Health and Care Jersey

Gouvèrnément d'Jèrri

Quality and Performance Report
March 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.

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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

Patients waiting over 52 weeks for first appointment

As in previous months there is a reduction in patients waiting over 52 weeks for their first outpatient appointment. This reduction is most notable in clinical genetics testing through the full implementation of the FHARAS software which has enabled HCJ to manage these patients on Island rather than relying on off-Island provision which has limited capacity.

Capacity within the gastroenterology and ENT services is unable to meet the demand of the referrals being received and as such the services are currently prioritising the urgent cases with patients who have less urgent symptoms experiencing lengthy waits.

Orthopaedic spinal waits have increased due to surgeon availability. The team are working through options to ensure all patients referred into this specialty are seen and treated.

Patients on Elective Lists greater than 52 weeks

The number of patients waiting over 52 weeks for an elective procedure has risen for the 10th month in a row. As described in previous reports, a lack of available beds, equipment and breakdowns has contributed to this rise over recent months.

However, as winter pressures have subsided, beds are now able to be ring fenced for elective surgical procedures resulting in the start of increased theatre productivity. It is expected patients waiting over 365 days will reduce over the summer.

Elective Care Performance

Access to diagnostics greater that 6 weeks

Diagnostics waits continue to rise, however all urgent tests are prioritised.

New to Folow-up ratio

The ratio continues to remain relatively static and within reasonable levels.

DNA and WNB rates

The number of patients who have not attended their appointment continues to fall as we implement processes to ensure patients are aware of their appointment dates and times.

Elective theatre utilisation

Utilisation of elective theatres continues to rise in line with the focus on data capture processes and operational improvements in the theatre planning.

Theatre Cancellations for non-clinical Reasons

On the day cancellations for non-clinical reasons continues to fall due to improved availability of beds and equipment.

Escalations

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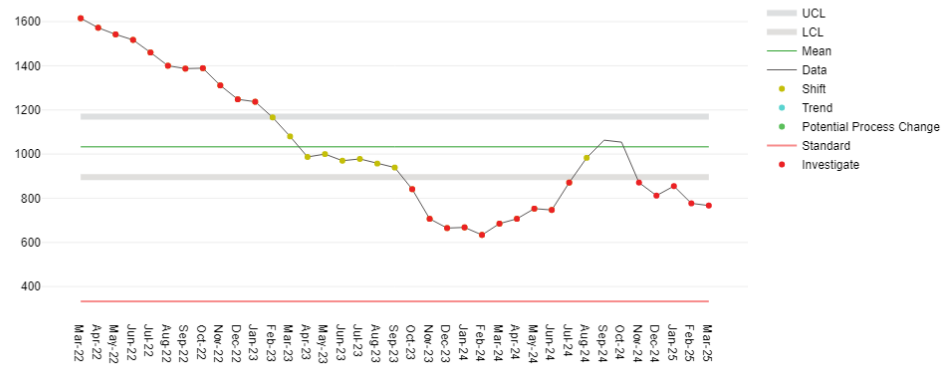
Elective Care Performance

Patients waiting for first outpatient appointment greater than 52 weeks

Latest value	Standard
767	<333

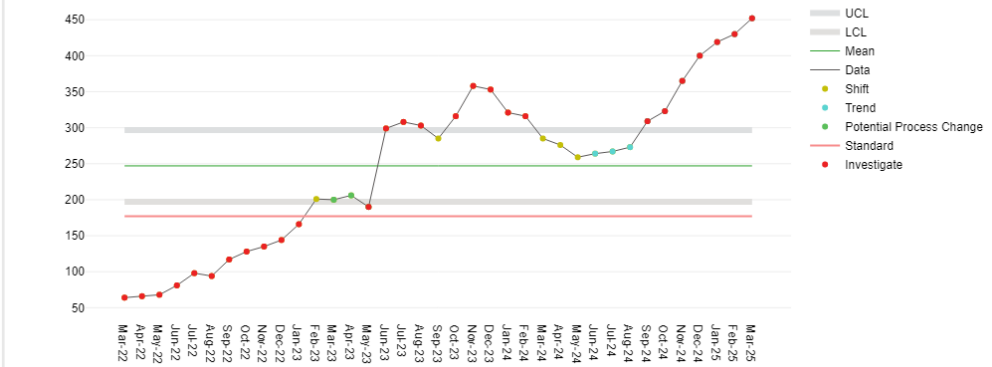


Definition
Number of patients who have been waiting for over 52 weeks for a first outpatient appointment at period end

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
452	<177



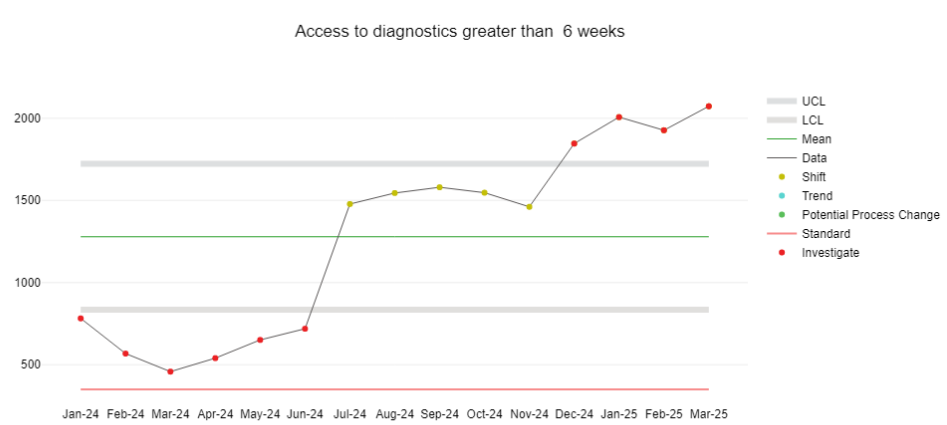
Definition
Number of patients on the elective inpatient waiting list who have been waiting over 52 weeks at period end.

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
2073	<350

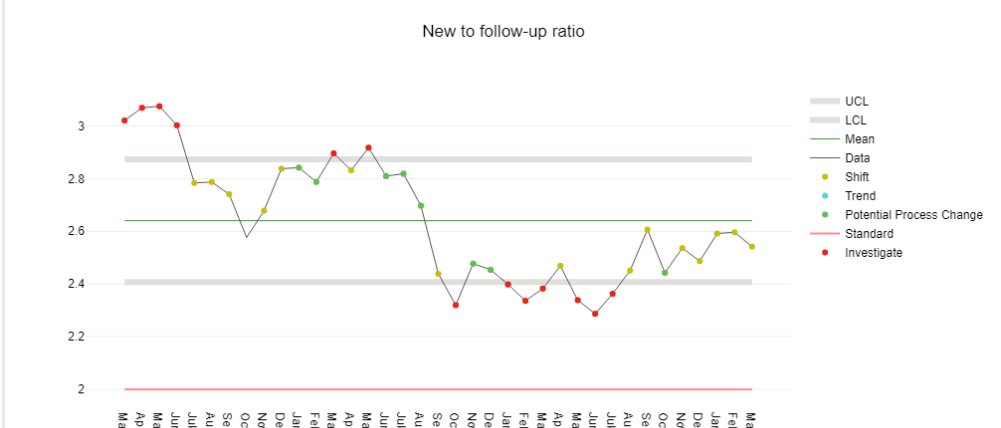


Definition
Number of patients waiting longer than 6 weeks for a first diagnostic appointment at period end. Data only available from January 2024. Indicator is being developed to include diagnostic investigations comparable to those monitored in the NHS DM01 return. Currently HCJ is unable to report 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
2.54	2



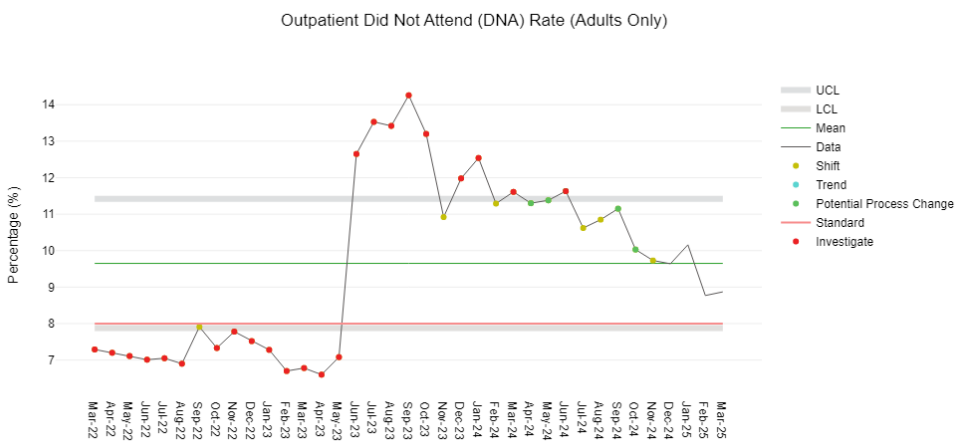
Definition
Rate of new (first) outpatient appointments to follow-up appointments, this being the number of follow-up appointments divided by the number of new appointments in the period. Excludes Private patients.

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%

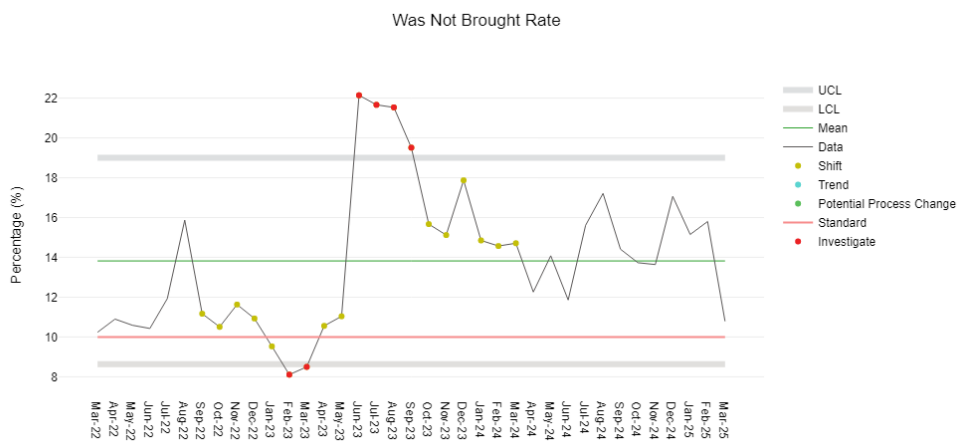


Definition
Percentage of JGH/Enid Quenault outpatient (>=18 Years old) appointments where the patient did not attend and no notice was given. Excludes Private patients.

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
10.8 %	<=10%



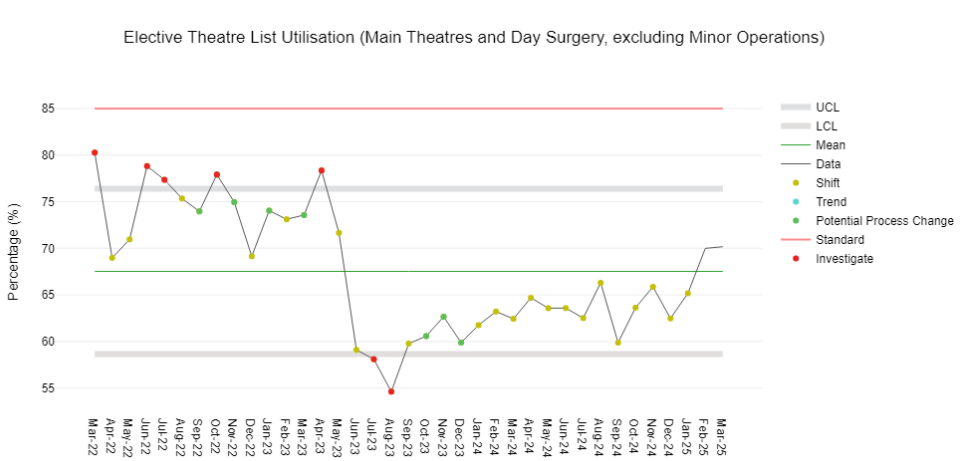
Definition
Percentage of JGH/Enid Quenault public outpatient appointments where the patient did not attend (was not brought). Under 18 year old patients only. All specialties included. Excludes Private patients.

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
70.2 %	>85%

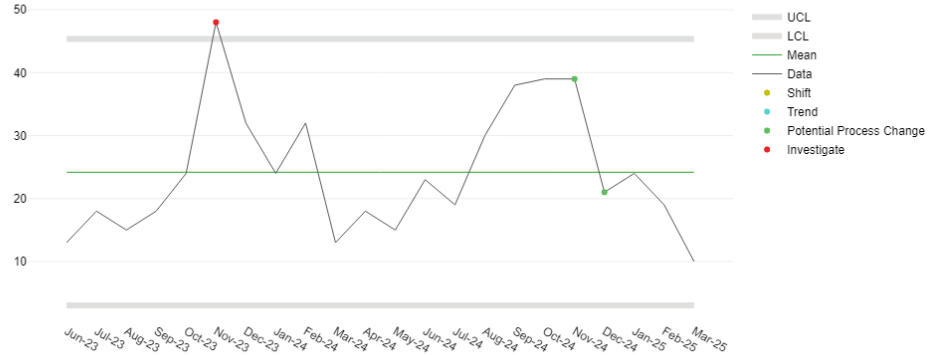


Definition
The percentage of booked theatre session time that is used for actively performing a procedure. This being the sum of touch time divided by the sum of booked theatre session duration (as a percentage). This is reported for all operations (Public and Private) with the exception of Minor Ops,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

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), 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
10	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

Attendance & Admissions

* Total Attendees: 3,625, reflecting a decrease from January and 66 fewer than in March 2024.
* 4-Hour Target Compliance: Improved to 72.4%, with minors achieving 92.5%, exceeding current benchmarks reported in England.
* 12-Hour Breaches: Reduced to 2.0%, with 44 breaches linked to patients requiring admission.
* Admission Rate: 15.5% of ED attendees required admission, showing a slight decrease from the previous month.

Operational Improvements & Initiatives

Red 2 Green (R2G) Implementation

* Continued embedding of R2G principles to enhance patient flow.
* Dedicated patient review days scheduled in advance of Bank Holiday periods to support proactive recovery.

Non-Clinical Patient Transfers

* Significant reduction in out-of-hours non-clinical transfers, ensuring greater clinical continuity.
* Monitoring of all non-clinical transfers is now standard practice during operational bed meetings, in response to learnings from a recent serious incident.

Length of Stay (LOS) & Readmissions

* Emergency LOS: Currently rated amber, with progress noted in addressing Royal College of Physicians (RCP) recommendations.

Emergency Care Performance

* Acute Bed Occupancy at Midnight: Reduced to 81%.
* 30-Day Readmissions: Increased to 13.8%, requiring further analysis to identify root causes and mitigate risks.
* Morning Discharges (8 AM – Noon): Decreased to 13.0%, placing us back into red status.

Escalations

March performance continued to reflect operational pressures, particularly in managing prolonged ED waits due to:

* Isolation requirements delaying patient movement.
* Gender-specific bed constraints.
* Ongoing capacity pressures across the system.

Actions Underway

* Maintaining additional capacity to support patient flow.
* Conducting line-by-line R2G reviews ahead of each Bank Holiday.
* Implementing targeted LOS reduction initiatives to improve clinical productivity.
* Delivering an externally supported clinical flow improvement strategy to optimise throughput.

As part of the clinical productive programme an urgent care & patient flow working group has been established. This group will oversee the ward patient flow improvement programme which will include further embedding of the SAFER care bundle which supports effective patient flow through the hospital.

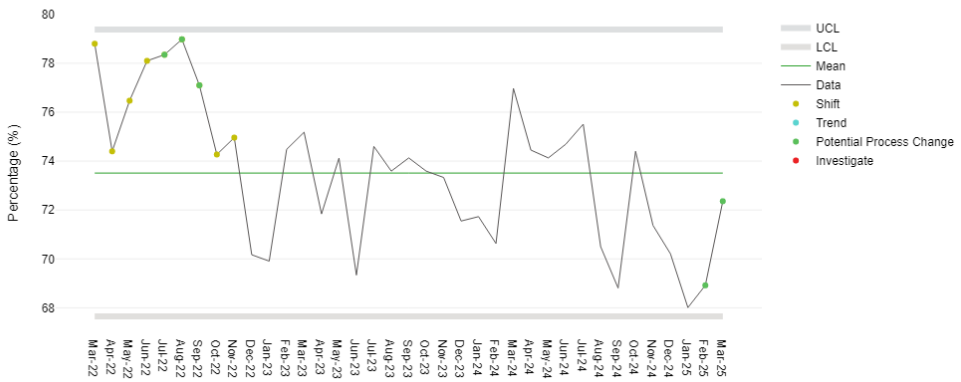
Whilst an improvement in ED performance has been noted in March 2025, analysis of the ED dataset has found data quality issues exist resulting in patients having longer stays recorded than are occurring. Daily breach validation processes have been implemented to improve the data quality to ensure accurate reporting, it is envisaged that this will be demonstrated in April reporting.

An increase in readmissions within 30 days is noted within March 2025, the data set does include admission which may take place for other reasons than the initial admission. A readmissions review group is planned to be established which will meet monthly to undertake an assessment of the readmissions to further understand the causes of readmission and identify future learning.

Emergency Care Performance

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

Latest value	Standard	Mean
72.4 %	NA	73.5 %

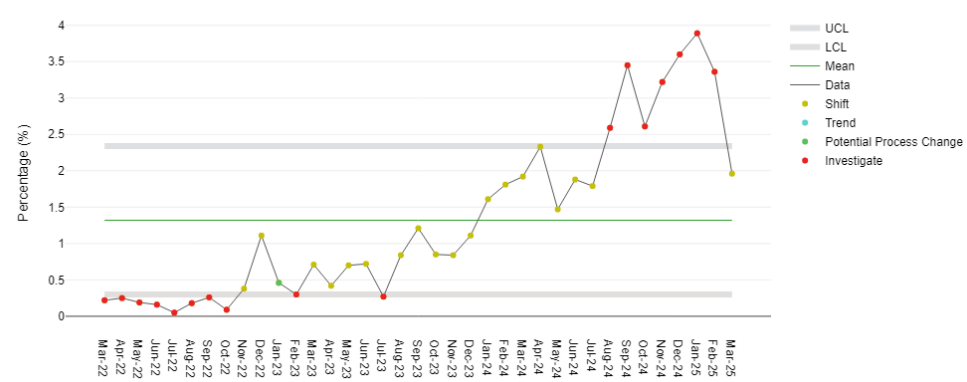


Definition
Percentage of patients in the Emergency department less than or equal to 4 hours from arrival to departure or admission

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
2 %	NA	1.3 %



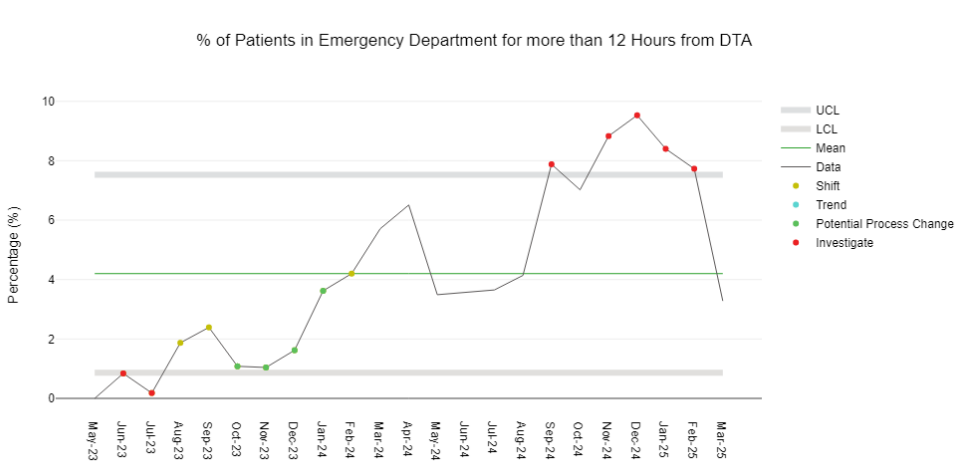
Definition
Percentage of patients in the Emergency department for more than 12 hours from arrival to departure or admission

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
3.3 %	NA	4.2 %

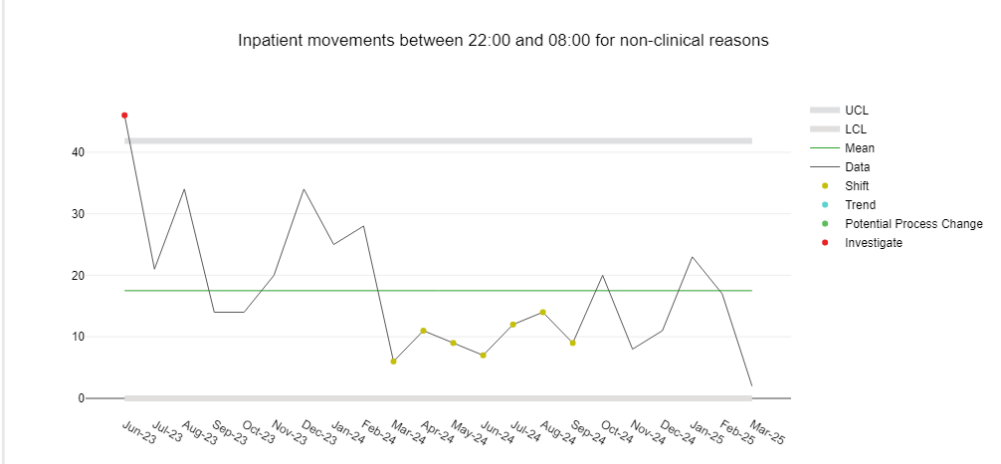


Definition
Percentage of Patients in Emergency Department for more than 12 Hours from DTA where a DTA has occurred

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
2	NA	17.5



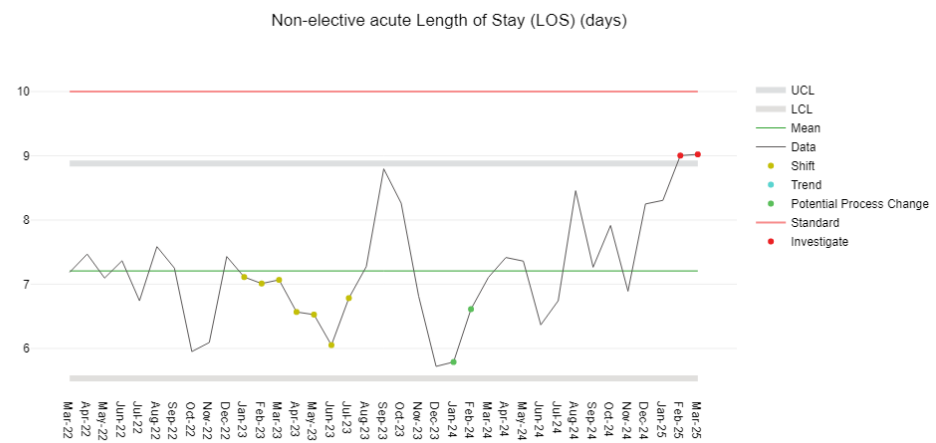
Definition
Number of inpatient moves within wards or between wards, between the hours of 22:00 and 08:00 for non-clinical reasons, in the reporting period.

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
9.02	<10	7.21

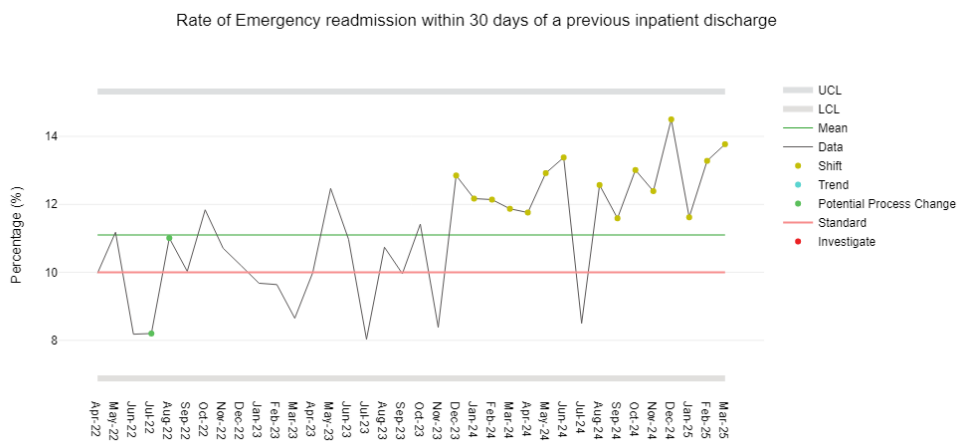


Definition
Average (mean) Length of Stay (LOS) in days of all emergency inpatients discharged in the period from a General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This 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
13.8 %	<10%	11.1 %



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

March highlighted ongoing systemic challenges across ED and inpatient services. Nonetheless, structured interventions—such as R2G implementation, operational refinements, and external support—are establishing a more resilient framework to manage winter pressures. Sustained focus on patient flow, discharge planning, and targeted interventions will remain key in maintaining patient safety and service quality in the months ahead.

Maternity

Section Owner

Chief Nurse

Performance Narrative

Our caesarean section rate has decreased this month to 46% (24 out of 52 births), with 24% being elective procedures. This marks a drop from previous months. Of the 24 caesarean sections, 12 were emergency cases. According to the Robson Criteria, the largest cohorts fall under Group 5—women with a previous caesarean birth, a single cephalic pregnancy at term—and Group 2a—induced labour. Patient choice continues to be a significant factor influencing our caesarean section rate, in line with both UK national and international trends. There was one caesarean birth performed at full dilatation.

In response to the ongoing decline in birth rate, we are reviewing data from the past five years to better understand trends in caesarean sections and to inform future service planning.

Our induction of labour rate has remained stable overall, with a slight increase this month to 48%. This reflects our continued commitment to offering induction based on individual clinical needs and at the most appropriate gestation.

Breastfeeding initiation remains strong, with 71.2% of mothers choosing to breastfeed.

There was one major obstetric haemorrhage reported this month. The case was reviewed by the Serious Incident Review Panel (SIRP) and demonstrated effective clinical management and good practice. No further investigations were required, and the case was thoroughly assessed using our NICHE tool.

Escalations

The implementation of a dedicated maternity-specific Electronic Patient Record (EPR) system remains pending. We are still awaiting a confirmed go-live date. This system is expected to enhance data collection and reporting, ultimately supporting improvements in service delivery.

Maternity - Key Performance Indicators

Indicator	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	YTD
Total Births	58	56	53	69	59	62	53	67	62	65	51	48	52	151
Mothers with no previous pregnancy (Primips)	19	15	20	34	22	27	26	31	35	30	24	18	26	68
Mothers who have had a previous pregnancy (Multips)	30	29	25	25	31	32	25	27	23	33	26	23	23	72
Mothers with unknown previous pregnancy status	9	12	8	10	6	3	2	9	4	2	1	7	3	11
Bookings ≤10+0 Weeks	7	8	8	9	7	4	9	6	8	4	2	2	2	6
% of women that have an induced labour	31.58%	22.22%	16.33%	19.4%	28.07%	18.33%	28.3%	38.46%	33.93%	29.51%	38%	29.55%	48%	38.89%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	21	10	19	19	12	22	17	10	12	14	12	9	13	34
Number of Instrumental deliveries	5	2	3	7	4	6	4	6	7	5	4	0	3	7
% deliveries by C-section (Planned & Unscheduled)	43.86%	66.67%	51.02%	52.24%	61.4%	51.67%	47.17%	46.15%	44.64%	52.46%	54%	61.36%	46%	53.47%
% Elective caesarean section births	15.79%	37.04%	28.57%	29.85%	35.09%	40%	26.42%	33.85%	26.79%	37.7%	42%	38.64%	24%	34.72%
Number of Emergency Caesarean Sections at full dilatation	1	1	1	0	4	0	1	0	1	0	0	1	1	2
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)	0	7	2	7	7	0	4	5	2	4	1	5	0	6
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)	5	5	1	4	4	2	3	3	3	3	7	3	4	14
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)	2	5	3	7	4	6	2	7	2	6	2	5	4	11
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)	5	6	5	4	10	10	9	5	2	5	8	6	4	18
Number of deliveries home birth (Planned & Unscheduled)	1	1	1	1	3	0	1	0	0	0	0	0	1	1
Mothers who were current smokers at time of booking (SATOB)	3	4	6	2	3	3	4	6	0	2	1	3	1	5
Mothers who were current smokers at time of delivery (SATOD)	3	0	2	2	3	6	3	3	4	4	3	1	4	8

Maternity - Key Performance Indicators

Indicator	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	YTD
Number of Mothers who were consuming alcohol at time of booking	2	0	0	0	0	0	0	0	0	2	0	1	1	2
Number of Mothers who were flagged as consuming alcohol after delivery	6	4	3	6	4	5	6	4	1	2	1	0	0	1
Breastfeeding Initiation rates	65.5%	73.2%	69.8%	71%	79.7%	67.7%	79.2%	65.7%	71%	78.5%	66.7%	70.8%	71.2%	69.54%
Transfer of Mothers from Inpatients to Overseas	1	1	0	1	0	1	2	3	0	0	2	1	1	4
Number of births in the High dependency room / isolation room	0	0	0	0	0	0	1	1	0	0	0	0	1	1
Number of PPH greater than 1500mls	1	6	0	1	3	1	0	1	3	2	3	2	2	7
Number of 3rd & 4th degree tears – all births	1	0	0	0	0	0	1	1	0	0	0	0	0	0
% of babies experiencing shoulder dystocia during delivery	0%	1.79%	0%	4.35%	0%	0%	0%	2.99%	1.61%	1.54%	1.96%	2.08%	0%	1.32%
% 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)	7.41%	3.85%	3.45%	2.78%	5.13%	2.56%	2.5%	2.22%	0%	2.33%	5.88%	9.68%	2.63%	5.83%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	0	1	2	0	1	0	0	1	0	1	1	0	2
Transfer of Neonates from JNU to an off-island facility	0	1	0	1	0	1	0	0	0	0	2	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)	8	1	2	2	3	4	1	4	5	8	3	4	3	10
Neonatal Readmissions at Less Than 28 days old	4	5	5	6	4	5	9	5	11	5	6	5	5	16

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

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

This month has shown some improvement in the access KPIs relating to both Jersey Talking Therapies and the Memory Assessment service.

Challenges remain in relation to capacity of the Autism service (which is related to staffing availability within the service) and the ADHD service (both assessment and treatment)

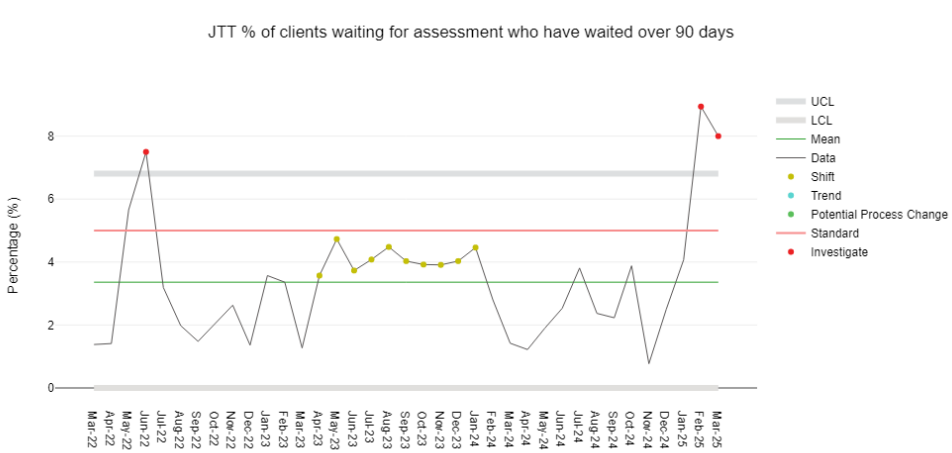
Access targets for mental health services continue to be well met, with 95% of crisis assessments completed within 4 hours ; 90% of routine referrals seen within 10 days; and 46% of clients in the alcohol & drug service being seen within 3 weeks.

Escalations

The inpatient mental health services have been running at over 100% occupancy, and in month 20% of the beds have been occupied by patients who no longer need to be in hospital. Significant positive partnership work is underway with Housing Advice Service colleagues to help address some of the issues that contribute to this, and the service (and the wider Mental Health Partnership Board) continue to monitor / review this.

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

Latest value	Standard	Mean
8 %	<5%	3.4 %



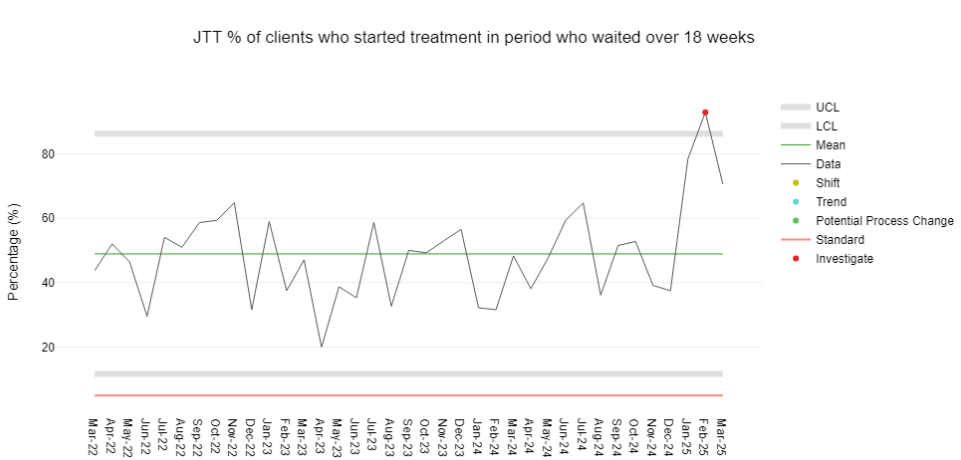
Definition
Number of Jersey Talking Therapy (JTT) clients who have waited over 90 days for assessment, divided by the total number of JTT clients waiting for assessment

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
70.6 %	<5%	48.9 %

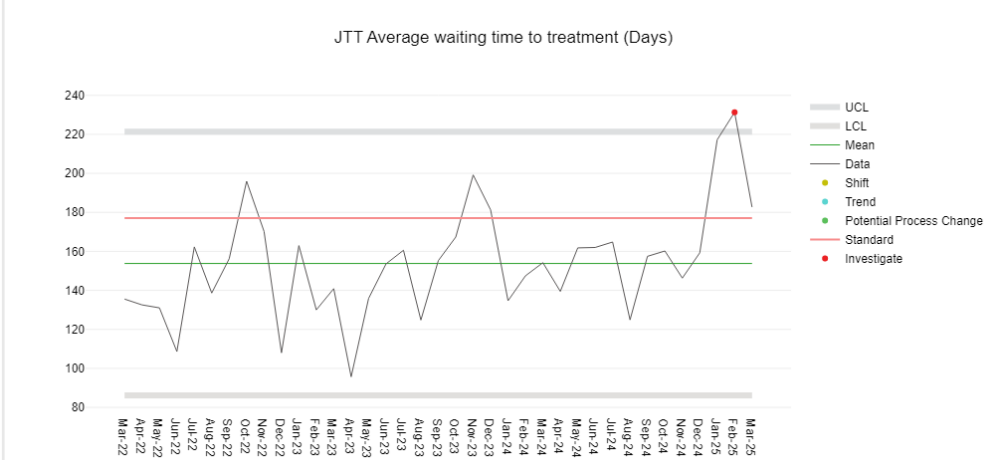


Definition
Percentage of Jersey Talking Therapy (JTT) clients commencing treatment in the period who had waited more than 18 weeks to commence treatment.

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
182.71	<=177	153.79



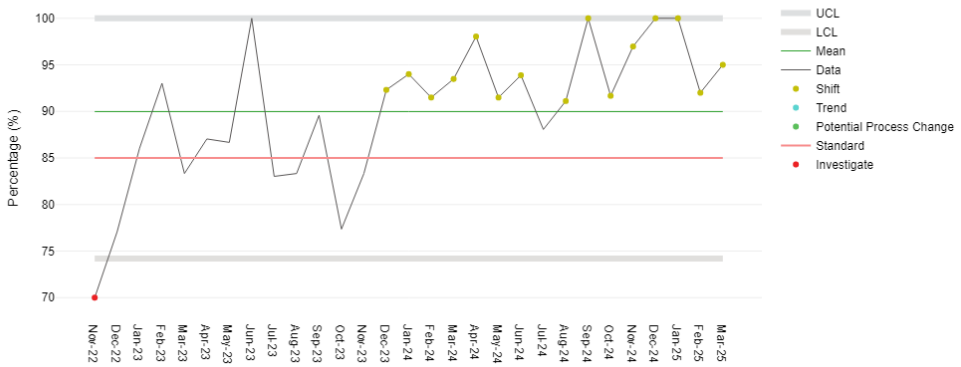
Definition
Average (mean) days waiting from Jersey Talking Therapy (JTT) referral to the first attended treatment session for patients commencing treatment in period

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
95 %	>85%	90 %

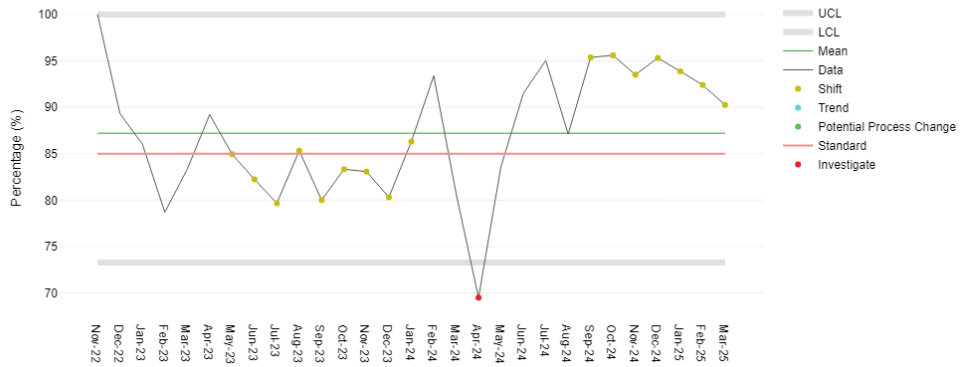


Definition
Percentage of Crisis Team referrals assesed within 4 hours

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
90.3 %	>85%	87.2 %



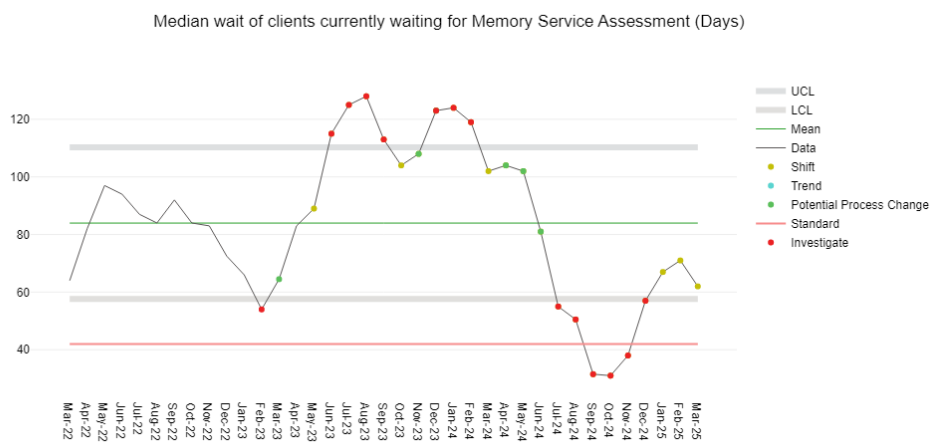
Definition
Percentage of referrals to Mental Health Assessment Team that were assessment within 10 working day target

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
62	<=42	83.97

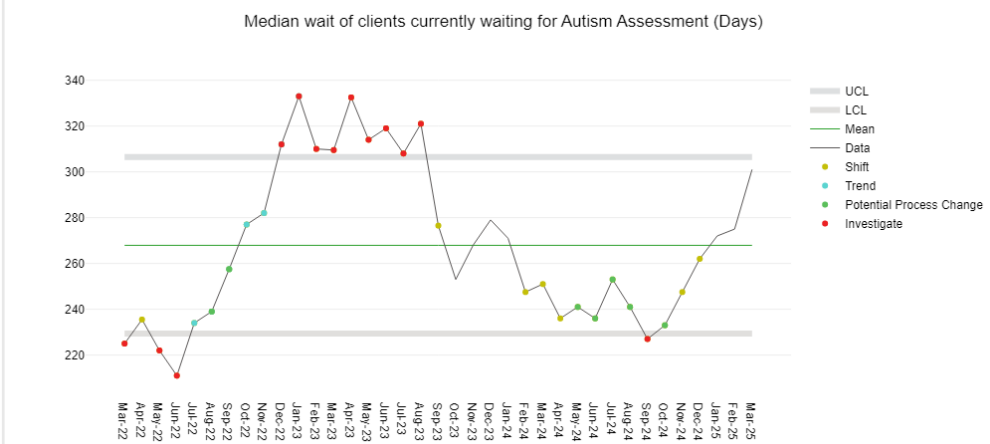


Definition
Memory Service Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

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
301	NA	267.91



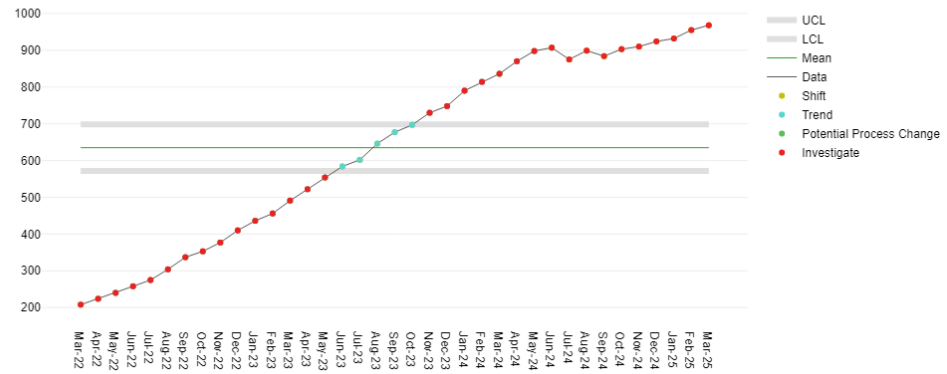
Definition
Autism Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

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
968	NA	634.97

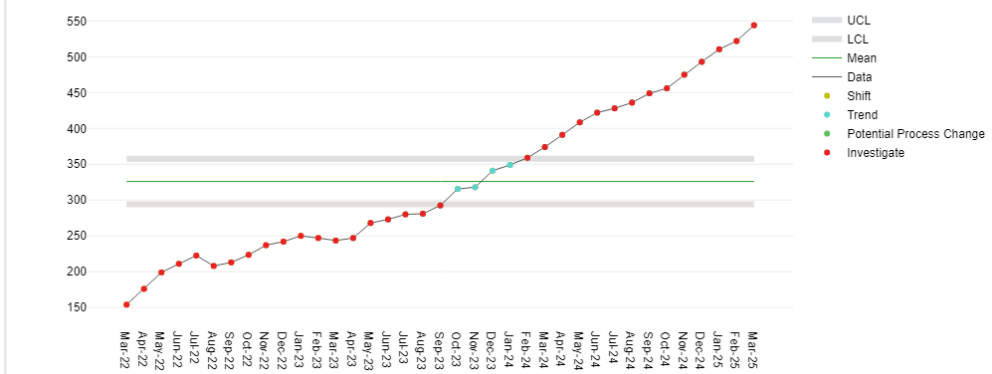


Definition
Number of clients waiting for ADHD assessment

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
544	NA	325.93



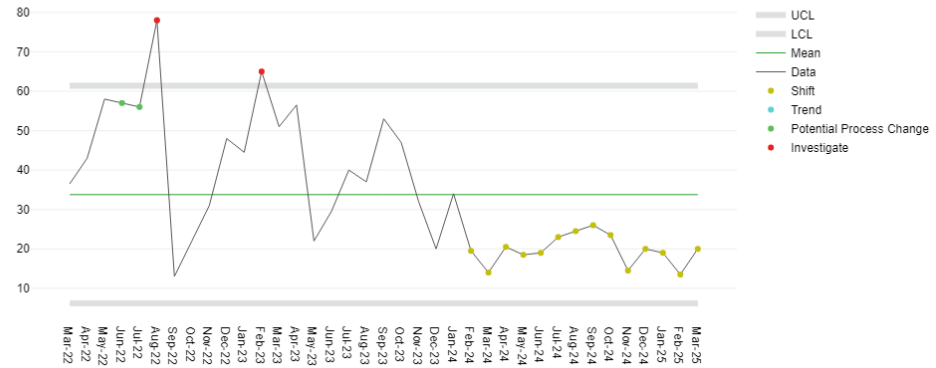
Definition
ADHD Assessment Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

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	33.77

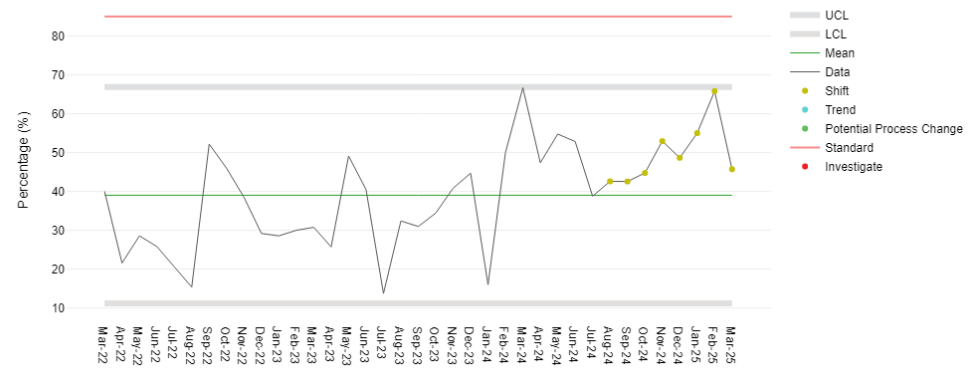


Definition
Alcohol and Drugs Median Waiting times from date of referral to last day of reporting period for people on waiting list at period end

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
45.7 %	>85%	39 %



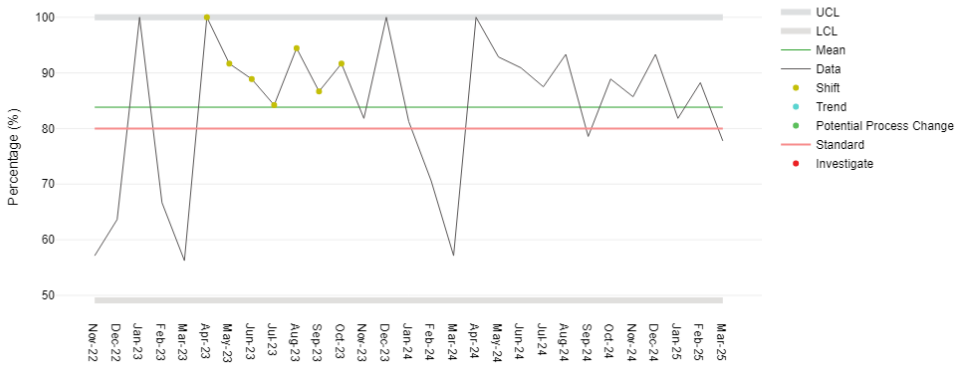
Definition
% of clients who waited less than 3 weeks for their first attended appointment, who were seen in reporting period

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
77.8 %	>80%	83.8 %

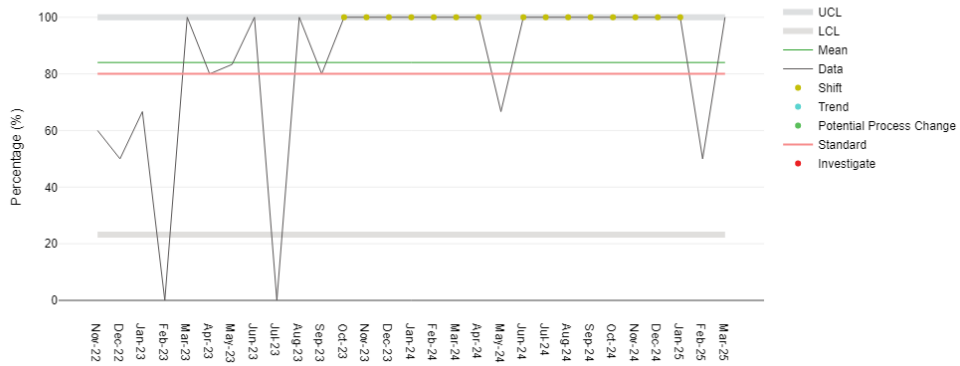


Definition
Percentage of patients discharged from Mental Health Inpatient Unit with an Adult Mental Health Specialty' with a Face-to-Face contact from Community Mental Health Team (CMHT, including Adult & Older Adult services) or Home Treatment within 72 hours

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
100 %	>80%	84 %

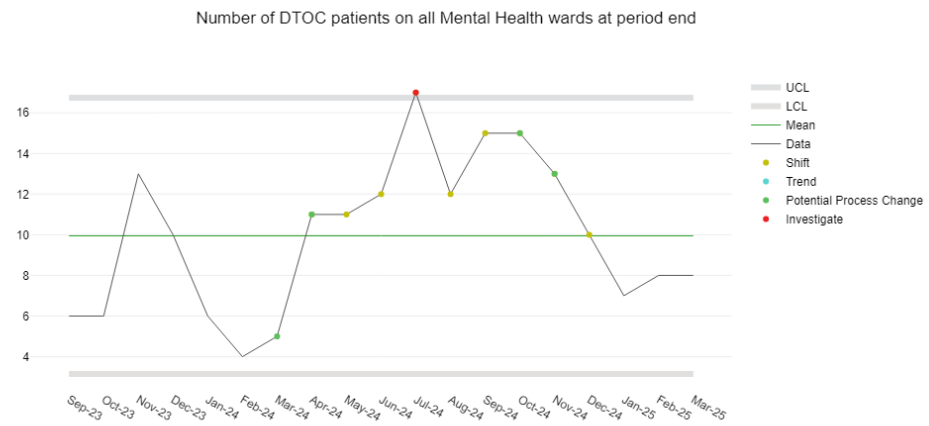


Definition
Percentage of patients discharged from an 'Older Adult' unit with a Face-to-Face contact from Older Adult Community Mental Health Team (OACMHT) or Home Treatment within 72 hours

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
8	NA	9.95



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

The target percentage of Learning Disability Service clients with a completed physical health check in the past year continues to be achieved. Work is ongoing within the team to ensure that DNAs do not negatively impact on this.

The percentage of assessments completed and authorised within 3 weeks

(ASCT) continues above the target rate.

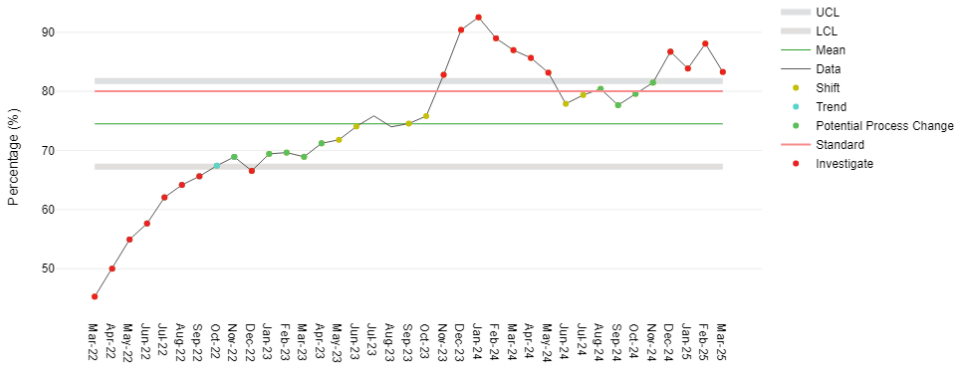
Unfortunately, we are not yet in a position to report against the new 2025 KPIs agreed for the service; this has been escalated to the Executive Director for the service and the Chief Clinical Information Officer, and work is underway to resolve this.

Escalations

Social Care

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

Latest value	Standard	Mean
83.3 %	>80%	74.5 %

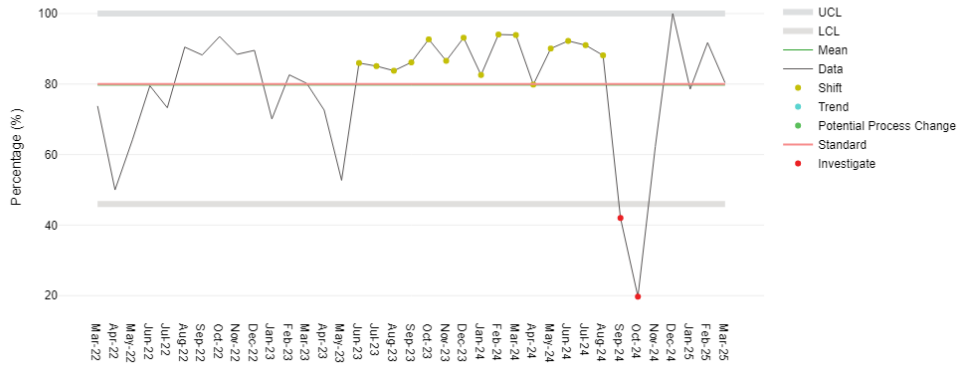


Definition
Percentage of Learning Disability (LD) clients with an open involvement in the period who have had a physical wellbeing assessment within the past year.

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

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

Latest value	Standard	Mean
80.4 %	>=80%	79.7 %



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

Quality & Safety

Section Owner

Medical Director / Chief Nurse

Performance Narrative

In March 2025, Health and Community Services Jersey received 12 new complaints. Each was carefully categorised to support timely resolution, efficient tracking, and identification of recurring trends. The continued decline in formal complaints reflects our commitment to responding swiftly and effectively to concerns. Key themes identified this month included delays in appointment or surgery dates and aspects of care delivery, such as discharge processes and medication management. Each care group is actively addressing these areas to drive measurable improvements.

During the same period, 138 compliments were recorded in the Datix system. The top three services commended were Jersey Talking Therapies (JTT), the Oncology Department, and the Patient Experience Team. This positive feedback underscores our dedication to delivering high-quality, compassionate care. Compliments are consistently captured in collaboration with wards and departments to recognise and celebrate the efforts of our staff.

The Patient Advice and Liaison Service (PALS) recorded 116 interactions in March, reflecting the growing trust placed in the team's support and guidance. PALS works closely with care groups to respond to enquiries and concerns, ensuring patients and their families are well-informed and supported throughout their healthcare journey.

Healthcare-Associated Infections – March 2025

In March, one case of Clostridioides difficile (C. difficile) was reported. A full root cause analysis has been completed, and key learning points have been shared with clinical teams. An improvement plan has also been developed to support ongoing monitoring and ensure best practices are followed.

Antimicrobial stewardship remains a focus. Strengthening how we monitor, guide, and adjust the use of antibiotics is essential to preventing infections and promoting safe, effective care.

No cases of MRSA, MSSA, Klebsiella, or Pseudomonas bloodstream infections were reported in March. One case of E. coli was identified, and a root cause analysis is currently underway to understand and address any contributing factors.

Pressure Ulcers Report – March 2025

We are pleased to report that no category 3 or 4 pressure ulcers, or deep tissue injuries, were acquired during care in March. This reflects continued efforts to maintain high standards of skin care and prevention across our services.

A total of 21 pressure ulcers were identified as present upon admission, either from home or other care settings. Importantly, none of these ulcers worsened during the patient's stay, demonstrating the effectiveness of the care provided. Early detection, routine assessments, timely treatment, and preventative measures played a key role in maintaining skin integrity and preventing further complications.

Falls Report – March 2025

Falls Resulting in moderate harm = 1 - This incident has been fully documented, and appropriate actions were taken to ensure the patient's safety and well-being. Following the fall.

Falls Resulting in severe harm = 0

Quality & Safety

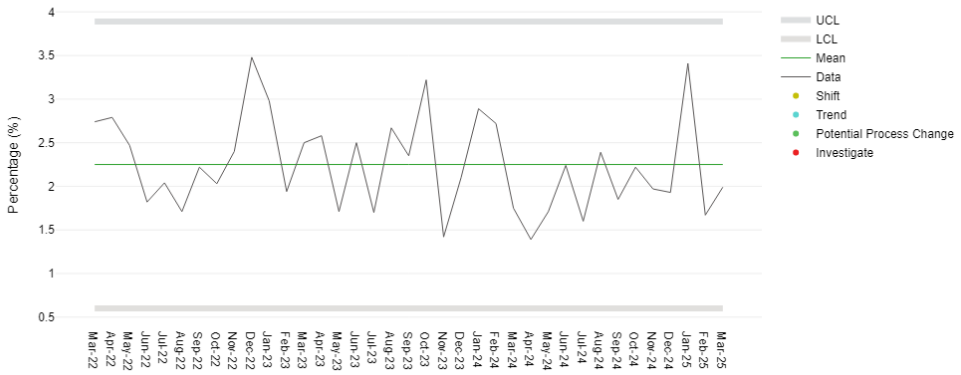
The Falls and Frailty Team continues to prioritise patient safety. To further lessen the risk of falls, several proactive measures have been introduced. These include thorough assessments and the use guidance on the appropriate use of non-slip socks, as well as the implementation of hourly intentional rounding. Intentional rounding has been used in Corbiere ward to apply the test of change and has had significant impact on reducing falls with the incidents during the test of change less in comparison to previous months. The Falls and Frailty team will feed back to the chief nurse with a view of initiating this throughout other wards within the hospital.

Escalations

Quality & Safety

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

Latest value	Standard	Mean
2 %	NA	2.3 %

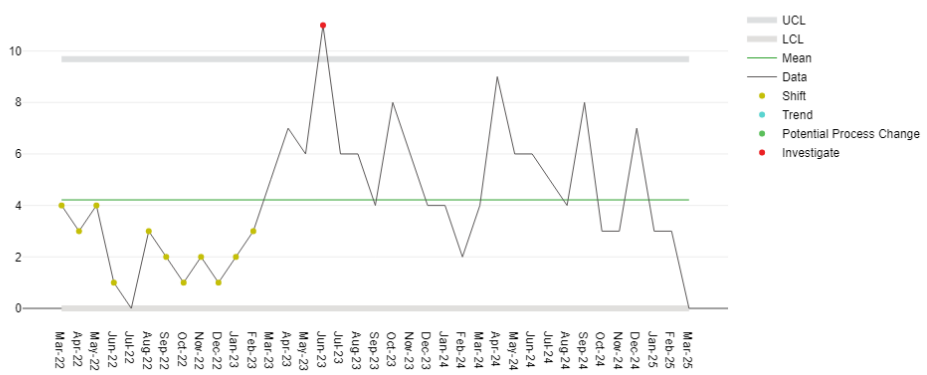


Definition
A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of 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	4.22



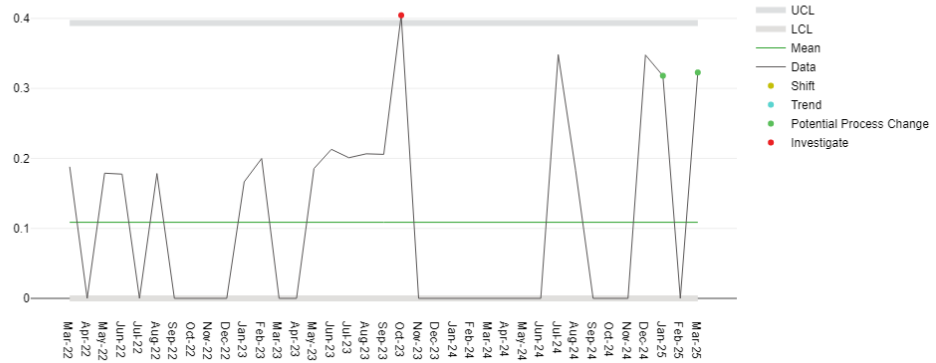
Definition
Number of safety events recorded in Datix where the event is marked as a 'Serious Incident' in the period

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
0.32	NA	0.11

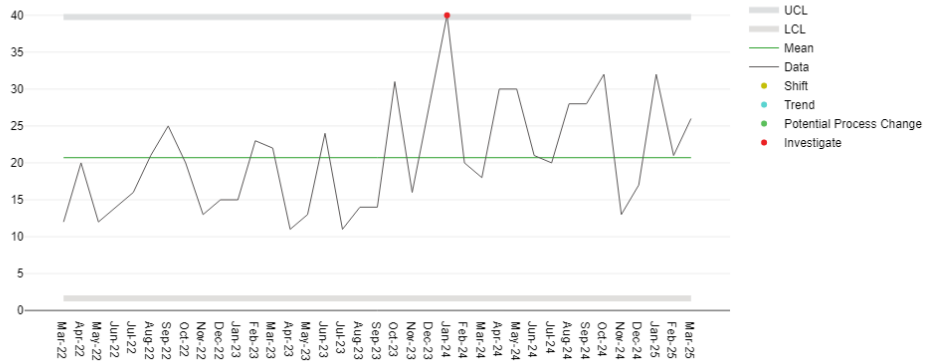


Definition
Number of inpatient falls with moderate or severe harm recorded where approval status is not "Rejected" per 1000 occupied bed days

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
26	NA	20.7



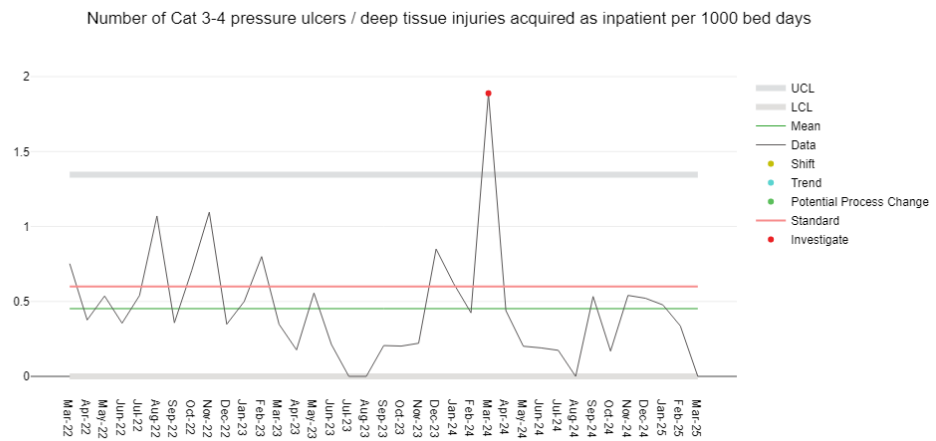
Definition
Number of pressure ulcers upon inpatient admission to any HCJ inpatient unit where the approval status is not recorded as "Rejected". All pressure ulcers under sub-category "present before admission" but excluding those recorded as "present before admission from other ward".

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	<0.60	0.45

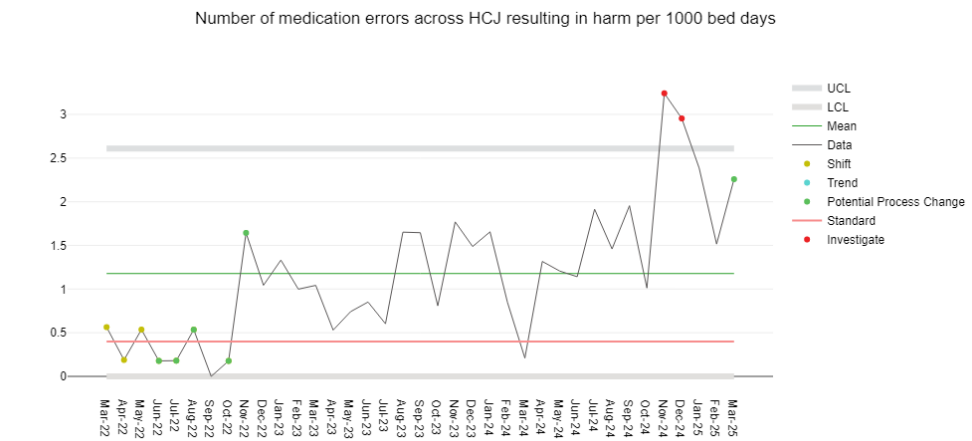


Definition
Number of inpatient Cat 3 & 4 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days

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
2.26	<0.40	1.18



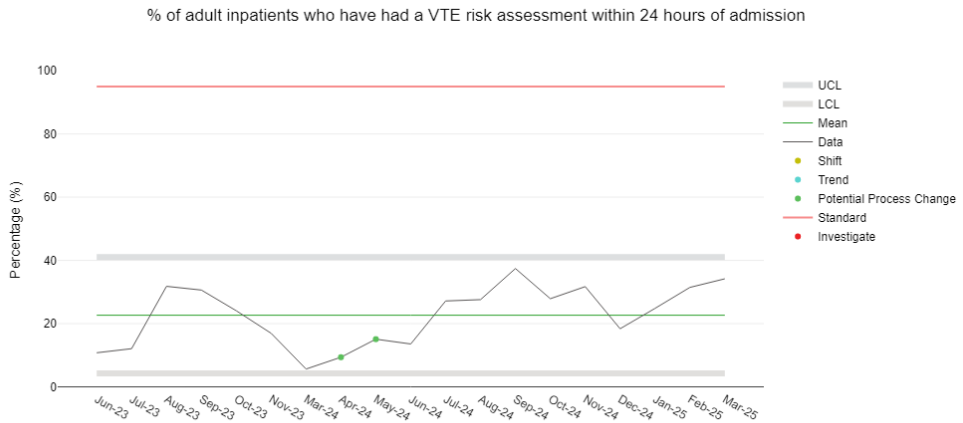
Definition
Number of medication errors across HCJ (including Mental Health) resulting in harm where approval status is not "Rejected" per 1000 occupied bed days. Note that this indicator will count both inpatient and community medication errors due to recording system limitations. As reporting of community 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
34.2 %	>95%	22.7 %

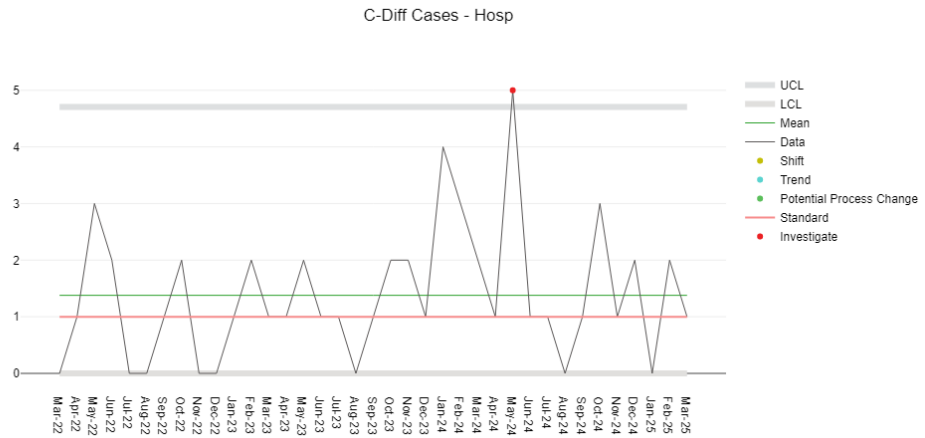


Definition
Percentage of all inpatients (aged 17 and over), (excluding paediatrics, maternity, mental health, and ICU) that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission.

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

C-Diff Cases - Hosp

Latest value	Standard	Mean
1	1	1.38



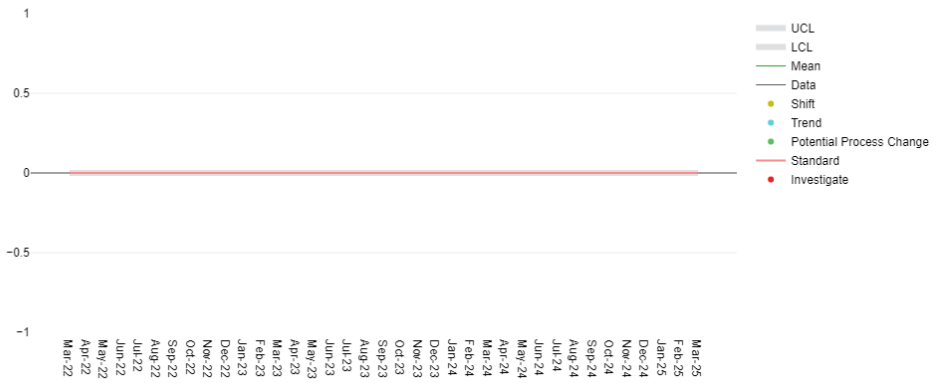
Definition
Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team

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

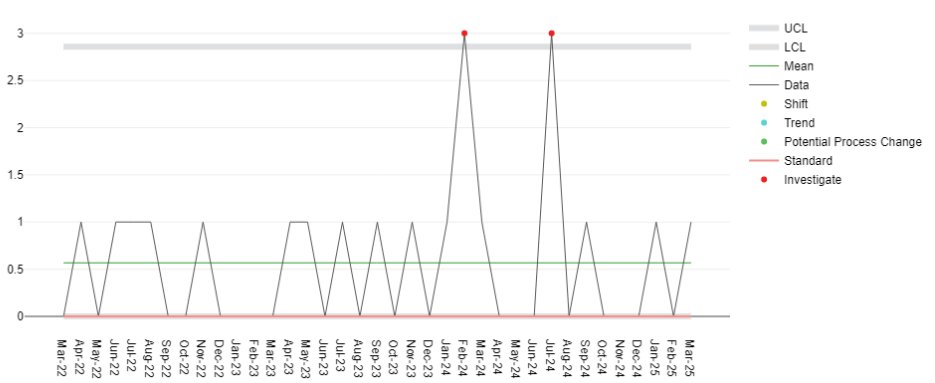


Definition
Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team

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	0.57



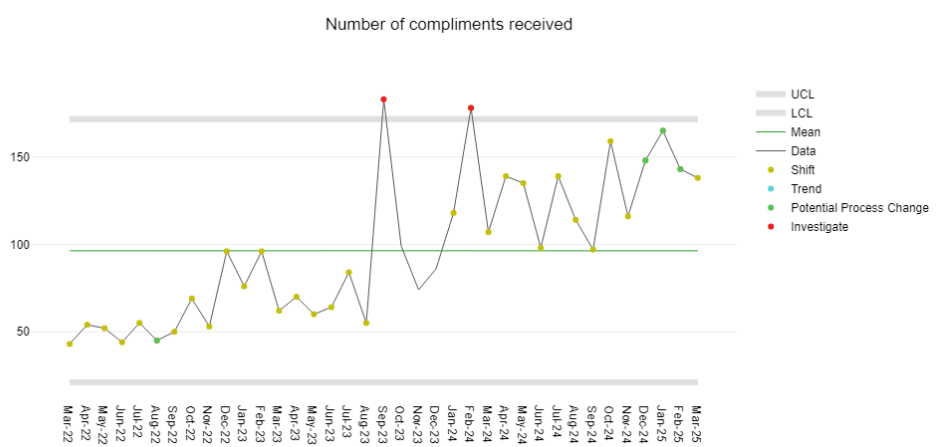
Definition
Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team

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
138	NA	96.32



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
12	NA	26.65

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