Health and Community Services

# Health and Community Services Advisory Board
# Part A - Meeting in Public

30 MAY 2024 9:30AM – 12:15PM

Government of Jersey

Health and Community Services

**AGENDA**

**MEETING:** Part A - Health and Community Services Advisory Board
**DATE:** Thursday 30th May 2024
**TIME:** 9:30am – 12:15pm
**VENUE:** Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

| | Agenda Item | Purpose | Presenter | Time |
|---|---|---|---|---|
| 1 | **Welcome and Apologies (including quoracy)** | For **Information** | Chair | **9:30pm** |
| 2 | **Declarations of Interest** | For **Information** | Chair | |
| 3 | **Minutes of the Previous Meeting** | For **Decision** | Chair | |
| 4 | **Matters Arising and Action Tracker** | For **Decision** | Chair | |
| 5 | **Chair's Introduction**<br>*Verbal* | For **Information** | Chair | **9:40am** |
| 6 | **Board Assurance Framework**<br>*Paper* | For **Assurance** | Chief Officer / Board Secretary | **9:50am** |
| 7 | **Chief Officer's Report**<br>*Paper* | For **Information** | Chief Officer | **10:05am** |
| 8 | **Safeguarding**<br>*Presentation* | For **Information** | Chair of the Safeguarding Partnership Board (SPB)<br>Chief Nurse / Director of Mental Health Services HCS | **10:20am** |
| 9 | **Quality and Performance Report (Month 4)**<br>*Paper* | For **Assurance** | Chief Operating Officer – Acute Services, Director of Mental Health Services and Adult Social Care, Medical Director and Chief Nurse | **10:35am** |
| 10 | **Workforce Report (Month 4)**<br>*Paper* | For **Assurance** | Chief Officer | **10:50am** |
| | **Comfort Break** | | | **11:00am** |
| 11 | **Finance Report (Month 4)**<br>*Paper* | For **Assurance** | Interim Lead of Finance Business Partnering HCS | **11:10am** |
| 12 | **HCS Response to Jersey Care Commission (JCC) Single Assessment Framework Consultation**<br>*Paper* | For **Information** | Chief Officer | **11:20am** |
| 13 | **Outcome of RCA of Deep Tissue Injuries**<br>*Paper* | For **Assurance** | Chief Nurse | **11:25am** |
| 14 | **Maternity Improvement Plan** | For **Information** | Medical Director | **11:35am** |

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| | *Paper* | | | |
| **15** | **Medicine Improvement Plan**<br>*Paper* | For **Assurance** | Chief Operating Officer – Acute Services | **11:45pm** |
| **16** | **HCS Annual Plan**<br>*Paper* | For **Information** | For Information Only | |
| **QUESTIONS FROM THE PUBLIC (Relating to Agenda Items Only)** | | | | |
| | **Questions** | | Chair | **12:00 midday** |
| | **MEETING CLOSE**<br><br>Date of next meeting: **25 July 2024** | | | **12:15pm** |

**Health and Community Services Department Advisory Board**
**Part A – Meeting in Public**
**Minutes**

Health and Community Services

| Date: 25 April 2024 | Time: 9:30 – 12:30pm | Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL |
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| **Voting Members:** | | |
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| Carolyn Downs CB - **CHAIR** | Non-Executive Director | **CD** |
| Anthony Hunter OBE | Non-Executive Director | **AH** |
| Julie Garbutt | Non-Executive Director | **JG** |
| Chris Bown | Chief Officer HCS | **CB** |
| Patrick Armstrong MBE | Medical Director | **PA** |
| Obi Hasan | Finance Lead – HCS Change Team | **OH** |
| **Non-Voting:** | | |
| Jessie Marshall | Chief Nurse | **JM** |
| Claire Thompson | Chief Operating Officer – Acute Services | **CT** |
| Dr Anuschka Muller | Director of Improvement and Innovation | **AM** |
| Bill Nutall | Director of Workforce | **BN** |
| Dr Cheryl Power | Director of Culture, Engagement and Wellbeing | **CP** |
| Cathy Stone | Nursing / Midwifery Lead – HCS Change Team (TEAMS) | **CS** |
| Emma O'Connor Price | Board Secretary | **EOC** |
| Daisy Larbalestier | Business Support Officer | **DL** |
| Becky Sherrington | Chief Inspector, Jersey Care Commission (Item 7 only) | **BS** |
| Ashling McNevin | Freedom to Speak Up Guardian (item 17 only) | **AMN** |

| 1 | **Welcome and Apologies** | **Action** |
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CD welcomed all in attendance. It was communicated at last month's meeting that CD will chair the meetings but is not acting as Chair. The responsibilities of the Chair will be split between the current four Non-Executive Directors (NEDs),

- CD will lead on finance and workforce issues (until the 5th (finance) NED is recruited).
- TH / JG will lead on out of hospital, mental health and commissioning
- CG will lead on quality and safety.

The process for recruiting the fifth NED is underway and hopeful that this will be sooner rather than later. This NED will be responsible for finance issue.

Regarding the appointment of a Chair, there is no benefit in starting the process again as the Board is due to be reviewed in April 2025. The Board fully supports the decisions made by the Minister for Health and Social Services (MHSS) on this matter.

The Minister for Health and Social Services (MHSS), Deputy Barbara Ward and Deput Andy Howell were welcomed.

Meeting is quorate.

Apologies received from:

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| Professor Simon Mackenzie | Medical Lead – HCS Change Team | **SMK** |
| Dr Clare Gerada DBE | Non-Executive Director | **CG** |
| Andy Weir | Director of Mental Health Services and Adult Social Care | **AW** |
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| 2 | **Declarations of Interest** | **Action** |
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No declarations.

| 3 | **Minutes of the Previous Meeting** | **Action** |
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The minutes of the previous meeting held on 28 March 2024 were agreed as accurate.

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| 4 | Matters Arising and Action Tracker | Action |
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| The actions were acknowledged as either being addressed through today's agenda or a future agenda. | | |

| 5 | Chair's Introductions | Action |
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| As above. | | |

| 6 | Chief Officer's Report | Action |
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CB took the paper as read and reminded the Board that this report is a summary of the key issues facing HCS and most are covered in further detail on the agenda. In addition:

- In reference to the recent success of the healthcare assistant (HCA) recruitment campaign, seven applications are being processed and there are more to follow.
- CB advised the Board that this is BN's final Board meeting as he will be leaving HCS at the beginning of May 2024. BN made a personal statement advising that his decision to leave is based on private family matters (as opposed to any work-related issues) and added that it has been a pleasure and privilege working with the Board and serving the people of Jersey.
- Regarding the increase in deep tissue injuries (DTIs), JM explained that these are currently being investigated and the results will be presented to the Board next month. For the benefit of those present, a DTI is a breakdown in the skin as a result of trauma (prolonged period in the same position, medical equipment). In response to CD's questions, JM explained that the increase has been from zero cases to seven cases and have occurred across several wards rather than one area.
- The Jersey Nursing Assessment and Accreditation System (JNAAS) has been replaced by a programme of peer review which is multidisciplinary (both clinical and non-clinical). The reviews include discussions with both patients and staff. Following the first round of reviews, there have been issues requiring immediate action in addition to the identification of medium to long term actions. Noting that peer reviews are very good practice, CD asked if consideration had been given to including a lay person as part of the team. In addition, should peer review cover all services rather than limited to wards? CS advised that during this 'proof of concept' phase, lay members had been included as part of the team and JM is in discussion with the Assistant Ministerial team to further incorporate patient engagement. CS reassured the Board that any immediate concerns were raised at the time in the clinical area and also shared at the feedback session following the reviews, recognising there will be themes across all areas. CS sought to commend the Chief Nurse for the establishment of the programme and implementation across all wards (except for three areas). The peer reviews will take place monthly (as opposed to annual JNAAS) in an unannounced format targeting specific areas e.g. nutrition and hydration. CB in full support of lay member inclusion. CB also advised that the externally commissioned reviews are another example of peer reviews and are key to ensuring safe, effective and up-to-date services.

ACTION: Results of the DTI investigations to be presented to the Board in May 2024.

ACTION: On completion of the first cohort of peer reviews, the Board is to receive a summary of the outcomes (including any issues arising).

AH thanked CB for this overview. Reflecting on the Picker Survey results, it was important to share these results with staff and continue to focus on improving staff / patient experiences.

Noting the reference to concerns about the prescribing of cannabis for people with known serious mental illness, CD asked for a report to go to the Quality, Safety and Improvement Committee clearly detailing the patient safety issues.

ACTION: Following concerns about the prescribing of cannabis for people with known serious mental illness, a report is to be presented to the Quality, Safety and Improvement Committee.

| 7 | Jersey Care Commission – Single Assessment Framework | Action |
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Becky Sherrington, Chief Inspector Jersey Care Commission (JCC) was welcomed to the meeting. BS advised it was encouraging to see members of the public, particularly as this consultation is a public consultation.

The JCC regulates health and social care in Jersey and undertakes 107 inspections each year, including healthcare, day centres, care homes and home care providers. More recently, elements of social care have been included such as Child and Adolescent Mental Health Service (CAMHS) and children's social work. Fostering and adoption will be undertaken soon. In the spirit of transparency, all reports are published and can be found on the JCC website.

As the Executive Lead for the JCC, BS has a team of regulation officers and is governed by the JCC Board. The Chair of the JCC is based in Northern Ireland and as the previous Chief Inspector for the Northern Ireland Inspectorate, has a lot of experience in this area.

The purpose of the regulator is to improve health and social care (not 'catch services out'). Regulation services must be based on-Island so that the law can be used when required. The current consultation / proposal is that the JCC regulate and inspect the hospital. As a small regulator, the JCC recognise that this cannot be achieved alone and are working with other regulators to provide expert support (a contract has been signed by the Care Quality Commission (CQC)). This blended model will provide the required level of expertise and also strengthen the independence of inspection.

There are currently two public consultations. Firstly, the Government of Jersey are consulting on an amendment to the Regulation of Care Law which will include the hospital, mental health services and ambulance services (also include private ambulance services – St Johns Ambulance and Normandy Rescue). The amendments will then be debated by the States Assembly. In anticipation of this, the JCC is preparing and have written the proposed set of standards. The standards have been written so that providers are clear about what they should be providing, and service-users are clear as to the level of service they should be receiving. All Islanders and staff are encouraged to respond to the consultation. The feedback received on the standards for Childrens Services resulted in amendments to the standards.

The consultation is open until the end of May 2024. Two consultation events have been planned and will be held at the Library and in the St Helier Parish Hall. Translators will be available to support those for whom English is not their first language. Also working with learning disabilities services and the Childrens Commissioner.

A series of slides was presented (included as part of the Board papers).

The framework begins with the Key Elements of care which sets the expectation that services should provide an environment that is **safe**, **effective**, **caring**, **responsive** and **well-led**. Under this are 35 standards.

CD thanked BS for the presentation and advised that following consideration, the Board will provide and publish its response to the consultation.

CD noted that the standards are very good and clear and what this means for HCS. However, from a service-user perspective, the standards may be less clear – specifically regarding regulation of HCS services and the regulation of out of hospital services. BS responded that regulation services are underdeveloped in Jersey, and this is being addressed by a phased approach. There are some services that are not in scope of regulation such as General Practitioners (GPs) and community pharmacies.

Reflecting on his experience of working in regulated services, CB advised the proposal is very much welcomed. Staff feedback from the Hollies and Sandybrook Day Centre suggest that staff view regulation as positive for focussing improvement work.

BS noted the importance of feedback and explained that feedback from areas that have been inspected is sought annually through a survey. 55% services have responded to the most recent survey, and this will be published next week.

Whilst acknowledging that feedback from inspection can be sometimes be uncomfortable for services, it is important to be transparent and ensure that any findings are based on fact and not anecdotal evidence.

Various members reflected on their experience of working within regulated services and the importance of this to continuous service development.

Regarding outcome ratings, BS explained this has been debated and a decision has made that the hospital will not receive an overall rating (which is the same currently for other providers). However, reports will detail areas requiring improvement. CD welcomed this decision, recognising that there will both good and bad areas of complex organisations and it is difficult to reflect this into one rating. OH asked if a rating will be applied across the five key elements of care to inform an overall view. Until the inspection methodology has been fully agreed, BS unable to answer this fully and will revert.

Providing the amendments are accepted, it is anticipated that the legislation will be in effect from January 2025 and HCS will have 6 months to register. Likely that the first inspection will take place at end 2025 and will be announced. The focus of the inspection has not been decided.

Noting the CQC has resumed inspection of Local Authorities, AH is interested to understand how the JCC will be looking at care and support needs (out of hospital). BS advised that the inspection of areas is guided by the Regulation of Care law. However, a whole system approach can be considered for the future.

CD thanked BS for attending and reassured BS that HCS will be preparing for inspection.

| 8 | **Quality and Performance Report (QPR) Month 3** | **Action** |
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As the Board receives this monthly, CD invited CT to appraise the Board of any deviations. CT responded with the following,

- There is a slight change in the rate of progress to reduce those waiting > 52 weeks for 1st outpatient appointment. This is due to a larger cohort of patients waiting in the 180–300-day category and the impact of waiting list initiatives. However, as we progress through April, CT is confident that the rate of progress will increase particularly in dermatology and clinical genetics.
- HCS received 500 more referrals during March than January 2024. However, whilst this does not impact those waiting > 52 weeks, it does impact how capacity is used particularly for those triaged as urgent / soon.
- The work regarding inpatient capacity is starting to impact performance and reduce the numbers of those waiting for inpatient care.
- Other elective performance metrics continue to improve with the work carried out around diagnostics.
- The new to follow-up ratio is consistent with further detailed work in some specialities continuing through the clinical productivity workstream.
- Pleasingly, on the day cancellations for non-medical reasons continues to reduce.
- Elective theatre utilisation continues to improve.
- Emergency Care: although more patients were seen, treated and discharged within four hours, patients have been waiting longer in the Emergency Department (ED). However, for those waiting > 12 hours, some of these patients will have been discharged and others will have been delayed admissions for isolation reasons. However, it can be demonstrated that capacity is being managed in a safer way specifically through the reduction in overnight transfers.
- PA sought to provide assurance regarding massive obstetric haemorrhage (MOH). There has been a reduction in numbers. In addition, the externally commissioned thematic review has been received and a number of recommendations have been made. However, the vast majority of these have already been implemented. The findings of the

report will be included in the Maternity Improvement Plan MIP) report for the Board meeting in May.

ACTION: The findings of the thematic review of MOH will be presented to the Board in May 2024 as part of the MIP report.

In reference to the outpatient waits > 52 weeks and *plans to increase the capacity within the service is ongoing with a long-term strategy proposal in its infancy,* CD asked for clarity. CT explained this refers to dermatology and the development of a service plan to address the waiting list and maintain current progress. Both nursing and medical recruitment has been made and the overall dermatology waiting list is starting to reduce.

CD also asked for the reasons in the increase in referrals (> 500) and has this continued through April. CT explained this is currently under review to help to develop future service plans. Whilst there are variations across any year, many of these referrals are for physiotherapy. In addition, Public Health campaigns such as community dental can result in increase in referrals. The current data states that the number of referrals has reduced to levels seen in previous months. CB noted this can also be discussed at the next Primary Care Board (PCB) meeting. CD stated that importance of understanding the impact of the wider health and care system such as the campaigns mentioned above to allow HCS to better prepare for any impacts.

| 9 | **Workforce Report (Month 3)** | **Action** |
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CD wished BN the very best for the future and invited any key points.

- The vacancy rate is consistent at 17%.
- The turnover rate is consistent but has reduced from 6.9 to 6.6%. The voluntary turnover rate is consistent.
- Leaver's headcount has increased.
- Sickness absence has increased. The current occupational healthcare contract runs out November 2024 and a review of these services will be concluded at end April 2024.
- Objective approved shows a marked increased from the beginning of Q1 to end Q1 2024, from 8 to 27.5%. However, it is important that the outcomes of appraisal can be realised with individuals / teams and that the investment can be made to ensure improvements.
- The reconciliation work to establish accurate establishment and vacancy data has not been completed. To mitigate this, a vacancy tracker has been created.
- Since beginning of 2024, 151 new staff have joined HCS. There are 284 vacancies where recruitment activity has not started. However, there are 138 vacancies going through the onboarding process.
- The recent HCA recruitment campaign captured 35 potential candidates.
- A contract is now in place with an external company to carry out cohort nursing recruitment from May to July 2024. This series of planned recruitment is a positive change in HCS recruitment activity.
- Hoping to recruit a Chief Allied Healthcare Professional who will play a role in the strategic recruitment of AHPs.
- A reduction in the time-to hire requires further discussions with People and Corporate Services (PCS) as HCS not currently in control of some of the administration processes. Ideally, HCS should have its own administration team to support the activity of the recruitment team.
- HCS has received a report regarding exit interviews and the feedback has been shared with the HCS senior leadership team to inform improvements.
- Talent Acquisition system will help to align and steam line recruitment activity and processes.

Given the challenges regarding the systems that underpin data acquisition, JG thanked BN for the report. JG suggested that a piece of work should be carried out with other providers to look at how people are encouraged to work within healthcare and how healthcare can be made an attractive career. Noting the success of the recent HCA campaign, JG applied caution and noted that these staff could be moving around the healthcare system in Jersey and whilst this improved HCS's position, there could be impacts on other parts of the system. Could a joint initiative be

considered to bring HCAs into the Island? BN responded that following a meeting with PCS, changes will be made to the GOJ website and partnership work will be promoted.

AH noted the sickness rate has doubled from the same period last year and stated that it is important for HCS to understand the reasons for this. In addition, whilst the objective setting rate has improved, it still remains low and the Board needs to be assured that this is being actioned.

ACTION: The People and Workforce Culture Committee to receive a detailed report on the sickness absence rates. The summary of this discussion will then be reported to the Board.

Noting the reference to the action regarding improving the rate of completed objectives, CD asked what this action is and what will be different / change as a result of this.

ACTION: The People and Workforce Culture Committee to receive a detailed report on the work being undertaken to improve the rate of completed objectives and the impact of this. This can be included in the workforce report.

Noting the exclusion of manual workers from the agreed appraisal / objective setting process, CD sought assurance that this group of staff will be supported and developed. CB explained that there was an agreement between the GOJ and the Trade Unions that manual workers would not be subject to appraisal. However, even with this staff group excluded from the current data, the rate of objective setting remains low.

CD noted the absence of the report detailing the outcomes of the exit interviews (as stated in the report) is disappointing and this report must be presented at the next People and Culture Committee meeting. BN advised that this had been discussed by the Executive Leadership Team and the report will be circulated to the Board members.

ACTION: The People and Culture Committee to receive the Law at Work Exit Interview Report and a summary of action will be presented to the Board.

| 10 | **Finance Report (Month 3)** | **Action** |
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OH invited to highlight any key points from the report.

- The Financial position for YTD Month 3 is a £5.4m deficit vs budget giving a headline monthly run-rate deficit of £1.8m. Adjusting for exceptional items and non-recurrent costs the underlying run-rate deficit is £1.5m.
- FRP savings delivery is £1.82m vs £1.0m plan at M3 (M2 £0.51m) over-achieving by £0.82m in Q1.
- The current FY24 year-end forecast remains a deficit of £18.0m, The key factors driving the forecast deficit are budget cost pressures, risk of FRP savings slippage and one-off exceptional costs.
- Working to put the enablers in place. Proceeding at risk is not entirely within the control of HCS as the approval of the States Employment Board will be required for some posts, causing delay.

AH feels assured by the effort that is going into understanding the financial position, the key drivers, associated risks and mitigations. The Board must be clear and able to assure the Ministerial team of the absolute drive for efficiencies that are not impacting on service delivery. Any impacts on service delivery become a political decision. Secondly, a large part of the long-term solution is appropriate out of hospital care to reduce demand on the hospital. JG and AH are looking to work with the Executive Directors to develop this work.

CB advised the Board that quality impact assessments (QIA) are undertaken where necessary. The integrity of the FRP remains and many of the delays are out with HCS's control. As the Accountable Officer (AO), CB has a legal duty to deliver the financial plan and within budget. Options to mitigate risk will be brought forward to the Ministerial team and some of these will require very difficult decisions.

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| CD recognised the situation that at this point in 2024, the £18m deficit has not changed and it is unlikely to do so. To uphold transparency, any QIAs should be presented to the Board. CD suggested that the board's view is that the £18m is not achievable without serious impacts to service and therefore there needs to be political conversations as to the implications and whether the deficit could be ameliorated by the GOJ. However, noting CB's fiduciary duty, this cannot be delayed. CD asked if there is anymore that Board can be doing to support. CB in agreement that the task at present is to ensure that the £18m deficit does not increase.<br><br>In conclusion, the Board supports the MHSS's view that additional funding will need to be given in this financial year. However, this does not mean that HCS will not deliver every efficiency possible and that in the long-term we will not continue to seek better, more efficient ways of working. It would be irresponsible not to raise this formally and therefore the Board wishes to raise this formally and support the MHSS in progressing this.<br><br>OH emphasised that belief in the FRP is required as it is a quality led financial improvement programme: it balances quality and balances the money. The FRP is key to long-term sustainability and describes a clear road map that balances quality care with the finances. However, the enablers must be in place. HCS cannot keep asking for permission to do the right thing. As an example, HCS could manage its own recruitment and is then held to account for this. CD noted that the Board does not disagree with this, but it could be month 8 before this is in place; the short-term (in-year) issues must be managed. | |

| 11 | **People and Culture Committee** | **Action** |
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| Paper taken as read. | | |

| 12 | **Nursing Appraisal** | **Action** |
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| JM took the paper as read and highlighted the following key points,<br><br>- The overall rate of completed objectives is 27.5%. This paper specifically focuses on Nursing, Midwifery and HCAs.<br>- Some areas continue to complete the appraisals on a paper-based system, and this has been considered.<br>- Recent peer review has identified when combining the paper-based appraisal systems with the existing connect system a compliance of 54% (both objectives set, and objectives agreed).<br>- It should be noted that staff on long-term sick leave and paternity leave are included in the number of staff with no objectives set – this accounts for approximately 5%.<br>- Challenges remain with misaligned reporting lines. Appraisals are given focus during the weekly Lead Nurse meetings and ensuring that managers are encouraged and supported to make the required changes.<br>- Ward compliance varies between wards and departments of greater than 85% to less than 50%. The Lead nurses will be doing some targeted work to ensure staff are trained in the system and that paper-based systems are not used.<br>- The aim is to continue to improve this position.<br><br>Whilst CD acknowledged the current position is not optimal, it is twice as good as HCS overall. CD thanked JM for this candid report and this practice should be repeated across the piste. The figures demonstrate that some senior nurses are doing very well, and others are not carrying out their leadership / management role as well as they should be. This should be managed as part of their appraisal. Those that take a leadership position must recognise that there are obligations, and these must be fulfilled. If not, the job is not being done properly. CD suggested that the Board needs to be robust in its approach to this, recognising this is not limited to Nursing and Midwifery.<br><br>BN advised that objective / appraisal is now a standing item on both the Executive Leadership Team (ELT) and Senior leadership Team (SLT) agendas. BN suggested that those managers who have done this well should be invited to these meetings to share how they have achieved this. In addition, as HCS does not have its own training budget, we are unable to develop first line supervisory managers in the art of leadership and management. It cannot be taken for | |

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| granted that because staff are appointed into a position, they immediately have all the skills required. | |

| 13 | Maternity Improvement Plan | Action |
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| Paper taken as read. In addition,<br><br>- Whilst no further recommendations have been signed off, continue to monitor progress weekly.<br>- The SLT have had a particular focus on culture and the development of a Maternity Strategy.<br>- Ongoing follow-up reviews of which 75 out of 99 recommendations have completed 30-, 60-, 90- day follow-up reviews, evidencing ongoing embedment of recommendations. In areas with limited assurance, a review is carried out at 120-days.<br>- Picker Institute surveyed Maternity Services during December 2023 and January 2024, with results provided to HCS Executives in March 2024. These are awaiting final sign-off prior to distribution with the organisation, expected April. It is noted that Maternity Services received positive outcomes.<br>- A Practice Development Midwife and a Maternity Governance Midwife have been appointed and are expected to commence in July 2024.<br><br>Noting the alignment with SHIP Integrated Care Board, JG asked if benchmarking with Guernsey and Isle of Man has been considered as similar healthcare jurisdiction. In addition, is there an update regarding Consultant recruitment. PA responded that the first round of recruitment was unsuccessful and due to readvertise imminently.<br><br>Regarding the issue of benchmarking, CS responded that the Director of midwifery is in close contact with both Guernsey and the Isla of Man. It is worth noting that SHIP does include the Isle of Wight which is comparable to Jersey. To-date, 100 recommendations have been completed.<br><br>CD suggested that the Quality, Safety and Improvement Committee now receives detailed reports on the MIP (rather than the Board) as business as usual. The report should expand on areas that would be reported in the UK such as still births, brain cooling etc. CB suggested that the MI group continues to meet weekly to maintain momentum with the improvement work. CS stated that Jersey is part of EMBRACE UK (National Reporting Data Base), and any poor outcomes are reported and followed up.<br><br>JG suggested that the issues regarding clinical recruitment should be reviewed at the People and Culture Committee.<br><br>ACTION: The Quality, Safety and Improvement Committee to receive a detailed report regarding the MIP. The Board will receive a 6-monthly report. | |

| 14 | Medicine Improvement Plan | Action |
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| Paper taken as read. In addition,<br><br>- CT advised the Board that a review of the current action plan has been commissioned and will follow the same themed approach taken by the maternity improvement group.<br>- May is a crucial month as it includes the onboarding of capacity to support quality and safety performance, operational performance and project management.<br>- A meeting has taken place to address the recommendation regarding the model of care for the Enhanced Care Area (ECA). There was good representation from both intensivists and acute physicians.<br>- Interviews are scheduled for Consultants which will provide substantiative capacity and support the response to the concerns raised by the Royal College of Physicians (RCP).<br><br>CB advised this is a key priority and recommended that the Board continues to receive a monthly report. Acute Medicine is a core service for the people of Jersey, and it has to be right: the RCP position describing the provision of 'largely poor care' in this area is not acceptable. | |

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| ACTION: The paper for the next board meeting (May 2023) to include the action plan and need to understand more fully how existing staff are being consulted regarding the service redesign, what are their views, how many staff are involved, how many of these staff are actively involved in the conversations and at what level? How are people being taken forward together to make this a success? Need to balance the recommendations of the RCP with what is practical within HCS's resource. | |

| 15 | Patient Experience | Action |
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| Paper taken as read.<br><br>- The data provided demonstrates the positive steps the team are making by showing a reduction in the number of days taken to respond to a complaint from 54 days in Q1 2023 to 15 days in 2024 for the same period. This is due to the hard work of the patient experience team working with the care groups and senior leadership teams weekly.<br>- Overall complaints are down 64% year on year for the same period.<br>- The Patient Advisory and Liaison Service (PALS) will be formally launched in Quarter 2, with new branding, a uniform, and a media campaign to highlight the work that the service offers. The aim of the relaunch is to let patients, relatives and carers know that they can contact the PALS team for help.<br>- Work is also being caried out within the team to ensure good engagement and communication with patients, relatives and carers who want to log a formal complaint.<br>- Regarding lessons learnt a number of workstreams have been established including a working group to look at ways to improve patient experience for the dDeaf community within HCS, specific suggestion box to be set up in Emergency Department following feedback and suggestions from patients about the patient wating area environment and targeted staff training following complaints related to attitude.<br>- Establishing a consistent approach as to whether complaints are upheld, not upheld or partially upheld will bring HCS in-line with the GOJ policy.<br>- JM asked the Board to note the contents of the report, recognising the work undertaken by the patient experience team to ensure timely resolution of complaints.<br><br>AH commended the work to-date and stated that where there are complaints related to attitude, this does require focus and understanding (although recognising that attitude can be misinterpreted if people do not like what they here).<br><br>CD congratulated the team on the improvements made and stated it would be useful to see the number of complaints as a percentage of the whole to understand whether the current number is concerning. Also, in agreement with AH, staff attitude as a theme of complaints stands out as unnecessary and need to understand where and why this is happening. Linking this to appraisals, it would also be useful to know whether staff attitude is a theme on wards where staff have not had appraisals. This triangulation of data will provide a clear view of pockets of poor leadership and performance.<br><br>CD stated she has received direct positive feedback regarding the current PALS service leader.<br><br>CB stated that staff attitude is concerning and is about basic good customer care and good communication. Reflecting on his experience of other healthcare jurisdictions, poor communication is at the heart of most of complaints. | |

| 16 | Board Assurance Framework | Action |
|---|---|---|
| EOC advised that this is the first Board Assurance Framework that has been developed for HCS. It is not a unique tool and is widely used in both the public and private sectors. Following the development of the board objectives (detailed in the Annual Plan), the key risks were identified which could prevent achievement of these objectives.<br><br>The BAF is a proactive element of risk management, identifying and mitigating risks before they materialise. It is important to note that this will develop over time, particularly once the assurance committees establish their cycle of business. The assurance committees will request deep dives | | |

into the key controls and assurance to make sure these are fully understood and represented accurately.

Key to the effective use of the BAF is making sure it becomes BAU. The paper details some prompt questions (sourced from a Board Secretary Network) that can be used in HCS meetings to ensure that the impact of any business on the BAF is considered.

Further work will include linking operational risks to the BAF.

Noting the importance of the BAF and as part of the Well -Led standards for the JCC, CD asked when the BAF will come to the Board and reviewed in greater detail. EOC explained that this should be part of every board / assurance committee agenda. In addition, it will be considered at the HCS SLT meeting.

ACTION: CD asked for the BAF to be at the beginning of the next board agenda to provide a more detailed review.

| 17 | **Freedom to Speak Up Guardian** | **Action** |
|---|---|---|

AMN was welcomed to the meeting. CD advised the Board that she had specifically requested this report as one of the specific standards within the JCC single assessment framework relates to people's freedom to speak up, and for HCS to be successful, there has to be absolute confidence in people's ability to speak up and do so confidentially. As a Board and a community, there is a need to support all efforts to make FTSU a success. If it is not success, there are not only immediate concerns regarding inspection, but it is also not good for staff or patients.

CD asked AMN to clarify the issues regarding confidentiality, the line management of the FTSUG and the relationship between the FTSUG and the HCS Executive Team.

AMN thanked the Board for the opportunity to talk about the role of the FTSUG. AMN clarified that the role of the FTSUG within HCS is independent and offers an impartial service to all employees. The FTSU reports directly to the Chief Officer for Strategic Policy, Planning and Performance (who sits outside of HCS). Fortnightly meetings take place.

The role of the FTSUG in Jersey continues to evolve. The National Guardians Office (NGO) in the UK oversees FTSU in England. Whilst Jersey sits outside this, the role of the FTSU in Jersey is in line with practice of FTSUG in England. Strong relationships and mentorship have been developed with other FTSUGs and this has been beneficial regarding the setup of the service.

The overarching aims of FTSU is that staff have a safe space to speak about things that are impacting on their ability to do their job and also enable the service provider to provide a safe service. The limits to confidentiality are explained before any disclosures once an individual approaches the FTSUG. The limits of confidentiality exist to protect individuals and ensure that any safeguarding issues or issues that harm or compromise safety can be addressed.

If an individual is happy to continue, the FTSU makes notes during the discussion which are typed and sent back to the individual. Individuals are anonymised in the report. The reports are stored by number (rather than name / issue). A FTSU Datix form has been developed and provides another mechanism for individuals to raise issues. Once submitted, these forms are only seen by the FTSU. In addition, the information can be stored secured in Datix. Datix also facilitates the analysis of themes.

The themes arising from FTSU disclosures (also including areas), must be reported back into HCS so that improvement can be made. Whilst areas may be identifiable, individuals are not.

Since the last FTSU board report, the Chief Nurse has been identified as the Executive Lead for FTSU. An Executive Lead for this service is in-line with National Guardians principles and guidance. The role of the Executive Lead is to be the champion to support FTSU and cultural change.

There are two aspects to the role of the FTSU. Firstly, the interpersonal meetings with staff and secondly, the more proactive side including what is speaking up, how can this be developed, how can staff be encouraged to approach their managers to speak up and empowerment of managers to be open to understanding and listening and learning from staff.

The difference between confidentiality and anonymity were explained. Individuals are assured confidentiality. However Datix offers the opportunity to report concerns anonymously (identity would not be known by the FTSU). However, anonymous reporting means that feedback cannot be provided which can lead to feelings of futility.

CB also advised that Board that some staff give their permission for the FTSU G to speak with the Executive Team about issues raised. However, the Executive Team will not be approached if permission has not been given.

AMN noted that key to FTSU is trust, recognising the courage it takes for individuals to raise issues. In addition, when addressing the wider issues around FTSU, the FTSUG is placing trust in the organisation to work to resolve any issues. The only time an individual will be identifiable to anyone other than the FTSUG is when they have given their express permission to do so.

CB recognised that FTSU whilst FTSU is an important way to raise issues, staff also regularly approach the Executive team directly to raise issues. In his 12 months at HCS, CB has a sense that more people are coming forward to raise concerns and some of the issues addressed daily are because of concerns being raised. It is an important part of improving the safety for patients and improving experience for staff working in HCS. The FTSU service in larger organisations will be led by a team of FTSUG so the ongoing peer-to-peer contact with other FTSUG is supported.

CD advised that when FTSU was introduced in England, they were treated with cynicism regarding their independence which probably reflects similar behaviours in Jersey. However, this has been overcome with time and FTSUGs are seen as a positive. Reflecting on her observations as an NHS NED, CD noted the success of the relationship between the FTSUG working with the NED Lead for FTSU, providing direct support. The NED Lead for FTSU is Dame Clare Gerada. It is important that the FTSUG has enough support to enable the job to be carried out and protect the independence of this role. CD advised that the Board should be very vigilant to maintaining the independence of the role and seen to be independent.

CD further advised that the Board should receive an annual report from the FTSUG. The FTSU Report at a Birmingham Hospital Trust resulted in the hospital being put into special measures (despite good medical outcomes) and the replacement of the Chair of the Board and senior executives. Recognising that this is unlikely to happen here, a culture and environment must be created for the FTSUG to operate in the same way as other FTSUG elsewhere.

Recognising that the role of the FTSUG must have the trust of both staff and senior managers, AH stated that the Board needs to be assured that AMN is confident that the role can be carried out.

| | **Questions from the Public** | **Action** |
|---|---|---|
| No written questions submitted in advance.<br><br>**Member A**: Regarding finances and pharmacy, member A reflected on a recent hospital admission where her own medicines were discarded and reissued from pharmacy. In addition, some medicines were missing. What a waste of money. In addition, there were two pharmacist on the ward and why are two required given the long queues for outpatient pharmacy?<br><br>**Response**: PA agreed this sounds like a waste of money. CD noted that pharmacist have to be present on the ward and without knowing the detail, there could have been two as one of them was in training or a pharmacy technician. CD thanked member A for raising the issue of wasted medicines and this will be reviewed by CB and OH. | | |

**Member B:** Mainly observations from today and previous meetings. Firstly there has been a lot of debate and discussion regarding recruitment process and recruitment, however there are a group of doctors who have entered the recruitment process who have advised that the advert was incorrect and six weeks into the process, the applicants are unaware of the outcome. Surely, efforts should be made to retain these staff?

Second observation is in relation to appraisals. Whilst it is good to see the work underway, a lot of clinicians / managers feel under a lot of pressure to get these done and feel it is a tick box exercise – the focus on individual performance is therefore not what it should be, and this undermines the appraisal process. Also the use of corporate objectives does not necessarily enhance an individual's development.

Thirdly, regarding finance, member B urged the Executive Directors to scrutinise the way in which overtime / locum shifts are authorised. Member B states that a couple of Consultants in specific areas have raised this and that often, the most appropriate resource is not used i.e. a higher grade is used when a lower grade could be used. These things can be managed through good operational management.

**Response**: Regarding recruitment and retention, CB noted this was unacceptable and asked BN to discuss member B after the meeting.

Regarding appraisal and objective setting, CB advised that the quality of an appraisal is hugely important, and it cannot be a tick box exercise with objectives that are meaningless to people. CB referred to the work that PA is doing to improve doctor appraisal.

OH advised that one of the key workstreams of the FRP is a focus on rota compliance. The rotas are scrutinised 6 weeks in advance to ensure that they are safe, appropriate and follow financial disciplines. CD advised that this may be the role of the individual Executive leads to ensure that the right people are being overtime and that there is no favouritism (which creates disharmony). PA aware of these issue raised, and this is being addressed.

**Member C**: Following the resignations in pharmacy last month, how will these people be replaced noting the current recruitment process (possibility of gaps in service).

**Response**: CB responded that additional staff for pharmacy have been agreed and any gaps will be covered by agency / locum until substantive recruitment has taken place. However, this is a known hard to recruit area.

**Member D**: Member D described her current recruitment process: an interview was held in May 23 and returned to Jersey (from Jersey) at end July with no rota / no contact / no job role. No accommodation arrangements had been made (luckily able to go to her parent's house). Several other doctors have taken a job elsewhere as they have received no communication regarding Jersey employment. In addition, member 2 had a further interview over a month ago and to-date has received no communication as to what the plan is from August 2024 onwards.

**Response**: CD invited member D to attend the People and Culture Assurance Committee in May to discuss her experience of going through the recruitment process. Also invited member D to bring anyone else along with a similar experience. CD wants to understand in detail what individuals are personally experiencing going through the recruitment process. CD acknowledged that a lot of this will relate to the broader system rather than HCS, however, the NEDs need to know the root causes so this can be raised appropriately.

CD emphasised that if these functions come back to HCS (HR / finance), they must be done really well. Therefore listening to people's experiences is very important. CB noted it may be worthwhile inviting the Chief People Officer to the assurance committee meeting.

**Member E**: Sought a point of clarification regarding the meaning of culture issues in maternity.

**Response**: PA responded this is predominantly about the way people interact with each other, both within professional groups and between professional groups. It is about respecting each other's skills and staff being able to feel that they have a voice to either raise concerns or relay

| | |
|---|---|
| their point of view. CD clarified that this is an issue in maternity units across the UK and not unique to Jersey.<br><br>PA also advised that whilst this some of this is due to individual behaviour, it is also about the environment that HCS creates as an organisation within which they work. It is about what HCS provides and includes some of the issues discussed today such as appraisal and people feeling valued.<br><br>CD reflected that people often say that middle managers are not fully capable in many organisations and questioned the role of leadership in creating an environment where middle managers can flourish. It is incumbent on everybody, particularly the Board, to make sure that HCS is an environment where people can thrive.<br><br>CD thanked all those in attendance and for their contributions. | |

| | **MEETING CLOSE** | **Action** |
|---|---|---|
| **Date of next meeting:** Thursday 30 May 2024 | | |

| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | HEALTH AND COMMUNITY SERVICES ADVISORY BOARD - ACTION TRACKER (OPEN) | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | **Action Number** | **Meeting Date** | **Agenda Item** | **Agenda Description** | **Action** | **Accountable Executive** | **By When** | **Progress report** | **Escalated to / when?** | **Action Closed Date** | **Status** |
| 4 | 139 | 25-Apr-24 | 14 | Medicine Improvement Plan | The paper for the next board meeting (May 2023) to include the action plan and need to understand more fully how existing staff are being consulted regarding the service redesign, what are their views, how many staff are involved, how many of these staff are actively involved in the conversations and at what level? How are people being taken forward together to make this a success? Need to balance the recommendations of the RCP with what is practical within HCS's resource. | C. Thompson | May-24 | | | | May Agenda |
| 5 | 134 | 25-Apr-24 | 8 | Quality and Performance Report | The findings of the thematic review of MOH will be presented to the Board in May 2024 as part of the MIP report. | Patrick Armstrong | May-24 | | | | May Agenda |
| 6 | 132 | 25-Apr-24 | 6 | Chief Officer Report | On completion of the first cohort of peer reviews, the Board is to receive a summary of the outcomes (including any issues arising). | Jessie Marshall | Jul-24 | | | | July Agenda |
| 7 | 131 | 25-Apr-24 | 6 | Chief Officer Report | Results of the DTI investigations to be presented to the Board in May 2024. | Jessie Marshall | May-24 | | | | May Agenda |
| 8 | 129 | 28-Mar-24 | 9 | Workforce Report (Month 2) | Invest to save options to speed up the recruitment process to be explored and brought back to the next meeting (April 2024). | O. Hasan | Apr-24 | | | | Apr Agenda |
| 9 | 127 | 29-Feb-24 | 14 | #BeOurBest Programme - Annual update | CP to present the culture dashboard at a future Board meeting. | C. Bown | Jun-24 | Update 28 March 2024<br>CP confirmed that the culture dashboard will be presented to Board in June 2024. Remain OPEN. | | | Jun Agenda |
| 10 | 125 | 29-Feb-24 | 13 | Mental Health External Review Implementation | CD asked for an update on the work to join up Mental Health Services and Acute Services as it progress (timescale to be determined) | A. Weir | Apr-24 | Update 28 March 2024<br>AW confirmed that meetings have taken place between Mental health And Acute Services. A summary of this can be presented to the board in April 2024. Remain OPEN | | | Apr Agenda |
| 11 | 123 | 29-Feb-24 | 8 | Waiting List Report Month 1 | CT will present the fully validated waiting lists within the next three months | C. Thompson | by Jun 2024 | | | | Jun Agenda |
| 12 | 121 | 29-Feb-24 | 7 | Quality and Performance Report | CG and CT to discuss remote physiotherapy opportunities. | C. Thompson | Mar-24 | Update 28 March 2024<br>Meeting between CG and CT to discuss remote physiotherapy opportunities to be confirmed. Remian OPEN | | | OPEN |
| 13 | 114 | 25-Jan-24 | 7 | Quality and Performance Report | AW to provide a paper on neurodevelopmental services in May 2024. | Andy Weir | May-24 | | | | May Agenda |
| 14 | 96 | 06-Dec-23 | 6 | Chief Officer's Report | The board to receive a report indicating progress on increasing the number of ACPs (March 2024). | Jessie Marshall | ~~01/03/2024~~<br>Aug 2024 | Update 28 March 2024<br>The number of ACP's is to be increased – currently there a small number in post however a Project Lead has been appointed with start date 1st July to the position of Practice Development, Advanced Practice and Independent Prescribing who will support the further development of Advanced Clinical Practice across HCS in line with new NMC regulations due 2025/26. Anticipate an update after July 2024. Remain OPEN. | | | Aug Agenda |
| 15 | 76 | 1st Nov 2023 | 4 | Management of Incidents of Racial Abuse | Prosecution Policy to be presented to the Board ( link to action 70). | Andy Weir | ~~01/02/2024~~<br>May 2024 | | | | May Agenda |
| 16 | 31 | 10-Jul-23 | 13 | Finance Report – Month 5 | HMT and CB will discuss the lack of budgetary information available to budget holders with KPMG. | H. Mascie Taylor / Chris Bown | May 2024<br>~~Feb 2024~~<br>~~December 2023~~<br>~~01/10/2023~~ | Update 28 March 2024<br>OH advised that Treasury have confirmed that budget holders should have access to the budget data by end April 2024. Remain OPEN.<br><br>Update 6 Dec 2023<br>It is anticipated that budget holders will have electronic access to their budgets in Jan / Feb 2024 (Q1 2024). To mitigate the risk, the finance business partners provide manual reports to the care groups monthly and accountable officers are held to account through the performance reviews. For a further update in February 2024.<br><br>Update 4 October 2023<br>OH explained that the lack of budgetary information available to budget holders has been tracked over the last six months. Following the implementation of the new system, access rights were changed. The HCS finance team have been told that work to resolve this has been delayed with a revised timeframe of Quarter 1 (Q1) 2024. The HCS Finance Business Partners have limited access, it is the wider access across HCS that will take time. CB noted this was not a satisfactory position. To mitigate the risk associated with this lack of access, the finance business partners download the information and produce reports for budget holders. However, this is an inefficient (manual) process. OH provided assurance that there is a process in place to hold budget holders to account for management of their budgets including weekly meetings with the care groups and the care group performance reviews. The Board asked to be provided with an update at the meeting in December Remain OPEN. | | | May Agenda |

Health and Community Services

# Health and Community Services Advisory Board Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Board Assurance Framework | | |
| **Report author (& title):** | Emma O'Connor Price, Board Secretary | **Accountable Executive:** | Chris Bown, Chief Officer HCS |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | The Board is asked to approve the risks and confirm that they are an accurate representation of the current significant risks to the delivery of HCS's strategic objectives. | Information | |
| | | Decision | |
| | | Assurance | √ |
| | | Update | |

## 2. Executive Summary

The report of HCS's key strategic risks to the achievement of the annual strategic objectives 2024 is presented here for approval by the Board.

## 3. Finance / workforce implications

There is a financial risk within this report.

## 4. Risk and issues

The report identifies the proposed framework to manage HCS's strategic risks.

## 5. Main Report

### 6.1 Introduction

The BAF provides a robust foundation to support HCS's understanding and management of the risks that may impact delivery of the 2024 corporate objectives.

The HCS Advisory Board is responsible for reviewing the BAF to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified.

Each risk within the BAF has a designated Executive Director lead whose role includes routinely reviewing and updating the risks,

- Testing the accuracy of the current risk score based on the available assurance(s) and / or gaps in assurance.
- Monitoring progress against action plans developed to mitigate the risk.
- Identifying any risks for addition or deletion.
- Where necessary, commissioning a more detailed review (deep dive) into specific risks.

### 5.2 BAF Review

**Quality and Safety:** Current risk was reviewed at SLT. The Quality, Safety and Improvement Committee will be meeting on 27 June and the agenda will be designed to scrutinise the key controls and assurances to test the accuracy of the current score and identify any further action, controls and assurance.

**Patient Experience**: Current risk was reviewed at SLT. The Quality, Safety and Improvement Committee will be meeting on 27 June and the agenda will be designed to scrutinise the key controls and assurances to test the accuracy of the current score and identify any further action, controls and assurance.

**Operational Performance**: Current risk was reviewed at SLT. The Finance and Performance Committee will be meeting on 26 June and the agenda will be designed to scrutinise the key controls and assurances to test the accuracy of the current score and identify any further action, controls and assurance.

**Workforce and Culture**: Current risk was reviewed at SLT. The People and Culture Committee will be meeting on 26 June and the agenda will be designed to scrutinise the key controls and assurances to test the accuracy of the current score and identify any further action, controls and assurance.

**Finance**: Current risk was reviewed at SLT. The Finance and Performance Committee will be meeting on 26 June and the agenda will be designed to scrutinise the key controls and assurances to test the accuracy of the current score and identify any further action, controls and assurance.

### 5.3 New Risks Recommended for Inclusion in the BAF

No new risks have been added to the BAF since the last Board meeting in April 2024.

### 5.4 Risks Accepted and De-Escalated from the BAF

No risks have been accepted or de-escalated from the BAF since the last Board meeting in April 2024.

### 5.5 Review Date

The BAF is reviewed bi-monthly by the Board and the committees of the Board. The next review date is scheduled for June 2024 (committee meetings).

## 6. Recommendation

The Board is asked to endorse the BAF and confirm that this is an accurate representation of the current significant risks to the delivery of HCS's objectives.

**END OF REPORT**

Health and Community Services

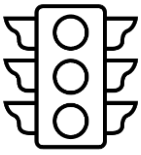
# Board Assurance Framework

2024

The content of this report was last reviewed as follows:

| | |
|---|---|
| Quality, Safety and Improvement Committee | February 2024 |
| People and Culture Committee | Exp. June 2024 |
| Finance and Performance Committee | Exp. June 2024 |
| Executive Team | May 2024 |

**How the Board Assurance Framework fits in**

| | |
|---|---|
|  | **Strategy**: The HCS Annual Plan 2024 provides a strategic overview of the key areas of improvement and strategic quality and performance reports for Health and Community Services (HCS) across the breadth of the Department. The HCS Advisory Board (the Board) and its Assurance Committees will drive and monitor improvements to the performance of HCS and its services. |
|  | **Strategic objectives**: The Board has agreed a number of objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The objectives focus on delivery of the strategy and what the organisation needs to prioritise and focus on during the year to progress the longer-term ambitions within the strategy. |
|  | **Board Assurance Framework**: The board assurance framework provides a mechanism for the Board to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy. |
|  | **Seeking assurance**: To have effective oversight of the delivery of the objectives, the Board uses its committee structure to seek assurance on its behalf. Each objective is allocated to a monitoring body who will seek assurance on behalf of, and report back to, the Board. |
|  | **Accountability**: Each strategic risk has an allocated director who is responsible for leading on delivery. In practice, many of the strategic risks will require input from across the Executive Team, but the lead director is responsible for monitoring and updating the Board Assurance Framework and has overall responsibility for delivery of the objective. |
|  | **Reporting:** To make the Board Assurance Framework as easy to read as possible, visual scales based on a traffic light system to highlight overall assurance are used. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance. |

**HCS Objectives**

The Board has developed five key objectives for 2024.

1. We will constantly review and compare our services to the best. We will learn and develop when we see good practice and when there are lessons to be learnt.

2. We will drive a culture that places the patient at the heart of everything we do and champions the use of continuous improvement that is rooted in patient feedback.

3. We will drive improvements in access to high quality, sustainable and safe services.

4. We will lead and support a high performing workforce. We will create a well-led and great place to work.

5. We will ensure effective financial management through budget planning, monitoring/reporting and delivery of HCS services within agreed financial limits.

The board assurance framework provides a mechanism for the Board to monitor the effect of uncertainty on the delivery of these agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.

**Understanding the Board Assurance Framework**

Risk Management Matrix:

| | | Impact | | | | |
|---|---|---|---|---|---|---|
| | | **Negligible 1** | **Minor 2** | **Moderate 3** | **Significant 4** | **Severe / Catastrophic 5** |
| **Likelihood** | **Very Likely 5** | **Low** | **Moderate** | **High** | **High** | **High** |
| | **Likely 4** | **Low** | **Moderate** | **Moderate** | **High** | **High** |
| | **Possible 3** | **Low** | **Low** | **Moderate** | **Moderate** | **High** |
| | **Unlikely 2** | **Low** | **Low** | **Low** | **Moderate** | **Moderate** |
| | **Very Unlikely 1** | **Low** | **Low** | **Low** | **Low** | **Low** |

Definitions:

| | |
|---|---|
| **Strategic Risk:** | Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors. |
| **Linked Risk:** | The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives. |
| **Controls:** | The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the strategic objective. |
| **Gaps in controls:** | Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk. |
| **Assurances:** | The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions that own and manage the risks, 2nd line functions that oversee or specialise in compliance or management of risk, 3rd line function that provides independent assurance. |
| **Gaps in assurance:** | Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk. |

## Summary Position

| Ref | Strategic Risk Summary | Executive Lead / Board Lead | Assurance Committee | Current Risk (L x C) | Change |
|---|---|---|---|---|---|
| 1 | **Quality and Safety**<br>Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation. | **Medical Director**<br><br>**Chief Nurse** | **Quality, Safety, and Improvement** | **20** | ↔ |
| 2 | **Experience**<br>We are unable to meet the needs of patients because we fail to understand and learn from feedback (patients, service-users, carers) alongside other sources of intelligence. | **Chief Nurse** | **Quality, Safety, and Improvement** | **12** | ↔ |
| 3 | **Operational Performance**<br>Our patients do not receive timely access to the care they need due to delays in treatment. | **Chief Operating Officer – Acute Services and Director of Mental Health Services and Adult Social Care**<br><br>**Director of Improvement and Innovation** | **Finance and Performance** | **20** | ↔ |
| 4 | **Workforce and Culture**<br>We are unable to meet the changing needs of patients and the wider system because we do not recruit, educate, develop, and retain a modern and flexible workforce and build the leadership we need at all levels. | **Director of Workforce**<br><br>**Director of Culture, Engagement and Wellbeing** | **People and Culture** | **16** | ↔ |
| 5 | **Finance**<br>We do not achieve financial sustainability including under delivery of cost improvement plans and failure to realise wider efficiency opportunities. | **Head of Strategic Finance** | **Finance and Performance** | **20** | ↔ |

## Risk Management

The heat map below shows the distribution of strategic risk based on their current scores:

| Likelihood \ Impact | Negligible 1 | Minor 2 | Moderate 3 | Significant 4 | Severe / Catastrophic 5 |
|---|---|---|---|---|---|
| Very Likely 5 | | | | | |
| Likely 4 | | | | People and Culture | Quality and Safety<br>Operational Performance<br>Finance |
| Possible 3 | | | | Patient Experience | |
| Unlikely 2 | | | | | |
| Very Unlikely 1 | | | | | |

Quality and Safety |Patient Experience | Operational Performance | Workforce and Culture | Finance

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Objective** | | | We will constantly review and compare our services to the best. We will learn and develop when we see good practice and when there are lessons to be learnt. | | | **Overall Assurance Level** | Medium |
| **Monitoring Committee** | | | Quality, Safety, and Improvement | **Board / Executive Lead** | Medical Director | **Date last reviewed** | 24 April 2024 |
| **Risk ID** | SR 1 | **Risk** | Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation. | **JCC Domain** | Awaited | **JCC Outcomes** | Awaited |

Risk Rating: (Likelihood x Impact): 5 x 5

| | |
|---|---|
| **Initial risk score** | 25 |
| **Previous risk score** | N/A |
| **Current risk score** | **20 (4 x 5)** |
| **Tolerable risk** | 10 |
| **Direction of travel** | N/A |

**Relevant Key Performance Indicators**

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Number of Falls resulting in harm (moderate/severe) / 1000 bed days** | 0.12 | | | |
| **Number of Serious Incidents completed in timeframe** | | | | |
| **Number of patients who have had a VTE risk assessment completed within 24 hours of admission** | 14.3% | | | |
| **Number of medication errors resulting in harm / per 1000 bed days** | 0.71 | | | |
| **Number of organisational never events** | 1 | | | |
| **Number of cat 3/4 pressure injury & deep tissue injury acquired in care / 1000 bed days** | 2.48 | | | |

| **Controls: (what are we currently doing about the risk)** | **Effectiveness of controls** | | | **Assurances: (How do we know if the things we are doing are having an impact)** | **Line of assurance** | | |
|---|---|---|---|---|---|---|---|
| | **Poor** | **Limited** | **Good** | | **1** | **2** | **3** |
| Quality Governance Structure in place | | √ | | Care Group Governance meetings review quality metrics | √ | | |
| Quality and Safety Team in place to facilitate embedding quality and safety across HCS | | √ | | Monthly Executive care group governance meetings review quality metrics | | √ | |
| Clinical effectiveness processes including clinical audit, NICE guidance compliance and Getting It Right First Time (GIRFT), SOPs and other guidelines | | √ | | Integrated Quality and Performance Report (QPR) reviewed by the Quality, Safety, and Improvement Committee and the HCS Advisory Board | | √ | |
| Structure and processes in place for staff to raise or escalate issues (Escalation Policy, GOJ HR Policies, Freedom to Speak Up Guardian, Incident Reporting System, Wellbeing Team) | | √ | | Serious incidents reviewed weekly by the Serious Incident Review Panel (SIRP) with focus placed on overdue reports and actions | √ | | |
| Processes in place to seek and receive patient feedback via multiple channels (complaints / survey) | | √ | | NICE guidance compliance data reviewed by the Quality, Safety, and Improvement (QSI) Committee and HCS Advisory Board. | | √ | |
| Strategic policies and procedures (SI Policy, Incident Management Policy, Risk Management Policy, Safeguarding, Infection Prevention and Control, Central Alert System (CAS)) | | √ | | Monthly review of SI activity reviewed at the Senior Leadership Team (SLT) meeting and quarterly by the QSI Committee. | | √ | |
| Development and implementation of action plans to address quality and safety issues recommendations raised through reviews. | | √ | | Patient feedback reported to QSI Committee quarterly. | | √ | |
| Clinical appraisal and revalidation | | √ | | Freedom to Speak Up Guardian (FTSU) report to the SLT monthly, QSI quarterly and the HCS Advisory Board. | | | √ |
| Job Planning (Medical and Specialist Nurses) | √ | | | My Experience Survey | | | √ |
| | | | | Picker Institute Survey | | | √ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Invited external reviews | | | √ |
| | | | | Executive oversight of improvement plans (Medicine and Maternity) | | √ | √ |
| | | | | Progress reports against action plans reviewed at Change Programme Board (CPB) monthly, QSI Committee and HCS Advisory Board monthly. | | √ | |
| | | | | Reporting of the progress of the Recognition, Escalation and Rescue (RER) Programme to the QSI Committee | | √ | |
| | | | | GIRFT | | | √ |
| | | | | Benchmarking of quality KPIs with other organisations | | | √ |
| | | | | Appraisal data available monthly through workforce report.<br>Nursing revalidation dates included within E-Roster. | | √ | |
| | | | | Mental Health and Capacity Legislation report quarterly to HCS advisory Board | | √ | |

| **Gaps in controls and assurances: (What additional controls and assurances should we seek?)** | **Mitigating actions: (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Multidisciplinary (MDT) peer-to-peer reviews of all clinical areas | Establishment of the Medical Rostering and eJob Planning Steering Group | Medical Director | October 2024 |
| Implementation of HQIP programme | HQIP audits have been agreed. Awaiting assignment of owners and data collection being agreed. | Associate Director of Quality and Safety | End 2024 |
| Quality Assurance Audit Programme | App has been purchased. Awaiting implementation plan. | Associate Chief Nurse | End Q2 2024 |
| Access to SI Investigators | | | |
| Compliance with NICE and other best practice guidance | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Objective** | | | We will drive a culture that places the patient at the heart of everything we do and champions the use of continuous improvement that is rooted in patient feedback. | | | **Overall Assurance Level** | Medium |
| **Monitoring Committee** | | | Quality, Safety, and Improvement | **Board / Executive Lead** | Chief Nurse | **Date last reviewed** | 24 April 2024 |
| **Risk ID** | SR 2 | **Risk** | We are unable to meet the needs of patients because we fail to understand and learn from feedback (patients, service-users, carers) alongside other sources of intelligence. | **JCC Domain** | Awaited | **JCC Outcomes** | Awaited |

Risk Rating: (Likelihood x Impact):5x4

| | |
|---|---|
| **Initial risk score** | 20 |
| **Previous risk score** | N/A |
| **Current risk score** | **12 (3 x 4)** |
| **Tolerable risk** | 6 |
| **Direction of travel** | N/A |

**Relevant Key Performance Indicators**

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Number of Compliments received | 390 | | | |
| Number of Complaints received | 68 | | | |

| **Controls: (what are we currently doing about the risk)** | **Effectiveness of controls** | | | **Assurances: (How do we know if the things we are doing are having an impact)** | **Line of assurance** | | |
|---|---|---|---|---|---|---|---|
| | **Poor** | **Limited** | **Good** | | **1** | **2** | **3** |
| Quality Governance Structure in place | | √ | | Care Group Governance meetings review quality metrics | √ | | |
| Structure and processes in place for patients to raise or escalate issues (through multiple channels) – Patient Advisory and Liaison Services (PALS), Patient Feedback, Government website. | | | √ | Monthly Executive care group governance meetings review quality metrics | | √ | |
| Strategic policies and procedures (Patient Feedback, GOJ Customer Feedback Policy, Patient Valuables Policy, Visitors policy) | | √ | | Integrated Quality and Performance Report (QPR) reviewed by the Quality, Safety, and Improvement Committee and the HCS Advisory Board | | √ | |
| Staff attendance at Customer Complaints training and online Customer Service eLearning. | √ | | | Patient feedback reported to QSI Committee quarterly. | | √ | |
| Establishment of the Patient and Public Panel to gather feedback to inform service change. | | √ | | My Experience Survey | | | √ |
| Sharing of results from survey across HCS | √ | | | Picker Institute Survey | | | √ |
| | | | | Monthly reporting of KPI data with GOJ. | | √ | |

| **Gaps in controls and assurances: (What additional controls and assurances should we seek?)** | **Mitigating actions: (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| User understanding of the role of the PALs service | Communication strategy to formally launch PALs service. | Patient Experience Manager | July 2024 |
| Hearing the voice of the child or young person | Targeted child or young person feedback that is easily accessible | Lead Nurse Women and Children | August 2024 |
| Vacancies within the patient experience team | Currently have an act-up patient experience manager in post whilst the Job description is reviewed, and the position goes out to advert. | Chief Nurse | August 2024 |
| Thematic analysis of patient / service-user feedback to support organisational learning. | The use of thematic analysis as part of regular patient reporting. | Patient Experience Manager | September 2024 |
| Embedded Volunteer Service | Currently position is vacant due to substantive employee in act-up position of patient experience manager. | Patient Experience Manager | October 2024 |

| | | | |
|---|---|---|---|
| Absence of Patient Charter | The absence of a patient charter, this piece of work will be started when the team is fully established. | TBC | TBC |

| | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective** | We will drive improvements in access to high quality, sustainable and safe services. | | | **Overall Assurance Level** | Medium |
| **Monitoring Committee** | Operations, Performance and Finance | **Board / Executive Lead** | Chief Operating Officer – Acute Services, Director of Mental Health and Adult Social care and Director for Improvement and Innovation | **Date last reviewed** | 24 April 2024 |
| **Risk ID** SR 3 | **Risk** Our patients do not receive timely access to the care they need due to delays in treatment. | **JCC Domain** | Awaited | **JCC Outcomes** | Awaited |

Risk Rating: (Likelihood x Impact): 5 x 5

| | |
|---|---|
| **Initial risk score** | **25** |
| **Previous risk score** | N/A |
| **Current risk score** | **20 (4 x 5)** |
| **Tolerable risk** | 10 |
| **Direction of travel** | N/A |

**Relevant Key Performance Indicators**

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Patients waiting for 1st outpatient appointment > 52 weeks | 662 | | | |
| Patient on elective waiting list > 52 weeks | 297 | | | |
| Cancer diagnosis | | | | |

| **Controls: (what are we currently doing about the risk)** | **Effectiveness of controls** | | | **Assurances: (How do we know if the things we are doing are having an impact)** | **Line of assurance** | | |
|---|---|---|---|---|---|---|---|
| | **Poor** | **Limited** | **Good** | | **1** | **2** | **3** |
| Restoration and recovery plans are in place and underpinned by modelling and trajectories (by service line). | | | √ | Monthly Executive care group meetings review operational performance and quality metrics | | √ | |
| Mechanisms are in place to ensure that all patients who are waiting for treatment are risk stratified and there is a process for addressing potential and actual harm. | | √ | | Integrated Quality and Performance Report (QPR) reviewed by the Quality, Safety, and Improvement Committee and the HCS Advisory Board | | √ | |
| Strategic policies and procedures (Procedures of Limited Clinical Value, Access Policy, Escalation, Winter Planning). | | √ | | Benchmarking of KPIs against other organisations | | | √ |
| Use of outsourcing arrangements for specific clinical services | | | √ | Care Group Governance meetings review quality metrics | √ | | |
| Contracts arrangements for externally commissioned services including KPIs for response times and activity levels. | | √ | | Quarterly review of contract data at Operations, performance, and Finance Committee. | | √ | |
| | | | | Weekly monitoring of the Patient Tracking Lists (PTL) | √ | | |
| | | | | | | √ | |

| **Gaps in controls and assurances: (What additional controls and assurances should we seek?)** | **Mitigating actions: (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Contractual consequences for non-achievement of KPIs to be included in all contracts. | Ensure robust KPIs and consequences for non-achievement are included in all contracts. | Head of Commissioning and Partnerships | At renewal of contracts. |
| Audit programme for strategic policies and procedures to measure compliance | Development of audit programme for strategic policies and procedures to monitor compliance and understand impact | Chief Operating Officer – Acute Services, Director of | TBC |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Mental Health and Adult Social Care | |
| **Strategic Objective** | | | We will lead and support a high performing workforce. We will create a well-led and great place to work. | | **Overall Assurance Level** | Medium |
| **Monitoring Committee** | | | People and Culture | **Board / Executive Lead** | Director of Workforce, Director of Culture, Engagement and Wellbeing | **Date last reviewed** | 22 April 2024 |
| **Risk ID** | SR 4 | **Risk** | We are unable to meet the changing needs of patients and the wider system because we do not recruit, educate, develop, and retain a modern and flexible workforce and build the leadership we need at all levels.<br><br>We are unable to develop and maintain a workplace culture in line with *Our Values, Our Behaviours* including promoting equality, diversity and inclusivity and prioritising the health and wellbeing of staff because we do not enable a co-ordinated structure and approach to organisational development. | **JCC Domain** | Awaited | **JCC Outcomes** | Awaited |

Risk Rating: (Likelihood x Impact): 5 x 5

| | |
|---|---|
| **Initial risk score** | **25** |
| **Previous risk score** | N/A |
| **Current risk score** | **16 (4 x 4)** |
| **Tolerable risk** | 4 |
| **Direction of travel** | N/A |

**Relevant Key Performance Indicators**

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Staff offered TRiM assessment/wellbeing check within 72 hours of incident. | 36 (excl. TRiM) | | | |
| Staff offered wellbeing support. | 152 | | | |
| Time to Recruit (TTR) | | | | |
| Time to Hire (TTH) | | | | |

| **Controls: (what are we currently doing about the risk)** | **Effectiveness of controls** | | | **Assurances: (How do we know if the things we are doing are having an impact)** | **Line of assurance** | | |
|---|---|---|---|---|---|---|---|
| | **Poor** | **Limited** | **Good** | | **1** | **2** | **3** |
| Development of a People and Culture Change Plan for 2024 completed including key actions and deliverables | | √ | | Monthly Executive care group meetings review workforce metrics | | √ | |
| Structure and processes in place for staff to raise or escalate issues through multiple channels and including FTSU Guardian | | √ | | Workforce report (including KPIs) reviewed monthly by the SLT, People and Culture Committee and HCS Advisory Board. | | √ | |
| Structure and process in place to engage with staff and collate staff feedback (surveys) | | √ | | Pulse Survey | | √ | |
| Staff attendance in external Leadership and Management Development programme | | | √ | Be Heard Survey<br>Leadership and Management Development programme feedback | | | √ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Programme of activity for staff engagement (Schwarz Rounds, HCS Team Talks) | | | √ | Internal Leadership / Managerial programmes | | √ | |
| Programme of activity for staff reward and recognition (Our Star Awards). | | | √ | External Leadership / Managerial Programmes (GOJ Cohen-Brown Leadership and Management Development Programme) | | | √ |
| Strategies, Policies and Procedures (including GOJ Policy Framework, Diversity, Equality (DEI) and Inclusion Strategy) | | √ | | Monthly FTSU Report (including thematic analysis) at SLT, quarterly reporting to the People and Culture Committee and QSI Committee and reporting to the HCS Advisory Board | | | √ |
| Statutory and Mandatory training (Health and Safety, Maybo) | | √ | | REACH or DEI Representation at SLT / Committee meeting level. | | √ | |
| Processes and systems in place (including recruitment, objective setting, appraisal, revalidation, exit interviews, internships) | √ | | | Objective setting, appraisal and revalidation data reviewed monthly at the SLT, quarterly through the People and Culture Committee and monthly at the HCS Advisory Board. | | √ | |
| Wellbeing Framework (including Wellbeing Services, TRiM) | | √ | | Independent Exit Interview data provided by Law at Work (Director of Workforce to recommend minimum of quarterly review by the Executive Leadership and SLT) | | | √ |
| Recruitment Campaigns | √ | | | Monthly reporting at the People and Culture Committee.<br>Quarterly reporting at the Change Programme Board | | √ | |
| | | | | Monthly Analysis of wellbeing data | √ | | |
| | | | | Quarterly Wellbeing report to the People and Culture Committee and reports to HCS Advisory Board | | √ | |
| | | | | Quarterly reporting of Health and Safety Data (including audit data) at People and Culture Committee | | √ | |
| | | | | Progress against Cultural Change Programme monitored monthly through Change Programme Board, quarterly through People and Culture Committee and HCS Advisory Board. | | √ | |
| | | | | Quarterly reporting of Recruitment Campaign impact at the People and Culture Committee | | √ | |

| **Gaps in controls and assurances: (What additional controls and assurances should we seek?)** | **Mitigating actions: (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Absence of a Workforce Strategy | During QTR 2 initial work on developing a HCS workforce strategy to commence. Towards the end of QTR3 succession planning processes to be reviewed for HCS. | Director of Workforce | Oct/Dec 2024 |
| Some staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised | Development of Freedom to Speak Champions to support the work of the FTSUG | Chief Nurse/Director of Workforce | April - July 2024 |
| Absence of an Education Strategy and organisation wide plan detailing education and development needs to upskill existing and future workforce. | Development of an overarching (multidisciplinary) Education Strategy.<br><br>Review education and development needs accompanied by the development of a skills review exercise. | Head of Nursing, Midwifery and AHP Education.<br><br>Chief of Service – Medical Education | Oct 2024 |
| Limited resource to deliver culture intervention/organisational development | Review resource required for targeted service areas | Director Culture, Engagement & Wellbeing | May- June 2024 |
| Inadequate ICT infrastructure, hardware, and software to access on-line learning. | Executive Leadership to review the level of GOJ supply of ICT infrastructure, Hardware and software to enable staff to access e-leaning v the TNA (Training Needs Analysis) agreed | Director of Digital Health and Informatics (when in post) | June 2024 |

| | | | |
|---|---|---|---|
| | with HCS Directors and their managers for e-learning | | |
| Continued staff exposure to violence and aggression by service-users | Review of Violence and Aggression in the workplace policy<br>Cross agency working group with SoJP established to agree procedures following violence.<br>Continue review of Datix reports of violence and aggression | Director of Mental Health Services and Adult Social Care | May – June 2024 |
| Absence of a People and Culture Dashboard with relevant KPIs to measure the impact of the Cultural Change Programme. | Development of the People and Culture Dashboard is underway and will be presented to Board June 2024 | Director Culture, Engagement & Wellbeing / Director of Workforce | June 2024 |
| An immature restorative and just learning culture | Review of safety huddles post incident.<br><br>Lessons learned are collected on Datix incident reporting. Further work is required to ensure lessons learned are implemented into practice with a restorative approach. | Director Culture, Engagement & Wellbeing | October to December 2024 |
| Recruitment redesign process | New Workforce Attraction/ Recruitment and Retention Packages being developed in March/April for approval by HCS Executive and the States Employment Board | FRP Change Team | May 2024 |
| GOJ Internship Programme / Patchy take up of internship by HCS managers linked to process. | Undertake regular soundings with HCS Managers throughout the course of the year in advance of the time when Internship opportunities are promoted by GOJ | Director of Workforce | April to Dec 2024 |
| | Dedicated recruitment campaigns for specific services / Developing dedicated nurse cohort recruitment campaigns in QTR 2<br><br>Provisional planning of events, discussions with specialist recruiting companies and cost estimates to be set against the Recruitment Budget.<br><br>Work above to be advised on from a GOJ Recruitment Campaign advisor working with the Head of HCS Resourcing | Director of Workforce/Head of HCS Resourcing | April – May 2024 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Strategic Objective** | | | We will ensure effective financial management through budget planning, monitoring/reporting and delivery of HCS services within agreed financial limits. | | | **Overall Assurance Level** | Medium |
| **Monitoring Committee** | | | Operations, Performance and Finance Committee | **Board / Executive Lead** | Finance Lead | **Date last reviewed** | 22 April 2024 |
| **Risk ID** | SR 5 | **Risk** | We do not achieve financial sustainability including under delivery of cost improvement plans and failure to realise wider efficiency opportunities. | **JCC Domain** | Awaited | **JCC Outcomes** | Awaited |

Risk Rating: (Likelihood x Impact): 5 x 5

| | |
|---|---|
| **Initial risk score** | **25** |
| **Previous risk score** | N/A |
| **Current risk score** | **20 (4 x 5)** |
| **Tolerable risk** | 9 |
| **Direction of travel** | N/A |

**Relevant Key Performance Indicators**

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Monthly Actual versus Budget Variance | 7.5% | | | |
| FRP Delivery | £1.853m | | | |

| **Controls: (what are we currently doing about the risk)** | **Effectiveness of controls** | | | **Assurances: (How do we know if the things we are doing are having an impact)** | **Line of assurance** | | |
|---|---|---|---|---|---|---|---|
| | **Poor** | **Limited** | **Good** | | **1** | **2** | **3** |
| Finance Budget Review and Accountability | | | √ | Monthly finance report at SLT, monthly, and reporting to the HCS Advisory Board | | √ | |
| Budget Setting Process | | | √ | Budget sign-off by Care Groups/Directorates and ongoing monthly monitoring | | √ | |
| Workforce Control Panel | | √ | | Monthly reporting of FRP progress to the Change Programme Board | | √ | |
| Financial Recovery Programme | | | √ | FRP In delivery and being tracked through weekly/fortnightly reviews and reported fortnightly and monthly. Risks and issues including slippage from plan being escalated with mitigations. | | √ | |
| Compliance with Public Finance Manual | | √ | | Monthly review meetings involving Executive Directors with Care Groups/Directorates leadership teams holding budget holders to account and supporting with any corrective action required. | | √ | |
| | | | | Monthly CGPRs include review of financial position. However, this has limited focus and rigour on variances to budget and accountability. Mitigation is Monthly Finance Budget Review and Accountability Meetings as described below. | √ | | |

| **Gaps in controls and assurances: (What additional controls and assurances should we seek?)** | **Mitigating actions: (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Scheme of Delegation – purchasing approval limits are set in the Ariba system. HCS policy is required to be completed. | Complete HCS policy and authorisation | Deputy Head of Finance Business Partners HCS | Jun-24 |
| Monthly Finance and Budget Accountability Review Meetings | Monthly Finance and Budget Accountability Review Meetings Implemented as of Mar-24 | Finance Lead / Deputy Head of Finance Business Partners HCS | Mar-24 |

| | | | |
|---|---|---|---|
| Workforce Control Panel to receive complete workforce pay spend information for approval and assurance. Currently reviews/approves agency spend only. | To receive weekly complete workforce spend information for approval vs budget and assurance. | Director of Workforce / Finance Lead | May-24 |
| PFM – Implementation of No PO No Pay and HCS central buying function | To implement HCS central buying function followed by No PO No Pay controls | CT/RB OH/MQ | Oct-24 |
| Absence of accurate establishment and workforce data | Reconciliation works ongoing between HR and Finance systems | Director of Workforce, Finance Lead, Acting Chief People Officer, Deputy Head FBP | May 2024 |
| Noted exceptions to compliance with PFM are:<br>• Gaps in applying PO controls causing payment delays.<br>Breaches and exemptions due to non-compliance with procurement best practice. | Reporting documentation to be reviewed and updated with FRP colleagues. Currently being developed to be available by Apr-24. | Finance Lead | April 2024 |

Health and Community Services

# Health and Community Services Advisory Board Report

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|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Chief Officer Report | | |
| **Report author (& title):** | Chris Bown, Chief Officer HCS | **Accountable Executive:** | Chris Bown, Chief Officer HCS |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | The Chief Officer report provides,<br><br>• a summary of key activities for Health and Community Services (HCS),<br>• an overview of HCS' performance since the last Board meeting,<br>• a summary of key issues, some of which are presented in more detail through the relevant board papers.<br><br>The Board is asked to note the report. | Information | √ |
| | | Decision | |
| | | Assurance | |
| | | Update | √ |

## 2. Executive Summary

The Chief Officer report provides a summary of key activities for HCS and an overview of HCS' performance since the last board meeting.

## 3. Main Report

### New HCS Workforce Director

I am pleased to report Ian Tegerdine has been appointed as the new HCS interim Director of Workforce. Ian is a highly experienced health human resource and organisational development professional and will be starting on 4 June 2024.

### Culture Change Programme

Racist behaviours are unacceptable, and we stand against them in HCS. We know racism exists in HCS and the impact it may have on our colleagues can be harmful. In our commitment to improve the experience and wellbeing of our Black, Asian and Minority Ethnic colleagues, we recently

launched an anti-racism campaign across HCS. A lot of media activity has supported the launch of this campaign, involving posters for all our 70 plus HCS estates. All HCS colleagues need to feel safe in the workplace. Our managers have a role to play in supporting our colleagues and helping create psychologically safe places to work. As part of our ongoing programme of work to address this issue, our next steps will involve delivering Diversity and Inclusion training for HCS managers and leaders.

Several staff engagement events have taken place during April. I personally visited our Adult Day Centres; Sandybrook Day Centre and The Hollies Day Centre to meet colleagues and service users. The April HCS Team Talk event was attended by 52 HCS employees and was hosted from the Five Oaks estate and represented by our laundry, sterile services and stores departments.

HCS Engagements and Achievements

- HCS Colleagues were invited to take part in Freedom to Speak up training sessions.
- HCS entered a team into the corporate mixed netball league, with many colleagues putting themselves forwards to join the team. Matches will take place between May and July.
- Colleagues worked together to move patients/operations to Plemont Ward to allow for refurbishment works in Bartlett Ward.
- The Adult Learning Disability Service launched a policy and guidelines about relationships and sexuality for people with learning disabilities.
- Colleagues worked together to close Sorel Ward, to allow for redecoration.
- Colleagues took part in Connect People recruitment training.
- HCS celebrated National Administrative Professionals Day.
- Colleagues were invited to attend the New Healthcare Facilities drop-in sessions to hear and provide feedback about the future delivery of New Health Facilities.
- Colleagues were encouraged to take part in deaf awareness training.
- HCS Therapy Dog Frankie, visited many departments and colleagues throughout the month.
- HCS celebrated 100 years of nursing education. The Island was given accreditation to train new nurses in 1924 (May 2024).

**Rehabilitation Service (Samares Ward) move to St Ewolds**

Inpatient services were safely transferred from the Overdale site to St Ewolds on 14th May.

**Opening of Refurbished Maternity Unit**

On 5th May 2024, the refurbished maternity unit was officially opened by the Bailiff, which commenced in 2022. This project saw the realisation of a dedicated Midwifery-Led Unit (MLU) with a fixed birthing pool, a new High Dependency Unit (HDU) and a refurbished Jersey Neonatal Unit (previously Special Care Baby Unit SCBU). The completed improvements allow those who use hospital based Maternity Services to experience an enhanced and holistic space that supports mothers, birthing-people and the choices they make in relation to their delivery and care.

## Patient Experience

### Complaints

A noticeable decline in the number of formal complaints and an increase in the number of compliments received was noted in last month's report. This trend continues with 53% fewer complaints compared with the same period last year. There continues to be a significant improvement in closing formal complaints in line with Government policy. At the end of April there were a total of 23 official complaints open (18 stage one, 2 stage two and 3 at stage three.) This is a decrease of 9 compared to the previous month.

### Compliments

In April 2024 a total of 134 compliments were logged on the Datix system, which is an increase of 91% compared to April 2023. These compliments are being shared with staff through HCS on a weekly basis by the comms team.

The Patient Advice and Liaison Service (PALS) continue to work positively with enquires from the public with support from the care groups. The service has a media campaign plan to launch in June 2024 highlighting the support they can provide.

## Quality and Safety

### Pressure Ulcers

Following the increase reported in March 2024, it is encouraging to note that there has been a significant decline in the number of category 3-4 / deep tissue injuries (DTIs) in April 2024. Following a deep dive of the cases in March, there was evidence of pressure damage due to anti-embolism stocking use. There has been significant learning and education from these incidents which has been led by the tissue viability team and fully supported by area managers and lead nurses. A large supply of pressure relieving aids has arrived to complement the existing stock, which will be used for those patients at further risk of pressure damage.

The new Island Wide Pressure Ulcer Prevention and Management Framework has been ratified and a plan has been developed to embed this into practice.

### Falls

It is encouraging to note that we have had 0 falls resulting in with moderate/severe harm in April.

### Infection, Prevention and Control (IPaC)

We continue to see low levels of infection within HCS. The new appearance and uniform policy due to be ratified in the comings weeks, will further strengthen the IPaC principles including bare below the elbows and hand washing.

## Rheumatology Update

Since the HCS Board meeting in January 2024, the following progress has been made:

Completion of all reviews for current patients

The outcomes from these reviews were reported in the January Board meeting, except for the inpatient review as this was ongoing. This has now been completed, and details of all inpatients who had not been seen by another clinician since being treated by Dr X or Dr Y have been sent to the relevant GP to consider whether a hospital referral is required.

Duty of Candour

An assessment of possible medical harm is being undertaken by Specialist Rheumatology Consultants. This is expected to conclude in the coming weeks. Duty of Candour letters will be sent to patients, as directed by the outcomes of the assessment of possible medical harm.

Colleagues from the Law Officers Department are considering a process for patients to resolve any concerns or complaints arising from the review of their diagnosis, care and treatment. Once these considerations have concluded we will write to patients with more information.

PALS colleagues continue to be updated and will signpost patient queries to the appropriate department / clinician for response.

The Quality, Safety and Improvement Committee will be reviewing action plan progress at its meeting in June 2024.

## Maternity Improvement Plan

Since the last board meeting, three further recommendations have been identified as complete, these are the establishment and publication of the Maternity Dashboard through the Quality and Performance Report, ongoing linkage of the breastfeeding and perinatal mental health support services and enhanced support for mothers in early stages of labour. There is assurance of ongoing progress of remaining open recommendations, some of these are long-term, such as Culture. It is noted that the commencement of the Practice Development Midwife in July will be able to further several recommendations.

Ongoing follow-up reviews of which 77 out of 102 recommendations have completed 30-, 60-, 90-, and 120- day follow-up reviews, evidencing ongoing embedment of recommendations (up from 75 in April).

## Medicine Improvement Plan

Detailed information is provided in the report at item 15 on this meeting's agenda. Additional leadership and improvement capacity has started in month with the commencement of a senior physician experienced in quality and flow. Their focus has been on observing current activities and

standards, and attendance at the Medicine Improvement Group meeting.

## Mental Health and Social Care

Performance across mental health and social care remains stable, and it is pleasing to note continued improvements in access and waiting times across these services. ADHD waiting lists continue to increase; a new part time senior clinician has joined the team, with the specific focus of reviewing the waiting list and increasing diagnostic capacity.

Work has commenced on developing a mental health specific recruitment campaign, and planning continues for the forthcoming social care staff engagement event.

## Waiting Lists: Hospital Services

I am pleased to observe that HCS has continued to reduce the number of patients waiting the longest times for an inpatient procedure, with the percentage of patients on the elective list greater than 52 weeks reducing for the 5th month in a row. This will continue until all those waiting > 52 weeks have been treated.

Patients waiting over 52 weeks for an outpatient appointment has slightly deteriorated. Detail is provided in the Quality and Performance Report (QPR) elective care performance section and mitigating actions will confidently impact this metric by the end of June. However, the overall number of patients on the list has reduced from M12 2023 to M4 2024 by approximately 500 patients.

## Emergency acute services

Sustained improvement in flow metrics was impacted by overall bed availability and further complicated by gender and isolation requirements. Decisions were made to move the location of Same Day Emergency Care (SDEC) to release 6 beds which appears to be improving performance as we move into May. Insight from the initial assessment from the visiting physician will be used to compliment the clinical productivity workstream and a specific drive on morning discharges to achieve the 15% target will be monitored daily.

## Workforce

The Finance Team continues with the reconciliation of the Connect People system to the finance list of budgeted posts. This is a significant undertaking by the finance team to correct the budgeted establishment in Connect People, and still requires more work to rectify the remaining differences in May 2024.

The turnover rate for April 2024 remains constant at 6.7% (compared to last month 6.6%). The total turnover rate has also remained constant in the 12 months at around 7%.

The sickness absence rate has slightly reduced from February to April 2024, with the main reason for absence continuing to be coughs, cold and flu and gastrointestinal problems.

The April 2024 Connected Performance data report for objective setting has improved from 27.5% in March, to 35.4% in April 2024. These percentages include manual workers. The percentage, excluding manual workers is 41.4%.

**Finance and Financial Recovery Programme (FRP)**

- FY24 YTD M4 deficit is £8.3m giving a headline monthly run-rate of £2.1m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £1.8m.

- FRP savings of £2.4m have been delivered vs £1.84m plan at M4. This is made-up of £1.2m savings from original FRP schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.

- The year-end forecast is £18.0m deficit with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken. The key factors driving the forecast deficit are budget cost pressures £7.5m, FRP savings slippage due to delays in enabling support to ensure timely delivery £6m, exceptional one-off costs in-year, Tertiary care contracts price inflation, activity increases in high cost-low volume (HCLV) services, drugs and other non-pay inflation, and additional costs of implementing clinical/medical model following recommendations of Royal College reviews into Medicine and Maternity Services.

- Urgent mitigation actions are being taken to recover the forecast deficit position, working with the Care Groups to reduce the current overspend which now requires HCS to make additional savings this year to remain within the required budget constraints. As a result, additional FRP schemes and opportunities are being identified.

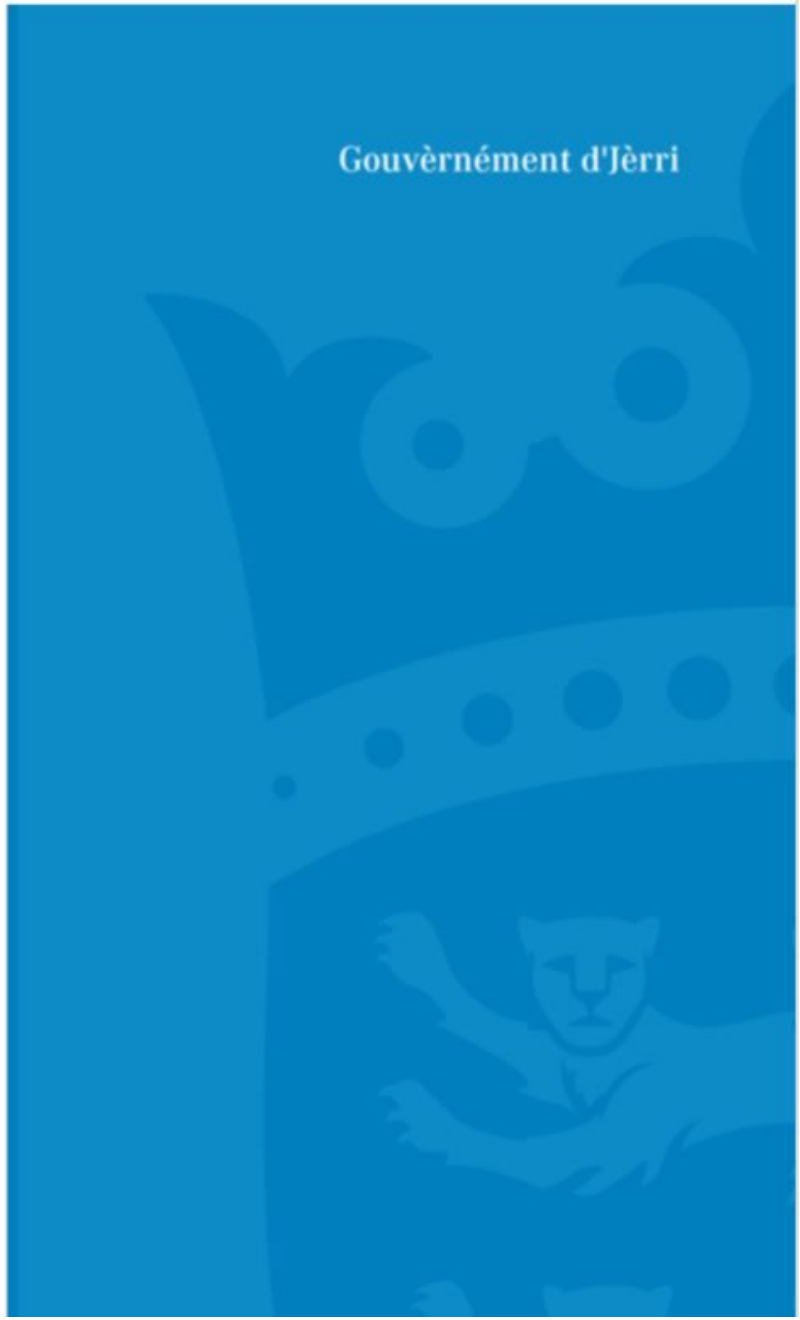
## 4. Recommendation

For noting.

**END OF REPORT**

Health and Community Services

# Quality and Performance Report
# April 2024



Health and Community Services

## INTRODUCTION

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

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

## SPONSORS:

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

## DATA:

HCS Informatics

Health and Community Services

# STATISTICAL PROCESS CONTROL (SPC) CHARTS

## WHAT ARE SPC CHARTS?

A statistical process control system (SPC) is a method of controlling a process or method utilizing statistical techniques. Monitoring process behaviour, identifying problems in internal systems, and finding solutions to production problems can all be accomplished using SPC tools and procedures. SPC charts used to monitor key performance indicators:

- Help find and understand signals in real-time allowing you to react when appropriate
- Tell you when something is changing, but you have to investigate to find out what changed by asking the right questions at the right time
- Allow you to investigate the impact of introducing new ideas aimed at improving the KPI; the SPC chart will help confirm if the changes implemented have significantly impacted performance

## HOW TO READ SPC CHARTS

| Legend | Visual | Description |
|---|---|---|
| **Mean** |  | The mean is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern. |
| **LCL** |  | These are the Control limits (UCL = Upper Control Limit, LCL = Lower Control Limit) and are the standard deviations located above and below the centre line of an SPC chart. If the data points are within the control limits, it indicates that the variation is normal (common cause variation). If there are data points outside of these control limits then they are not within the expected 'normal variation' and indicates that a process change or one off incident may have occurred (special cause variation). |
| **UCL** | | |
| **Data** |  | The data line connects the datapoints for the date range, allowing a visual representation of the performance of the indicator. |
| **Shift** |  | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. |
| **Trend** |  | When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. |
| **Potential Process Change** |  | On the moving range chart points which fall above the moving range process limit - grey line - are unusual and should be investigated. |
| **Standard** |  | In order for the standard to be achievable, it should sit within the control limits. Any standard set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes. |
| **Investigate** |  | Points which fall outside the grey lines (control limits) are unusual and should be investigated. They represent variations beyond what is considered normal. This does not necessarily reflect deteriorating performance. |

# Elective Care Performance

## Section Owner

Chief Operating Officer – Acute Services

## Performance Narrative

Outpatient new waits over 52 weeks

Work to reduce the amount of patient's waiting for an outpatient appointment for a new referral to below 52 weeks continues. Initiatives are in place across the most challenged specialties. In Ophthalmology the Cataract initiative now in place alongside additional activity on Island, will deliver a significant improvement by the end of June 2024. Dermatology remains compromised with plans still being drawn up to support the current long wait routine patients and a long-term sustainable solution being developed. Urgent dermatology referrals are being seen by the 2-week standard. Addressing these specialities will impact the performance metric in Q2. It is also noted that the overall new outpatient waiting list size continued to reduce namely 13,640 at M12 2023 to 13, 167 end of M4 which is now impacting the metric performance due to a smaller numerator. A key speciality to recover has been TIA outpatient appointments. This has been monitored at Medicine's Care Group performance review as an improving position.

Over the next couple of months, over 52-week waits were being forecast to increase in gastroenterology. However, with a new consultant starting in July and a short term WLI being planned prior to the new consultant starting as a mitigation we expect to mitigate this risk.

Our referral rate has steadied since the increase rates seen in February and March. Actions are in motion to mitigate these as best possible particularly in Community dental and physiotherapy as were key drivers of the increase observed.

Elective inpatient waits over 52 weeks

Patients waiting extended periods for their inpatient elective procedure has once again reduced for the 5th month in a row. This trend will continue until all over 52 week wait patients have been treated. General Surgery and Orthopaedics remain the specialties with the highest number of long waits. Initiatives in both services continue together with a theatre efficiency programme supporting improvement in utilisation.

Diagnostic waits over 6 weeks

There has been an increase in diagnostics waits in month. The completion of the recent endoscopy waiting list initiative which delivered additional capacity, reduced Dexa scanning capacity due to staff availability plus increased demand from specialities has impacted this metric. Plans are being developed to support a sustainable Dexa provision together with a short WLI to target the back log. Endoscopy waiting times were set to increase until the new gastroenterology consultant commences in July. However, a short internal WLI scheme is being worked up for endoscopy to prevent this.

The MRI waiting list reduction pilot scheme that delivered significant reduction in MRI waiting times at the end of 2023 (from 52 weeks to 7 weeks for routine patients) has now moved into a substantive implementation phase. There was a pilot scheme that assessed how increasing capacity to deliver improved access for private MRI activity, would support with providing funding for increased public capacity. We have commenced the recruitment into this model and would expect to have the full availability of this increased capacity in place by Q3. Waiting times have extended for routine patients to an average of 20 weeks, however we are confident that the newly formed enhanced service offer will move to a consistent position of improved access over the coming months and the board will observe the impact in this metric.

# Elective Care Performance

Overall planned outpatient capacity in month was impacted by 2 bank holidays in Jersey for noting.

New to Follow-up ratio

Although there has been a slight increase in month, this is entirely expected due to an increased focus on seeing long wait follow-up patients. The ratio is currently acceptable across most specialties but will continue to be monitored with action taken to address unwarranted variation.

DNA Rate

The DNA rate reduced again last month to 10.2%, however this remains over the expected standard of 8%. The outpatient improvement working group has this standard as a key priority. The role out of the reviewed access policy and associated implementation plan will support further improvement.

Elective theatre utilisation

Theatre utilisation has improved for the 4th month in a row thanks to the continued efforts of our theatre improvement group. However, the current rate is significantly below the standard and work will continue over the summer to establish robust processes to improve theatre flow and efficiency. Some of the actions to deliver this are focusing on consistent improved theatre start times, booking to entirety of sessions and a theatre schedule review as examples.

Was not Brought rate

This rate continues to drop in line with the DNA rate.

Operations cancelled for non-clinical reasons

A slight increase in month of on the day cancellations for elective theatre is noted. This was due to some specific equipment issues which has been reviewed and resolved with actions to address. There was an unusual level of a specific orthopaedic procedure. The cancellation and DNA working group continue to make progress in eliminating theatre cancelations for administrative issues.

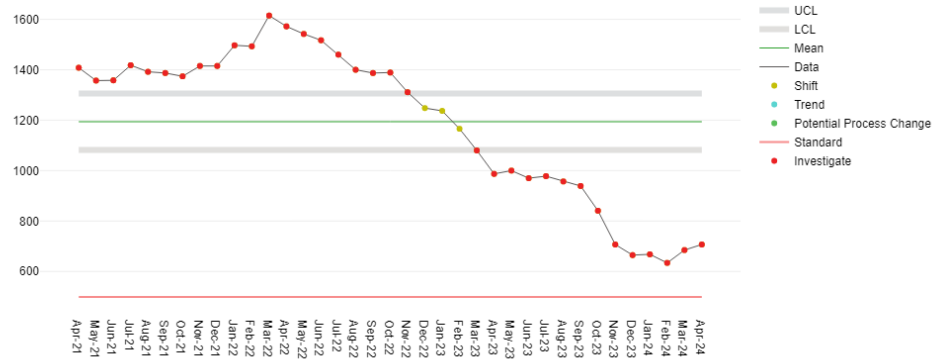
## Escalations

No escalations

# Elective Care Performance - SPC Charts

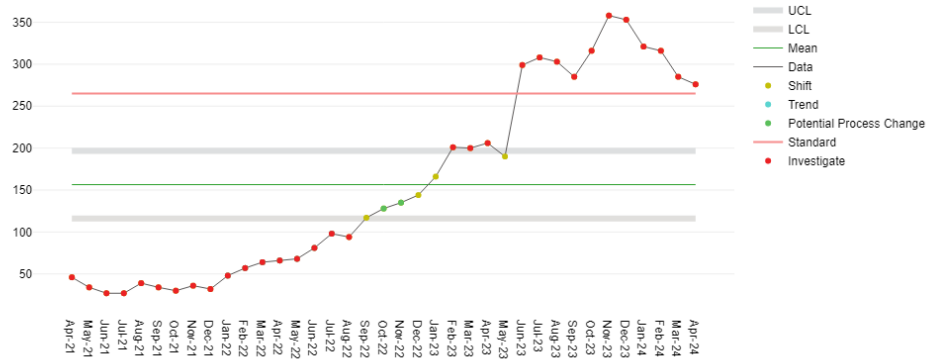
| Latest value | Standard |
|---|---|
| 707 | <499 |

Patients waiting for first outpatient appointment Greater Than 52 weeks




| Latest value | Standard |
|---|---|
| 276 | <265 |

Patients on elective list Greater Than 52 weeks

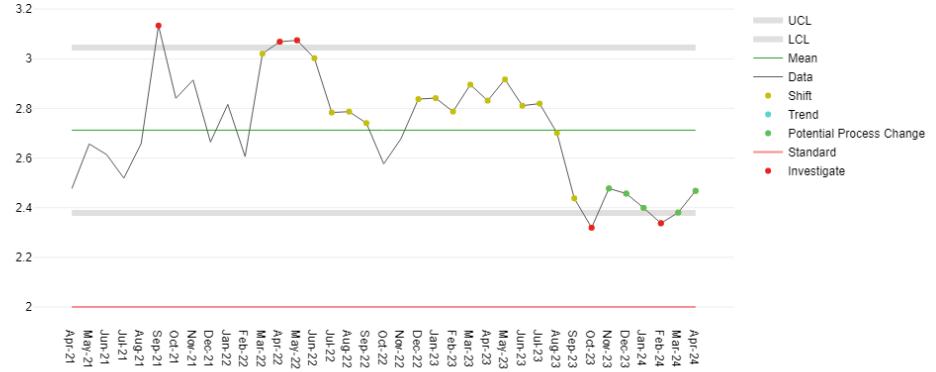



| Latest value | Standard |
|---|---|
| 540 | <525 |

Access to diagnostics Greater Than 6 weeks


| Latest value | Standard |
|---|---|
| 2.47 | 2 |

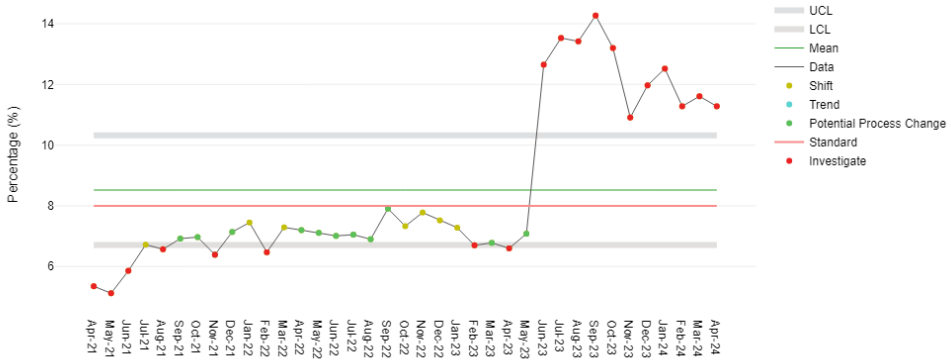
New to follow-up ratio



# Elective Care Performance - SPC Charts

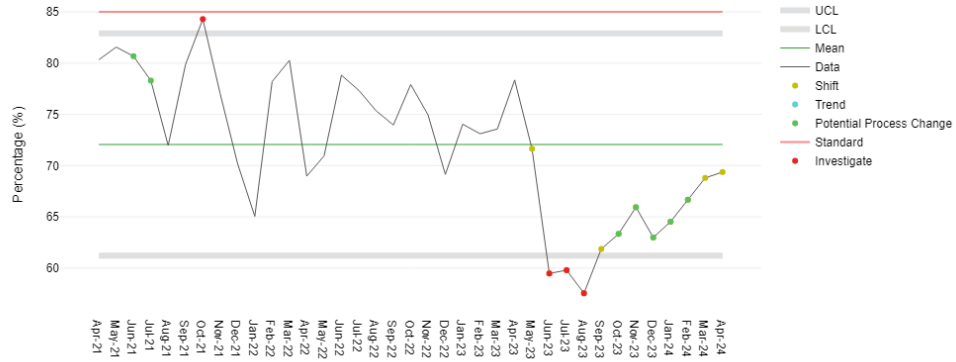
| Latest value | Standard |
|---|---|
| 11.3 % | <=8% |

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



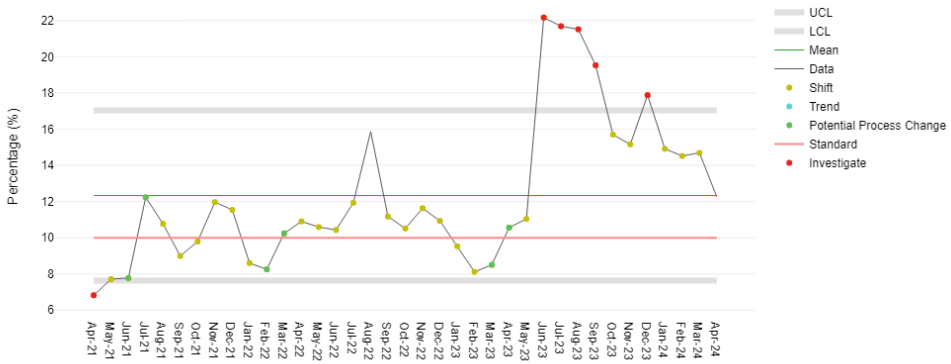

| Latest value | Standard |
|---|---|
| 69.4 % | >85% |

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



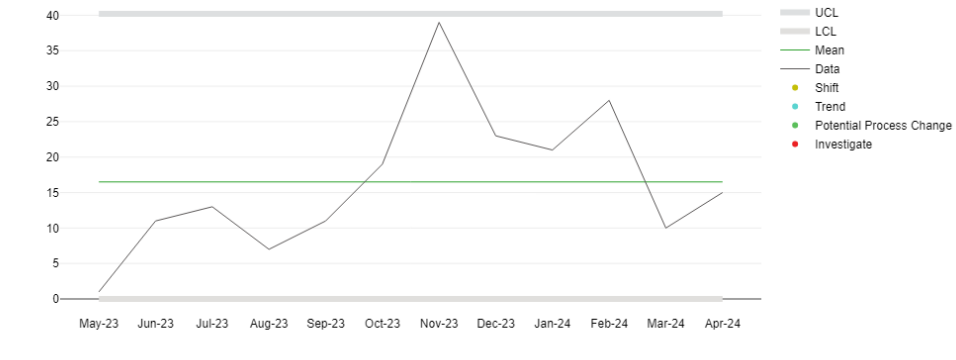

| Latest value | Standard |
|---|---|
| 12.3 % | <=10% |

Was Not Brought Rate




| Latest value | Standard |
|---|---|
| 15 | NA |

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



# Elective Care Performance - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Patients waiting for first outpatient appointment Greater Than 52 weeks | Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM)) | Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4 | Number of patients who have been waiting for over 52 weeks for a first Outpatient appointment at period end |
| Patients on elective list Greater Than 52 weeks | Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM)) | Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4 | Number of patients on the elective inpatient waiting list who have been waiting over 52 weeks at period end. |
| Access to diagnostics Greater Than 6 weeks | Maxims Outpatient Waiting List Reports (OP001DM and IP009DM), Cris report) | Standard set as a trajectory to get to 0 by year end, so 75% of 2023 year end value by end of Q1, 50% by end Q2, 25% by end Q3 and 0 by end Q4 | Number of patients waiting longer than 6 weeks for a first Diagnostic appointment at period end. Data only available from January 2024. Diagnostic investigatations included are comparable to those monitored in the NHS DM01 return. Currently HCS is unable to report on all of the diagnostic tests in DM01 due to technical system issues, but is working to include those at a future date. |
| New to follow-up ratio | Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM)) | Standard set locally | Rate of new (first) outpatient appointments to follow-up appointments, this being the number of follow-up appointments divided by the number of new appointments in the period. Excludes Private patients. |
| Outpatient Did Not Attend (DNA) Rate (Adults Only) | Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM)) | | Percentage of public General & Acute outpatient (>=18 Years old) appointments where the patient did not attend and no notice was given. Numerator: Number of General & Acute public outpatient (>=18 years old) appointments where the patient did not attend. Denominator: the number of attended and unattended appointments (>=18 Years old). Excludes Private patients. |
| Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations) | Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM)) | NHS Benchmarking- Getting It Right First Time 2024/25 Target | The percentage of booked theatre sessions that are used for actively performing a procedure. This being the sum of touch time divided by the sum of booked theatre session duration (as a percentage). This is reported for all operations (Public and Private) with the exception of Minor Ops, Maternity and Endoscopy. |
| Was Not Brought Rate | Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP14DM)) | Standard set locally based on average (mean) of previous two years' data | Percentage of JGH/Overdale public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale public outpatient appointments where the patient did not attend. Denominator: Number of all attended and unattended appointments. Under 18 year old patients only. All specialties included. Excludes Private patients. |
| Number of operations cancelled by the hospital on the day for Non-Medical Reasons | Hospital Electronic Patient Record (Maxims Theatres Cancellations report TH003DM and TCI Statuses IP0024DM) | Not Applicable | Count of the number of on the day cancellations by the hospital for non-clinical reasons in the reporting period. |

# Emergency Care Performance

## Section Owner

Chief Operating Officer – Acute Services

## Performance Narrative

A slight decrease is noted in the 4-hour standard within the emergency department this month from 77% in M3 to 74.6% M4. ED attendances were within normal variance; therefore, performance appears impacted by flow into our emergency bed capacity. Standards have been maintained across our commenced treatment time, ED conversion rate and Average time in ED. In April we seen 2 P1s, 19 P2s, 82 P3s and 29 P4s.

Patients in the department for more than 12 hours increased due to the reasons described above. Of the 3554 ED attendances, 131 were in the department more than 12 hours. 92 were admitted and 39 were discharged from the department direct. Work is underway to ensure early validation of these breaches to support early patient flow within the department. We continue to embed Red2 Green principles. Noting our conversion rate being of an acceptable standard some of these are also to avoid admission. However, the main attributable causes are bed waits for gender and isolation requirements due IPAC outbreaks.

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

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

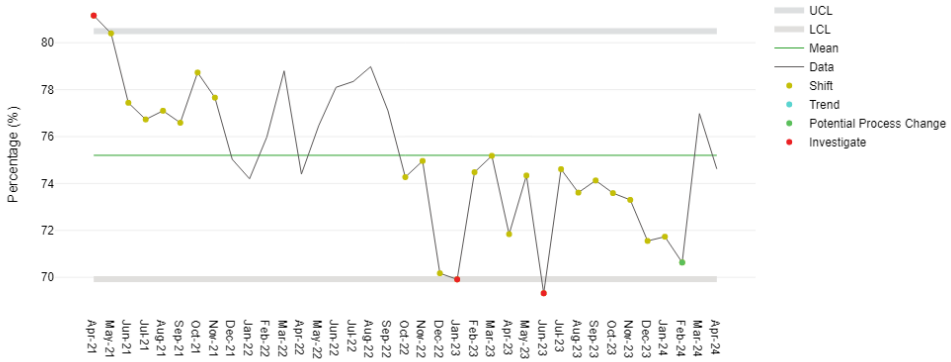
Rate of readmission is reducing slightly since the winter period. This is a marker of system effectiveness however understanding any opportunity to reduce this further will be an outcome of RCP Acute medicine. A deep dive into this metric has been conducted and taken to quality and risk assurance committee.

## Escalations

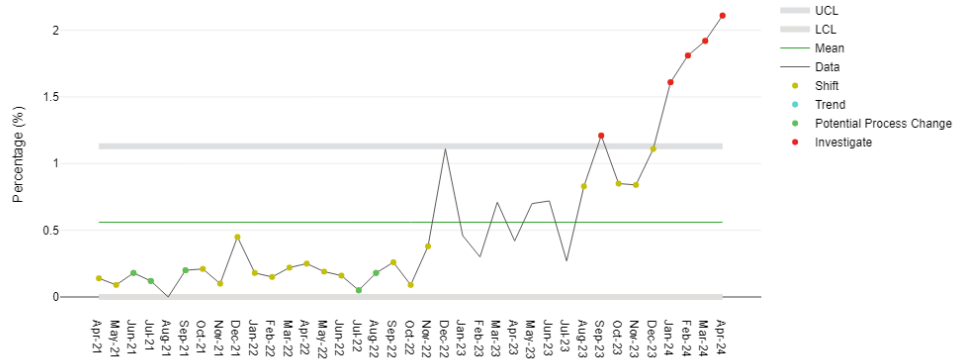
% Patients in ED for more than 12 hours-We continue to face challenges in relation to longer waits in ED with the main drivers of this including isolation, gender and general capacity. Actions being taken to address are maintaining additional capacity, R2G & length of stay activity in Clinical Productivity workstream.

# Emergency Care Performance - SPC Charts

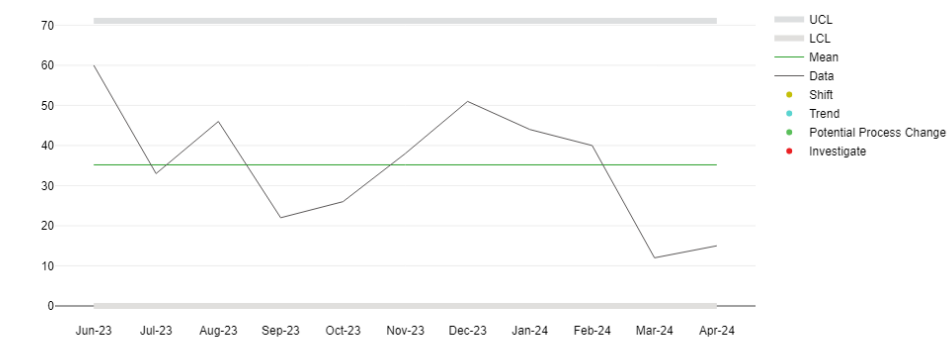
| Latest value | Mean |
|---|---|
| 74.6 % | 75.2 % |



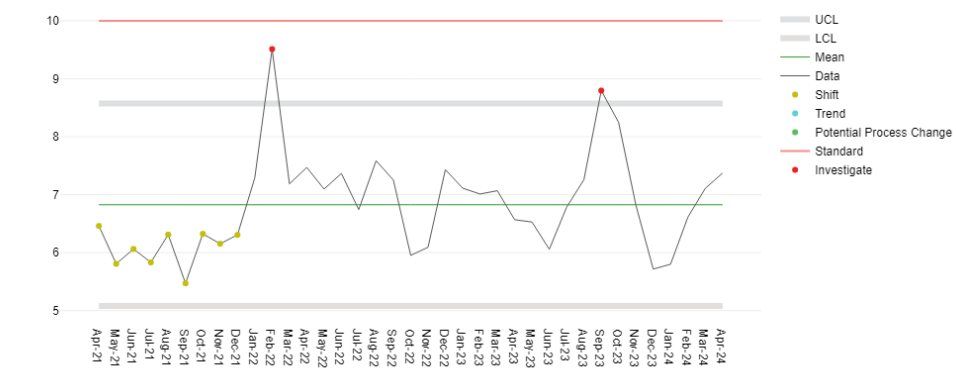

| Latest value | Mean |
|---|---|
| 2.1 % | 0.6 % |




| Latest value | Mean |
|---|---|
| 15 | 35.18 |

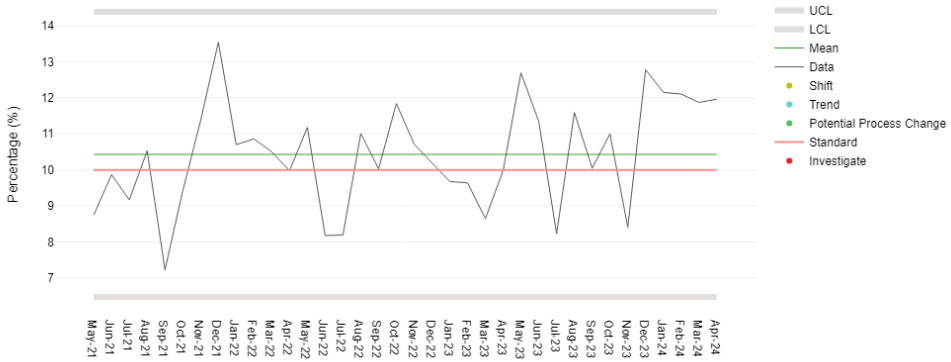



| Latest value | Mean |
|---|---|
| 7.37 | 6.83 |



# Emergency Care Performance - SPC Charts

| Latest value | Mean |
|---|---|
| 12 % | 10.4 % |



# Emergency Care Performance - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| % Patients in Emergency Department for less than or equal to 4 Hours | Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM)) | Not Applicable | Percentage of patients in the Emergency department less than or equal to 4 hours from arrival to departure or admission |
| % Patients in Emergency Department for more than 12 Hours | Hospital Electronic Patient Record (TrakCare Emergency Department Attendances (ED5A) & Maxims Emergency Department Attendances (ED001DM)) | Not Applicable | Percentage of patients in the Emergency department for more than 12 hours from arrival to departure or admission |
| Inpatient movements between 22:00 and 08:00 for non-clinical reasons | Hospital Electronic Patient Record (Maxims Inpatient Ward Movements report IP001DM) | Not Applicable | Count of inpatient moves within wards or between wards, between the hours of 22:00 and 08:00 for non-clinical reasons, in the reporting period. |
| Non-elective acute Length of Stay (LOS) (days) | Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM)) | Generated based on historic performance | Average (mean) Length of Stay (LOS) in days of all emergency inpatients discharged in the period from a General Hospital ward. All days of the stay are counted in the period of discharge. E.g. a Patient with a 100 day LOS, discharged in January, will have all 100 days counted in January. This indicator excludes Samares Ward. During the period 2020 to 2022 Samares Ward was closed and long stay rehabiliation patients were treated on Plemont Ward and therefore the data is not comparable for this period. |
| Rate of Emergency readmission within 30 days of a previous inpatient discharge | Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L, TrakCare Discharges Report (ATD9P), Maxims Admssions and Discharge Report (IP013DM)) | Generated based on historic performance | The rate of emergency readmission. This being the number of eligible emergency admissions to Jersey General Hospital occurring within 30 days (0-29 days inclusive) of the last, previous eligible discharge from hospital as a percentage of all eligible discharges from JGH and Overdale. Exclusions apply see detailed definition at: https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20I02040%20v3.3.pdf |

# Maternity

## Section Owner

Chief Nurse

## Performance Narrative

We continue to try and offer all pregnant people a booking appointment by the 10-week target as per NICE guidelines. We are in the process of developing a self-referral form so women have this option to inform the maternity department as early as possible when they find out there are pregnant. This is to ensure that women are given information relating to their baby's development stages, nutrition and screening available as early as possible.

We have seen a decrease in induction of labour from 31.58% in March to 22.22%, this does fluctuate month on month; but we continue to ensure we are offering induction at the correct gestation due to the clinical presenting picture.

Caesarean section rate was 66.67% in month which is a significant increase from last month (40.35%). Of these there was an increase in elective caesarean section births to 37.04%, with the main Robson group being in one (primigravida mothers'). Patient choice continues to play a key part in the increasing caesarean section rate which is in line with both UK national and international benchmarks.

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

## Escalations

Implementation of a maternity specific EPR system to enable better capturing of data; options being reviewed and considered at present.

# Maternity - Key Performance Indicators

| Indicator | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 | Apr 2024 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Births | 59 | 71 | 58 | 80 | 72 | 67 | 58 | 66 | 59 | 67 | 51 | 58 | 55 | 231 |
| Mothers with no previous pregnancy (Primips) | 36 | 38 | | | | | | | | 24 | 15 | 20 | 16 | 75 |
| Mothers who have had a previous pregnancy (Multips) | 23 | 25 | | | | | | | | 26 | 19 | 30 | 28 | 103 |
| Mothers with unknown previous pregnancy status | | 8 | | | | | | | | 17 | 17 | 8 | 11 | 53 |
| Bookings ≤10+0 Weeks | | | | | | | | | | 6 | 3 | 7 | 8 | 24 |
| % of women that have an induced labour | 23.73% | 34.78% | 22.81% | 20.27% | 27.78% | 31.25% | 17.24% | 30.77% | 38.98% | 30.16% | 24% | 31.58% | 22.22% | 27.23% |
| Number of spontaneous vaginal births (including home births and breech vaginal deliveries) | 20 | 17 | 23 | 26 | 25 | 23 | 21 | 18 | 11 | 25 | 13 | 22 | 10 | 70 |
| Number of Instrumental deliveries | 9 | 8 | 6 | 5 | 12 | 4 | 5 | 5 | 4 | 7 | 3 | 5 | 2 | 17 |
| % deliveries by C-section (Planned & Unscheduled) | 44.07% | 53.62% | 31.58% | 44.59% | 44.44% | 37.5% | 46.55% | 49.23% | 45.76% | 36.51% | 52% | 40.35% | 66.67% | 48.21% |
| % Elective caesarean section births | 23.73% | 26.87% | 23.21% | 23.94% | 22.22% | 21.88% | 23.64% | 27.69% | 29.31% | 23.81% | 32% | 16.07% | 37.04% | 26.91% |
| Number of Emergency Caesarean Sections at full dilatation | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 2 | 0 | 2 | 1 | 1 | 1 | 5 |
| Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour) | | | | | | | | | | 2 | 3 | 0 | 8 | 13 |
| Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour) | | | | | | | | | | 4 | 3 | 5 | 5 | 17 |
| 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 - will always be 100%) | | | | | | | | | | 3 | 3 | 2 | 5 | 13 |
| Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation) | | | | | | | | | | 4 | 6 | 5 | 6 | 21 |
| Number of deliveries home birth (Planned & Unscheduled) | 5 | 3 | 4 | 2 | 4 | 2 | 3 | 3 | 0 | 2 | 3 | 1 | 1 | 7 |
| Mothers who were current smokers at time of booking (SATOB) | | 1 | 3 | 4 | 0 | 1 | 4 | 3 | 2 | 7 | 7 | 3 | 4 | 21 |
| Mothers who were current smokers at time of delivery (SATOD) | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 3 | 0 | 4 |

# Maternity - Key Performance Indicators

| Indicator | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 | Apr 2024 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Mothers who were consuming alcohol at time of booking | | 0 | 1 | 3 | 1 | 1 | 2 | 0 | 3 | 1 | 1 | 2 | 0 | 4 |
| Number of Mothers who were consuming alcohol at time of delivery | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 4 | 6 | 2 | 19 |
| Transfer of Mothers from Inpatients to Overseas | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 3 | 1 | 1 | 5 |
| Number of births in the High dependency room / isolation room | | | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 |
| Number of PPH Greater Than 1500mls | 3 | 10 | 3 | 4 | 2 | 3 | 6 | 6 | 3 | 2 | 2 | 1 | 6 | 11 |
| Number of 3rd & 4th degree tears – all births | 0 | 0 | 3 | 1 | 1 | 2 | 2 | 1 | 0 | 2 | 2 | 1 | 0 | 5 |
| % of babies experiencing shoulder dystocia during delivery | | | 1.72% | 2.5% | 2.78% | 1.49% | 1.72% | 0% | 1.69% | 0% | 0% | 0% | 1.82% | 0.43% |
| Number of babies that have APGAR score below 7 at 5 mins | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 2 |
| % live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA) | 1.79% | 5.36% | 0% | 4% | 2.7% | 0% | 4.55% | 5% | 6.9% | 0% | 3.7% | 7.41% | 3.85% | 3.54% |
| Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 1 | 0 | 0 | 1 |
| Transfer of Neonates from JNU | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 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 | 2 | 7 | 0 | 6 | 2 | 2 | 7 | 1 | 2 | 1 | 1 | 8 | 1 | 11 |

# Maternity - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Total Births | Maternity Birth Registration Details Report | Indicator is for information only | Total number of births of any outcome. Includes live and stillbirth. |
| Mothers with no previous pregnancy (Primips) | Maternity Birth Registration Details Report | Indicator is for information only | Total number of births of any outcome to first-time mothers. Includes live and stillbirth. |
| Mothers who have had a previous pregnancy (Multips) | Maternity Birth Registration Details Report | Indicator is for information only | Total number of births of any outcome to mothers who have given birth at least once before. Includes live and stillbirth. |
| Mothers with unknown previous pregnancy status | Maternity Birth Registration Details Report | Indicator is for information only | Total number of births of any outcome to mothers with unknown previous pregnancy status. Includes live and stillbirth. |
| Bookings ≤10+0 Weeks | Maxims Deliveries Report (MT005) | Not Applicable | Number of women who attended their first pregnancy appointment where their gestation length was less than 70 days (10 weeks). |
| % of women that have an induced labour | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Standard set locally based on average (mean) of previous two years' data | Number of women that had an induced labour as a percentage of the total number of deliveries. |
| Number of spontaneous vaginal births (including home births and breech vaginal deliveries) | Maternity Delivery Details Report | Not Applicable | Number of spontaneous vaginal births including home births and breech vaginal deliveries |
| Number of Instrumental deliveries | Maternity Delivery Details Report | Not Applicable | Count of instrumental deliveries |
| % deliveries by C-section (Planned & Unscheduled) | Maternity Delivery Details Report | Indicator is for information only | Number of c-sections, planned and unplanned, as a percentage of the total number of deliveries. |
| % Elective caesarean section births | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Indicator is for information only | Number of Elective Caesarean sections, divided by total number of deliveries |
| Number of Emergency Caesarean Sections at full dilatation | Hospital Electronic Patient Record (TrakCare Deliveries Report (MAT23A) & Maxims Deliveries Report (MT005)) | Indicator is for information only | Number of Emergency Caesarean section births (This includes all Category 1 & 2 Caesarean Sections) where the mother's cervix is fully dilated |
| Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour) | Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM) | Indicator is for information only | A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and no labour-inducing drugs needed. |

# Maternity - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour) | Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM) | Indicator is for information only | A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and labour was started artificially. |
| Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gesation, caesarean birth prior to onset of spontaneous labour - will always be 100%) | Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM) | Indicator is for information only | A woman who hasn't previously given birth, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term and baby was delivered via elective caesarean section. |
| Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation) | Hospital Patient Administration System (Maxims, Caesarean Deliveries Report MT008DM) | Indicator is for information only | A woman who has previously given birth via caesarean section, baby is bottom and feet up with their head down near the exit, or birth canal, facing the mother's back. Baby is at full term. |
| Number of deliveries home birth (Planned & Unscheduled) | Maternity Delivery Details Report | Indicator is for information only | Number of deliveries recorded as being at "Home", planned and unplanned |
| Mothers who were current smokers at time of booking (SATOB) | Maternity Smoking & Drinking Details Report | Indicator is for information only | Total number of mothers who were recorded as being smokers at their pregnancy booking appointment. |
| Mothers who were current smokers at time of delivery (SATOD) | Maternity Smoking & Drinking Details Report | Indicator is for information only | Total number of mothers who were recorded as being smokers on their delivery date. |
| Number of Mothers who were consuming alcohol at time of booking | Maternity Smoking & Drinking Details Report | Indicator is for information only | Total number of mothers who were recorded as consuming alcohol at their pregnancy booking appointment. |
| Number of Mothers who were consuming alcohol at time of delivery | Maternity Smoking & Drinking Details Report | Indicator is for information only | Total number of mothers who were recorded as consuming alcohol on their delivery date. |

# Maternity - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Transfer of Mothers from Inpatients to Overseas | Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005)) | Indicator is for information only | Number of transfers of mothers out of Maternity inpatient wards to an off-island Healthcare facility. |
| Number of births in the High dependency room / isolation room | Maxims Deliveries Report (MT005) | Not Applicable | Number of births which took place in the High Dependancy Room / Isolation Room |
| Number of PPH Greater Than 1500mls | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Indicator is for information only | Number of deliveries that resulted in a blood loss of over 1500ml |
| Number of 3rd & 4th degree tears – all births | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Not Applicable | Number of women who gave birth and sustained a 3rd or 4th degree perineal tear |
| % of babies experiencing shoulder dystocia during delivery | Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001)) | Not Applicable | Total number of babies experiencing shoulder dystocia during delivery divided by the total number of births |
| Number of babies that have APGAR score below 7 at 5 mins | Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001)) | Indicator is for information only | Number of live births (only looking at singleton babies with a gestational length at birth between 259 and 315 days) that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth |
| % live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA) | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Indicator is for information only | Percentage of live births with a gestational age lower than the 3rd centile (3% of babies born at same gestational age will have a lower birth weight than them) delivered after 37 weeks and 6 days of pregnancy. |
| Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation | Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005)) | Not Applicable | Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation |
| Transfer of Neonates from JNU | Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005)) | Indicator is for information only | Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility. |
| Preterm Births ≤27 Weeks (Live & Stillbirths) | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Indicator is for information only | Live babies born who were born at or before 27 weeks |
| Preterm Births ≤36+6 Weeks | Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005)) | Indicator is for information only | Live babies born who were born before 37 weeks (less than or equal to 36+6 gestation) |

# Mental Health

## Section Owner

Director Adult Mental Health & Social Care

## Performance Narrative

Performance across mental health services remains stable, with some improvement in waiting times for psychological treatment (initial assessment continues to achieve the target of 90 days – in 99% of cases this month). It is pleasing to note that 98% if people in crisis were seen within 4 hours in April, and 100% of people discharged from hospital were followed up within 72 hours (both working age and older adult services). We also continue to see an improvement in waiting lists for both memory assessment and autism assessment.

## Escalations

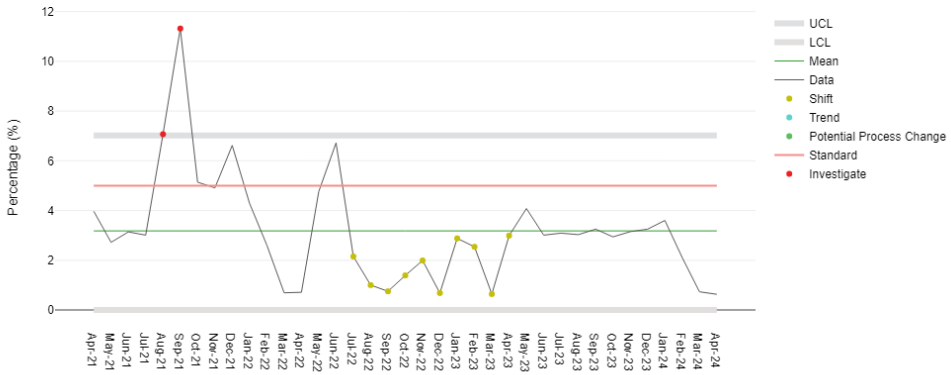
Completion of routine assessments within 10 days dropped to 69% this month (target 85%). This is unusual and has been examined in detail. 53 patients were not seen within the target 10 days – 19% of these related to service issues (delay), 60% related to service user choice / DNA and 21% related to other reasons (this is being explored further within the service).

The ADHD waiting list continues to grow, with an average wait of 399 days currently for patients that have been seen and a forecast wait of over 3 years for new referrals. A new senior practitioner is joining the team on a part time basis, with a specific focus on reviewing the waiting list and supporting the development of assessment capacity.

# Mental Health - SPC Charts

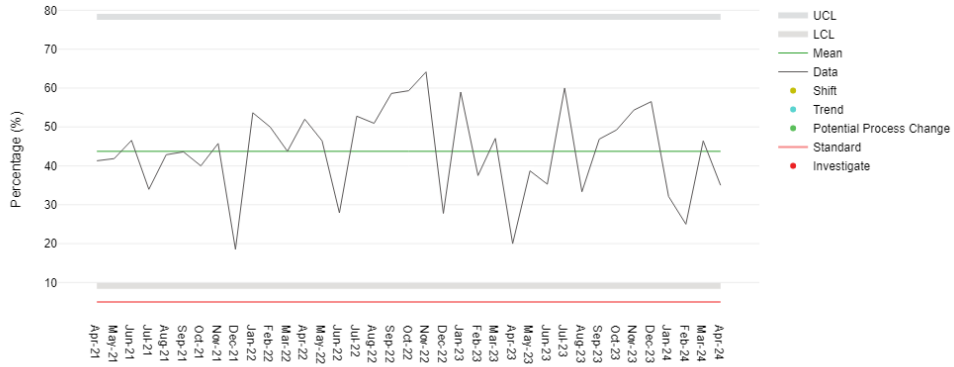
| Latest value | Mean |
|---|---|
| 0.6 % | 3.2 % |

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



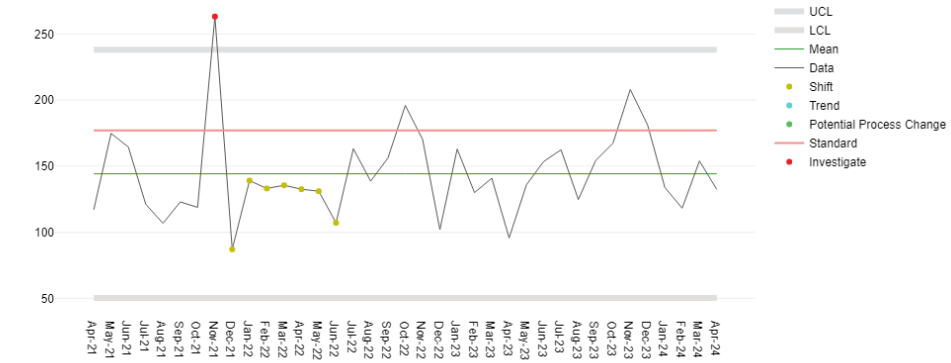

| Latest value | Mean |
|---|---|
| 35 % | 43.7 % |

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



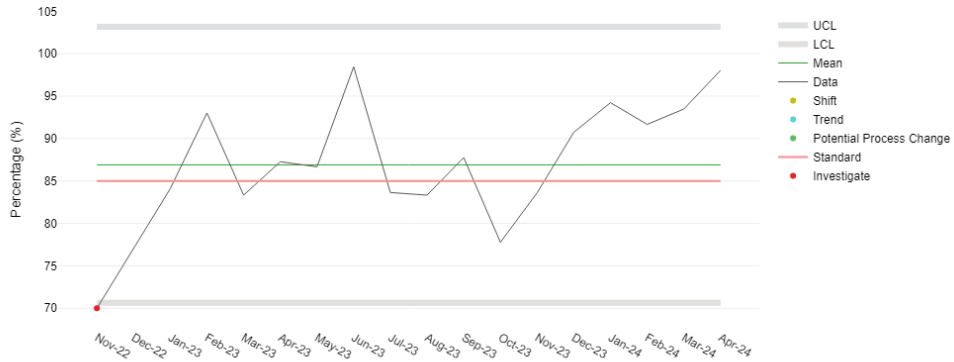

| Latest value | Mean |
|---|---|
| 132.41 | 144.23 |

JTT Average waiting time to treatment (Days)




| Latest value | Mean |
|---|---|
| 98 % | 86.9 % |

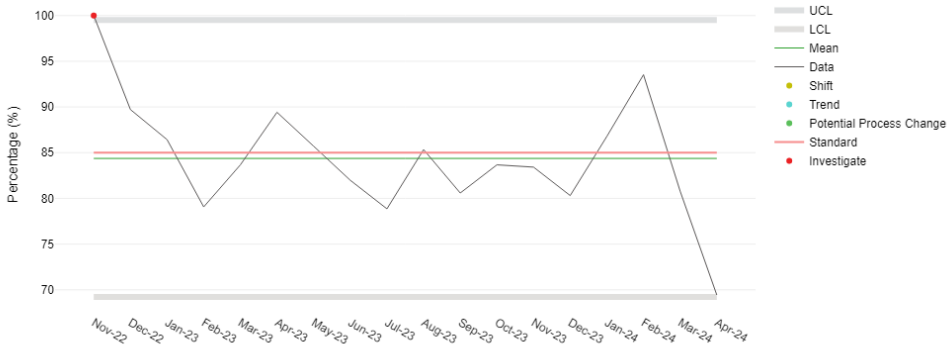
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



# Mental Health - SPC Charts

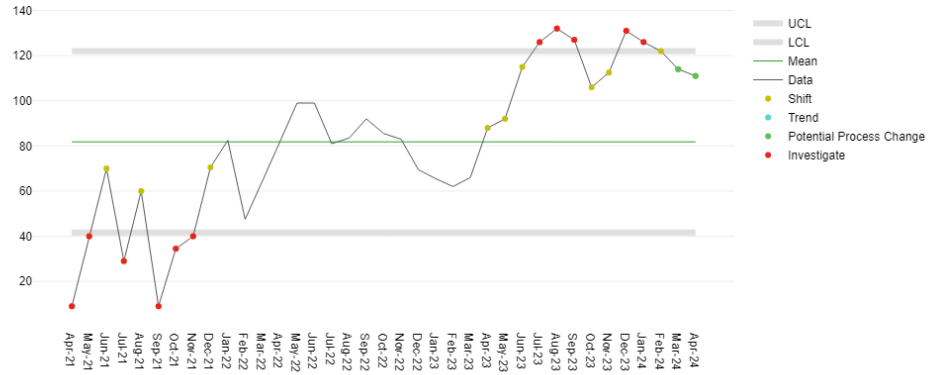
| Latest value | Mean |
|---|---|
| 69.4 % | 84.4 % |

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



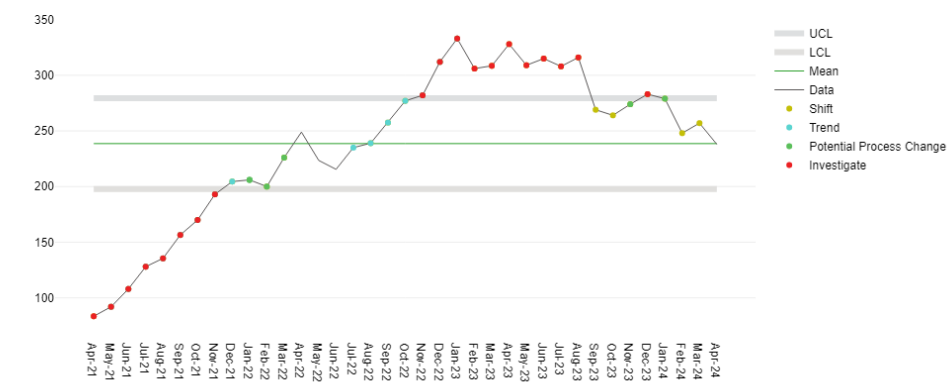

| Latest value | Mean |
|---|---|
| 111 | 81.81 |

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



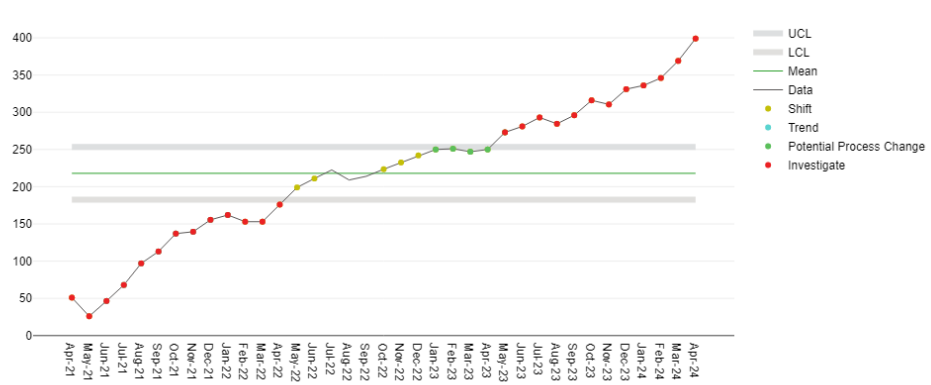

| Latest value | Mean |
|---|---|
| 238 | 238.62 |

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




| Latest value | Mean |
|---|---|
| 399 | 217.95 |

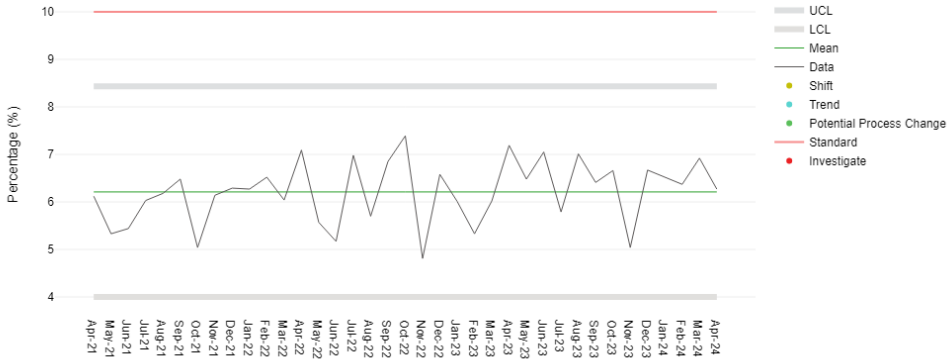
Median wait of clients currently waiting for ADHD Assessment (Days)



# Mental Health - SPC Charts

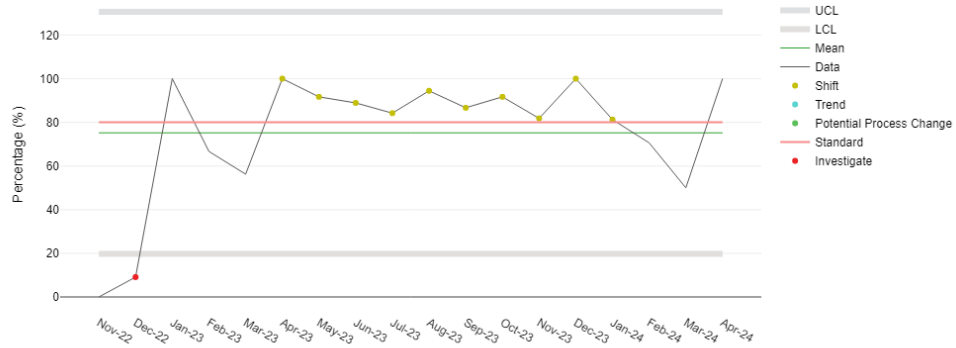
| Latest value | Mean |
|---|---|
| 6.3 % | 6.2 % |

Community Mental Health Team Did Not Attend (DNA) rate



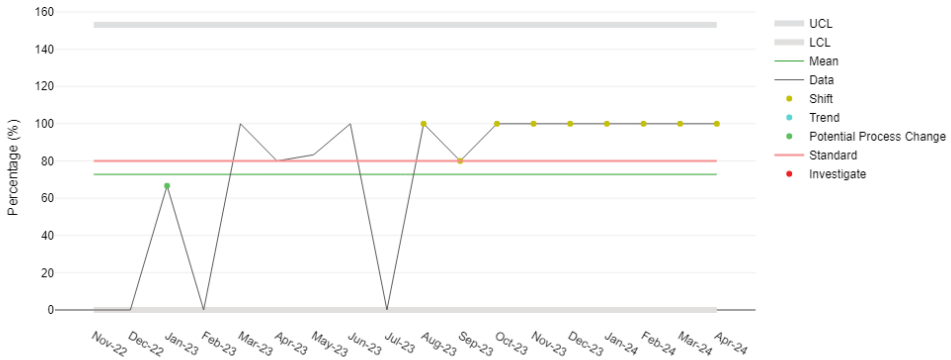

| Latest value | Mean |
|---|---|
| 100 % | 75.2 % |

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




| Latest value | Mean |
|---|---|
| 100 % | 72.8 % |

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



# Mental Health - Indicator & Standard Definitions

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

# Mental Health - Indicator & Standard Definitions

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

# Social Care

## Section Owner

Director Adult Mental Health & Social Care

## Performance Narrative

Both measures continue to achieve above the target. The variance seen is due to local factors – predominantly annual leave but is consistently under review to ensure the meeting of targets is maintained.

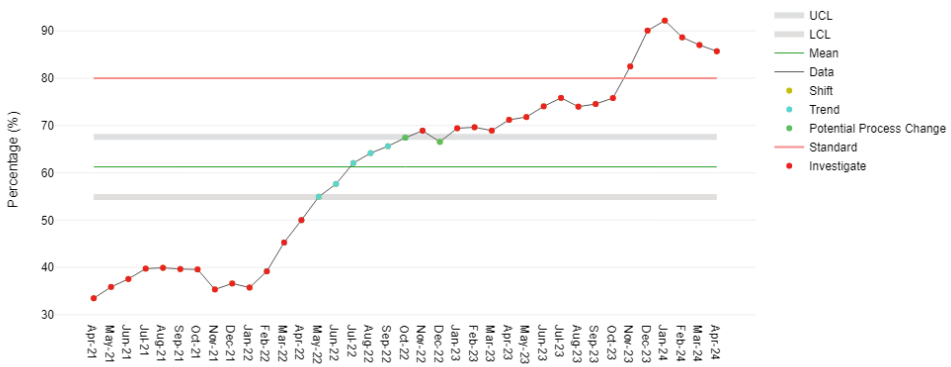
## Escalations

None

# Social Care - SPC Charts

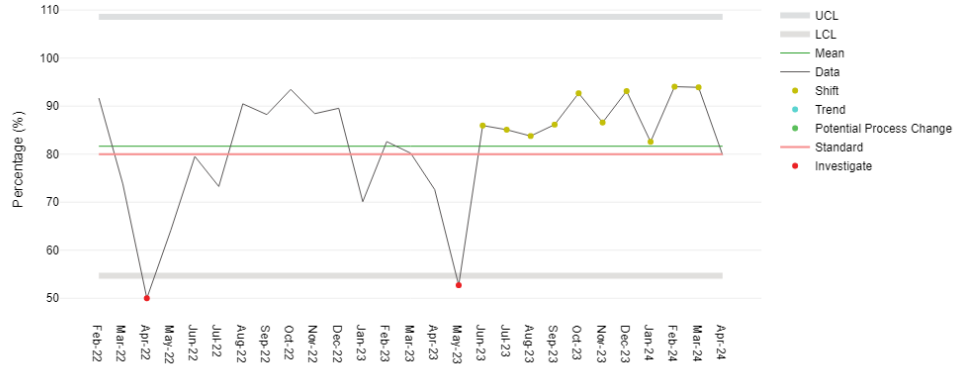
| Latest value | Mean |
|---|---|
| 85.7 % | 61.3 % |

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




| Latest value | Mean |
|---|---|
| 79.8 % | 81.7 % |

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



# Social Care - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Percentage of Learning Disability Service clients with a Physical Health check in the past year | Community services electronic client record system | Generated based on historic performance | Percentage of Learning Disability (LD) clients with an open involvement in the period who have had a physical wellbeing assessment within the past year. Numerator: Number of LD clients who have had a physical wellbeing assessment in the 12 months prior to period end. Denominator: Total number of clients with an open LD involvement within the period. |
| Percentage of Assessments completed and authorised within 3 weeks (ASCT) | Community services electronic client record system | Generated based on historic performance | Number of FACE Support Plan and Budget Summary opened in the ASCT centre of care that are opened then closed within 3 weeks, divided by the total number of FACE Support Plan and Budget Summary opened in the ASCT centre of care more than 3 weeks ago |

# Quality & Safety

The patient advice and liaison service continue to work positively with enquires from the public with support from the care groups. The service has a media plan to launch in June 2024 highlighting the support they can provide.

Falls

It is encouraging to note that we have had 0 falls resulting in with moderate/severe harm in April.

IPaC

We continue to see low levels of infection within HCS. The new appearance and uniform policy due to be ratified in the comings weeks, which will further strengthen the IPaC principles of bare below the elbows and hand washing.

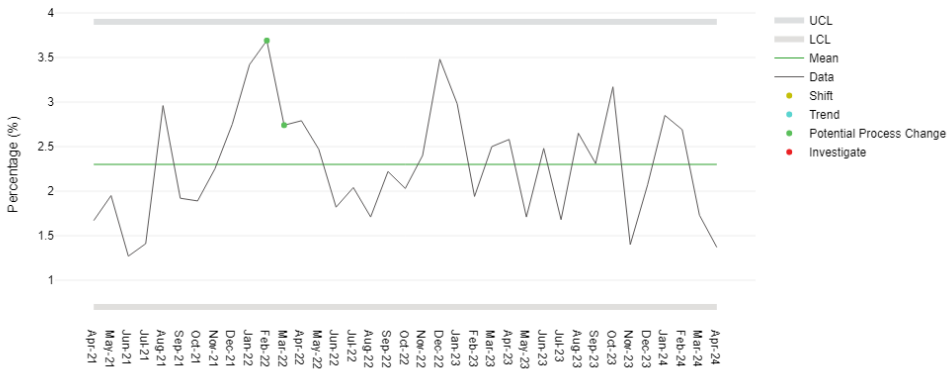
## Escalations

No escalations

# Quality & Safety - SPC Charts

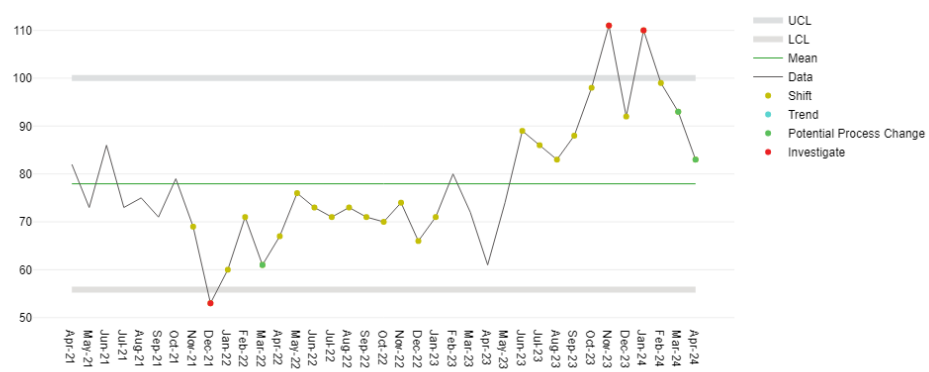
| Latest value | Mean |
|---|---|
| 1.4 % | 2.3 % |

Crude Mortality Rate (JGH, Overdale and Mental Health)



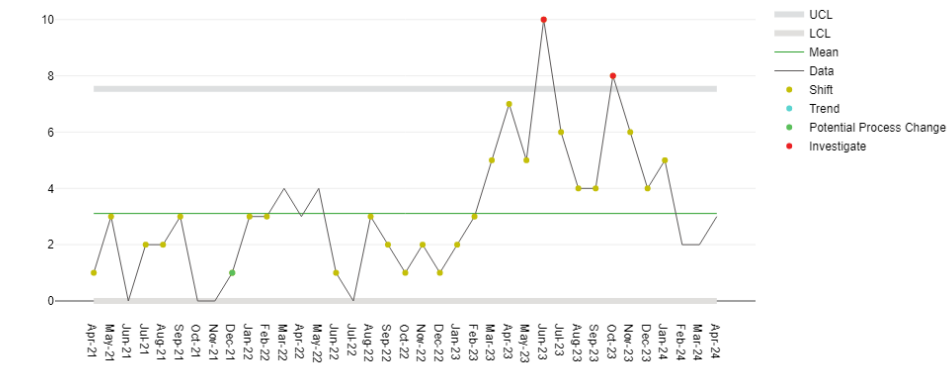

| Latest value | Mean |
|---|---|
| 83 | 77.95 |

Patient Safety Events per 1000 bed days



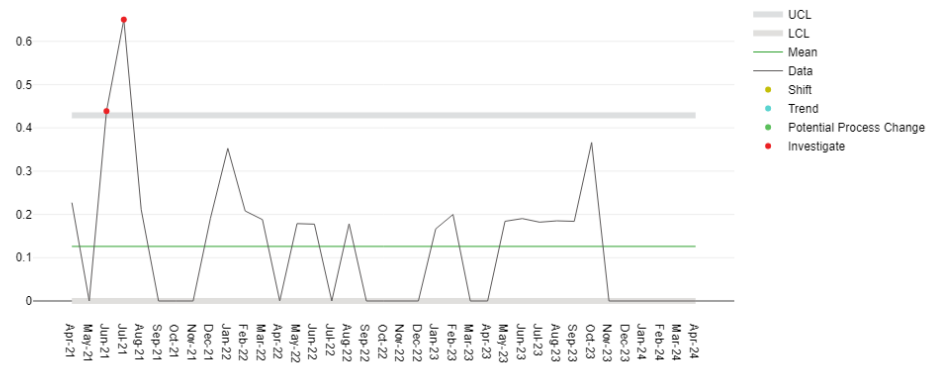

| Latest value | Mean |
|---|---|
| 3 | 3.11 |

Number of serious incidents




| Latest value | Mean |
|---|---|
| 0 | 0.13 |

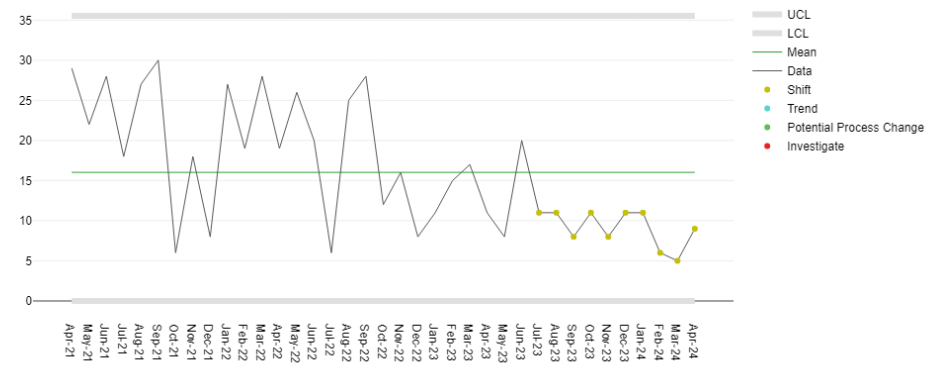
Number of falls resulting in harm (moderate/severe) per 1,000 bed days



# Quality & Safety - SPC Charts

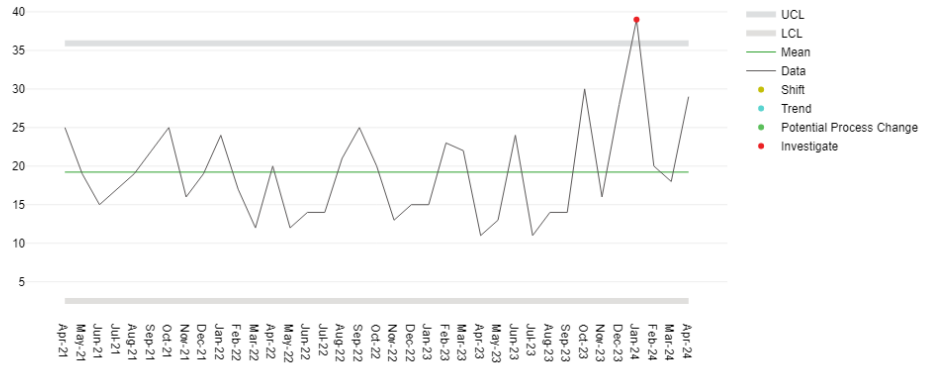
| Latest value | Mean |
|---|---|
| 9 | 16.03 |

Patient safety incidents with moderate/severe harm/death



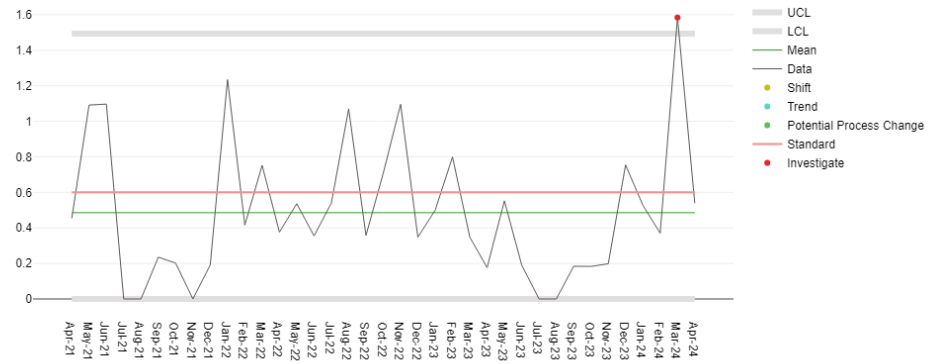

| Latest value | Mean |
|---|---|
| 29 | 19.22 |

Number of pressure ulcers present upon inpatient admission



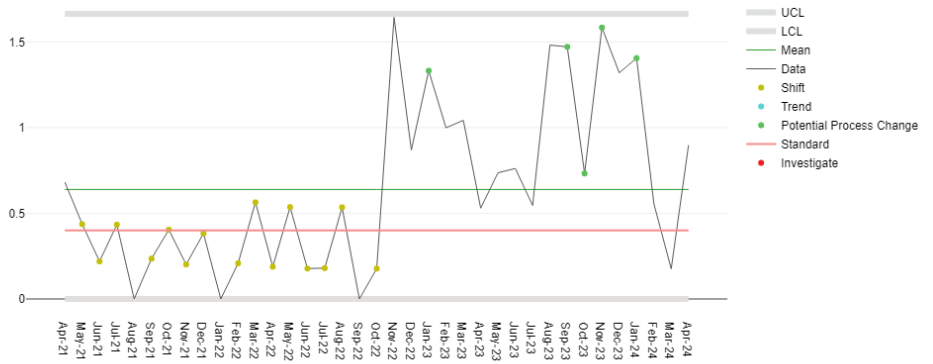

| Latest value | Mean |
|---|---|
| 0.54 | 0.49 |

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



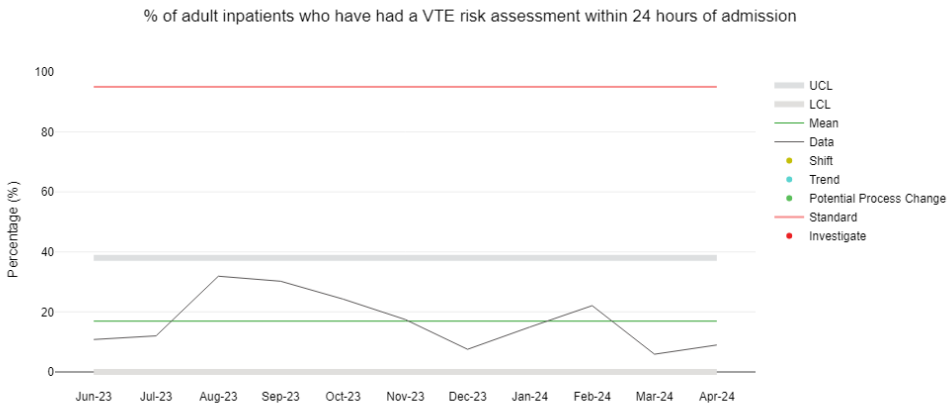

| Latest value | Mean |
|---|---|
| 0.9 | 0.64 |

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

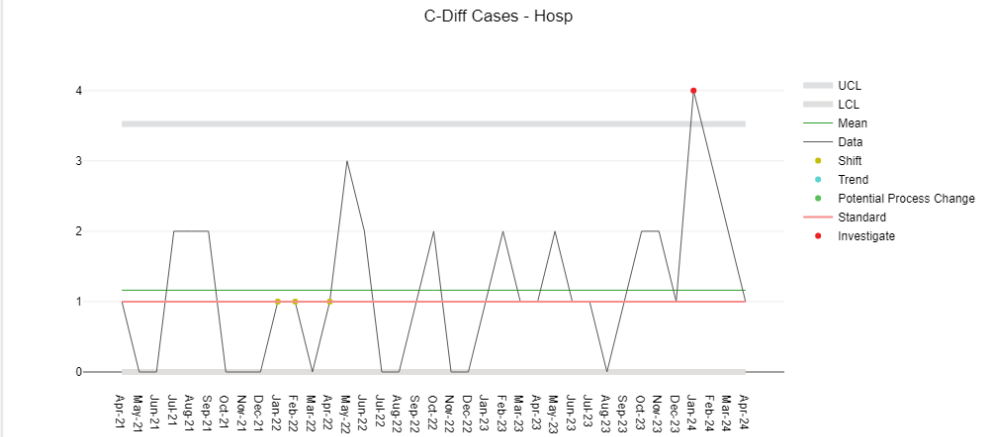


# Quality & Safety - SPC Charts

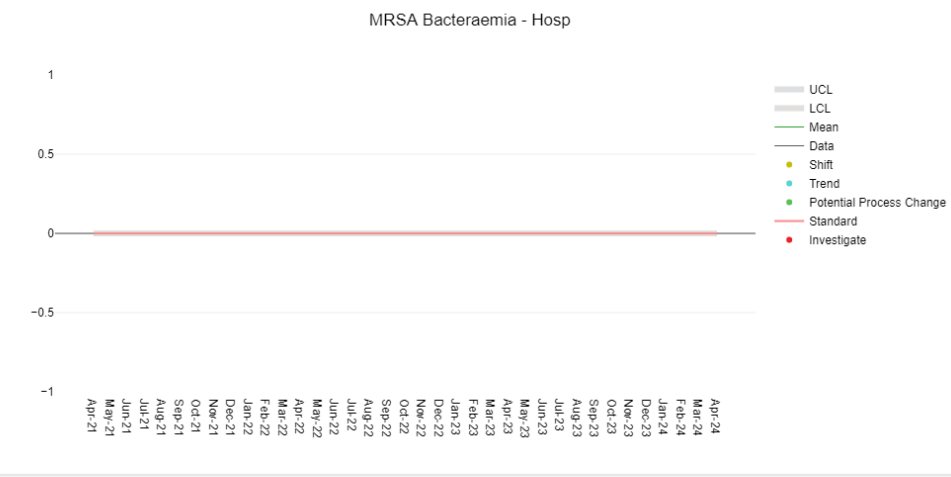
| Latest value | Mean |
|---|---|
| 9 % | 16.9 % |



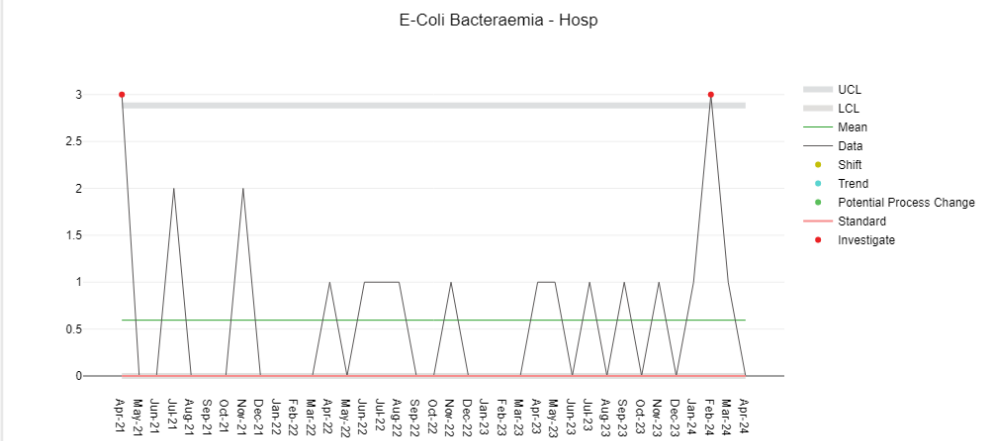

| Latest value | Mean |
|---|---|
| 1 | 1.16 |




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




| Latest value | Mean |
|---|---|
| 0 | 0.59 |



# Quality & Safety - SPC Charts

| Latest value | Mean |
|---|---|
| 126 | 70.46 |


| Latest value | Mean |
|---|---|
| 16 | 31.46 |

# Quality & Safety - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Crude Mortality Rate (JGH, Overdale and Mental Health) | Hospital Electronic Patient Record (TrakCare Inpatient Discharges Report (ATD9P) Maxims Inpatient Discharges Report (IP013DM)) | Not Applicable | A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted. |
| Patient Safety Events per 1000 bed days | HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) | Not Applicable | Number of patient safety events reported where approval status is not "Rejected" per 1,000 bed days |
| Number of serious incidents | HCS Incident Reporting System (Datix) | Not Applicable | Number of safety events recorded in Datix where the event is marked as a 'Serious Incident' in the period |
| Number of falls resulting in harm (moderate/severe) per 1,000 bed days | Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report | Not Applicable | Number of inpatient falls with moderate or severe harm recorded where approval status is not "Rejected" per 1000 occupied bed days |
| Patient safety incidents with moderate/severe harm/death | HCS Incident Reporting System (Datix) | Not Applicable | Number of patient safety events recorded with moderate, severe or fatal harm recorded where approval status is not "rejected" |
| Number of pressure ulcers present upon inpatient admission | HCS Incident Reporting System (Datix) | Not Applicable | Datix incidents in the month recording a pressure sore upon inpatient admission. All pressure ulcers recorded as "present before admsission" but excluding those recorded as "present before admission from other ward". |
| Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days | HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) | Standard set locally based on improvement compared to historic performance | Number of inpatient Cat 3 & 4 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days |

# Quality & Safety - Indicator & Standard Definitions

| Indicator | Source | Standard Source | Definition |
|---|---|---|---|
| Number of medication errors across HCS resulting in harm per 1000 bed days | HCS Incident Reporting System (Datix), Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) | Standard set locally based on improvement compared to historic performance | Number of medication errors across HCS (including Mental Health) resulting in harm where approval status is not "Rejected" per 1000 occupied bed days. Note that this indicator will count both inpatient and community medication errors due to recording system limitations. As reporting of community errors is infrequent and this indicator is considered valuable, this limitation is accepted. |
| % of adult inpatients who have had a VTE risk assessment within 24 hours of admission | Hospital Electronic Patient Record (Maxims Report IP026DM) | NHS Operational Standard | Percentage of all inpatients (17 and over), (excluding paediatrics, maternity, mental health, and ICU) that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Numerator: Number of eligible inpatients that have a VTE assessment recorded through IMS Maxims within 24 hours of admission or before as part of pre-admission. Denominators: Number of all inpatients that are eligible for a VTE assessment. |
| C-Diff Cases - Hosp | Infection Prevention and Control Team Submission | Standard based on historic performance (2020) | Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team |
| MRSA Bacteraemia - Hosp | Infection Prevention and Control Team Submission | Standard based on historic performance | Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team |
| E-Coli Bacteraemia - Hosp | Infection Prevention and Control Team Submission | Standard based on historic performance | Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team |
| Number of compliments received | HCS Feedback Management System (Datix) | Not Applicable | Number of compliments received in the period where the approval status is not "rejected" |
| Number of complaints received | HCS Feedback Management System (Datix) | Not Applicable | Number of formal complaints received in the period where the approval status is not "Rejected" |

Health and Community Services

# Health and Community Services Advisory Board Meeting Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Workforce Report – April data | | |
| **Report authors (& titles):** | Bill Nuttall – Director Workforce HCS<br><br>Els Aoutin – HR Business Partner | **Accountable Executive:** | Chris Bown, Chief Officer |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the Board? | This report provides the Board with data and metrics on the key workforce indicators across HCS.<br><br>The Board is asked to note the contents. | Information | X |
| | | Decision | |
| | | Assurance | X |
| | | Update | X |

## 2. Executive Summary

This report provides the Board with data on the main workforce indicators including,

- Vacancy Rate
- Turnover Rate
- Sickness absence rate
- Recruitment activity
- Compliance rate with appraisals

## 3. Finance / workforce implications

See main report.

## 4. Risk and issues

See main report.

## 5. Applicability to ministerial plan

See main report.

## 6. Main Report

See attached.

# Health and Community Services

# Advisory Board

# Workforce Report

## (April 2024 data)

# Executive Summary

The figures in the table below shown in **blue** are generated from the **Finance establishment report**. Figures shown in **black** all relate to the **HR dashboard numbers**.

For the purposes of the finance information, a vacancy is defined as any funded post against which no salary has been paid for in that month. It does not consider roles that have candidates appointed to them. Work is underway to capture that data and report vacancies accordingly.

| Metric | Dec 22 | Mar 23 | Jun 23 | Sep 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 |
|---|---|---|---|---|---|---|---|---|---|
| **Funded Establishment (FTE)** | **2631** | **2675** | **2709** | **2863** | **2900** | **2887** | **2871** | **2889** | **2877** |
| **Staff in post (FTE)** | **2200** | **2239** | **2228** | **2405** | **2413** | **2378** | **2374** | **2391** | **2387** |
| Vacancy data | | | | | | | | | |
| **Vacant (FTE)** | **411** | **436** | **481** | **458** | **487** | **509** | **497** | **498** | **493** |
| **Vacancy Rate** = Vacant (FTE) / Funded Establishment (FTE) | **16%** | **16%** | **18%** | **16%** | **16%** | **17%** | **17%** | **17%** | **17%** |
| Turnover and Leavers | | | | | | | | | |
| **Total Turnover Rate** | **7.5%** | **6.2%** | **6.5%** | **7.0%** | **7.3%** | **7.3%** | **6.9%** | **6.6%** | **6.7%** |
| **Voluntary turnover rate** | **5%** | **4%** | **4%** | **4.3%** | **4.3%** | **4.7%** | **4.6%** | **4.8%** | **4.5%** |
| **Leavers Headcount** | **26** | **15** | **13** | **16** | **8** | **13** | **11** | **13** | **12** |
| Sickness (% working days lost) * | | | | | | | | | |
| **Sickness Rate** * compared to same period last year | **6%** | **4.8%** | **5.6%** | **5.5%** | **6.5%** | **7.4%** | **8%** | **9%** | **10.7%** |
| Performance Management (Connected Performance) | | | | | | | | | |
| **Objectives approved - Including/ excluding Manual Workers (MW)** | | **3% (incl MW)** | **10% (incl MW)** | **21.5% (incl MW)** | **20.3% (incl MW)** | **8% (incl MW)** | **15.2% (incl MW)** | **27.5% (incl MW)** | **41.4% (excl MW) 35.4% (incl MW)** |
| **Mid-Year Review Complete** | | | **0.3%** | **10.6%** | **12.3%** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Year-end review** | | | | | **5.7%** | **N/A** | **N/A** | **N/A** | **N/A** |

# Commentary on the Metrics

## Workforce Data Fidelity

Work between the Financial Recovery Programme (FRP) Change Management Delivery Team, Finance, the GOJ Connect Systems Administration team continues towards producing accurate establishment and vacancy data to Workforce and Executive Directors. It is recognised that this work is taking longer than the initial 'go live' date of 8 March 2024. When completed, the work will produce reliable data that aligns staffing and budget reports. It is expected that this work should be completed by the end of May 2024. The Director of Workforce will keep updating the HCS Executive Leadership Team and Advisory Board at the monthly meetings.

## Turnover Rate

The turnover rate for April 2024 remains almost the same at 6.7% (compared to last month 6.6%). The total turnover rate has also remained constant in the 12 months at around 7%.

The voluntary turnover rate (i.e. resignations) has also remained constant around 4.5%. 111 staff did (voluntarily) resign over the previous 12 months.

## Sickness Absence

The sickness absence rate has slightly reduced from February to April 2024, with the main reason for absence continuing to be coughs, cold and flu and gastrointestinal problems.

| | Jan 2024 | Feb 2024 | Mar 2024 | Apr 2024 |
|---|---|---|---|---|
| Days lost | 2,645 | 2,343 | 2,307 | 2,266 |

Days lost in February 2024 were 2,343 sickness days, in March 2,307 days; and in April a further small reduction to 2,266 sickness days. (In January 2024, sickness days lost were 2,645 days lost.)

As the sickness absence rate is higher currently compared to 2023 this time, we need to be vigilant about monitoring this trend to see whether the rate will come down in the rest of QTR 2 (Apr-Jun).

## Connect Performance – Objective Setting

The April 2024 data report for objective setting has improved from 27.5% in March, to 35.4% in April. These percentages include manual workers. The percentage, excluding manual workers is 41.4% which is a significant increase.

It will remain an area of focus for the Executive Leadership Team with an action plan for increasing uptake in place for the rest of 2024. More details are documented in the Staff Appraisal and Development section of this report.

# Workforce Data

## Vacancy Rate

The following table shows the vacancy rate for each staff group. Superficially, the April 2024 data suggests an unchanged total vacancy rate for whole of Q1 (Jan-Apr) 2024.

There has been a reduction in the overall budgeted FTE in the Department of 12 FTE from the figure reported last month. The Finance Team are looking into this in the affected Care Groups. It is felt that the higher number included in March was an overstatement that has now been corrected. This appears to have been the result of the erroneous inclusion of Accommodation Service posts in the previous month's FTE, a service which is no longer in HCS.

We are now reporting a budgeted FTE of 2,877 FTE, versus appointments of 2,387. Although this gives a vacancy difference of 490 FTE between these numbers, with rounding's this gives a vacancy result of 493 FTE.

In the next 'Vacancy Rate' table, you will see the vacancies by staff type. The one thing that looks odd is the current over-establishment of Healthcare Assistants, which seems to be offset by a corresponding increase in registered nursing vacancies.

Healthcare Assistant roles have moved from a 23% vacancy rate seen over Jan-Mar, to a slight over-establishment, while the Nursing vacancy level has risen from 20-21% over Jan-Mar, to reach 31% in April.

Workforce has been advised by establishment/vacancy data validation team that reliable data should be available in the following months. The move away by Finance from maintaining appointments information in the HCS Establishment file was an intentional decision aligned with the move to Connect People.

The Finance Team continues with the reconciliation of the Connect People system to the Finance list of budgeted posts (as per monthly Finance establishment data). This has been a significant undertaking by the Finance team to correct the budgeted establishment in Connect People, and still requires more work to rectify the remaining differences in May 2024.

| | Vacancy Rate | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Oct 22** | **Aug 23** | **Dec 23** | **Jan 24*** | **Feb 24*** | **Mar 24***** | **Apr 24** |
| **Medical** | 19% | 18% | 16% | 13%** | 12%** | **12%**** | **16%** |
| **Nursing** | 20% | 23% | 20% | 21% | 20% | **20%** | **31%** |
| **Healthcare Assistants** | 13% | 20% | 17% | 23% | 23% | **23%** | **-2%** |
| **Civil Servants** | 17% | 19% | 17% | 18% | 18% | **18%** | **16%** |
| **Manual Workers** | 9% | 10% | 7% | 5% | 5% | **5%** | **5%** |
| **Total** | 16% | 18% | 16% | 17% | 17% | **17%** | **17%** |

**Please note:**

*Changes also due to 2024 budget mapping and classification exercise by Finance
**Samares wards now included
***March 2024 data not reliable

**Vacancies by Staff Type**

| | | Staf in Post | | |
|---|---|---|---|---|
| **Row Labels** | **Budget FTE** | **FTE** | **Vacant FTE** | **Vacancy %** |
| Medical | 283 | 238 | 45 | 16% |
| Nurses & Midwives | 880 | 613 | 269 | 31% |
| Healthcare Assistants | 346 | 351 | -6 | -2% |
| Civil Servants, AHP & Associated | 1,030 | 864 | 167 | 16% |
| Manual Workers | 338 | 321 | 17 | 5% |
| **Grand Total** | **2,877** | **2,387** | **493** | 17% |

**Vacancies by Care Group**

| Care Group | Budget FTE | Staff in Post FTE | Vacant FTE |
|---|---|---|---|
| Chief Nurse | 63 | 46 | 17 |
| Director Generals Office | 43 | 40 | 3 |
| Estates & Hard Facilities | 70 | 63 | 7 |
| Improvement & Innovation | 30 | 24 | 6 |
| Intermediate Care | 63 | 48 | 15 |
| Medical Director | 146 | 123 | 23 |
| Medical Services | 571 | 482 | 89 |
| Mental Health | 385 | 273 | 113 |
| Non-Clinical Support Services | 408 | 378 | 30 |
| Primary Care & Prevention | 147 | 117 | 30 |
| Social Care | 212 | 173 | 39 |
| Surgical Services | 533 | 449 | 86 |
| Women Children & Family | 206 | 170 | 36 |
| **Grand Total** | **2,877** | **2,387** | **493** |

The rollout of the new GOJ Connect Talent Acquisition system continued during April 2024. This will also help to consolidate a single source of accurate vacancy management information.

In the meantime, manual collation of data is providing data for some groups and the table below shows the pipeline information we have for the recruitment into nursing and Allied Health Professional roles.

**Table - Recruitment of nurses:**

| **Started** (11/03/2024 to date) | **Clearances complete awaiting start** | **Offered/Contract issued** | **Roles at interview stage** | **Roles at shortlisting stage** | **Currently at live advert** |
|---|---|---|---|---|---|
| 64 | 18 | 42 | 15 | 1 | Live: 10<br>Advert expired: 44 |

**Below is a summary of what the Workforce Data reporting is indicating**

**Nurses**
102 – Vacant – 'advertised'/shortlisting/interview/pending approval stage
62 – offer/clearance complete stage
78 – started since 01/01/2024

**HCA**
60 – vacant - 'advertised'/shortlisting/interview/pending approval stage
37 – offer/clearance complete stage
24 – started since 01/01/2024

**Civil Service**

132 vacancies
44 – in clearance
63 – started since 01/01/2024

## Recruitment Activity

Despite the feeling of having to work with unreliable workforce data, the April 2024 total vacancy rate has remained the same at 17% compared to January - March 2024.

Healthcare Assistant roles have moved from a 23% vacancy rate seen over Jan-Mar, to a slight over-establishment, while the Nursing vacancy level has risen from 20-21% over Jan-Mar, to reach 31% in April.

At the beginning of April 2024 an HCA Open Day event took place with broad media coverage and promotion. It is the start of developing an annual 'calendar of events' mapping targeted recruitment campaigns throughout a 12-month period.

Workforce attraction and recruitment and retention packages continue to be developed by the FRP Change Management Delivery Team. These will aim to address 'hard to fill roles' that have been identified and following discussions with the Chief People Officer, it is intended to present these proposals to the GOJ Executive Leadership Team and SEB by late June.

Work is being finalised between the FRP Change Management Delivery Team and Workforce Resourcing to establish a list of 'approved recruitment/specialist search companies' compliant with the GOJ procurement/contract standards that will support recruitment campaigns being planned to take place throughout 2024. These recruitment campaigns are being co-ordinated between Workforce Resourcing, the Chief Nurse's Team guided by a specialist Recruitment Campaign Advisor from People and Corporate Services.

In addition, work will also start on finalising the development of the dedicated nurse 'recruitment microsite' and the commencement of work associated with digital marketing nursing marketing.

Workforce Resourcing (a newly established function combining the focus on temporary health workers and permanent staff) includes 3 x FTE in house Recruiting Officers seconded from People and Corporate Services

who worked hard to reduce Time to Recruit (TTR) from 120-140 days to 60-90 days and the Time to Hire from 210-240 days to 150-180 days to coincide when the new GOJ Connect Talent Acquisition (TA) system went live across HCS during April 2024. TA replaces the Resource Link system. The key to success will be establishing a new relationship between hiring managers and the recruiters especially when it comes to securing a licence required for each post to be advertised and that the job description has been posted on Connect TA.

Before the Easter Break, a senior Workforce Specialist from the FRP Programme Management Delivery Team assisted the Head of Medical Staffing in mapping the current TTR and TTH metrics associated with the recruitment of Medical Consultants, advising on how time could be saved with new ways of working which would need to be agreed with the General Managers in each of the Care Groups.

Work is also ongoing to continue examining ways to improve the post hire activity that is onboarding which also included ensuring new permanent staff recruited to HCS recruits and junior medical staff have access to appropriate temporary accommodation.

## Junior Doctors

For F1 and F2 plus GPVTS doctors, we are part of the Wessex Deanery rotation, and they supply HCS with doctors who are UK graduates. If they are unable to fill the slots, we work with NHS Professionals – Gateway programme to fill the slots with overseas doctors, for example we currently have 3 doctors working with us from Myanmar.

For clinical fellow roles, we advertise in the British Medical Journal (BMJ), we often receive a good number of applications from international graduates and have taken doctors from India, Pakistan, Caribbean as well as several doctors in the UK that have completed their foundation training. In addition, we will have our own doctors who have completed foundation training electing to remain with JGH as a clinical fellow.

The Clinical Fellow posts are popular, and this is due to the excellent educational support they receive from our Medical Education team. You will be pleased to know that all our Clinical Fellow posts are filled for the August 2024 rotation.

## Other Planned Recruitment Activity

Other planned recruitment activity to take place during Q2 2024 includes the following:

- A review of the current BMJ contract (to end in July 2024) to ensure it is being used effectively to help recruit medical staff.
- The Head of Medical Staffing and her team are actively in collaboration with the FRP Change Programme Delivery Team to develop a strategy for recruiting 34 medical staffing vacancies some of which are recognised as 'hard to fill'. This will include reviewing job adverts to include opportunities for consultants to develop a private patient portfolio.
- Work continues to finalise the list of specialist recruitment agencies to support targeted recruitment campaigns.
- Reviewing progress on digital marketing projects to support recruitment campaigns.
- Getting the Job description of the new Chief/Director for AHP (Allied Health Professionals) Services job evaluated and advertised.
- The Director of Workforce viewed several flats/bedsits and a shared house available to HCS new starters providing temporary transitional relief before they enter the private housing market. A report has been submitted to the Chief Officer and will be discussed with the appropriate GOJ senior officials.
- Continued promotion of the 'Refer a Friend' recruitment initiative.
- Ensuring that the new team of in-house recruiters will support 'hiring managers' navigate and manage the new GOJ Talent Acquisition recruitment and on boarding system effectively.

# Retention

The total turnover rate for the last 12 months to the end of April 2024 is 6.7% and remains constant, which equates to 167 people leaving HCS. This is a slight increase in percentage compared to last month (March: 6.6%).

The voluntary turnover figure (which relates to resignations) for the 12 months to end of April 2024 is 4.5%, which is slightly higher compared the 4.2% this time last year. This equates to 111 (voluntary) leavers spread across the year.

In addition, there were 21 retirements over the previous 12 months. The remaining 35 'involuntary' leavers consisted of 27 leavers, due to end of contracts in Hospital and Community Services.

## Job Evaluation

The Director of Workforce has been working with colleagues in People and Corporate Services to re-establish HCS Representations on the Civil Service and Agenda for Change Job Panels with the aim of having a sufficient representation of HCS managers sitting on panels who will have the necessary knowledge, skills and experience to support the panels in reaching the right grading decision when analysing the various components of healthcare roles set out in new and updated job descriptions and person specifications. The concern was that not all panellists had adequate insight into the detailed workings of healthcare jobs.

New arrangements covering training for new panellists and refresher training for those HCS Managers who membership had lapsed for one reason and another as well as a new list of HCS representatives are to be established in 2024.

## Exit Interviews

It was reported at the previous Board meeting, that the HCS Executive Leadership Team had reviewed a report by Law at Work who were commissioned in 2023 to review a sample of exit interviews relating to staff who had left the employment of HCS during the same year. A copy of the report has been forwarded to the People and Culture Committee, who will review and consider the results of the report and the themes relating to why staff left and making recommendations for improving the working culture of the organisation. These themes are shown below.

| Reasons for Leaving | Number of staff who commented |
|---|---|
| Dissatisfaction with responsibility, integrity and poor decision making | 17 |
| Performance and conduct issues not dealt with | 16 |
| Career development | 15 |
| Not supported | 12 |
| Stress | 12 |
| Work life balance | 10 |
| Job expectations/demand of role | 10 |
| Relationship with line manager (lack of understanding of role; management style) | 8 |
| Leaving Jersey/cost of living / too expensive | 7 |
| Retirement | 7 |
| Not listened to | 6 |
| Lack of appreciation and acknowledgement | 5 |
| Better pay and conditions | 4 |
| Not considering reasonable adjustments | 4 |
| Unsafe working conditions | 4 |
| Bullying and harassment | 3 |
| Poor culture | 3 |
| Poor IT | 2 |
| Too many managers - not enough front-line staff | 2 |
| Communication | 2 |
| Personal reasons | 2 |
| Lack of feedback | 1 |
| Redundancy | 1 |
| End of contract | 1 |

## Induction – Corporate Days and Local Induction

The Director of Workforce has now circulated a Local Induction Checklist for managers to use when welcoming a new starter to their team. Once completed it should be sent to the People Hub with a copy retained by the appropriate manager.

This an important reference document in helping managers and HRBP/Consultants to consider whether there might be any indication post induction that might suggest the reasons behind any employment relationship issues that have developed during a new starter's initial 0–9-month period working for HCS.

## My Welcome

In addition to developments concerning HCS corporate and local induction, the GOJ My Welcome is the online Government of Jersey induction programme all new starters to working for the Government re expected to undertake. There continues to be a consistent uptake of the face-to-face element of the GOJ.

The completion rate of the My Welcome online programme remains at approximately 30% which is the average rate for the Government as whole.

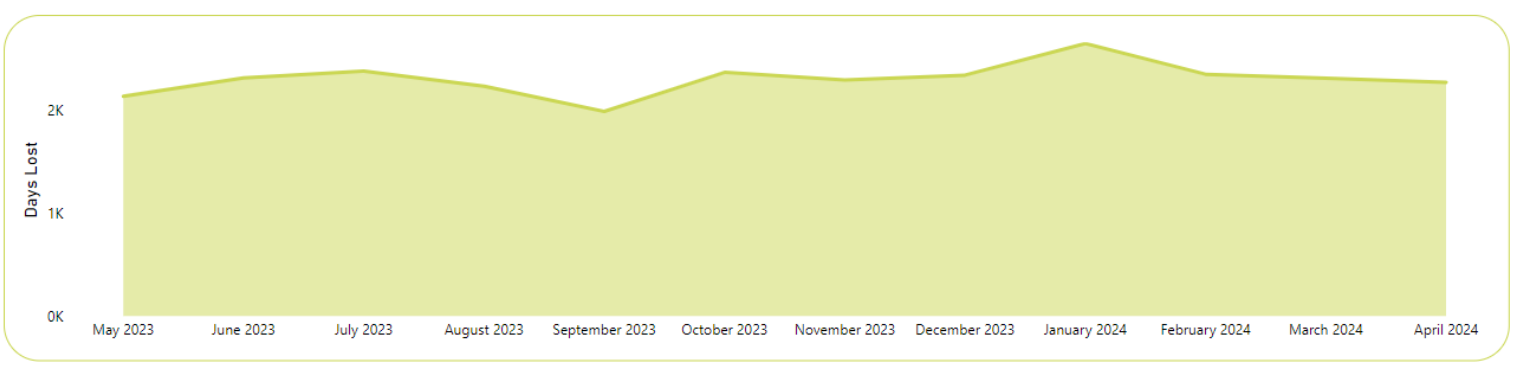
## Strategic Workforce Planning

During April 2024, the Chief Officer and the Director of Workforce began to outline the framework for developing a Strategic Workforce Plan for HCS to cover the next 4-5 years. One of the key drivers for this is the is the Planning for the New Healthcare Facilities which is currently out for consultation. A meeting with the senior PCS planning officer who co-ordinates workforce planning for GOJ will take place in early June to discuss and agree how the workforce planning framework for healthcare can be aligned with GOJ model which is being used by other Departments.

# Health and Wellbeing

Analysis of the AXA Health Remote Occupational report for April 2024, there has been a further decline in the number of days lost due to sickness absences compared to January - March 2024.

The average days sickness per employee is slightly lower (i.e. 11.1) compared to the average sickness absence in 2023 for the same period which was 11.8. This is shown in the graph and table below.




Sickness Analysis - May-23 - Apr-24

| Department | Sickness Hours | Days | Instances | % Working Days Lost | Av. Days Sick Per Employee* | Av. Days Same Period Last Year |
|---|---|---|---|---|---|---|
| Health and Community Services | 204,185.2 | 27,592.6 | 5,488 | 10.7% | 11.1 | 11.8 |
| **Total** | **204,185.2** | **27,592.6** | **5,488** | **10.7%** | **11.1** | **11.8** |

The main reasons for absence have remained constant with the predominant reason being recorded as cough, colds and flu followed by gastrointestinal problems.

THE AXA Health Occupational Health Service contract is being reviewed centrally by People and Corporate Services in advance of the re-tender date of November 2024. A report on the performance of AXA Health is awaited.

## Employee Relations (ER)

HCS Workforce HRBP/Consultants Service continues to monitor live formal cases with the GOJ People and Corporate Services Case Management (CM) Team meeting each month to review the CM report which covers a range of cases that have moved from informal attempts to resolve issues (via facilitated discussions/mediation/fact finds) to formal investigations leading to disciplinary hearings.

Closer working arrangements between HCS HRBP/Consultants Service and the Freedom to Speak Up Guardian (FTSUG) are being developed to facilitate early resolution locally without the immediate need for formal action being taken involving senior management – all done whilst protecting the neutrality of the FTSUG and maintaining confidentiality. Work also continues to promote a 'Freedom to Speak' culture within HCS.

## Staff Appraisal and Development

The April 2024 data report for objective setting has improved from 27.5% in March, to 35.4% in April. These percentages include manual workers. The percentage, excluding manual workers is 41.4% which is a significant increase.

During a review of the latest data produced by People and Corporate Services (PCS), the Executive Leadership Team questioned whether manual workers were included in the report as it was understood that an agreement had previously been reached with Trade Unions to exclude them from the process. The Director of Workforce is looking into this and will have further discussions with the Chief People Officer.

A review of the data from the past 3 months, highlighted managers whose direct reports have not yet set any objectives, or the form is currently sitting with the manager to approve during this time. Fifty of these managers (totalling 360 direct reports) have been offered additional support and upskilling through walkthroughs and online resources to read. This additional support aims to make the managers feel more confident in completing the objective setting stage of the form and, importantly, know the steps to approve the objectives to be accurately reflected in the statistics.

The HCS Workforce teams will continue receiving further Connect training to be able to continue supporting HCS managers with Connected Performance.

## Connect People Update

Nurses and Midwives began using Connect Talent Acquisition on 26th February and it was rolled out to the rest of HCS during April 2024.

To support managers, there is a range of face to face and online training available on Connected Learning as well as resources and a series of webinars.

Through April and May 2024, a daily drop-in call is being held on Teams from 09:00 to 09:30 where managers can drop-in if they need support.

TalentLink is closing in June 2024. We are currently in the process of moving Government jobs to our new careers site careers.gov.je.

## End of Report

Health and Community Services

# Health and Community Services Advisory Board Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services (HCS) Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Finance Report (M4) | | |
| **Report author (and title):** | Obi Hasan, Finance Lead Change Team, Interim Lead of Finance Business Partnering HCS | **Accountable Executive:** | Chris Bown, Chief Officer HCS |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | To provide an update on the Month 4 Financial position for 2024.<br><br>To discuss the financial position noting the risks and mitigations. | Information | x |
| | | Decision | |
| | | Assurance | x |
| | | Update | x |

## 2. Executive Summary

### FY24 Month 4 Finance Position

| | Current Month | | Year-to-Date | | | Full Year | | | Year-to-Date | Full Year |
|---|---|---|---|---|---|---|---|---|---|---|
| HCS Categorisation | Budget (£'000) | Actual (£'000) | Budget (£'000) | Actual (£'000) | Variance (£'000) | Budget (£'000) | Forecast (£'000) | Variance (£'000) | % Variance | % Variance |
| Staff Costs | 20,542 | 21,090 | 70,944 | 73,276 | (2,332) | 216,331 | 220,186 | (3,855) | (3.3%) | (1.8%) |
| Non Pay | 8,633 | 11,012 | 36,027 | 42,517 | (6,490) | 107,621 | 120,424 | (12,803) | (18.0%) | (11.9%) |
| Income | (2,318) | (2,353) | (8,165) | (8,727) | 563 | (28,419) | (27,064) | (1,354) | 6.9% | (4.8%) |
| **Grand Total** | **26,856** | **29,749** | **98,806** | **107,065** | **(8,259)** | **295,533** | **313,546** | **(18,013)** | **(8.4%)** | **(6.1%)** |

- The Financial position for YTD Month 4 is an £8.3m deficit vs budget giving a headline monthly run-rate of £2.1m.

### Underlying position and Run-rate

- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £1.8m.

### FRP savings delivery

FRP savings delivered are £2.4m vs £1.84m plan, made-up of £1.2m of original schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.

FRP savings will initially be recognised against the GoJ Value for Money (VFM) target for HCS of £3.986m which is included as part of the FRP target of £12m for FY24. In FY23, £3.2m of savings were delivered against a VFM target of £1.3m and FRP target of £3m.

**FY24 year-end forecast**

- The current FY24 year-end forecast remains a deficit of £18.0m. However, there are further downside risks, which are being carefully monitored. Mitigating actions continue to be developed and implemented.

  The key factors driving the forecast deficit are:

  - The year-end forecast is £18.0m deficit with further downside risks from cost pressures, before additional mitigation actions are taken. As reported previously, the key factors driving the forecast deficit are:
  - Budget cost pressures due to funding constraints identified when completing the FY24 budgets of £7.5m
  - FRP savings slippage due to delays in enabling support to ensure timely delivery £6m. However, this is a timing delay, and the savings are expected to be delivered in FY25 and FY26.
  - Exceptional one-off costs in-year
  - Tertiary care contracts activity and price increases
  - Activity increases (above baseline budget) in high cost-low volume (HCLV) services and treatments
  - Drugs and other non-pay inflation
  - WLI funding
  - Additional costs of implementing clinical/medical model following recommendations of Royal College reviews into Medicine and Maternity Services.

**Mitigating Actions being taken:**

- Urgent mitigation actions are being taken to recover the forecast deficit position, working with the Care Groups with weekly updates, to reduce the current overspend run-rate.
- This will require making additional savings this year to remain within the required budget constraints.

**Conclusion**

- FY24 YTD M4 deficit is £8.3m giving a headline monthly run-rate of £2.1m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £1.8m.
- FRP savings of £2.4m have been delivered vs £1.84m plan at M4 made-up of £1.2m savings from original FRP schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £18.0m deficit with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- The key factors driving the forecast deficit are budget cost pressures £7.5m, FRP savings slippage due to delays in enabling support £6m, exceptional one-off costs in-year, Tertiary care contracts price inflation, Activity increases in high cost-low volume (HCLV) services, Drugs and other non-pay inflation, WLI funding, and additional costs of implementing the recommendations of Royal College reviews into Medicine and Maternity Services.
- Urgent mitigation actions are being taken to recover the forecast deficit position, working with the Care Groups to reduce the current overspend run-rate. This requires making additional savings this year to remain within the required budget constraints.
- Therefore, additional FRP schemes and opportunities are being identified and delivered, including

high-cost drugs, income maximisation, enhanced bank, and workforce attraction packages.

## 3. Main Report

### FY24 Month 4 Finance Position

| | Current Month | | Year-to-Date | | | Full Year | | | Year-to-Date | Full Year |
|---|---|---|---|---|---|---|---|---|---|---|
| HCS Categorisation | Budget (£'000) | Actual (£'000) | Budget (£'000) | Actual (£'000) | Variance (£'000) | Budget (£'000) | Forecast (£'000) | Variance (£'000) | % Variance | % Variance |
| Staff Costs | 20,542 | 21,090 | 70,944 | 73,276 | (2,332) | 216,331 | 220,186 | (3,855) | (3.3%) | (1.8%) |
| Non Pay | 8,633 | 11,012 | 36,027 | 42,517 | (6,490) | 107,621 | 120,424 | (12,803) | (18.0%) | (11.9%) |
| Income | (2,318) | (2,353) | (8,165) | (8,727) | 563 | (28,419) | (27,064) | (1,354) | 6.9% | (4.8%) |
| **Grand Total** | **26,856** | **29,749** | **98,806** | **107,065** | **(8,259)** | **295,533** | **313,546** | **(18,013)** | **(8.4%)** | **(6.1%)** |

- The Financial position for YTD Month 4 is an £8.3m deficit vs budget giving a headline monthly run-rate of £2.1m.

**The key drivers are:**

**Year-to-date (YTD) position is a £8.3m deficit:**

- **Staff Costs £2.3m overspend** is made up of an agency overspend of £4.7m (no. of agency staff: 171 (40 doctors and 131 Nurses, AHPs and Other), an overtime overspend of £1.0m, and a budget pressure of £0.5m, offset by a substantive underspend of £3.9m (no. of vacancies: 493 FTE). Exceptional items include £1.1m re back pay following doctors' job planning, Operation Crocus, and the continued impact from previous years costs. Excluding these one-off items, the underlying position would be an overspend of £1.2m.

  The Care Groups/Directorates accounting for this Staff Costs overspend are Medical Services £1.7m, Surgical Services £1.1m, Women and Children £0.5m, Director General's Office £0.4m, Mental Health £0.4m, and less than £0.1m in Social Care. All other areas are underspent on staffing. £0.4m of the Surgical Services overspend relates to doctors' job planning impacts, with £0.2m in Medical Services. The Medical Services position includes £0.2m costs in relation to Operation Crocus.

- **Non-Pay £6.5m overspend** includes significant overspends in Medical Services £2.0m in relation to consumables and Oncology and Medical Day Care drugs, Social Care £1.0m mainly in relation to domiciliary care packages, and Surgical Services £0.9m in relation to consumables, Tertiary Care £0.9m in relation to acute hospital referrals to the UK, an overspend of £0.4m in Estates and Hard Facilities Management mainly in relation to utilities and maintenance.

  There is also an overspend of £0.8m in Director General's Office, which is mainly made up of £0.6m in relation to the opening budget pressure included here as part of budget setting for 2024, previous years' costs impact of £0.13m, £0.1m overspend on revenue equipment replacement, and a £0.37m cost pressure from inter-departmental recharges relating to accommodation service income 'voids' for Q1 which is being disputed. These overspends are partially offset by an underspend of £0.6m mainly in Covid-19 PPE provision.

- **Income over-achievement £0.6m** mainly due to Health Education income received for April 2023-March 2024 with a £0.9m overachievement in Medical Director. This is offset by under-achievements in Surgical Services £0.2m, with an FRP additional income generation target, and in Non-Clinical Support Services with reduced recovery of income in Catering due to termination of a contract with CYPES for school meals, and an under-recovery of Laundry income, which has an FRP target for additional income generation from external customers.

- **Underlying position and run-rate** - Adjusting for the non-recurrent/one-off exceptional items the underlying deficit at M4 is £7.3m or an average monthly run-rate of £1.8m.

## FRP savings delivery

- FRP savings delivered are £2.4m vs £1.84m plan, made-up of £1.2m of original schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- FRP delivery will initially be recognised against the GoJ Value For Money (VFM) target for HCS of £3.986m. In FY23, £3.2m of savings were delivered against a VFM target of £1.3m and FRP target of £3m.

## FRP Delivery and Development Tracker – FY24 Savings Delivery

**FRP Savings Plan by Workstream**

| Workstreams | Projects | Scheme RAG | 2023 Saving Delivered | Full Year 2024 Planned Saving | Jan | Feb | Mar | Apr | Total 2024 Forecast Saving | Forecast Variance against Plan | Remaining FYE 2025 Planned Saving |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Delivery Tracker** | | | | | | | | | | | |
| | | | | | Actual | | | | | | |
| **Clinical Productivity** | Theatres Efficiency | | - | 1,940 | - | - | - | - | 1,940 | - | 466 |
| **Workforce** | Clinical - Medical | | 221 | 1,723 | 36 | 29 | 34 | 43 | 1,630 | -93 | 791 |
| | Clinical - AHPs | | 119 | 1,489 | 13 | 13 | 13 | 69 | 1,444 | -45 | 615 |
| | Clinical - Nursing | | - | 1,696 | - | - | - | - | 1,607 | -89 | 2,202 |
| | Pay Controls (WCP) | | - | 450 | - | - | - | 47 | 447 | -3 | 150 |
| **Non-Pay and Procurement** | Non-Pay Controls (NPCP) | | - | 1,099 | 19 | 19 | 74 | 25 | 978 | -121 | 158 |
| | Procurement | | 585 | 195 | 65 | 65 | 65 | - | 195 | - | - |
| | Medicines Management | | 98 | 133 | 19 | 17 | 20 | 9 | 131 | -1 | - |
| | Other Non-Pay | | - | 124 | 9 | 9 | 9 | 11 | 124 | - | 5 |
| **Income** | Other Income Opportunities | | 163 | 781 | 65 | 68 | 68 | 29 | 691 | -90 | - |
| | Private Patients | | 242 | 371 | 54 | 57 | 59 | 59 | 414 | 43 | - |
| **Care Groups and Non-Clinical Directorate schemes** | £3m in 3 months | | 1,914 | - | - | - | - | - | - | - | - |
| **Total schemes currently in delivery** | | | 3,341 | 10,000 | 280 | 277 | 343 | 290 | 9,601 | -399 | 4,387 |
| **Development Tracker** | | | | | | | | | | | |
| | | | | | Planned | | | | | | |
| **Clinical Productivity** | Patient Flow and Discharge/LOS | | | 38 | - | - | - | - | 38 | - | 27 |
| | Theatres Efficiency | | | 452 | - | - | - | - | 452 | - | 226 |
| **Workforce** | Clinical - Nursing | | | 534 | - | - | - | - | 534 | - | 517 |
| | Clinical - Medical | | | 148 | - | - | - | - | 148 | - | 254 |
| | Workforce Savings | | | 583 | - | - | - | - | 583 | - | 417 |
| **Non-Pay and Procurement** | Procurement | | | 406 | - | - | - | - | 406 | - | 829 |
| | Medicines Management | | | 222 | - | - | - | - | 222 | - | 311 |
| | Other Non-Pay | | | 172 | - | - | - | - | 172 | - | 100 |
| | Non-Pay Controls (NPCP) | | | 8 | - | - | - | - | 8 | - | 12 |
| **Income** | Other Income Opportunities | | | 94 | - | - | - | - | 94 | - | 1,827 |
| | Private Patients | | | 432 | - | - | - | - | 432 | - | 1,496 |
| **Mitigating Schemes** | Unidentified recurrent effect of 2023 £3m in 3m | | | 887 | - | - | - | - | 887 | - | - |
| **Total Schemes being prepared for delivery** | | | | 3,976 | - | - | - | - | 3,976 | - | 7,854 |
| **TOTAL FRP SCHEME SAVINGS** | | | 3,341 | 13,976 | 280 | 277 | 343 | 290 | 13,577 | -399 | 12,242 |

- The FRP Programme over the three years has identified savings of £29m with a risk-adjusted value of £21m, which are phased to be delivered over 3 years.

## FRP Savings FY23-FY25 - At a glance

## FRP Project Plans Development Summary

*All checks okay*

| Workstreams | Projects | Total Savings Identified | FY23 Delivered Savings | FY24 Identified Savings | FY25 Identified Savings | Total Risk Adj Amount | RAG Staus |
|---|---|---|---|---|---|---|---|
| **Clinical Productivity** | Patient Flow and Discharge/LOS | 64 | - | 38 | 27 | 28 | |
| | Theatres Efficiency | 3,084 | - | 2,392 | 692 | 2,576 | |
| **Workforce** | Clinical - Medical | 3,137 | 221 | 1,871 | 1,045 | 2,734 | |
| | Clinical - Nursing | 4,949 | - | 2,230 | 2,719 | 4,931 | |
| | Clinical - AHPs | 2,224 | 119 | 1,489 | 615 | 2,254 | |
| | Non-Clinical/ Directorate | 1,840 | - | - | 1,840 | 460 | |
| | Workforce Savings | 1,000 | - | 583 | 417 | 250 | |
| **Non-Pay and Procurement** | Medicines Management | 763 | 98 | 354 | 311 | 543 | |
| | Procurement | 2,015 | 585 | 601 | 829 | 1,089 | |
| | Other Non-Pay | 401 | - | 296 | 105 | 277 | |
| | Non-Pay Controls (NPCP) | 1,277 | - | 1,107 | 170 | 1,374 | |
| **Income** | Other Income Opportunities | 2,865 | 163 | 875 | 1,827 | 999 | |
| | Private Patients | 2,540 | 242 | 802 | 1,496 | 1,055 | |
| **Care Groups and Non-Clinical Directorate schemes** | £3m in 3 months | 1,914 | 1,914 | - | - | 2,404 | |
| **Mitigating Schemes** | Unidentified recurrent effect of 2023 £3m in 3m | 887 | - | 887 | - | 222 | |
| **TOTAL FRP SAVINGS** | | **29,559** | **3,341** | **13,976** | **12,242** | **21,646** | |

### FY24 Year-end Forecast

- The current FY24 year-end forecast remains a deficit of £18.0m. However, there are further downside risks, which are being carefully monitored. Mitigating actions continue to be developed and implemented.

  The key factors driving the forecast deficit are:

  - The year-end forecast is £18.0m deficit with further downside risks from cost pressures, before additional mitigation actions are taken. As reported previously, the key factors driving the forecast deficit are:
  - Budget cost pressures due to funding constraints identified when completing the FY24 budgets of £7.5m
  - FRP savings slippage due to delays in enabling support to ensure timely delivery £6m. However, this is a timing delay, and the savings are expected to be delivered in FY25 and FY26.
  - Exceptional one-off costs in-year
  - Tertiary care contracts activity and price increases
  - Activity increases (above baseline budget) in high cost-low volume (HCLV) services and treatments
  - Drugs and other non-pay inflation
  - WLI funding
  - Additional costs of implementing clinical/medical model following recommendations of Royal College reviews into Medicine and Maternity Services.

The detailed break-down of the variances is as follows:

**Staff Costs £3.9m forecast overspend** due to a £9.6m overspend on agency locums (total forecast spend £16.0m), and £1.5m from negative budget pressures, partially mitigated by a £7.2m underspend on substantive staffing due to vacancies.

The net impact above is made-up of:

- Net overspends due to agency/locums and substantive costs in Surgical Services £2.0m, Medical Services £1.9m, Women and Children's Services £1.1m, which are mitigated by substantive pay underspends of £1.6m in other Care Groups (Primary Care and Prevention £0.6m, Non-Clinical Support Services £0.4m, Improvement and Innovation £0.2m, Intermediate Care, Medical Director and Estates and Hard FM all £0.1m).

  The DG's Office adverse variance of £4.7m (Pay £0.4m and Non-pay £4.3m) is due to holding £2.7m of the total £7.5m of opening budget pressures and a £2m contingency for additional cost pressures arising during the year.

- £1.2m re the full year impact of doctors' back-pay from job planning.
- £0.7m in staff costs re Operation Crocus for which budget is expected to be received during the year.

**Non-Pay overspend £12.8m** with the main forecast overspends in DG's Office £4.4m, Medical Services £2.7m, Social Care £1.0m, Tertiary Care £0.9m, Estates £0.9m, Medical Director £0.7m, Surgical Services £0.6m, Mental Health £0.6m, Non-Clinical Support Services £0.5m, Women and Children £0.3m, Improvement and Innovation £0.2m and Primary Care £0.1m.

**Income under-achievement £1.4m** is due to the current forecast shortfall in Surgery private patient income of £1.8m due to a planned delay in launching the improved ways of working to increase theatres productivity which is expected to be recovered during the year. The forecast will be updated in Q2/Q3 to recognise this. There is also a £0.5m under-achievement in Non-Clinical Support Services, mainly due to delays in delivery of expected additional Laundry income, and the cessation of school meals provision to CYPES. These pressures are offset by non-recurrent over-recovery of Health Education England income in Medical Director.

**Mitigating Actions being taken:**

- Urgent mitigation actions are being taken to recover the forecast deficit position, working with the Care Groups with weekly updates, to reduce the current overspend run-rate.
- This will require making additional savings this year to remain within the required budget constraints.

## 4. Recommendation

The Board is asked to note:

- FY24 YTD M4 deficit is £8.3m giving a headline monthly run-rate of £2.1m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £1.8m.
- FRP savings of £2.4m have been delivered vs £1.84m plan at M4 made-up of £1.2m savings from original FRP schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £18.0m deficit with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- The key factors driving the forecast deficit are budget cost pressures £7.5m, FRP savings slippage due to delays in enabling support £6m, exceptional one-off costs in-year, Tertiary care contracts price inflation, Activity increases in high cost-low volume (HCLV) services, Drugs and other non-pay inflation, WLI funding, and additional costs of implementing the recommendations of Royal College reviews into Medicine and Maternity Services.
- Urgent mitigation actions are being taken to recover the forecast deficit position, working with the Care Groups to reduce the current overspend run-rate.
- This requires making additional savings this year to remain within the required budget constraints.

Therefore, additional FRP schemes and opportunities are being identified and delivered.

Health and Community Services

# Health and Community Services Advisory Board Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Health and Community Services Response to Jersey Care Commission (JCC) Single Assessment Framework (SAF) Consultation | | |
| **Report author (& title):** | Jessie Marshall, Chief Nurse | **Accountable Executive:** | Chris Bown, Chief Officer HCS |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | To provide the Board with an update on the outcome of the Health and Community Services consultation process on the Jersey Care Commission proposed Single Assessment Framework. | Information | √ |
| | | Decision | |
| | | Assurance | |
| | | Update | |

## 2. Executive Summary

The Jersey Care Commission (JCC) Chief Inspector attended the Health and Community Services (HCS) Advisory Board on 25 April 2024 to provide an overview of the consultation document regarding the JCC Single Assessment Framework (SAF).

Internally the document has been shared widely across the organisation encouraging staff to share their thoughts through the HCS internal communications process. The SAF also forms a regular item on the HCS Communication briefing.

In addition, focussed sessions have been held with the Advisory Board/ Executive team/ Individual Care Groups/ Governance teams / Senior Nurses and Allied Health Professionals /Estates/ Infection Control/ and Safeguarding for example.

Within the document some of the individual Universal Requirements have highlighted key areas which may not be relevant to HCS, in addition how specialised services are linked directly to the universal statement (see Appendix A).

There is a total commitment regarding the introduction of regulation (with all the anticipated concerns related to implementation and preparation). Overall, the principles of the standards are fully supported.

## 3. Finance / workforce implications

Following the outcome of a gap analysis in respect of implementation and ongoing assurance, a future paper may be presented to the Executive Leadership Team (ELT) team if additional resources are required.

## 4. Risk and issues

The consultation has been shared widely across HCS to determine views. The key area of concern will be attributed to the evidence and ongoing assurance of sustained quality care.

## 5. Recommendation

The Board is asked to note the content of this report and fully support HCS through this process.

**END OF REPORT**

| Appendix A: Single Assessment Framework |
| --- |
| |
| **Overarching Themes** |
| |
| Scope of regulation does not explicitly identify Community Services provided by HCS (Intermediate and Primary Care Services). |
| It would be helpful if Learning Disability could be identified as a service within their own right (currently merged with Mental Health Services). These are currently Community Services and in future will include inpatient provision for people with a Learning Disability. |
| The application of the Mental Health (Jersey) Law, and the systems of assurance that the organisation has in relation to this which are referenced in Standard 15 (Consent) and Standard 11 (Rights), could be strengthened to include how we maintain assurance (within Well-Led?). This is a focus of regulation in the UK. |
| Health records may be held personally by service users in Mental Health and Maternity services (Standard 6). |
| Restrictive practice would be a key focus of CQC inspection in Mental Health Services and would include a wider focus on restrictive practices and least restrictive principles. The proposed standards only reference physical restraint (Standard 15). |
| There is no explicit reference to the new Children and Young People (Jersey) Law in any standards (although it is referenced in the relevant links page). |
| It is not explicit where the scope for the Community Learning Disability Nursing Services falls under Regulation. |
| Does ‘outpatient’ include screening and preventative services i.e. breast, colorectal? |
| PPI Care and Intermediate Care are not mentioned within the scope of this document. |
| With reference to standard 27.1.5, the ReSPECT tool is not currently used in HCS. Similar tool in place, Treatment Escalation Plan (TEP). |

Health and Community Services

# Health and Community Services Advisory Board Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30th May 2024 | | |
| **Title of paper:** | Pressure damage update | | |
| **Report author (& title):** | Beverley Hales<br>Interim Deputy Chief Nurse | **Accountable Executive:** | Jessie Marshall<br>Interim Chief Nurse |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | To update the Board on improvements of care related to pressure damage whilst in hospital | Information | x |
| | | Decision | |
| | | Assurance | x |
| | | Update | x |

## 2. Executive Summary

The Quality and Performance Report presented to the Board in April 2024, showed an increase in reported pressure damage to patients during March 2024.

In March 2024, seven deep tissue injury-pressure damage incidents were reported and on investigation this harm was due to care provided during their inpatient stay. The theme of the damage related to the incorrect sizing of anti-embolism stockings (also known as compression stockings). These stockings are specially designed to help reduce risk of developing deep vein thrombosis (DVT) or blood clot in the lower leg.

Organisation wide training and education was enacted to ensure correct measurements are taken to ensure the correct size stockings are applied to prevent future recurrence.

Whilst it is regrettable and deep tissue injury should not occur whilst in our care, the damage identified was minimal. In addition, staff identified the pressure damage early and interventions were undertaken immediately to prevent further deterioration. In all cases, a full recovery has been made.

In April, the number of reported deep tissue injuries has reduced significantly to three. Following investigation it was identified that the common theme related to the timely repositioning of the patient. This is now being addressed through ward manager leadership reviewing care plans, peer reviews and specialist tissue viability nurse (TVN) support.

At the time of writing this report the number of reported cases has reduced to one. This demonstrates the impact of ongoing learning and improvement.

## 3. Main Report

### Mattress audit

The National mattress audit was undertaken in May, the purpose of which is to ensure all tissue viability equipment is fit for purpose to optimize patient care. Whilst this is a Nationally mandated audit within the NHS, many providers fail to undertake the audit in a timely fashion This audit involves every mattress in the acute hospital being reviewed and replaced (if required on one day).

The tissue viability and nursing teams are to be commended on the completion of the audit within a timely fashion which resulted in minimal patient disruption and ensures future patients receive safe care. The next phase of the ongoing work will be targeted at cushions for chairs and with the support of the physiotherapy team will further enhance care to patients.

### Care review rounds

Visibility of the Senior Nursing Leadership team is recognised as a key indicator for quality safe care. In line with key NHS and European initiatives, the (Interim) Chief Nurse is introducing formal weekly care rounding of all hospital wards. These will be led by the (Interim) Chief Nurse and the senior nursing workforce and will commence 21st May 2024. All care will be reviewed to provide a 'fresh eyes' approach which in turn will ensure ongoing learning and improvement.

The Interim Deputy Chief Nurse will provide a monthly update to the Executive team and a full report will be provided to the Quality, Safety and Improvement Committee on a quarterly basis.

### Workforce training

Monthly training days are held called 'Inside out'. These days are led by the TVN and Nutritional Nurse Specialists as it is important to ensure that patients are nourished and hydrated to protect the integrity of the skin and to aid healing should there be any tissue damage. To support the specialist nurses in delivering skills and knowledge in the care of skin, all wards now have tissue viability champions. The Pressure Ulcer Prevention and Management Framework was approved on Friday 10th May and will now be disseminated by TVN visiting individual wards.

## 4. Recommendation

**END OF REPORT**

Health and Community Services

# Health and Community Services Advisory Board Meeting Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30th May 2024 | | |
| **Title of paper:** | Maternity Improvement Plan | | |
| **Report author:** | Livi Methven Higgins Senior Change Manager / WACs SLT approved | **Sponsor:** | Patrick Armstrong, Medical Director Jessie Marshall, Chief Nurse |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of ELT? | To provide information and update on the Maternity Improvement Plan.<br><br>The Board are asked to note the content of the report and acknowledge the ongoing progress of completion. | Information | X |
| | | Decision | |
| | | Assurance | X |
| | | Update | X |

## 2. Executive Summary

The Maternity Improvement Plan (hereafter referred to as MIP) was established on 28th June 2023, the purpose of the programme is to deliver coordinated and sustained improvements within Maternity to address the recommendations from internal and external reports which have been received and been within the organisation since 2018, with clear assurance and accountability. This includes reviews of maternity services in the UK with included recommendations of relevance to quality improvement in obstetric and maternity care. The programme aims to consolidate the themes and actions within the plans in addition ensuring that the responses become part of the embedded business-as-usual governance process of the organisation, with a sustained, lasting improvement in Jersey Maternity Services.

Maternity Services are keen to ensure that voices of the women and families that use their service are heard at all levels. The Jersey Maternity Voices Partnership will be essential in providing the patient voice within the co-design of the Maternity Strategy during March and April. The Jersey Maternity Voices Partnership are currently developing their 2023 report, which is due early 2024. The Maternity Voices Partnership are a group of volunteers who work with women, birthing people and their families together with Maternity Services providers, such as midwives, doctors, and other health care providers, to improve maternity services in Jersey.

Since the last HCS Advisory Board, further progress has been made:

- On 5th May 2024, the refurbished maternity unit was officially opened by the Bailiff, which commenced in 2022. This project saw the realisation of a dedicated Midwifery-Led Unit (MLU) with a fixed birthing pool, a new High Dependency Unit (HDU) and a refurbished Jersey Neonatal Unit (previously Special Care Baby Unit SCBU). The completed improvements allow those who use hospital based Maternity Services to experience an enhanced and holistic space that supports mothers, birthing-people and the choices they make in relation to their delivery and care.
  Three further recommendations have been identified as complete, these are the establishment and publication of the Maternity Dashboard through the Quality and Performance Report, ongoing linkage of the breastfeeding and perinatal mental health support services and enhanced support for mothers in early stages of labour. There is assurance of ongoing progress of remaining open recommendations, some of these are long-term, such as Culture. It is noted that the commencement of the Practice Development Midwife in July will be able to further several recommendations.

- Ongoing follow-up reviews of which 77 out of 102 recommendations have completed 30-, 60-, 90-, and 120- day follow-up reviews, evidencing ongoing embedment of recommendations (up from 75 in April).

- Picker Institute surveyed Maternity Services during December 2023 and January 2024, with results provided to HCS Executives in March 2024. The Picker Report results were received by the service on 14th May 2024 and are under review for identification of improvements. It is noted that Maternity Services received positive outcomes. The Picker patient experience survey lead the development of patient experience measures as a way of understanding the quality of person-centred care from the patient's perspective.

- Culture improvement plan events have been confirmed and circulated with maternity staff; it is recognised that culture change is ongoing. Maternity Services, with support from the Director of Culture, Engagement and Wellbeing, are continuing to implement the culture improvement plan for the service. Specialist mediation was held in April and May.

- Following engagement with the maternity service fully at the maternity away days held in March, there are ongoing developments of the maternity strategy for the continuation of the Maternity Improvement Plan. It is envisioned that the maternity strategy will ensure sustainability of the completed recommendations and see the completion of the outstanding recommendations. The co-design of the maternity strategy is integral for its success and for continued improvements within the service. Maternity Services have commenced gathering of ideas and future ways of working identified at the away days to create the maternity strategy. Maternity services will be co-designing their maternity strategy during March to May, with the aim for this to be approved and published in June 2024.

- First perinatal mental health training module was held by the Perinatal Mental Health Midwife Specialist with Maternity Staff discussing birth trauma and communication.

- NICHE report received and action plan under development for recommendations, presently going through HCS governance processes prior to sharing externally. To note, the NICHE report has not highlighted any new concerns with a significant number of recommendations having already been completed.

To enable clear comparison with another maternity provider, maternity services were due to benchmark their 2024 service dashboard against the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Integrated Care Board (ICB). Ongoing changes to comparison dashboards are being made in NHS England. Once this is finalised, maternity services will benchmark their 2024 service dashboard, to be included as an appendix in HCS Advisory Board papers. The 2024 dashboard is used within the Women's and Children's Care Group Performance Reviews and is part of business-as-usual processes.

Key actions for June:

- The culture improvement plan for the remainder of 2024 includes values and behaviours sessions, psychological safety in teams, restorative behaviours, reflective safe spaces and dedicated leadership sessions for the Women and Children's Senior Leadership Team as part of the HCS wide offering.

- Following presentation of the Maternity Improvement Plan at the Women's and Children's Inset Day and maternity away days for the co-design of the maternity strategy, to develop this further ready for sign-off in June.

- Following reconfiguration of the SHIP Integrated Care Board (ICB), to align with this ICB further.

- Following finalisation of comparison dashboards, to benchmark 2024 service dashboard.

- To refine the 2024 maternity dashboard.

**Progress to date**

Currently 102 out of 127 recommendations have been identified by Women and Childrens Senior Leadership Team as complete (up from 99 in April), of which 99 have been confirmed as having robust evidence/ business-as-usual process. Three are under review to ensure robustness of evidence and sustainability of any business-as-usual processes.

High level progress to date can be found below:

| Total Number of recommendations | March | April | May |
|---|---|---|---|
| | **127** | **127** | **127** |
| **Complete signed off** | 96 | 96 | 99 |
| **Complete** | 3 | 3 | 3 |
| **Green** | 22 | 22 | 18 |
| **Amber** | 6 | 6 | 7 |
| **Red** | 0 | 0 | 0 |

**Maternity Improvement Plan - transfer to business-as-usual**

As each recommendation is approved by Women and Children's Senior Leadership Team, the project management support is undertaking 30-, 60- and 90-day reviews to ensure that each recommendation is embedded within business-as-usual activities. Process is in place to ensure

areas of non-compliance are identified and escalated first to the Director of Midwifery, then to the Maternity Improvement Plan Monitoring Meeting. To date, 77 out of 102 recommendations have completed 30-, 60-, 90- day follow-up reviews, evidencing ongoing embedment of recommendations, with 20 recommendations having ongoing follow-up reviews. Seven recommendations of the 20 have been identified to have extended follow-up reviews past 120 days to ensure embedded business-as-usual processes, these have been escalated and confirmed with the Director of Midwifery and to the Maternity Improvement Plan Monitoring Meeting.

It is recognised that new areas for improvement will be identified through existing embedded governance processes, making it important to define mechanisms to ensure that the learnings and method from the Maternity Improvement Plan continues and is embedded into the routine governance processes for the division. Project management support is available to support the service with identifying this process and support the service with their transfer to business-as-usual. Maternity Services have been co-designing their Maternity Strategy during March - May, with the aim for this to be approved and published in June 2024.

## 3. Finance / workforce implications

Workforce:

- Practice Development Midwife
    - Women and Children's have appointed to this role, unexpected delay to commencement in post from May to July 2024.
- Maternity Governance Midwife
    - The Quality and Safety Team are supporting Maternity with oversight from the Director of Midwifery.
    - Maternity Services have appointed to the substantive Maternity Governance Midwife post, expected commencement date in July 2024.
- Maternity Services are continuing with recruitment to substantive posts across the department.

## 4. Risk and issues

To date, Maternity Services have completed 102 out of 127 recommendations, owing to the dedication of staff within the service to ensuring that the plan is successful.

It is recognised that culture change is ongoing. Maternity Services, with support from the Director of Culture, Engagement and Wellbeing, are continuing to implement the culture improvement plan for the service.

Engagement is ongoing with maternity for Phase 2 with the Maternity Improvement Plan across the professional groups within maternity services. Project management support, alongside the Director of Midwifery, developed communications shared at the Women's and Children's Inset Day, and Maternity Away Days, held in March. These communications provided a background of progress to date and engaged fully with the service to develop the strategy for the continuation of the Maternity Improvement Plan. It is envisioned that the Maternity Strategy will ensure sustainability of the completed recommendations and see the completion of the outstanding recommendations.

Further engagement opportunities are in place at weekly "Time to Chat" sessions with the Director of Midwifery and monthly posters shared across the service which detail Maternity

Improvement Plan updates.

There is ongoing risk in relation to the medical workforce and leadership arrangements for the division; there remain two substantive consultant vacancies open, which are covered by locums. Medical leadership continues to be provided by an interim Chief of Service and there will be a need to defined arrangements for a substantive leadership role and to recruit to this an individual with an appropriate Obstetric and Gynaecology background.

## 5. Recommendation

The Board are asked to note the content of the cover report and acknowledge the ongoing progress of completion and assurance of embedded practice.

Appendix:
202404 – Maternity Improvement Plan – Poster – Approved 20240423

**END OF REPORT**

# Maternity Improvement Plan

**April 2024**

## What is the Maternity Improvement Plan?

The Maternity Improvement Programme (MIP) was established in June 2023. The purpose of the MIP is to deliver coordinated and sustained improvements within Maternity to address the recommendations from the internal and external reports which have received and been within the organisation since 2018. The MIP will ensure that responses become part of the embedded business-as-usual governance process of the organisation.

## What has progressed in April?

- 99 completed recommendations out of 127, with remaining open recommendations being long-term such as culture.
- Ongoing development of the Maternity Strategy following the Maternity Away Days.
- First perinatal mental health training module to be held on 25 April covering Birth Trauma & Communication.
- Positive initial results from Picker Institute survey completed in Maternity Services with full report to be shared by Chief Nurse soon.
- Commenced drafting of the Standard Operating Procedure for Perinatal Adult Mental Health Services in conjunction with Mental Health Services, due to be presented and shared with the Maternity Service in June for consultation.
- Multidisciplinary PROMPT and Clinical Skills Day held on 03 & 04 April.

## What's happening in May?

- Official opening day of our refurbished maternity unit on 08 May.
- Commencing attendance at SHIP (Southampton, Hampshire, Isle of Wight, Portsmouth) daily safety huddles for Maternity and Neonates.
- Commencing attendance at SHIP LMNS (Local Maternity and Neonatal Systems) Board meetings to enable alignment.

## Your voice

To get involved, please speak to your line manager for further information.

Ros, our Director of Midwifery, holds weekly "Time to Chat" open sessions, providing a platform to share your views, concerns and suggestions directly. These are held on Wednesdays, 2:00–3:00pm in the Learning & Development Room/Inpatients Office –Maternity Ward.

If you have concerns, or if there is an issue stopping you from delivering the best possible patient care, please contact Ashling McNevin, our Freedom to Speak up Guardian, to ensure your voice is heard.
Email: speakup@health.gov.je

Health and Community Services

# Health and Community Services Advisory Board Meeting Report

| | | | |
|---|---|---|---|
| **Report to** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30th May 2024 | | |
| **Title of paper:** | Medicine Improvement Plan | | |
| **Report author (& title):** | Senior Change Manager/ Medicine Care Group SLT approved | **Sponsor (incl. Title):** | Claire Thompson, Chief Operating Officer – Acute Services |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the Board? | To provide information and update on the Medicine Improvement Plan.<br><br>The Board are asked to note the content of the report and acknowledge the ongoing progress of completion. | Information | x |
| | | Decision | |
| | | Assurance | |
| | | Update | x |

## 2. Executive Summary

The Medicine Improvement Plan was established on 1st November 2023, with the aim to deliver a comprehensive improvement plan following external reviews from Royal College of Physicians (RCP) in 2022, Service Review 2014, Service Review November 2022, Service Review June 2023 and followed up by Dr Rob Haigh (external consultant physician expert) in 2023.

The recommendations have been collated and consolidated, totalling 70 recommendations to become embedded as part of the business-as-usual processes of the organisation.

Following the success of the Maternity Improvement Plan, the structure and response has been replicated to the Medicine Improvement Plan.

During May the following progress has been made:

- Commencement of external physician advisory support with expertise in patient safety and operational flow improvement to support the care group Senior Leadership Team. Dr Sturgess is nationally regarded for his leadership of quality improvement and medical change in acute medicine.

- Dedicated project management support (PMO) has commenced from the Improvement and Innovation Team to support medicine to deliver against the recommendations, who also supports the Maternity Improvement Programme.

- Plan has been reviewed and restructured to support delivery, tracking and control of progress. A thematic review has been undertaken of recommendations to address commonality between reviews such as governance processes, policies and protocols and staffing.

- Themes have been identified, similar to the Maternity Improvement Plan, to ensure consistency of approach. These themes, and corresponding HCS Executive Sponsors are:
    - Workforce – Director of Workforce
    - Governance – Medical Director and Chief Nurse
    - Performance – Chief Operating Officer – Acute Services
    - Strategy – Chief Operating Officer – Acute Services

- Review of prioritisation of recommendations within the Medicine Improvement Plan to enable focused work. To date the focus has been on compliance to the RCP review of 2022.

- At the time of writing the report, the service aims to complete in May:
    - Confirmation of focus of high priority recommendations.
    - Identification of Operational Leads for the high priority recommendations.
    - Identification of sub-tasks and due dates for high priority recommendations.
    - Ongoing evidence collation of recommendation completion and/or evidence of embedment of business-as-usual process to support sustainability of the completed recommendations. This will then be presented to the Medicine Care Group Senior Leadership Team for critical review and final approval.

- The reporting and governance process of the Medicine Improvement Plan have been reviewed and confirmed as follows:
    - Medicine Care Group SLT and Medicine Improvement Plan Working Groups
        - Weekly review of excel Medicine Improvement Plan
        - Purpose is to review progress of actions and their tasks, support requirements and identify risks and issues. To approve recommendations as complete.
    - Medicine Improvement Plan Monitoring Meeting – led by the Chief Operating Officer – Acute Services
        - Weekly presentation progress report and theme summary
        - Purpose is to review reds, decisions required, escalation of non-delivery of items, risks and issues and receive assurance on the completion of recommendations.
        - Terms of reference have been approved and implemented for this.

- HCS Senior Leadership Team – Change Programme Board
  - Monthly cover page and exception report
  - Purpose is to receive assurance and review any further exceptions or escalations.
- HCS Advisory Board
  - Monthly cover page and exception report
  - Purpose is to provide assurance of progress against the Medicine Improvement Plan and embedding and sustainability of outcomes.

- It is noted that consultant presence on the wards and in particular at daily ward rounds, is an integral part of the improvements required within Jersey General Hospital. Work to date to strengthen this and some initial observations from the visiting physician are:

  - more stability of Consultant presence on base wards, albeit via locum staff. This activity is improving the safety of care but is generating a cost pressure to the medical care group.
  - Well-structured board rounds observed on some base wards, further improvement needed in others.
  - Weekend (non-Acute Assessment Unit (AAU)) Ward rounds – one Consultant and a Registrar Saturday and Sunday review of 'sick' and of potential discharges – latter can be variable if the volume of sick patients consumes the time. This is an improvement on a year ago but is outside of available substantive budget and is contributing to current run rate pressure.
  - AAU-daily Consultant Acute Physician led ward rounds commencing at 0800 to 0830 and multi-disciplinary team (MDT) at 11am. Weekends (outside of funding), one AAU Consultant ward round of all of AAU and the roving reviews of in-take to improve flow and safety.
  - Bank Holiday– full Ward round of medical in-patients by two Consultants Physicians, two Registrars and two clinical fellow – this is in addition to the AAU rounds. This has been on-going for one year.

  In summary, although there is still variability in the way Board Rounds and Ward Rounds operate, there is more consistency than a year ago, but still room for further appropriate standardisation. Options are continuing to be explored to mitigate the funding pressure these improvements generate. The possibility to redirect staffing to ward areas from areas of planned care for example have been explored but were not supported by the HCS Advisory Board and a review is underway to determine alternative solutions.

Key actions for June:

- Established governance processes embedded for the Medicine Improvement Plan.
- Recruitment and solidifying the pipeline to ensure coverage of vacancies across the Medical Care Group.
- To discuss the further investment required for a robust medical model.
- Review of evidence for recommendations identified as complete.
- To establish the communications plan for the Medicine Improvement Plan
- To review the establishment of a communication and engagement plan for the Medicine Improvement Plan to ensure there is continuous engagement with staff. It is noted to

date that the Medicine Improvement Plan has been shared with staff through Consultant Meetings and Inset Days. The Plan will be further shared with senior clinical leaders at the Medicine Strategy Day to be held in June 2024.

**Progress to date**

Currently 7 out of 70 recommendations have been identified as complete. These completed recommendations are undergoing review of robust evidence and/or business-as-usual process prior to approval by Medicine Care Group Senior Leadership Team.

High level progress to date can be found below:

| Total Number of recommendations | May |
|---|---|
| | **70** |
| **Complete signed off** | 0 |
| **Complete** | 7 |
| **Green** | 8 |
| **Amber** | 44 |
| **Red** | 11 |
| **Escalate** | 0 |

Key:

Complete signed off: The recommendation is considered complete by Medicine Care Group Senior Leadership Team with robust evidence and sustainability of business-a-usual processes

Complete: The recommendation is considered complete; evidence is being gathered for approval by Medicine Care Group Senior Leadership Team

Green: Work to deliver against recommendation is on track no escalation required, evidence is available to support this status.

Amber: Work to deliver against recommendation is off track but recoverable by operational lead

Red: Work to deliver against recommendation is off track and requires resource to mitigate

**Escalate** – To be escalated to Medicine Improvement Plan Monitoring Meeting or Medicine Care Group Senior Leadership Team

High level information of the red recommendations can be found below, each of these has been discussed with an agreed mitigating action at the Medicine Improvement Group on 15th May 2024. A detailed breakdown of these can be found in the attached exception report.

| Rec.ID | Topic | Exception | MIPMM Outcome |
|---|---|---|---|
| 006 | Nursing Workforce Planning | There is currently a lack of Nursing Strategy within HCS. Require advice from Chief Nurse on progression. | Nursing Workforce Strategy meeting arranged for 20th May and noted resource due to commence in July 2024 to support |
| 017 | Audit Process | Meeting required with Quality | Noted Care Group have |

| | | | |
|---|---|---|---|
| | | and Safety Team to develop plan. | signed up to HQIP audit programme. Chief of Service to meet with Clinical Audit and Effectiveness Manager to identify audit plan. |
| 024 | Blister Packs | Process is not efficient with only two pharmacies producing blister packs. Scoping meeting required with Pharmacy. | Chief of Service to discuss improvements to process with Pharmacy. |
| 062 | Patient Charter | Unknown progress of recommendation. | Identified Patients Panel are developing a Patient's Charter, to be discussed with Chief Nurse 21st May. |
| 073 | ERCP Referral | Meeting required with Surgical Care Group to develop | To review contract service level agreements (SLAs) with tertiary provider. To further identify learnings and recommendations from Serious Incidents to bring to working group. |
| 071 | Bed Escalation Policy | Unknown progress of recommendation. | Policy under development. Noted reporting of non-clinical transfers is reported to the HCS Advisory Board. |
| 015 | Clinical Strategy | Unknown progress of recommendation. | Meeting scheduled with Senior Medical Staff to discuss strategy on 3rd June. |
| 031 | AAU Strategy | Unknown progress of recommendation. | Require confirmation from Care Group if AAU Strategy is to be included within the Clinical Strategy Rec.ID#015. |
| 044 | Same Day Emergency Care (SDEC) Strategy | Unknown progress of recommendation. | Confirmed SDEC Standard Operating Procedure in place but requires review. To identify staff inclusion within working group. |
| 054 | Cardiology Inpatient Clinical Strategy | Unknown progress of recommendation. | Require confirmation from Care Group if Cardiology Inpatient Clinical Strategy is to be included within the Clinical Strategy Rec.ID#015. |
| 058 | Neurology Review | Unknown progress of recommendation. | Confirmed that the Neurology service is due to be consulted |

| | | | |
|---|---|---|---|
| | | | with in June regarding this recommendation. |

## 3. Finance / Workforce Implications

The following recommendations have identified finance and workforce implications:

- Rec.ID#004
    - Ongoing recruitment to the "Future Vision" medical model which aspires to ensure resilience and evidence-based medicine of high calibre Consultant Grade posts to support the ambition to provide high quality care to the service users within Jersey.
    - Five Consultant Grade posts have been advertised with interviews scheduled for 17th May 2024.
    - Further 6 posts required to enable a resilient workforce model.
    - One Flow Co-Ordinator post advertisement delayed due to funding.
    - Following stakeholder engagement, a training needs analysis is to be conducted to ensure correct workforce skill set and model are adequately supported.
    - A business case is to be established following this to support the implementation of the model.

## 4. Risk and Issues

The competing goals of delivering operational performance and evidencing against recommendations place a great deal of pressure on clinical department lead staff and Medicine Care Group SLT. Additional resource has been sourced by the COO Acute Services and Chief Officer to include an external physician experienced in both patient safety and operational flow improvement to support the care group as well as operational leadership and project management capacity. This resource has commenced in May 2024 to support the care group in their delivery.

Recruitment to vacancies remains a priority. Actions to shorten the time to recruit to allow for sustained pace to quality improvements also sit within the financial recovery programme (FRP) due to risk of agency premium. Escalations have been received via check and challenge of ongoing risk and actions will be developed at the Financial Oversight Group.

## 5. Main Report

The Board are asked to note the content of the cover report and acknowledge the ongoing progress of completion and assurance of embedded practice.

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## 6. Recommendation

The HCS Advisory Board are requested to note this monthly progress report and attached recommendation exception report, acknowledge the ongoing development of the Medicine Improvement Plan and recognise the challenges which remain.

**END OF REPORT**

Health and Community Services

# Health and Community Services Advisory Board Report

| | | | |
|---|---|---|---|
| **Report to:** | Health and Community Services Advisory Board | | |
| **Date of meeting:** | 30 May 2024 | | |
| **Title of paper:** | Annual Plan 2024 – updated version for information | | |
| **Report author (& title):** | Harry Hambrook, Senior Business Planner | **Accountable Executive:** | Anuschka Muller, Director Improvement and Innovation |

## 1. Purpose

| | | | |
|---|---|---|---|
| What is the purpose of this report?<br><br>What is being asked of the HCS Advisory Board? | To provide the updated and finalised version of the Annual Plan for 2024.<br><br>To note the changes and updates made. | Information | x |
| | | Decision | |
| | | Assurance | |
| | | Update | x |

## 2. Executive Summary

The HCS Annual Plan was presented to the Board in February 2024. Due to the political changes, ministerial priorities were not available at that time. The Common Strategic Policy has since been lodged and approved by the States Assembly; this details the priorities for the next two years.

The Board have agreed in a number of workshops the five key objectives for HCS for 2024 (see below), which are now incorporated into the Annual Plan and will be monitored through the Board Assurance Framework agreed by the Board in April 2024.


In addition, a section on commissioning has been included as per Board request.

## 3. Finance / workforce implications

None

## 4. Risk and issues

Included in the BAF and individual plans

## 5. Recommendation

The Board is asked to note the updated version of the HCS Annual Plan 2024.

**END OF REPORT**

Health and Community Services

Gouvèrnément d'JÈRRI

# Annual Plan 2024

# Version Control

| Status | Version | Date | Changes |
|---|---|---|---|
| Draft | V0.1 | 16/1/2024 | Final Draft for Board discussion |
| Draft | V0.2 | 19/2/2024 | Final Draft for Board approval<br>- Ministerial Priorities removed |
| Draft | V0.3 | 14/3/2024 | Final Draft for Board approval, with:<br>1. Additions:<br>- New Sections:<br>o Corporate Governance Structure<br>o Commissioning<br>- New ELT roles:<br>o Director of Workforce and Financial Recovery Director<br>2. Amendments:<br>- Departmental Structure:<br>o Primary, Prevention, Therapies & Community Dental: moved from Chief Operating Officer – Acute Services to Director of Mental Health and Adult Social Care<br>o Estates: moved from Chief Operating Officer – Acute Services to Director of Improvement and Innovation |
| Draft | V0.4 | 19/3/2024 | Final Draft for Board, with:<br>1. Additions:<br>a. Commissioning objectives |
| Draft | V0.5 | 15/5/2024 | Additions:<br>1. New 'Common Strategic Policy' sub-section in previously titled 'Minister for Health and Social Services' section.<br>2. New vacant Director of Digital Health post in ELT.<br><br>Amendments:<br>1. Minor amendment to BAF objective wording, as per V5 of the BAF.<br>2. 'Minister for Health and Social Services' section retitled as 'Ministerial'.<br>3. Corrections on some report dates within the 'Improvement Recommendations' section.<br>4. Advisory Board sub-committee titles updated. |

# Contents

# Foreword

This Annual Plan provides a strategic overview of key areas of improvement, strategic initiatives, and quality and performance reports for Health and Community Services (HCS) across the breadth of the Department. The HCS Advisory Board (the Board) and its Assurance Committees will drive and monitor improvements to the performance of HCS and its services. Board papers can be found here Health and Community Services Advisory Board (gov.je).

HCS has several significant and varied programmes of work to undertake in 2024, such as the New Healthcare Facilities Programme (NHF), preparing for the Jersey Care Commission (JCC) inspection. In addition, the Minister for Health and Social Services has set ambitious priorities for the Board and the Department to deliver.

We know that that there is much to deliver in 2024, which is why we are working to secure vital governance improvements on the quality, safety and effectiveness of services delivered by the department. By Q2 2024, all Board committees, reporting structures and assurance frameworks will be fully established.

A key governance improvement in 2024 will be the development and publication of a Board Assurance Framework (BAF). An assurance framework provides a structured way of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect. This will bring together, in one place, all the relevant information on the risks, controls and assurance to successfully deliver the strategic outcomes and objectives.

The BAF will support the Board in receiving assurance that processes and controls are effective that will result in achievement of strategic objectives. The Board will in turn advise the Minister for Health and Social Services on the quality, safety and performance of the Department's services.

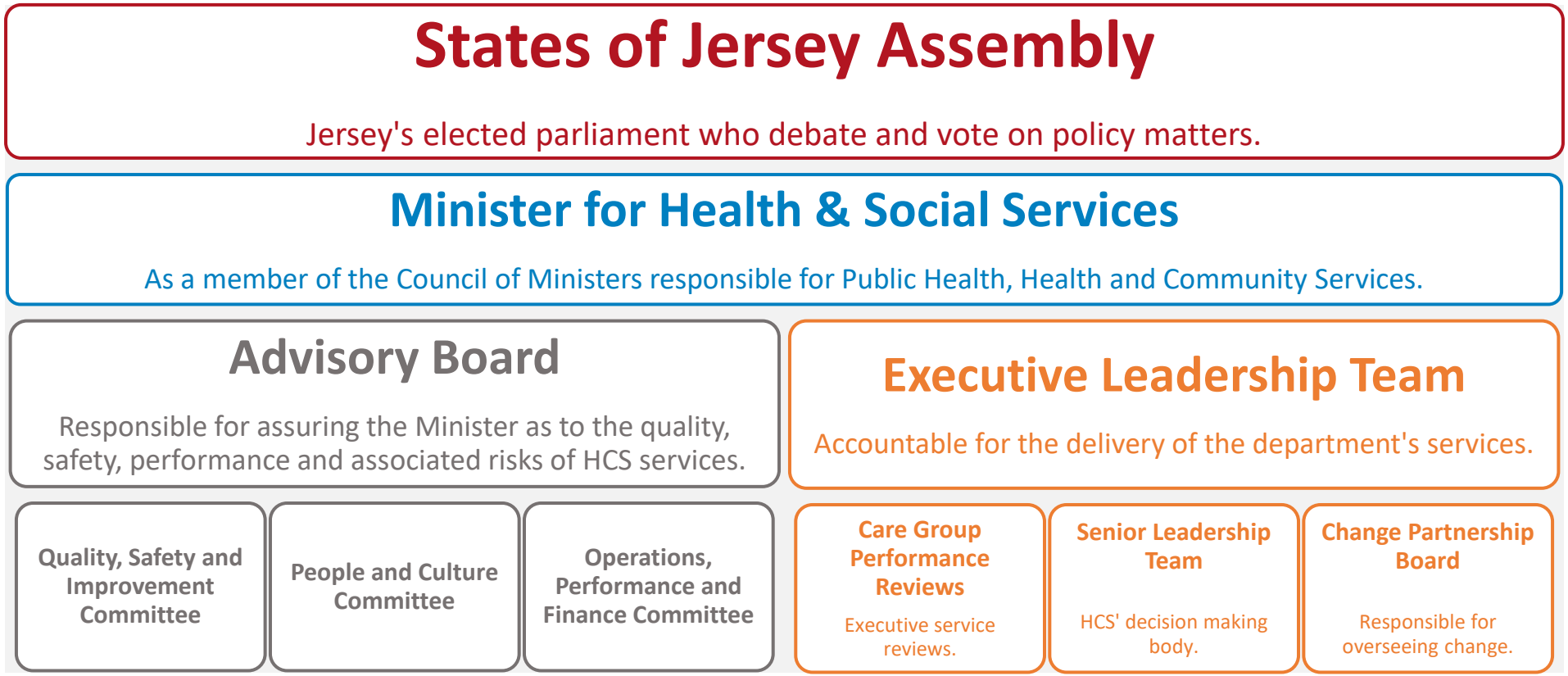
Every day, we aim to provide excellent care and support for Islanders that is centred around the patient / service user. We aim to offer a great place to work which is well-led and resourced, where we work with partners and colleagues to continuously improve the care, experience and outcomes for Islanders.

We have a significant programme of work for 2024 and only with our fantastic and dedicated staff and partners will we be able to achieve this.

Chris Bown
Chief Officer, Health and Community Services

# Corporate Governance Structure

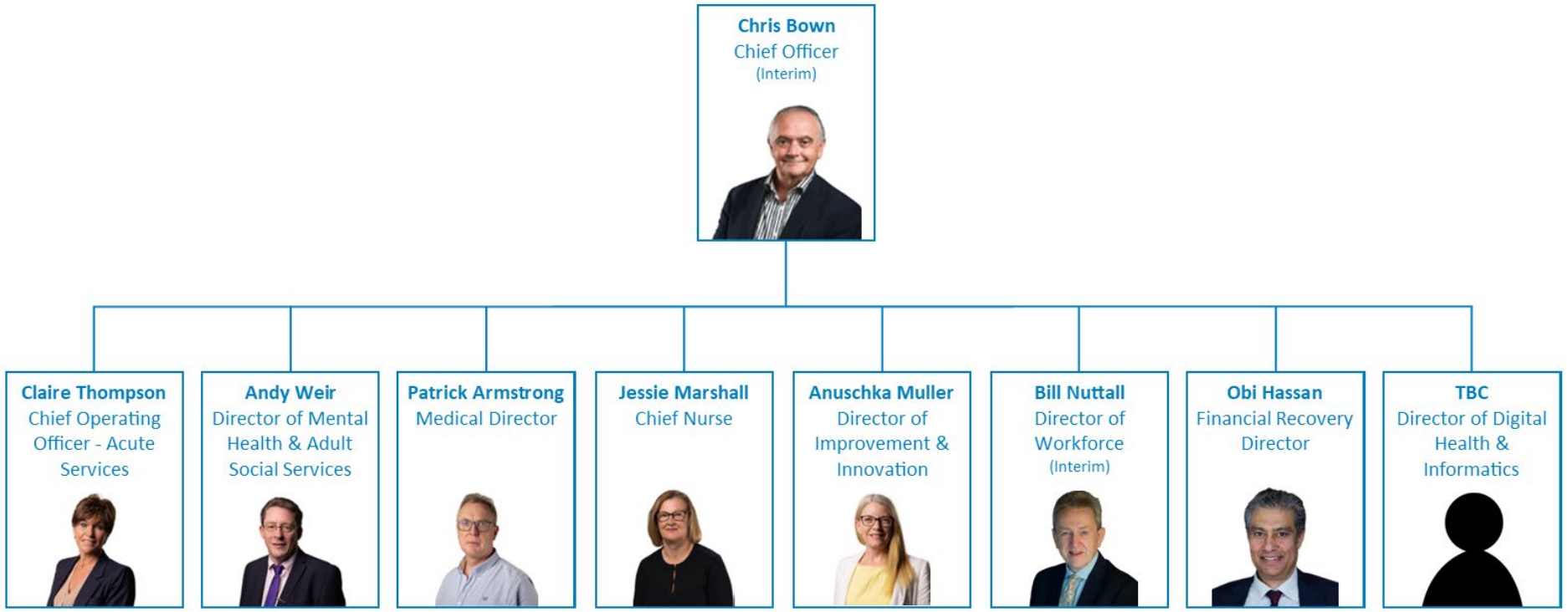
Governance is the means by which organisations make sure that decision-making is effective, risk is managed and the right outcomes are delivered. In HCS, this means delivering high quality services in a caring and compassionate environment whilst collaborating with partners.



# Meet the Team

## Executive Leadership Team

The Executive Leadership Team (ELT) is comprised of the Chief Officer and eight Executive Directors. They are accountable for the delivery of the department's services, through a  political, strategic and governance focus.



## Senior Leadership Team

The Senior Leadership Team (SLT) is comprised of the ELT members, plus the below senior support service managers and clinical leaders.

SLT is the decision-making body of the department.

### Clinical

Simon West
**Deputy Medical Director**

Adrian Noon
**Chief of Service - Medical Services**

Simon Chapman
**Chief of Service - Surgical Services**

Matthew Doyle
**Chief of Service - Primary, Prevention, Therapies and Community Dental**

David Hopkins
**Chief of Services - Women's Children's and Family Care**

Paul Rendell
**Chief Social Worker**

### Support

Cheryl Power
**Director of Culture, Engagement and Wellbeing**

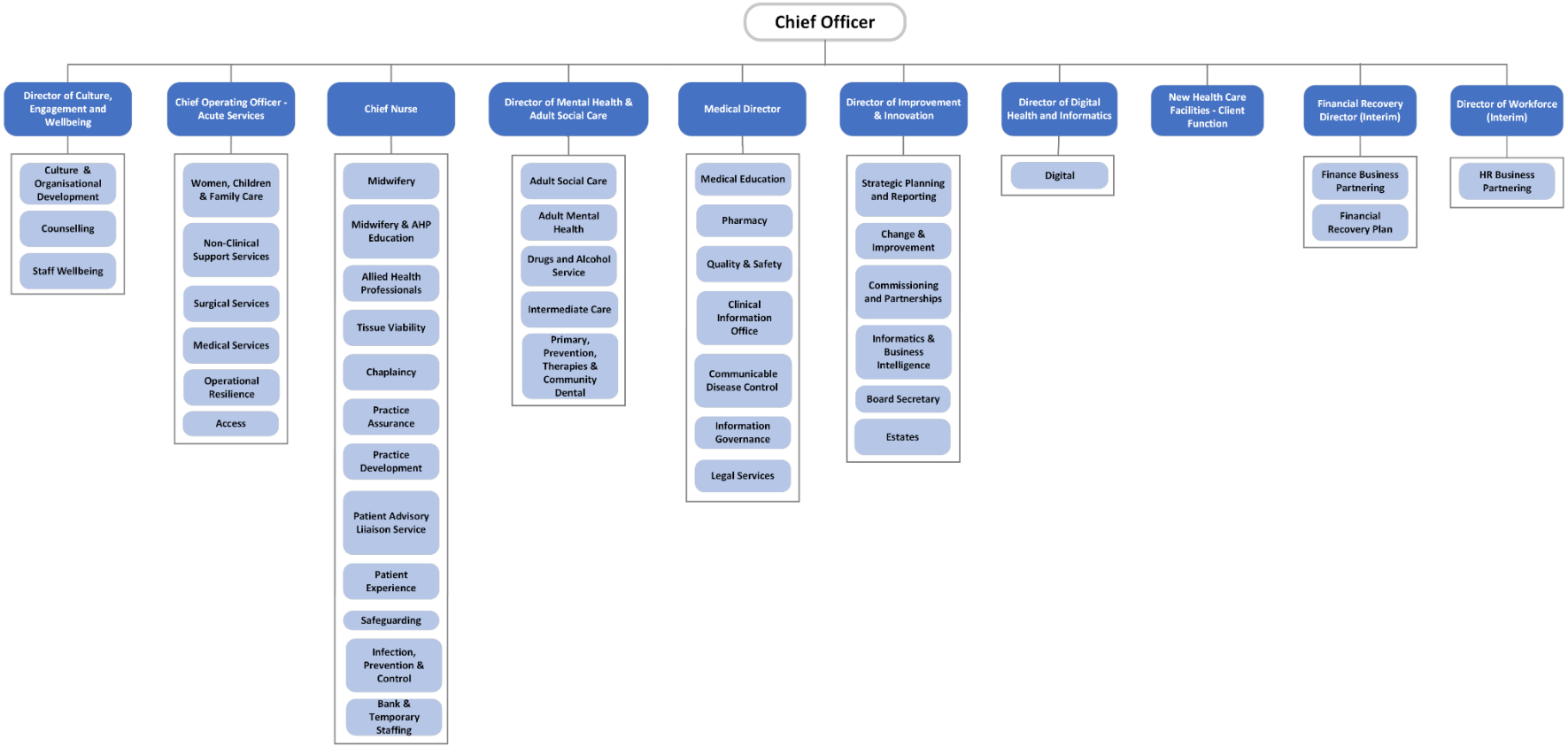
Sophia Bird
**Head of Communications**

Mark Queree
**Deputy Head of Finance Business Partnering**

Washington Gwatidzo
**REACH Representative**

# Departmental Structure

Health and Community Services (HCS) is a combined acute, mental health, community and social care provider that encompasses a range of clinical and professional care groups. Some services are provided in partnership with external partners. Below are the structure and functions of the department.



# Ministerial

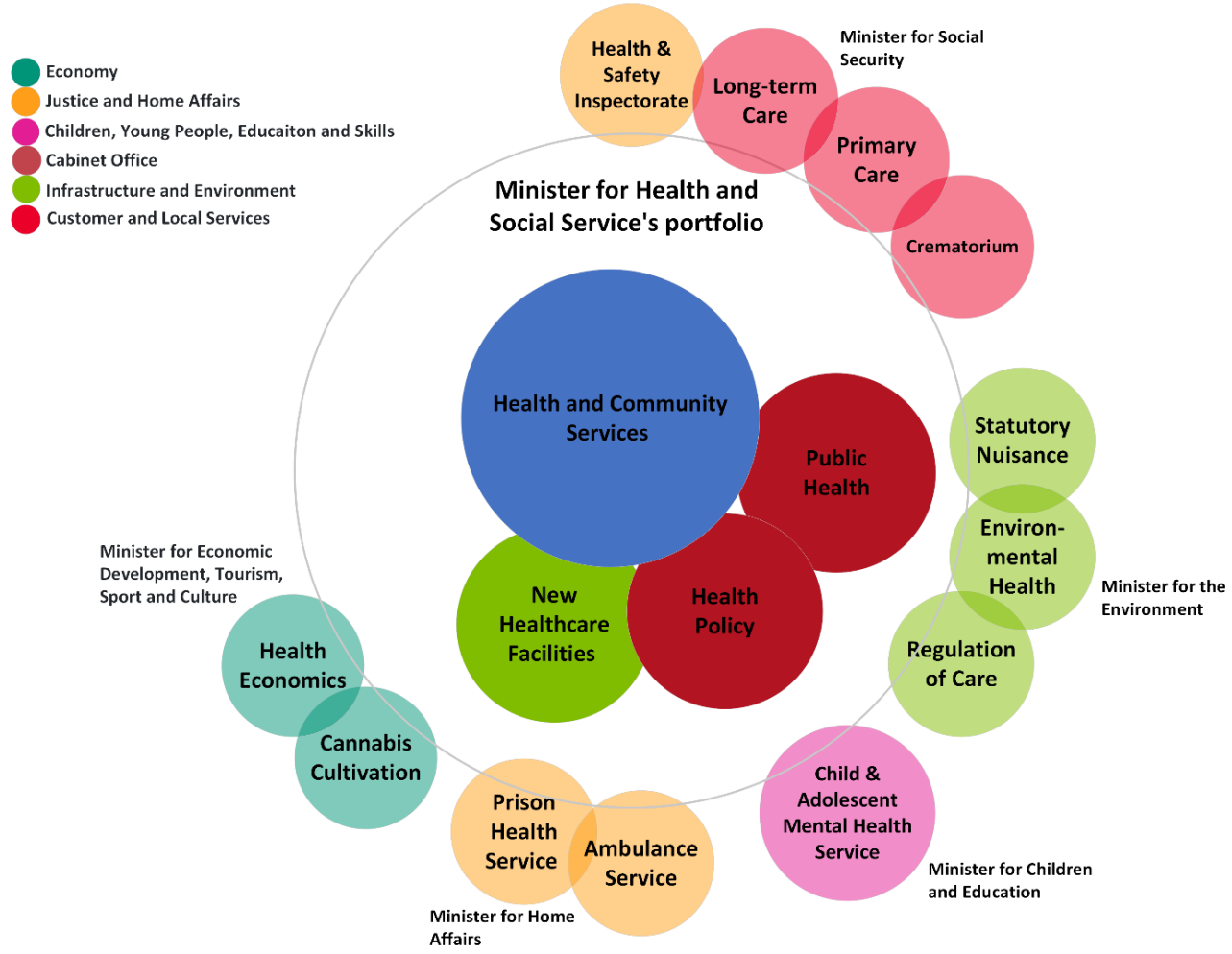
## Common Strategic Policy

The Council of Ministers (CoM) have identified 12 priorities which are aligned to the long-term vision set out in the Future Jersey report. The Common Strategic Policy (CSP) (P.21/2024) was approved by the States Assembly on 21 May 2024. The CSP can be found on gov.je.

## Minister for Health and Social Services' Portfolio

The Minister for Health and Social Services ("the Minister") has a diverse portfolio, which covers operational services delivered by HCS, as well as the Health Policy and Public Health functions, which sit in the Cabinet Office. The Minister also works closely with other departments and Ministers across Government, to ensure health outcomes for Islanders are considered across all portfolios.

Whilst the diagram on the right does not cover all the Minister's working relationships, it seeks to provide an overview of the breadth of services and functions that the Minister is engaged with.



# Board Assurance Framework

The Board Assurance Framework (“the BAF”) aims to provide the HCS Advisory Board (“the Board”) with assurance that the key risks agreed by the Board, relating to the delivery of HCS’ strategic aims, are being managed appropriately. The Board will use the BAF and the assurance outcomes to focus its agenda and discussions, to inform decision making, to instigate further checks, challenge, and investigate where further concerns exist. By doing this, the Board can be assured that it is doing everything possible to manage its risks and achieve its objectives. The full BAF can be found on gov.je/hcs and progress against the BAF is reported at each Board meeting.

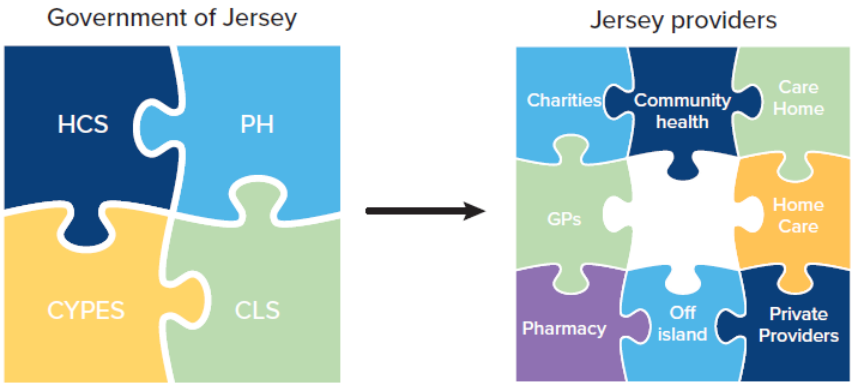
## Objectives

# Commissioning

Commissioning in Jersey is defined as 'the process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, ensure equity and enhance experience within the resources available. The commissioning process is repeated on agreed time cycles and comprises a range of activities including:

- Understanding and assessing need.
- Strategic planning and development of services.
- Implementation and delivery of outcomes through procuring and contracting services.
- Monitoring and evaluating the outcomes/services.
- Revising and adapting.

HCS works in partnership with other Government departments to commission from a range of providers. For example, HCS is working closely with Public Health on strategic and specific Health Needs Assessments, which is the process of identifying unmet health and healthcare needs in Jersey and the changes needed to meet them.




## How we will deliver

The below actions represent the high-level tasks that HCS' Commissioning function will deliver in 2024.

| Action | Measure | Due Date |
|---|---|---|
| Use the Mental Health Provider Framework to procure services in a fair and transparent way. Run a mini competition for low level anxiety and depression services. | Contract award following mini competition | Q2 2024 |
| Develop and deliver a neurodiversity strategy for Jersey, working in partnership with Autism Jersey and key stakeholders. | Ratification of strategy | Q3 2024 |
| Recommission community services to up-to-date specifications based on assessment of need ensuring best outcomes for Islanders. | Contract award following commercial process | Q3 2024 |
| Continue implementation of the Palliative and End of Life Care Strategy through commissioning education and end of life care at home services. | Education and end of life care at home service commencement | Q4 2024 |

# Improvement Recommendations

**from C&AG, PAC, and Scrutiny Panels**

HCS receives recommendations from various bodies and individuals, following reviews and audits conducted on the department. The below table shows the number of open recommendations from the Public Accounts Committee (PAC), Scrutiny Panels and the Comptroller & Auditor General (C&AG). Progress is being monitored on a quarterly basis with evidence of progress and ultimately completion being provided to agree the closure of recommendations.

| Date Published | Report | Author | No. of open recs. |
|---|---|---|---|
| 09/10/2023 | Handling and Learning from Complaints – Follow up | Comptroller & Auditor General | 2 |
| 10/12/2015 | Review of Community and Social Services | | 1 |
| 20/10/2021 | Governance Arrangements for Health and Social Care (Follow Up) | | 1 |
| 22/09/2022 | Child and Adolescent Mental Health Services | | 3 |
| 24/01/2023 | Deployment of Staff Resources in Health and Community Services | | 12 |
| 15/05/2023 | Learning from Previous Hospital Projects: A Follow Up Review 2023 | | 6 |
| 12/04/2022 | Response to the COVID-19 Pandemic by the Government of Jersey | Public Accounts Committee | 1 |
| 01/10/2021 | Our Hospital Outline Business Case and Funding Review | Future Hospital Review Panel | 2 |
| 10/12/2020 | Review of the Government Plan: 2021 – 2024 | Government Plan Review Panel | 1 |
| 06/03/2019 | Assessment of Mental Health Services | Health and Social Services Scrutiny Panel | 9 |
| 06/07/2021 | Review of Maternity Services | | 23 |
| 09/01/2021 | Government Plan 2022 – 2025 Scrutiny Review | | 4 |
| 22/04/2022 | Follow-Up Review of Mental Health Services | | 20 |
| 26/04/2022 | Regulations for the Licensing, Production and Export of Medicinal Cannabis in Jersey | Economic and International Affairs Scrutiny Panel | 1 |
| | | **Total open recommendations (as of Feb-24)** | **86** |

# Jersey Care Commission Preparation

The Jersey Care Commission (JCC) regulates and inspects services for both adults and children provided by the Government of Jersey, Parishes, private providers, and the voluntary sector. The services currently regulated include care homes providing nursing and personal care, domiciliary care, adult day care, and children's services. The JCC are currently working with the Care Quality Commission (CQC) to draft standards for hospital services and those, alongside updated legislation, will go out to public consultation. HCS could be inspected at any time following approval of the standards and the updated Regulation of Care (Jersey) Law 2024.

## Key Lines of Enquiry

To prepare for inspection, whilst the Jersey standards are being prepared, HCS will focus on ensuring that we can evidence the Care Quality Commission's (CQC) five Key Lines of Enquires (KLOEs) and what these mean for patients and service-users.

- **Is it safe?** Patients / service users are protected from abuse and avoidable harm.
- **Is it effective?** Care, treatment, and support achieve good outcomes, help patients /service users to maintain quality of life and are based on the best available evidence.
- **Is it caring?** Staff involve and treat patients/service users with compassion, kindness, dignity, and respect.
- **Is it responsive?** Services are organised so that they meet patients'/service users' needs.
- **Is it well-led?** The leadership, management and governance of the organisation make sure they are providing high-quality care that is based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

## How we will deliver

| Action | Measure | Due Date |
|---|---|---|
| Establish a Steering Group of key senior staff to develop a programme of work, including mock inspections and benchmarking against CQC standards. | Steering Group established | Q1 2024 |
| Picker Institute to conduct a patient experience survey and publish results which will inform our understanding of patient experience and any changes since the 2022 survey. | Results published | Q1 2024 |
| Secure capacity to support clinicians in preparing for JCC inspections and to lead on preparation and response to JCC inspections. | Capacity established | Q2 2024 |
| Timely registration of HCS services once JCC opens the registration process. | Registration completed | Q1 2025 (depending on law changes and JCC processes) |

# New Healthcare Facilities

We know that our current facilities (buildings) are deteriorating, this represents a considerable risk to our capacity to deliver acute health and care services. We need environments to be fit for purpose and to meet modern healthcare standards. Several capital construction projects will be delivered, with the key elements of the planned work including delivery of a new acute facility at Overdale, the development of Ambulatory Care facilities on Kensington Place, whilst utilising some of the existing General Hospital site, a health village at St Saviours, that integrates elements of physical health with mental health services. In addition, the programme has already delivered the Enid Quenault Health and Wellbeing Centre on the former Les Quennevais School site, which provides a range of outpatient services and is an exciting new addition to the healthcare facilities in Jersey.

## Design

A significant amount of work was undertaken as part of the previous ‘Our Hospital’ project, and none of this has been lost. The design of the acute facility will be the priority for 2024 to ensure plans are ready for planning application. As the year progresses, the plans for this site should be developed to RIBA stage 4a (technical design).

The design development of the Ambulatory Care Centre and the Health Village will be progressed further throughout 2024.

## Clinical Input

Two Clinical Advisors were appointed in 2023 to provide advice and guidance on clinical matters, acting as clinical ambassadors in the development of the design and briefs for each of the projects, whilst engaging and communicating with their clinical peers across HCS to ensure that they are kept fully briefed, and to ensure all their opinions are heard. These two roles will play a key part in any clinical user groups that are required to refine and finalise plans, layouts, and room schedules.

In addition to providing clinical input into the design, HCS teams will be engaged in advising on the detail of the known and anticipated revenue consequences that will arise of delivering care and services across more sites and in new and different ways. They will also be involved in the development of the Facilities Management Strategy and the Digital Strategy, both of which will ensure that the facilities delivered will operate smoothly and efficiently, making best use of technological advances to improve patient care and enhance operational delivery of services.

# How we will deliver

| Action | Due |
|---|---|
| Completion of Outline Business Case for an acute site at Overdale. | Q2 2024 |
| States Assembly funding debate: to secure finances to support the delivery of the first phases of the Programme. | Q2 2024 |
| Transfer of the current Rehabilitation Ward into new, temporary facilities, where they will stay until the development of the Health Village is completed. | Q1 2024 |
| The demolition of buildings on the Overdale site, in preparation for the acute hospital build. | Q3 2024 |
| Submission of the Planning application for the revised plans to develop the Acute Hospital on the Overdale site. | Q2 2024 |
| Improvements on the Kensington Place site, with some possible temporary use of the site for HCS requirements. | Q3/Q4 2024 |

# Existing Facility Maintenance

The HCS Estate Team manages, plans, and delivers a portfolio of work which averages about 20 small projects each year, aimed at mitigating operational and clinical risk in our ageing healthcare facilities. The Government has allocated £5m in the 2024 Government Plan for this essential work. The annual list of work has been informed by a review of the risks within the department. For 2024, the portfolio consists of a wide range of works including but not limited to:

- Ward refurbishments and improvements.
- Maternity ward re-modelling finalisation.
- Cold and hot water management.
- Roofing repairs and window replacement.
- Fire Safety improvements.
- Air handling and fan coils.
- Minor works across all HCS sites.

# Digital Programme

The Digital Health Strategy is a five-year programme, which has the vision of making Jersey a digitally-world-class health and care system that uses technology everywhere to deliver accessible, joined-up, person-centred care. The below table shows the larger projects that are being delivered in 2024, in addition to these there are multiple smaller 'business-as-usual' replacements. The Digital Health Board meets throughout the year to review and monitor progress.

| Project | Detail |
|---|---|
| Faecal Immunochemical Testing (FIT) | To digitally support the FIT booking and screening process which will increase the number of patients who can be screened - improving detection and treatment. |
| General Practitioner (GP) Oder Comms | To replace the paper-led requesting and reporting process which will reduce result turnaround times, provide a fully audited service. |
| Picture Archiving and Communications Systems | Replacement of a legacy system, with migration of images and image reporting history. Will also provide clinical image reporting services. |
| Vendor Neutral Archive | Implementation of a strategic method for clinical image storage, which improves efficiency and scalability. |
| Sexual Health Clinic Electronic Patient Record (EPR) | To capture structured clinical data and remove the current paper-based process. |
| Electronic Record System for Adult Social Care | Transformation of the system and processes to meet the service's needs. |
| ePrescribing Chemotherapy | To reduce clinical risk and comply with best practice. |
| Electronic Patient Medicines Administration | Deployment of infrastructure, to improve clinical compliance and safety. |
| Ophthalmology Electronic Patient Record (EPR) | Implementation of a new EPR system to create automation and efficiencies, to deliver shorter waiting times. |
| Cervical Cancer Screening | An essential upgrade to support the service in achieving screening targets, through increased efficiency and automation. |
| eConsent for surgical procedures | A system that enables patients to provide their consent online. |
| Jersey Health & Care Index | An essential project to ensure consistency of patient data. |
| Primary Care System review | Review the current Primary Care system solution and establish requirements for re-tender. |
| Obstetric Sonography System Software | Replace / upgrade the current ultrasound / scanning report application. |
| Audiology: Audit Data replacement for Practice Navigator | Replace legacy system. |
| Virtual consultations | Enable virtual consultations to improve waiting times by providing Consultant led services remotely. |
| eReferral Process | Implement a solution to replace the predominantly email led referral process. |
| Essential Hospital Wi-Fi | To improve connectivity in the hospital. |
| IT Service Model review for commissioned services | Ensuring compliance with IT infrastructure standards and contractual arrangements. |

# Quality and Performance Metrics

## Quality and Performance Report & Service Performance Measures

The ***Quality and Performance Report*** (QPR) provides the performance metrics and monthly performance for clinical services. The QPR is discussed monthly at the HCS Advisory Board and published in addition on Health and Community Services Quality and Performance Reports (gov.je). The full list of indicators that will be reported in 2024 is shown below. Further details including detailed description and calculation of each metric will be included in the 2024 QPR.

The ***Service Performance Measures*** (SPMs) are a sub-set of the Quality and Performance Report indicators and are published quarterly alongside other government departments' SPMs. They aim to provide a broad overview of the delivery of key services by all government departments. The HCS indicators that are SPMs are indicated in the below table in the right-hand column.

| Section | Subsection | Indicator | SPM |
|---|---|---|---|
| **Elective Care Performance** | Elective Pathways | Patients waiting for first outpatient appointment > 52 weeks | Yes |
| | | Patients on elective list > 52 weeks | Yes |
| | | Access to diagnostics > 6 weeks | Yes |
| | Efficiency | Outpatient New to Follow Up (NFU) rate | Yes |
| | | Outpatient DNA rate (Adults only) | Yes |
| | | Outpatient WNB rate (Patients under 18) | Yes |
| | | Theatre Utilisation (capped) | Yes |
| | | On the day Theatre cancellations | |
| **Emergency Care Performance** | Emergency Care Pathway | Waits in emergency care > 4 hrs | Yes |
| | | Waits in emergency care > 12 hrs | |
| | Patient Flow | Patient moves for non-clinical reasons >22:00 and <08:00 | |
| | | Total Bed Days Delayed Transfer of Care (DTOC) | |
| | Emergency Inpatients | Emergency acute Length of Stay (LOS) | |
| | | Rate of Emergency readmission within 30 days of a previous inpatient discharge | Yes |

| Section | Subsection | Indicator | SPM |
|---|---|---|---|
| **Maternity** | Pregnancy & Births | Total births | |
| | | % primary postpartum haemorrhage >= 1500ml | |
| | | % spontaneous vaginal births (including home births and breech vaginal deliveries) | |
| | | % of babies that have APGAR score below 7 at 5 mins | |
| | | % of births less than 27 weeks | |
| | | % of births less than 37 weeks | |
| | | Transfer of Mothers from Inpatients | |
| | | Transfer of neonates from JNU | |
| | | % 3rd & 4th degree tears – all births | |
| | | % emergency caesarean sections at full dilation | |
| | | Number of admissions to JNU at or above 37 weeks gestation (per 1000) | |
| | | % babies born before arrival (BBA) | |
| | | % live births < 3rd centile delivered > 37+6 weeks (detected and undetected SGA) | |
| | | Number of still births | |
| | | Proportion of mothers who were current smokers at booking appt. | |
| | | Proportion of mothers who were smoking at delivery | |
| | | Proportion of mothers who were consuming alcohol at booking appt. | |
| | | Proportion of mothers who were consuming alcohol at delivery | |
| | | Neonatal mortality rate (<28 days) | |
| | | HIE (per 1,000) | |
| | | Transfer of care during pregnancy (planned) | |
| | | Rate of Intrapartum stillbirth (per 1,000) | |
| | | Booking <70 days gestation | |
| **Mental Health** | Jersey Talking Therapies (JTT) | % of clients waiting for assessment who have waited over 90 days | |
| | | % of clients who started treatment in period who waited over 18 weeks | |
| | | JTT Average waiting time to treatment (Days) | |
| | Community Mental Health Services | Memory Service - Average Time to assessment (Days) | |
| | | % of referrals to Mental Health Crisis Team assessed in period within 4 hours | Yes |
| | | % of referrals to Mental Health Assessment Team assessed in period within 10 working days | Yes |
| | | ADHD Waiting Times (New indicator – detail being worked up) | |
| | | Autism Waiting Times (New indicator – detail being worked up) | |
| | | % of Adult Acute discharges with a face-to-face contact from an appropriate Mental Health professional within 3 days | |
| | | % of Older Adult discharges with a face-to-face contact from an appropriate Mental Health professional within 3 days | |
| | | Community Mental Health Team did not attend (DNA) rate | |
| | Inpatient Mental Health | Mental Health Unit Bed Occupancy | Yes |
| | | Average daily number of patients Medically Fit for Discharge (MFFD) on Mental Health inpatient wards | |

| Section | Subsection | Indicator | SPM |
|---|---|---|---|
| **Social Care** | Learning Disability | Percentage of clients with a Physical Health check in the past year | |
| | Adult Social Care Team (ASCT) | Percentage of Assessments completed and authorised within 3 weeks (ASCT)<br>** being reviewed (New PTL process being introduced during Q1 – Indicator will be replaced) | |
| **Quality & Safety** | Mortality | Crude mortality - % patients whose discharge outcome = death | |
| | Safety | Reporting rate of patient safety incidents per 1000 bed days | |
| | | Patient safety incidents with severe/major/extreme harm/death | |
| | | Serious Incidents | |
| | | Number of falls resulting in moderate / severe harm per 1000 bed days | |
| | | Pressure Ulcers on admission | |
| | | Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days | |
| | | Number of medication errors across HCS resulting in harm per 1000 bed days | |
| | | % of adult inpatients who have had a VTE risk assessment within 24 hours of admission | |
| | | NEWS compliance | |
| | Infection Control | Healthcare Associated C. Difficile Infections | |
| | | Healthcare Associated MRSA blood steam Infections | |
| | | Healthcare Associated E. coli blood steam Infections | |
| | | Outbreaks | |
| | Experience | Compliments received | |
| | | Formal complaints received | |

# Financial Recovery Plan

During 2023, it was identified that HCS had an underlying £34m deficit. A three-year Financial Recovery Programme (FRP) has been established which will enable HCS to make £25m savings over three years, which are within the departments control. Outside of HCS' control is a structural deficit, which has been included in the FRP and supported with Government funding.

This quality led FRP is built on a set of core values that combines patient focused quality improvement, financial recovery, clinical, staff and stakeholder engagement, teamwork, and inclusive leadership to deliver sustainable improvements. Importantly, we need to change our ways of working, by updating practices and improving our governance and culture to ensure we deliver efficient quality care to Islanders.

The FRP has identified opportunities for improved efficiency and effectiveness of services to help reduce costs and increase income - establishing appropriately funded services. The programme is a three-year roadmap towards financial sustainability, which will ensure that the department's services can be delivered within the revised budget limits outlined in the 2024 Government Plan.

A Project Management Office (PMO) has been established to support delivery of the FRP and the department's Value for Money (VFM) target; by working alongside the Care Groups and Directorates.

## Workstreams

To address the challenge, we have developed efficiency schemes which sit within seven workstreams:

1. Workforce
2. Non-Pay and Procurement
3. Clinical Productivity
4. Income
5. Digital
6. Care Group / Directorate schemes
7. Medicines Management

## Forecast Savings

The below table shows the annual and cumulative savings that will be delivered by the FRP. Progress will be reported quarterly to the HCS Advisory board.

| | FY 2023 (£000) | FY 2024 (£000) | FY 2025 (£000) |
|---|---|---|---|
| **Total cumulative savings** | **3,000** | **15,000** | **25,000** |
| FRP efficiencies FY2023 | 3,000 | 3,000 | 3,000 |
| FRP efficiencies FY2024 | | 8,429 | 8,429 |
| VFM Savings FY2023-24 | | 3,571 | 3,571 |
| FRP efficiencies FY2025 | | | 10,000 |

# Quality Account

The Quality Account is an annual report published by HCS to inform the public of how we monitor the quality of services we provide.

Quality in healthcare is made up of four core dimensions:

1. Patient experience – how patients experience the care they receive.
2. Patient safety – keeping patients safe from harm.
3. Clinical effectiveness – how successful the care provided is.
4. Staff wellbeing

The account demonstrates our commitment to provide Islanders with the best quality healthcare services. It also encourages transparency about our service quality and helps us to develop ways to continually improve. It also looks forward and defines the priorities for quality improvement for the year ahead and how we expect to achieve and monitor them.

The 2023 Quality Account is the second annual account produced by HCS. It includes details of our progress and achievements related to quality and safety for the previous year. The report will be available on gov.je.

## 2024 Priorities

The 2024 priorities have been developed using triangulation of data and learning from incidents, serious incidents, complaints, litigation and performance against the Jersey Nursing Assessment and Accreditation System (JNAAS). In addition, senior teams and clinicians have been engaged in the development. The 2024 Quality Account priorities will be presented to the HCS Advisory Board in February 2024 alongside the Board Assurance Framework.

| Priorities and Objectives |
|---|
| **Priority 1: Develop a Learning from Deaths (LfDs) Framework for HCS** |
| Publication of a Mortality Strategy for HCS. |
| Implementation of Mortality Learning Review (MLR) Programme. |
| Re-introduce Mortality and Morbidity (M&M) meetings. |
| Commence a Learning Disability Mortality Review Programme |
| **Priority 2: HCS will transform Maternity Services for a Brighter Future in Jersey** |
| Publication of the improvement plan for maternity – 'Our Plan for the Way Forward with Maternity Services in Jersey' (strategy) |
| Ensure processes are in place to ensure Safe Staffing across maternity. |
| Create a collaborative culture of safety, learning and support through effective leadership. |
| Work with service users, staff, and community voices to shape our services. |
| **Priority 3: Develop a Nutrition and Hydration Strategy for HCS** |
| Improve the visibility and governance of nutrition and hydration across HCS. |
| Improve compliance and documentation of nutritional screening. NICE CG32: all adult inpatients should be screening for nutrition within 24 hours of admission, and all outpatients on first appointment. |

| Priorities and Objectives |
|---|
| Provide all inpatients with nutrition and hydration which meets their nutritional needs and dietary / cultural preferences in line with national standards for healthcare food and drink* BDA Digest: all healthcare menus must meet the nutrition standards for both nutritionally well and nutritionally vulnerable. |
| Ensure appropriate and safe prescribing of oral nutrition support, enteral and parenteral nutrition |
| **Priority 4: Inpatient Mental Health: Quality and Patient Experience** |
| Develop Quality Improvement plan |
| Improved service user experience measures |
| Improved staff experience |
| **Priority 5: Dementia and delirium within the General Hospital** |
| Reduce inappropriate use of sedation to manage distress and challenging behaviour |
| Review clinical protocols / procedures in use |
| Dementia care audit completed |
| Completion of carer survey |
| **Priority 6: Improve the management of the patient feedback processes and enhance patient experience** |
| Senior staff make sure every employee of HCS knows how they can create and deliver a just and learning culture for handling complaints, and that all staff can demonstrate how they contribute to this culture through practical example. |
| Staff respond to complaints at the earliest opportunity and consistently meet expected timescales for acknowledging a complaint. |
| They give clear timeframes for how long it will take to investigate the issues considering the complexity of the matter, and clearly communicate this to complainants. |
| Implement Core Standards for the management of patient feedback across HCS. |
| **Priority 7: Staff Wellbeing** |
| Deliver a range of wellbeing initiatives for all HCS employees |

# Culture and Workforce

We want to be a great place to work, where staff feel supported, respected, and valued. We have started a journey to establish a culture and workforce programme in 2022 and we are now building on the activities and improvements delivered in 2023. The below table sets out our plan to deliver culture and workforce improvements within HCS during 2024.

| | Goals | Actions | Due | Success Measures |
|---|---|---|---|---|
| Our Culture | a. Always putting the patient/client at the centre of what we do.<br>b. Work environments are respectful and promote inclusiveness enabling safety to share information.<br>c. Improve multi-professional team working and collective decision making, escalating concerns where needed.<br>d. Create better opportunities to safely learn, innovate and improve following incidents.<br>e. Develop opportunities to safely reflect on professional practice.<br>f. Engage colleagues in understanding the Be Heard Results, so they can actively participate in the developing and implementing the People and Culture Plan. | Work environments are respectful and promote inclusiveness enabling safety to share information. | Commenced in January 2023 and ongoing throughout 2024. | • Freedom to Speak Up activity.<br>• Reduced dignity and respect grievances.<br>• Decrease I sickness absence where data reports absence as anxiety, stress, and depression.<br>• Improved learning following an incident.<br>• Improved reflective practice. |
| | | Improve multi-professional team working and collective decision making, escalating concerns when needed. | CSL to be launched in January 2024 and continue embedding alongside other cultural interventions throughout 2024. | |
| | | Create better opportunities to safely learn and innovate and improve following incidents. | Quarter 2/3 2024. | |
| | | Develop opportunities to safely reflect on professional practice. | Corporate Psychological Safety in Teams training to commence Q1 2024 with Maternity services. | |
| | | Engage colleagues in understanding the Be Heard survey results & our initial proposed response to this so they can actively participate in developing & implementing the People & Culture plan. | Quarter 2/3 2024. | |

| | Goals | Actions | Due | Success Measures |
|---|---|---|---|---|
| **Leadership and Management Development** | a. Our Values, Our Behaviours are visible and demonstrated throughout all levels of leadership & management.<br>a. Leaders have clear leadership objectives.<br>b. Managers are developed and invested in through formal qualifications/GoJ manager training/mentoring. | Executive Leadership to undertake leadership and management development, to support their teams in delivering sustainable models of high-quality care. | Q2 2024. | • Improved performance (managers responding to issues).<br>• Increase in Connect Performance returns (with SMART objectives and progress).<br>• Reduced number of dignity & respect grievances. |
| | | Corporate team to deliver core leadership training programme to General Managers, Clinical Leads, Lead Nurses, Lead AHP's etc. | Q4 2024 and ongoing throughout 2024. | |
| | | Identify Short/Medium/Long Term plan for all middles management development including participation in World Class Manager sessions. | Q2 2024. | |
| **Engagement and Communications** | a. Continue staff engagement following Be Heard survey through regular listening events and pulse surveys. Ensure colleagues are aware of, & feel engaged with the development & delivery of the People & Culture plan.<br>b. Improve engagement & communication, including understanding HCS purpose, the strategic plan and care group/service priorities.<br>c. Ensure the communications for the HCS People & Culture plan & the individual care group People & Culture plans are connected & aligned to HCS vision and objectives. | Continue delivering a range of listening events; Team HCS Talks, Be Our Best forums, Professional forums (MSC, Nursing & Midwifery, AHP), Schwartz Rounds, Breakfast with Chief Officer, ward/service walkarounds. | Ongoing throughout 2024. | • Increased staff engagement.<br>• Improved staff collaboration & connection.<br>• Smarter decision making.<br>• Improved performance. |
| | | Develop & implement quarterly Pulse Surveys. | Quarterly pulse surveys to commence January 2024. | |

| | | | | |
|---|---|---|---|---|
| **Diversity and Inclusion** | a. Create a Diversity and Inclusion plan for HCS. | Working Group has been created to develop anti-racism statement for HCS.<br><br>Use working group to develop wider strategy, plan & key deliverables. | Anti-racism statement to be launched alongside Civility Saves Lives programme Quarter 1 2024. | • D&I plan.<br>• Reduced numbers of dignity & respect grievances.<br>• Improved workplace relationships.<br>• Improved performance.<br>• Greater readiness to innovate & improve. |
| **Wellbeing** | a. Continue wellbeing support for colleagues across HCS aligned with NICE guidance; 'Mental Wellbeing at Work'. | Use established Culture, Engagement & Wellbeing committee to create & develop plan & key deliverables. | Ongoing throughout 2024. | • Increase in wellbeing engagement factors.<br>• Reduced sickness absence rates.<br>• Reduced anxiety/stress related absence.<br>• Improved performance. |
| **Strategic Workforce Plan** | a. Produce a strategic workforce plan for HCS | Ensure engagement with PCS strategic workforce plan team at Care Group and Executive level. | January 2024. | • Understanding of emerging capabilities and skill requirements.<br>• Development of a plan to meet future needs and mitigate risk.<br>• Identification of areas requiring succession planning and training requirements. |
| **Recruitment** | a. Increase number of substantive employees.<br>b. Reduce reliance on agency and locum workers. | 1. Continue the multi-approach method to recruitment.<br>2. Develop recruitment pipeline metrics.<br>3. Engage with apprenticeship and internship programmes. | Ongoing throughout 2024. | • Reduced vacancy numbers and reduced agency numbers.<br>• Increased numbers of interns and apprentices. |

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|---|---|---|---|---|
| **Connect People** | Maximise Usage of Connect across HCS. | 1. increase usage of Connect Performance through 2024.<br>2. Utilise Connect Learning for delivery and recording of training.<br>3. Implement Connect People (Employee Central) for managers.<br>4. Implement Talen Acquisition for hiring new recruits | Ongoing throughout 2024. | • Increased number of colleagues with recorded objectives and appraisals.<br>• Ability to record and report training compliance.<br>• All staff changes completed via Employee Central.<br>• Quicker time to hire. |
| **Support the Freedom to Speak Up Guardian** | Continue to liaise with CO and FTSU Guardian on issues relating to staffing and employment matters. | 1. Regular meetings with CO and FTSU Guardian to resolve issues relating to employment matters. | Ongoing throughout 2024. | • Resolution of matters where possible |

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