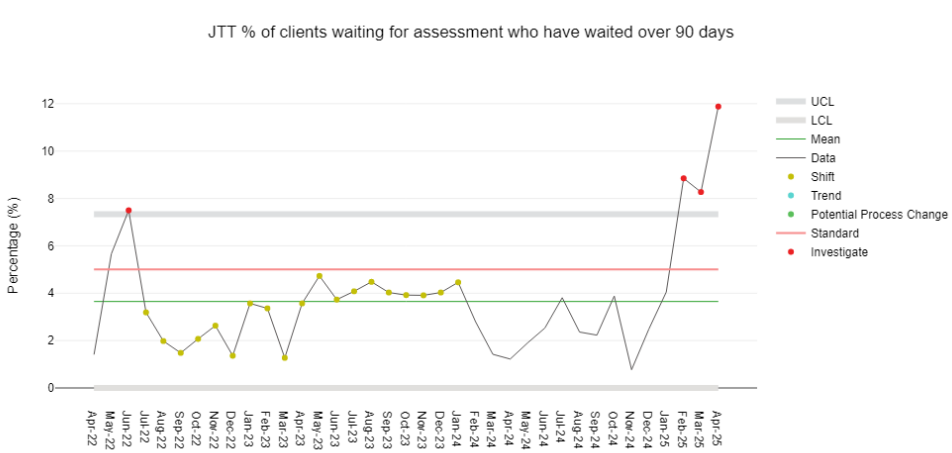
The mental health crisis assessment target of 4 hours face to face was (unusually) narrowly missed this month, achieving 83.6% against a target of 85%. We are currently reviewing all referrals to the crisis team to understand this, and to review referrals that are not considered to require a face to face assessment. Other access targets (for mental health routine referrals and for the alcohol & drug service) have been met. Follow up on discharge (both working age and older people) has performed less well this month; this will be discussed in the mental health Senior Leadership Team. It is of note that the service has been experiencing particularly high levels of activity and occupancy in the month, and that the number of patients within the inpatient unit that are identified as a delayed discharge has risen to 12.

Escalations

Pressures within the ADHD and Autism pathways remain as previously, with continued growth in the waiting lists and waiting times for these services.

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

Latest value	Standard	Mean
11.9 %	<5%	3.7 %



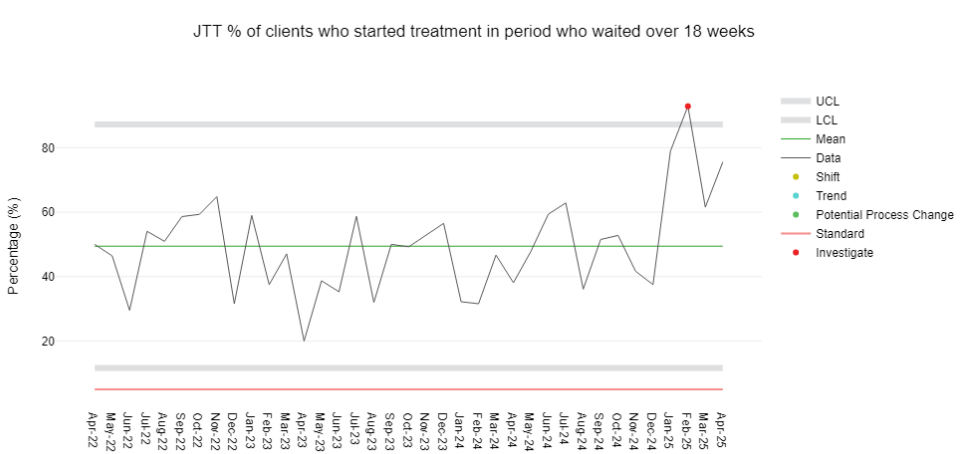
Definition
Number of Jersey Talking Therapy (JTT) clients who have waited over 90 days for assessment, divided by the total number of JTT clients waiting for assessment

Data Source	Standard Source
Patient Case Management Information System (PCMIS)	Improving Access to Psychological Therapies (IAPT) Standard

Mental Health

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

Latest value	Standard	Mean
75.6 %	<5%	49.4 %

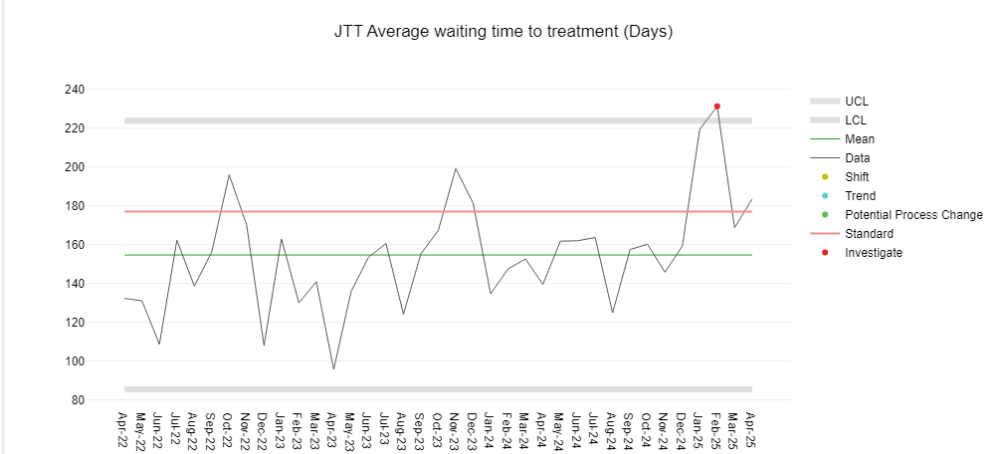


Definition
Percentage of Jersey Talking Therapy (JTT) clients commencing treatment in the period who had waited more than 18 weeks to commence treatment.

Data Source	Standard Source
Patient Case Management Information System (PCMIS)	Improving Access to Psychological Therapies (IAPT) Standard

JTT Average waiting time to treatment (Days)

Latest value	Standard	Mean
183.38	<=177	154.65



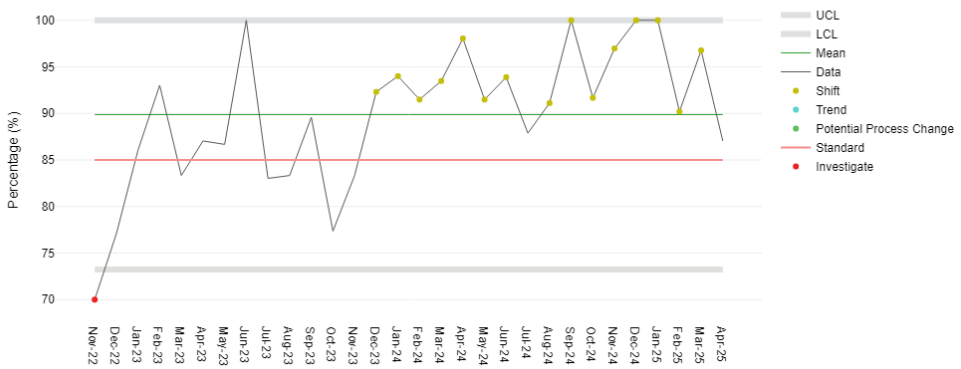
Definition
Average (mean) days waiting from Jersey Talking Therapy (JTT) referral to the first attended treatment session for patients commencing treatment in period

Data Source	Standard Source
Patient Case Management Information System (PCMIS)	Generated based on historic percentiles

Mental Health

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

Latest value	Standard	Mean
87 %	>85%	89.9 %

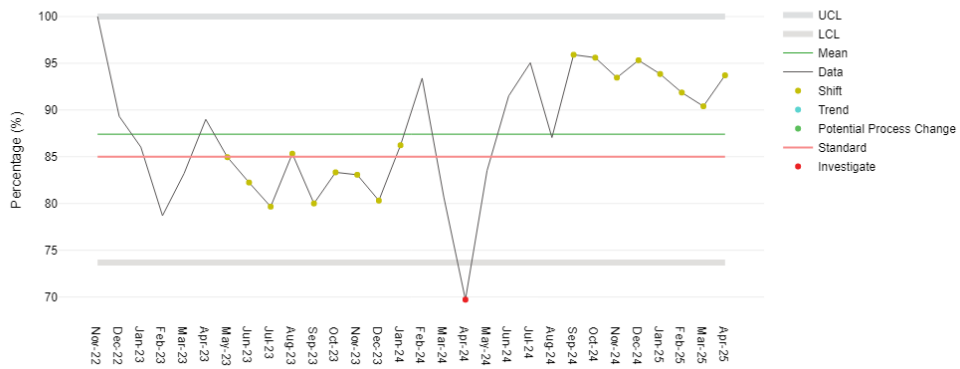


Definition
Percentage of Crisis Team referrals assesed within 4 hours

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Agreed locally by Care Group Senior Leadership Team

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

Latest value	Standard	Mean
93.7 %	>85%	87.4 %



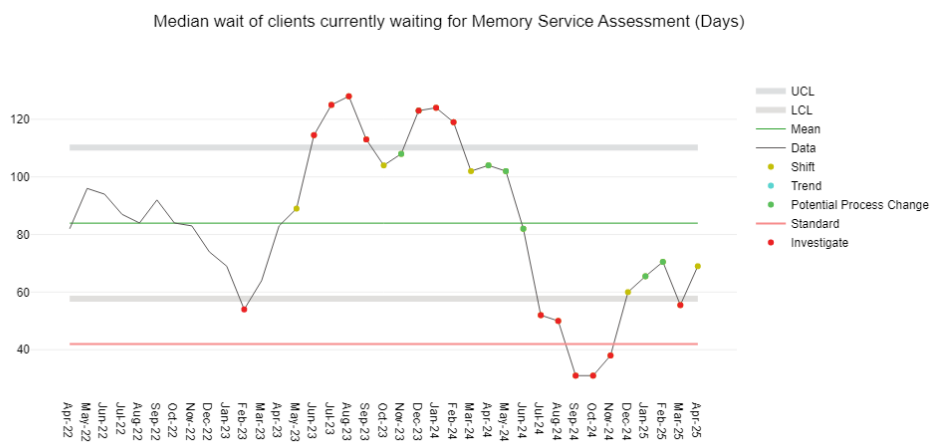
Definition
Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Agreed locally by Care Group Senior Leadership Team

Mental Health

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

Latest value	Standard	Mean
69	<=42	83.95

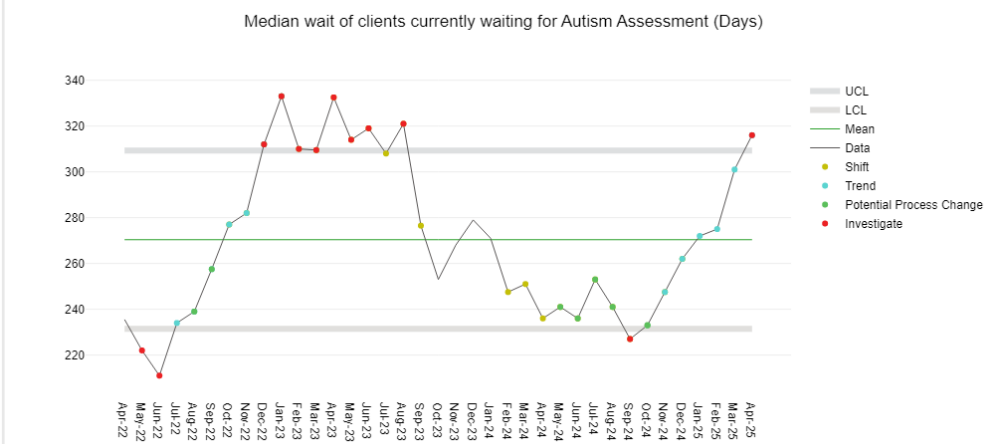


Definition
Memory Service Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Agreed locally by Care Group Senior Leaders

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

Latest value	Standard	Mean
316	NA	270.36



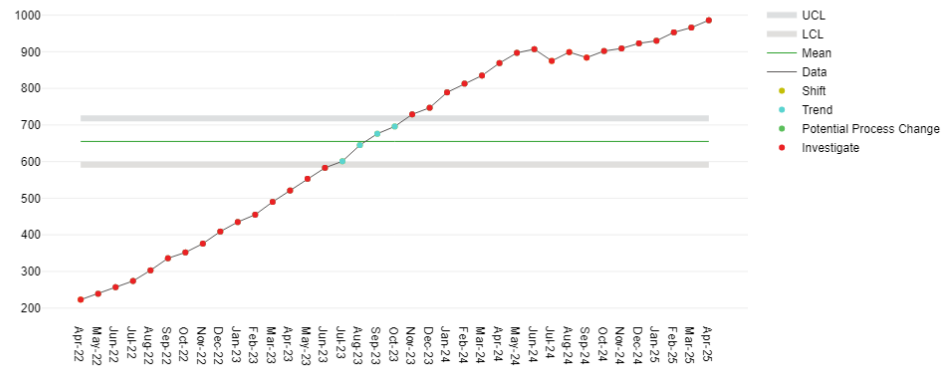
Definition
Autism Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Not Applicable

Mental Health

Number of clients currently waiting for ADHD Assessment

Latest value	Standard	Mean
986	NA	655.05

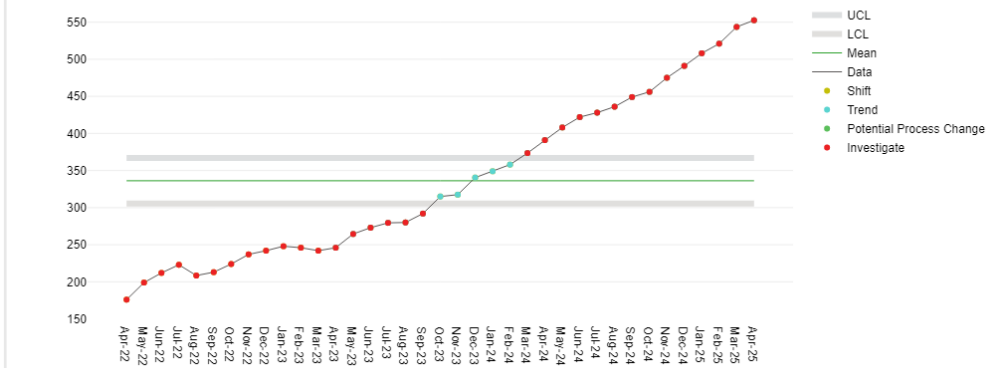


Definition
Number of clients waiting for ADHD assessment

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Not Applicable

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

Latest value	Standard	Mean
552.5	NA	336.22



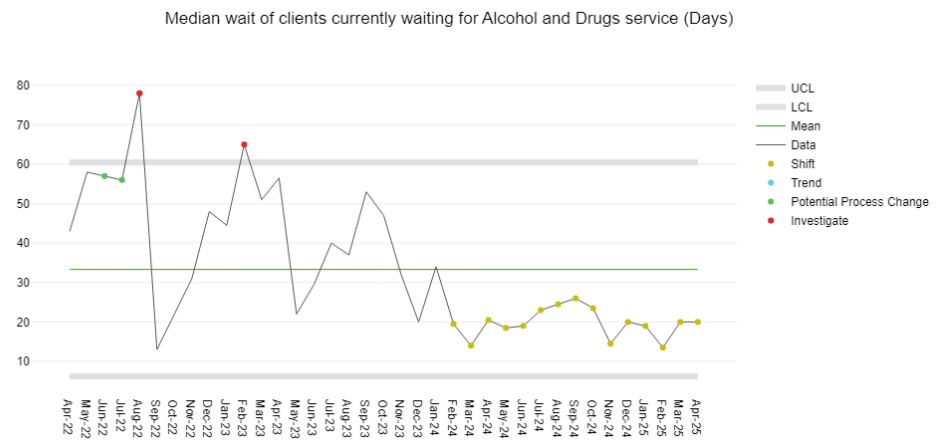
Definition
ADHD Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Not Applicable

Mental Health

Median wait of clients currently waiting for Alcohol and Drugs service (Days)

Latest value	Standard	Mean
20	NA	33.32

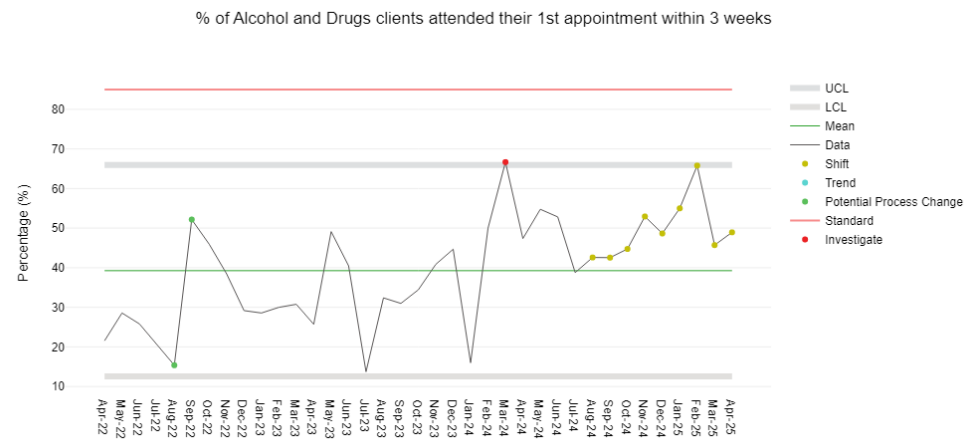


Definition
Alcohol and Drugs Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Report WLS6B & Maxims Report OP2DM)	Not Applicable

% of Alcohol and Drugs clients attended their 1st appointment within 3 weeks

Latest value	Standard	Mean
48.9 %	>85%	39.3 %



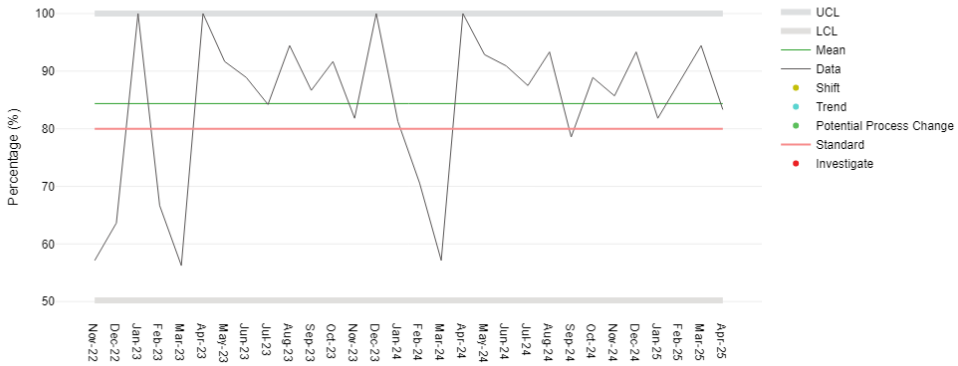
Definition
% of clients who waited less than 3 weeks for their first attended appointment, who were seen in reporting period

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Report WLS6B & Maxims Report OP2DM)	Agreed locally by Care Group Senior Leaders

Mental Health

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

Latest value	Standard	Mean
83.3 %	>80%	84.4 %

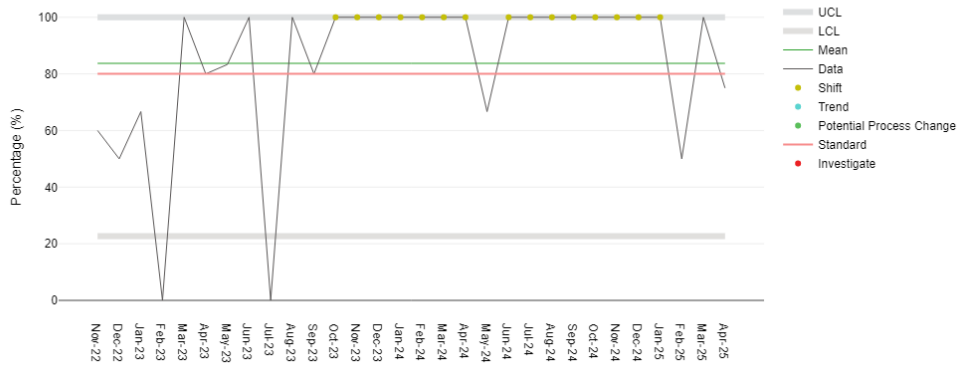


Definition
Percentage of patients discharged from Mental Health Inpatient Unit with an Adult Mental Health Specialty' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Reports ATD9P & ATD5L and Maxims Report IP013DM) & Community services electronic client record system (Care Partner)	National standard evidenced from Royal College of Psychiatrists

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

Latest value	Standard	Mean
75 %	>80%	83.7 %

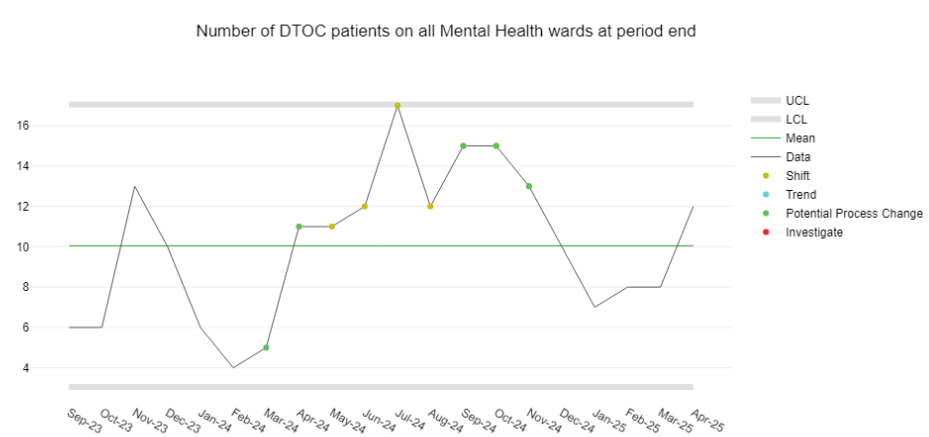


Definition
Percentage of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Reports ATD9P & ATD5L and Maxims Report IP013DM) & Community services electronic client record system (Care Partner)	National standard evidenced from Royal College of Psychiatrists

Number of DTOC patients on all Mental Health wards at period end

Latest value	Standard	Mean
12	NA	10.05



Definition
Number of patients who are recorded as Delayed Transfer of Care (DTOC) on the last day of the reporting period

Data Source	Standard Source
Hospital Electronic Patient Record (Maxims Report IP020DM)	Not Applicable

Social Care

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Percentage of Learning Disability Service clients with a Physical Health

check in the past year and Percentage of Assessments completed and authorised within 3 weeks are both performing very well at present, with targets exceeded.

No action other than ongoing monitoring is required at present.

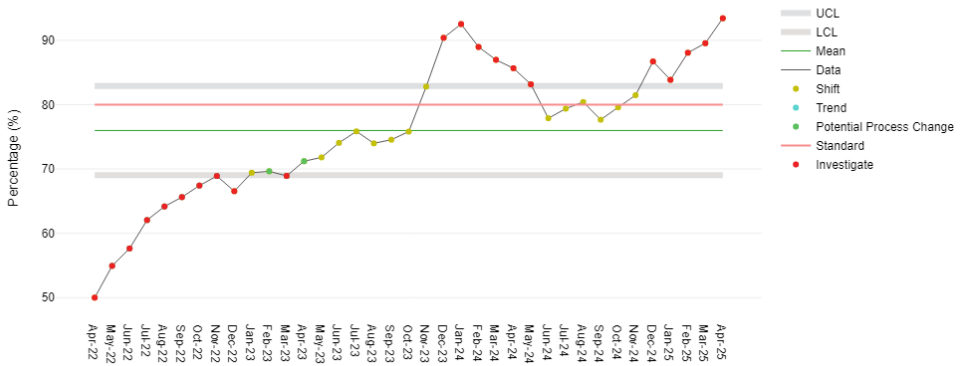
Escalations

N/A

Social Care

Percentage of Learning Disability Service clients with a Physical Health Check and Health Action Plan in the past year

Latest value	Standard	Mean
93.4 %	>80%	76 %

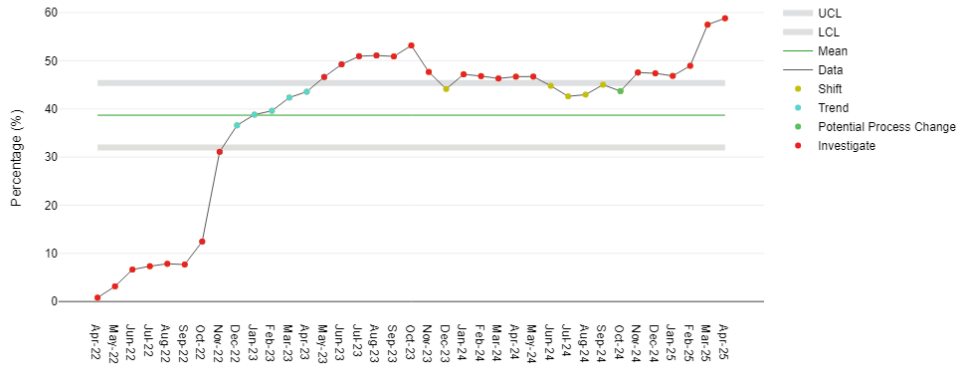


Definition
Percentage of Learning Disability (LD) clients with an open involvement in the period who have had a Physical Wellbeing Assessment and a Health Action Plan within the past year.

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Generated based on historic performance

Annual Support Plan Review Compliance Rate (LD) – % of Clients Review Compliant Within 12 Months

Latest value	Standard	Mean
58.8 %	>=90%	38.7 %



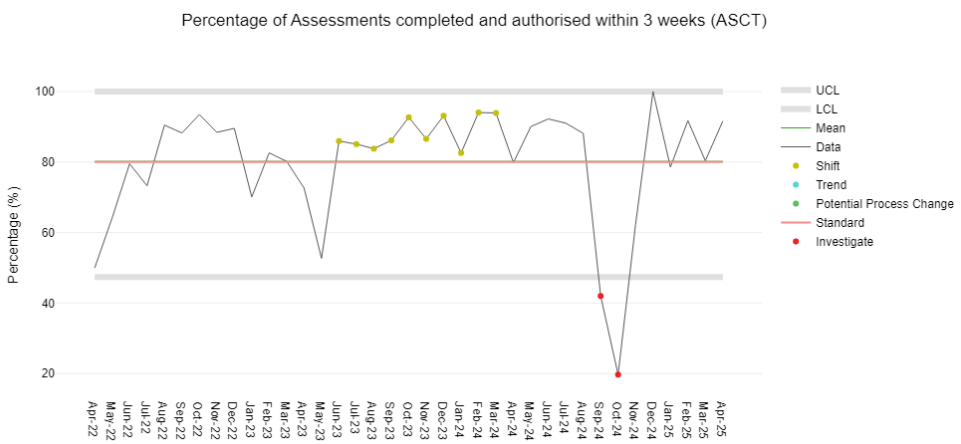
Definition
% of clients in the ASCC group with a Support Plan Review completed within 12 months of their last review or initial involvement, compared to the total caseload. A client is considered review compliant if their Next Review Due Date is within the past 12 months and on or before the Caseload Month, regardless of the specific CoC within ASCC where the review was completed.

Data Source	Standard Source
Community services electronic client record system (Care Partner)	NHS Care Act 2014

Social Care

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

Latest value	Standard	Mean
91.6 %	>=80%	80.2 %

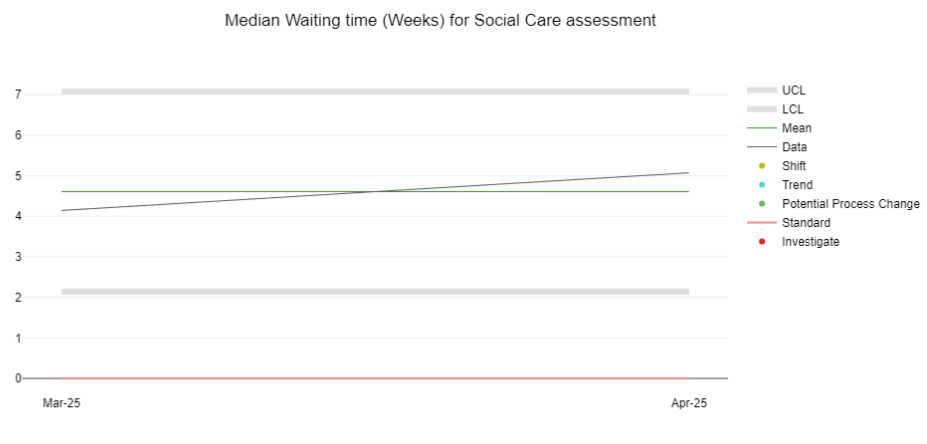


Definition
Number of FACE Support Plan and Budget Summary opened in the ASCT centre of care that are opened then closed within 3 weeks, divided by the total number of FACE Support Plan and Budget Summary opened in the ASCT centre of care more than 3 weeks ago

Data Source	Standard Source
Community services electronic client record system (Care Partner)	Generated based on historic performance

Median Waiting time (Weeks) for Social Care assessment

Latest value	Standard	Mean
5.07	TBC	4.61



Definition
Median Waiting times to assessment (Weeks)

Data Source	Standard Source
Community services electronic client record system (Care Partner)	TBC

Social Care Quarterly Indicators

Indicator	2024-Q3	2024-Q4	2025-Q1
% of service users who say the service made them feel safe and secure			59.68%
% of service users who agree that the care and support they received during their visit has made things better for them	100%	91.67%	100%
% of service users who agree that after their visit they find it easier to carry out everyday activities	100%	91.67%	100%

Quality & Safety

Section Owner

Medical Director / Chief Nurse

Performance Narrative

Pressure Ulcers

Acquired in care

There were no datix submissions for Pressure ulcers category 3 and above for April 2025

Present before admission

There were 20 datix submissions for pressure ulcers present before admission to hospital

13 – home

7 – residential / nursing home

9 of these were category 3 and above

6 – home

3 – residential /nursing home

Launch of Island-Wide Pressure Ulcer Prevention and Management Framework

We are pleased to announce the launch of the revised Island-Wide Pressure Ulcer Prevention and Management Framework on Wednesday 21st May.

About the Revised Framework

Replacing the 2021 version, the updated framework offers a more consistent, evidence-based, and person-centred approach to care. Co Authored by the Tissue Viability Teams at Health Care Jersey (HCJ) and Family Nursing and Home Care (FNHC) following consultation with Key stakeholders across the Island, the revised framework:

* Strengthens the prevention, identification, and management of pressure ulcers.

* Clarifies roles, responsibilities, and escalation pathways.

Quality & Safety

* Aligns with national legislation, national care standards, and the principles of realistic medicine.

* Applies to people of all ages and across all care settings, including hospitals, general practice, community teams, care homes, hospices, home care, day centres, and prison and ambulance services.

* Supports care for individuals with both physical and mental health needs, promoting multidisciplinary collaboration and a strong emphasis on safeguarding.

Complaints

In April, 18 new complaints were received across Health and Community Jersey. A slight increase in complaints compared to April 2024 with 15 complaints received. All complaints were categorised for efficient tracking, prompt resolution, and trend identification.

The two identified themes for April were attitude & behaviour and care concern delivery including basic nursing care. Drawing on this feedback two key areas of quality improvement have been identified to support fundamental care delivery.

1. Implementation of Healthcare Assistant Skills Training – 'Care Certificate'

HCJ Health Education Department launched a new training programme titled the Care Certificate. This initiative focuses on equipping Healthcare Assistants with the essential skills required to deliver high-quality basic nursing care.

2. Nutrition & Hydration Improvements

HCJ Nutrition & Hydration Working Group conducted a comprehensive catering survey to better understand patient preferences, current offerings, and areas for enhancement. Based on the findings, actionable changes will be implemented in May 2025. These include the introduction of clearly displayed snack menus at each bedside, ensuring all inpatients are aware of available options.

Compliments

In April 2025, 163 compliments were logged in the Datix system. This was a significant increase from April 2024 with 139 compliments recorded.

The top three areas receiving the most compliments in April were, Beauport Ward, Mental Health Community Services and Robin Ward.

Health Care Jersey (HCJ) continues to show a positive trend with compliments, reflecting our commitment to excellence. We ensure all patient and family compliments are documented in the Datix system through collaboration with various wards and departments.

Patient Advice & Liaison Service (PALS)

In April 2025, PALS logged 98 interactions through PALS Concern and enquiry, a stark increase from 79 in April 2024, highlighting the growing reliance on their support and guidance.

Quality & Safety

Healthcare Associated Infections

C. difficile:

There have been three C. difficile infections in April located across three wards. The root cause analysis investigations are currently underway.

MRSA/ MSSA

There have been no MRSA/ MSSA bacteramia in April

E. coli bacteraemia

There has been one E. coli bacteramia in April. Root cause analysis investigation underway.

Pseudomonas bacteraemia

There has been one pseudomonas bacteramia in April. Root cause analysis investigation underway.

Klebsiellla bacteraemia

There were no klebsiella bacteramia in April.

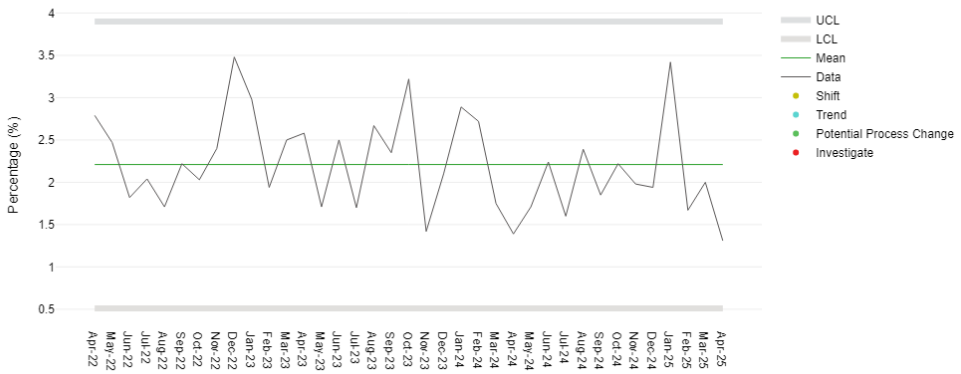
Escalations

Please note three C. difficile infections in April. Enhanced infection prevention and control measures in place, antimicrobial prescribing under review as part of the root cause analysis. Resource implications for antimicrobial stewardship continue.

Quality & Safety

Crude Mortality Rate (JGH, Overdale, St Ewolds and Mental Health)

Latest value	Standard	Mean
1.3 %	NA	2.2 %

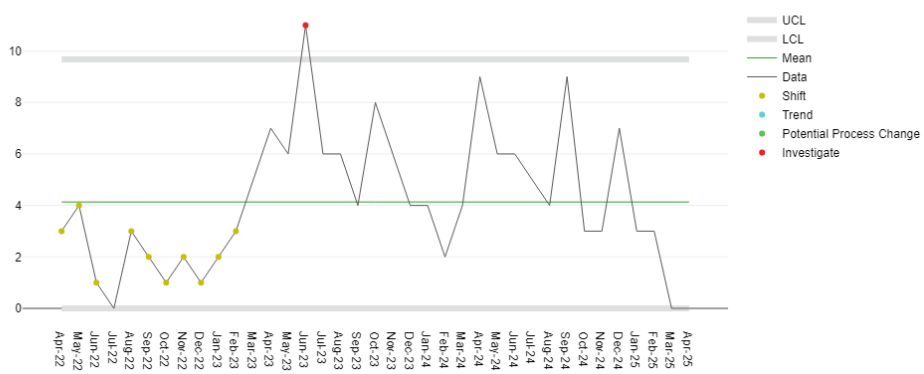


Definition
A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted.

Data Source	Standard Source
Hospital Electronic Patient Record Inpatient Discharges (TrakCare Report ATD9P & Maxims Report IP013DM)	Not Applicable

Number of serious incidents

Latest value	Standard	Mean
0	NA	4.14



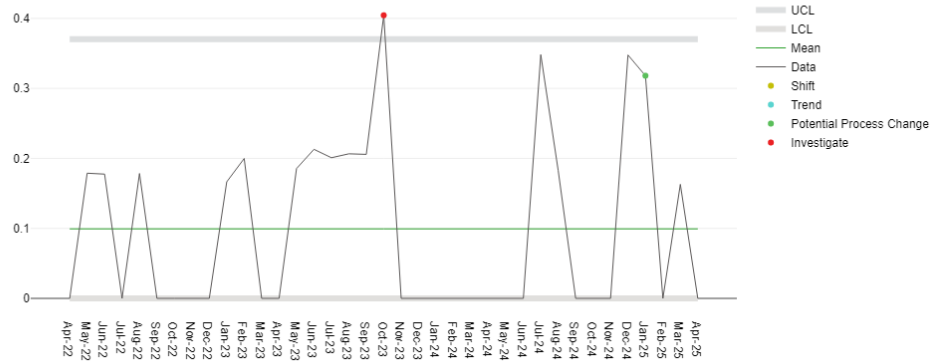
Definition
Number of safety events recorded in Datix where the event is marked as a 'Serious Incident' in the period

Data Source	Standard Source
HCJ Incident Reporting System (Datix)	Not Applicable

Quality & Safety

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

Latest value	Standard	Mean
0	NA	0.1

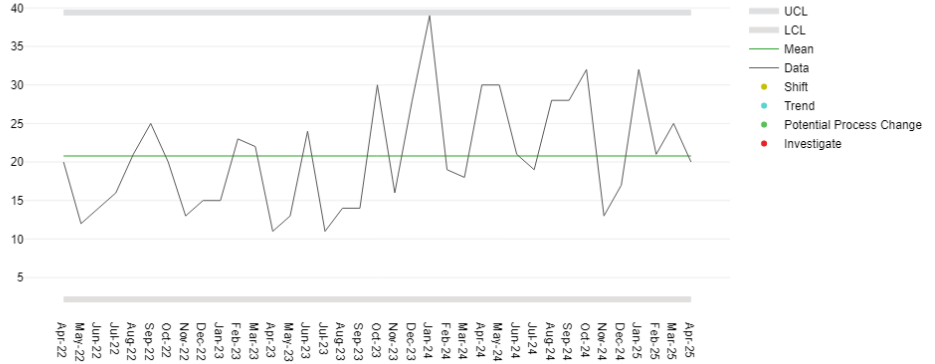


Definition
Number of inpatient falls with moderate or severe harm recorded where approval status is not "Rejected" per 1000 occupied bed days

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Not Applicable

Number of pressure ulcers present upon inpatient admission

Latest value	Standard	Mean
20	NA	20.78



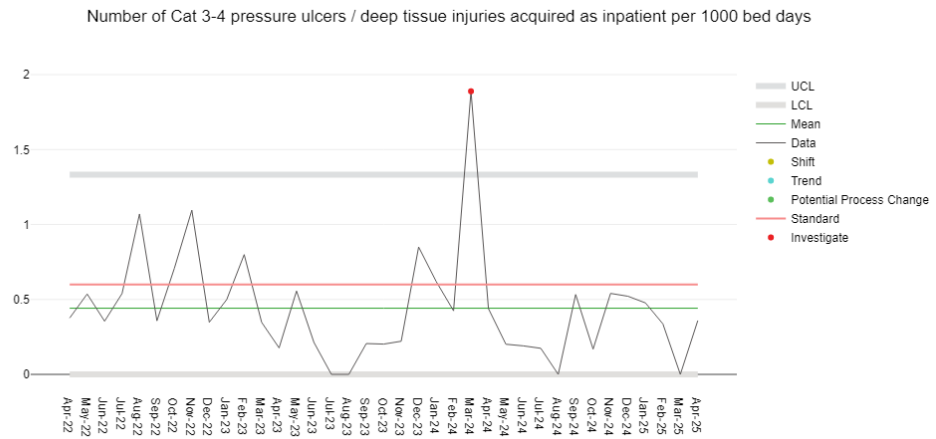
Definition
Number of pressure ulcers upon inpatient admission to any HCJ inpatient unit where the approval status is not recorded as "Rejected". All pressure ulcers under sub-category "present before admission" but excluding those recorded as "present before admission from other ward".

Data Source	Standard Source
HCJ Incident Reporting System (Datix)	Not Applicable

Quality & Safety

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

Latest value	Standard	Mean
0.36	<0.60	0.44

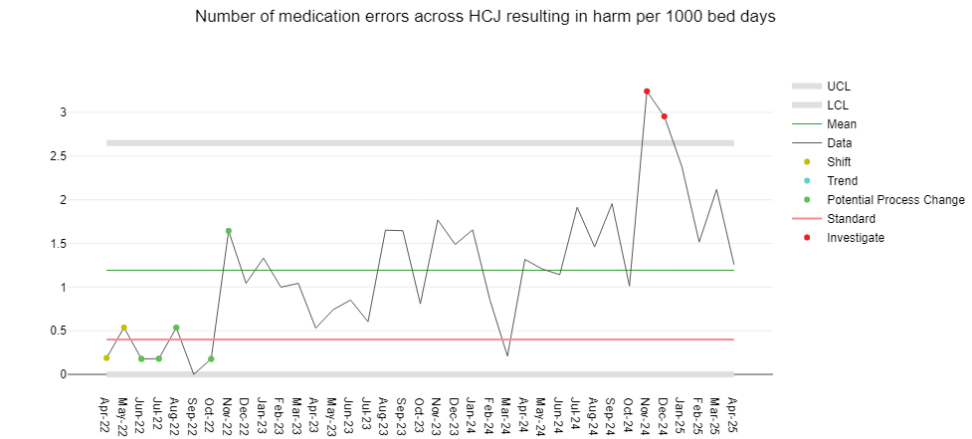


Definition
Number of inpatient Cat 3 & 4 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days

Data Source	Standard Source
HCJ 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 HCJ resulting in harm per 1000 bed days

Latest value	Standard	Mean
1.26	<0.40	1.19



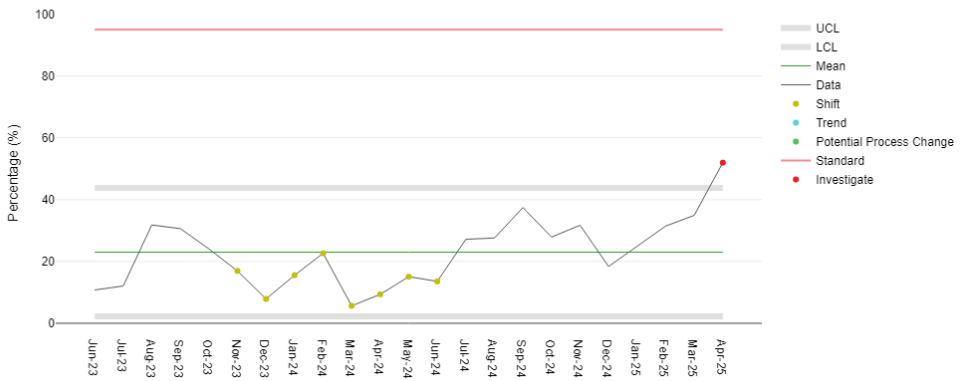
Definition
Number of medication errors across HCJ (including Mental Health) resulting in harm where approval status is not "Rejected" per 1000 occupied bed days. Note that this indicator will count both inpatient and community medication errors due to recording system limitations. As reporting of community errors is infrequent and this indicator is considered valuable, this limitation is accepted.

Data Source	Standard Source
HCJ 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

Quality & Safety

% of adult inpatients who have had a VTE risk assessment within 24 hours of admission

Latest value	Standard	Mean
51.9 %	>95%	23 %

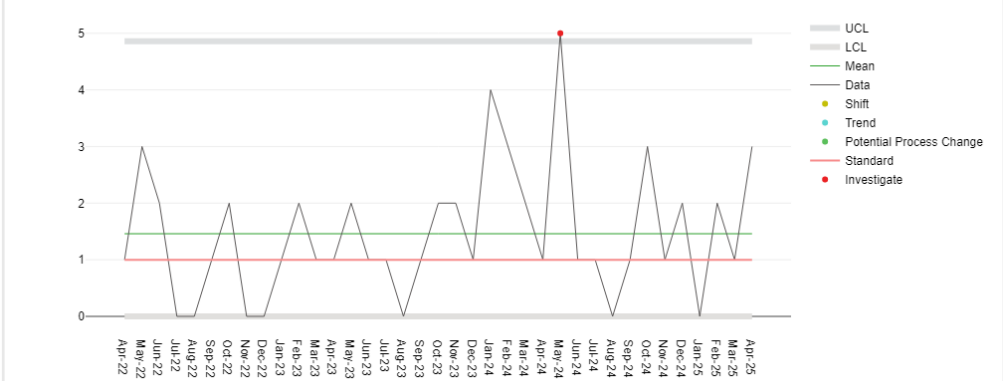


Definition
Percentage of all inpatients (aged 17 and over), (excluding paediatrics, maternity, mental health, and ICU) that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission.

Data Source	Standard Source
Hospital Electronic Patient Record (Maxims Report IP026DM)	NHS Operational Standard

C-Diff Cases - Hosp

Latest value	Standard	Mean
3	1	1.46



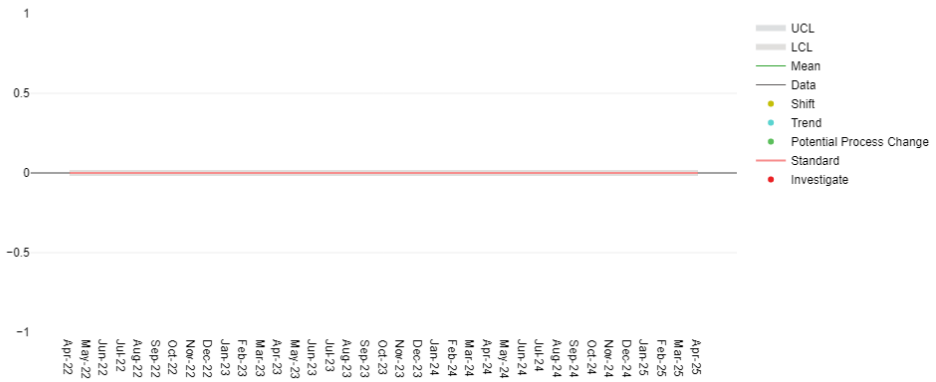
Definition
Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team

Data Source	Standard Source
Infection Prevention and Control Team Submission	Standard based on historic performance (2020)

Quality & Safety

MRSA Bacteraemia - Hosp

Latest value	Standard	Mean
0	0	0

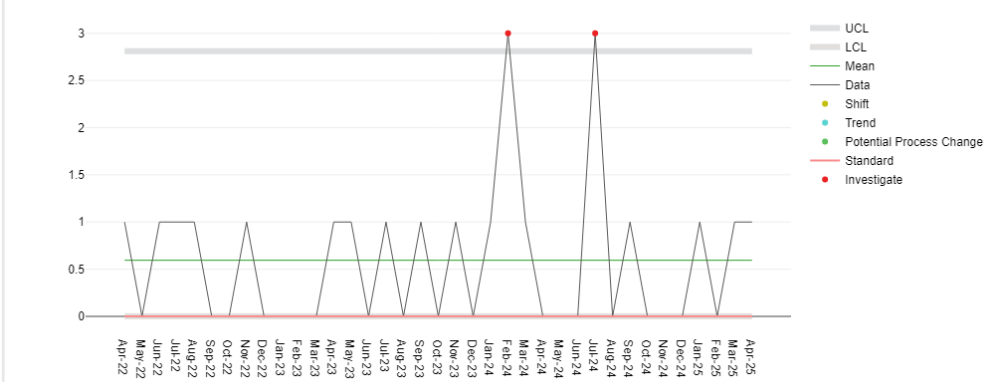


Definition
Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team

Data Source	Standard Source
Infection Prevention and Control Team Submission	Standard based on historic performance

E-Coli Bacteraemia - Hosp

Latest value	Standard	Mean
1	0	0.59



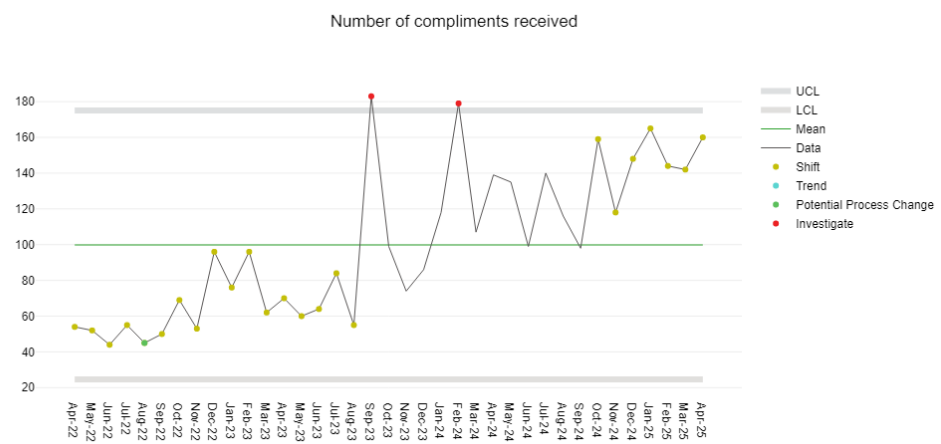
Definition
Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team

Data Source	Standard Source
Infection Prevention and Control Team Submission	Standard based on historic performance

Quality & Safety

Number of compliments received

Latest value	Standard	Mean
160	NA	99.84



Definition
Number of compliments received in the period where the approval status is not "rejected"

Data Source	Standard Source
HCJ Feedback Management System (Datix)	Not Applicable

Number of complaints received

Latest value	Standard	Mean
18	NA	26.46

Definition
Number of formal complaints received in the period where the approval status is not "Rejected"

Data Source	Standard Source
HCJ Feedback Management System (Datix)	Not Applicable