Health and Community Services

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

28 NOVEMBER 2024

Government of Jersey

Health and Community Services

AGENDA

MEETING: Part A - Health and Community Services Advisory Board
DATE: 28 November 2024
TIME: 9:30am – 12:30pm
VENUE: Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

Non-Executive Board Members (Voting):		
Carolyn Downs CB	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director	**CG**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
David Keen	Non-Executive Director	**DK**
Executive Board Members (Voting):		
Tom Walker	Interim Chief Officer HCS	**TW**
Patrick Armstrong	Medical Director	**PA**
Obi Hasan	Head of Strategic Finance HCS	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
Matin Carpenter	Director of Digital Health and Informatics	**MC**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**

Quorum requirements: Three non-executive directors and two executive directors. At least one more non-executive director than executive director.

The Chair reminds members and attendees to consider equality, diversity and inclusion when discussing all items on this agenda.

	Agenda Item	Purpose	Presenter	Time
1	**Welcome and Apologies (including quoracy)** *Verbal*	For **Noting**	Chair	**9:30pm**
2	**Declarations of Interest** *Verbal*	For **Assurance**	Chair	
3	**Minutes of the Previous Meeting** *Paper*	For **Decision**	Chair	
4	**Matters Arising and Action Tracker** *Tracker / Paper*	For **Decision**	Chair	

	a. **Feedback on issues raised at the previous HCS Advisory Board meeting – externally commissioned providers**			
5	**Chair's Introduction** *Verbal*	For **Information**	Chair	**9:40am**
6	**Chief Officer's Report** *Paper*	For **Information**	Chief Officer	**9:45am**
7	**The New Healthcare Facilities Programme** *Presentation*	For **Information** and **Discussion**	NHF Programme Team	**9:50am**
8	**a. HCS Annual Plan 2025** **b. Quality and Performance Report 2025** *Paper*	For **Approval**	Director of Improvement and Innovation	**10:20am**
9	**Harm Review – Patient Tracking List Management Process** *Paper*	For **Assurance**	Chief Operating Officer (COO) – Acute Services	**10:25am**
10	**Winter Plan 2024** *Paper*	For **Discussion**	COO – Acute Services	**10:35am**
11	**Finance Month 10** *Paper*	For **Assurance**	Finance Lead – Change team	**10:45am**
	Comfort Break			**11am**
12	**Workforce Month 10** *Paper*	For **Assurance**	Director of Workforce	**11:10am**
13	**Quality and Performance Month 10** *Paper*	For **Assurance**	COO – Acute Services, Medical Director, Chief Nurse	**11:20am**
14	**Committee Reports:** *Paper* **a. People and Culture** **b. Finance and Performance** **c. Quality, Safety and Improvement**	For **Assurance**	Committee Chair	**11:30pm**
15	**Medicine Improvement Plan** *Paper*	For **Noting**	Medical Director / Quality, Safety and Improvement Committee Chair	
16	**Maternity Improvement Plan** *Paper*	For **Noting**	COO – Acute Services, Quality,	

			Safety and Improvement Committee Chair	
17	**Integrated Health and Care System Proposals** *Presentation*	For **Information**	Associate Director Health Policy	**11:40am**
18	**Pharmacy Improvement Plan – Prioritised Actions and Culture** *Paper*	For **Discussion**	Medical Director	**12noon**
19	**Board Assurance Framework** *Paper*		Chair / Board Secretary	**12:10pm**
20	**Board Performance Review** *Verbal*		Chair / Board Secretary	
QUESTIONS FROM THE PUBLIC (Relating to Agenda Items Only)				
	Questions		Chair	**12:15pm**
	MEETING CLOSE **Date of next meeting**: Thursday 30 January 2025			**12:30pm**

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

Health and Community Services

Date: 26 September 2024	**Time:** 9:30am – 12:30pm	**Venue:** The Grand Suite, Jersey Grand Hotel, Esplanade, St Helier, JE2 3QA

Non-Executive Board Members (Voting):		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
David Keen	Non-Executive Director (TEAMS)	**DK**
Executive Board Members (Voting):		
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social care and Community Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Mark Queree	Deputy Head of Finance Business Partnering	**MQ**
Patricia Winchester	Chief Executive – My Voice Jersey (Item 7 only)	**PW**
Mike Palfreman	Chief Executive Officer – Jersey Hospice Care (Item 7 only)	**MP**
Chris Shelton	Chief Operating Officer – LV Care Group (Item 7 only)	**CSh**

1	**Welcome and Apologies**	**Action**

CD welcomed all to the meeting.

Apologies received from:

Dame Clare Gerada DBE	Non-Executive Director	CG
Obi Hasan	Head of Strategic Finance HCS	OH

2	**Declarations of Interest**	**Action**

No declarations.

3	**Minutes of the Previous Meeting**	**Action**

The minutes of the previous meeting, 25 July 2024, were agreed as accurate.

4	**Matters Arising and Action Tracker**	**Action**

No items identified for discussion at this meeting.

5	**Chair's Introductions**	**Action**

CD introduced David Keen as the recently appointed Non-Executive Director for Strategic Finance.

CD advised those present that today is CBs last Board meeting before a period of leave for an elective procedure. CB started working for the Government of Jersey as part of the turnaround

team in January 2023 and interim Chief Officer from April 2024. On behalf of the Non-Executive Directors, CD thanked CB for his help, support and kindness during his tenure.

On behalf of the Executive Directors, PA thanked CB, noting that he started in HCS at a difficult time but was leaving when HCS had an opportunity to spring forward, largely due to CBs leadership. The Executive Directors are grateful for his unwavering support and good humour (even through trying times) and wished CB a speedy recovery. All looking forward to having the opportunity to meet with CB when he returns in an advisory capacity.

CB thanked CD and PA for their kind words. In addition, CB advised that the following message will be communicated across HCS today,

"Mr Patrick Armstrong MBE has decided after five years in the role to stand down as our Medical Director as of 1 January 2025 to focus on full time clinical duties (orthopaedic surgeon). We will therefore start the process of recruiting a replacement with the Jersey Appointments Commission (JAC). I would like to thank PA on behalf of the Board for his dedication, commitment to patient safety, high standards of clinical governance and his integrity in addressing often very difficult and controversial issues during his appointment. We should also recognise his strong leadership during the pandemic for which he was recognised the award of an MBE. I and all the Board wish PA every success in this transition back to full time clinical practice".

CD also thanked PA and wished him all the best returning to clinical practice.

6	**Chief Officer Report**	**Action**

CB took the paper as read which provides a summary of key activities for Health and Community Services (HCS), an overview of HCS' performance since the last Board meeting, and a summary of key issues, some of which are presented in more detail through the relevant board papers.

Regarding leadership training (Cohen Brown), TH noted this is a good initiative and asked how this is progressing and how many more individuals will be attending? CB replied that there has been good representation across all tiers of leadership in HCS at each session, but the programme has now concluded. CP specified that 48 members of staff from HCS have attended, including the Executive Team and senior leaders; feedback has been positive. HCS have enquired as to whether the programme will continue as this is a GoJ led initiative.

Noting the community engagement events held by the Learning Disability (LD) service, TH advised that he spent a fantastic morning yesterday with staff and service users visiting Pine Ridge, Maison Jubilee, Klondyke and a further site. The LD service is very impressive and is comparable to some of the best services that TH has seen in local authorities / NHS environments – not only for the quality of facilities but more importantly, the highly personalised nature of the support provided by fantastic staff. CD responded that herself and JG had done a similar visit in June 2024 and echoed TH's assessment of the service.

CD asked CB / PA for an update regarding rheumatology. PA responded that the review of 2019 to-date cohort of deceased patients continues, of which there are 217. Of the 217, all those under the care of rheumatology services will be reviewed further. Of the 217, 67 are still to be reviewed. Of the 150 reviewed so far, 34 have been referred to the Viscount. The aim is to conclude the review of this cohort by end December 2024 / early 2025. Following this, deaths from previous years (prior to 2018) will commence. CB reminded the Board that the Viscount requested the extension to review deceased patients back as far as possible. CD asked if there is a timescale which the Viscount is working to, recognising that this process could take a long time. PA responded it is likely that this will take a long period due to the processes involved and the changes in medical leadership have been made in recognition of this i.e. Dr Noon released to focus on this. The length of time could also depend on any actions that both the Viscount and Police wish to take. Whilst it may take a long time, HCS has a duty to answer any concerns raised by patients and / or their families.

Noting there has been no cases of C. Difficile, MRSA and MSSA, CD highlighted this is an amazing achievement, particularly as infection control rates are deteriorating in the NHS; all staff should be applauded.

All other items are presented in detail through papers on this morning's agenda and will be addressed at the relevant time.

CD thanked CB for his report and his support and hard work whilst working as interim Chief Officer.

7	Partnerships in the Health and Social Care System	Action

CD welcomed the following to today's meeting,

- Chris Shelton - Chief Operating Officer – LV Care Group (Listening Lounge)
- Mike Palfreman – Chief Executive Officer, Jersey Hospice Care
- Patricia Winchester – Chief Executive, My Voice Jersey

CD explained that the proposed Jersey Care Commission (JCC) standards include how HCS works with partners. Three partners have been invited to present for five minutes to discuss,

1. What do you value about the current system?
2. What could be improved in the system to improve benefit to service-users?
3. How can HCS / partners work better together for the benefit of Jersy residents?

My Voice Jersey
PW presented a series of slides including an overview of My Voice and the service provided (addendum to these minutes). Key themes are,

- Commissioning process described as fair and equitable, based on services provided (rather than who you know), flexible, ensuring accountability and facilitates moving forward together.
- Needs to address balance of risk due to inflation (not receiving inflation uplift).
- Financial reserves: disproportionate amount of time is spent negotiating finances which detracts from service development
- Need to consider economies of scale – IT requirements, human resource requirements, insurance.

CD thanked PW for the excellent and informative presentation.

Jersey Hospice Care (JHC)
MP provided a verbal presentation and advised that he has been in post for three years and during this time has been working with GOJ on the development of the first Palliative Care and End of Life Care (EOL) Strategy for Jersey. This strategy has been borne out of real collaboration and partnership with parts of GoJ, including an excellent relationship with the HCS Associate Director of Improvement and Innovation and her team.

The strategy has necessitated additional funding for EOL care and has also provided JHC with the opportunity for additional funding for existing services which were previously poorly funded by GoJ. This provides more sustainability for JHC. New services are being developed to further expand the strategy and anticipate that a 3-year contract where GoJ funding will amount to 44% of total service costs will be in place. This is a better balance than the previous 18% of GoJ funding. JHC will fund 56% through fund raising and retail activities. For every £1 invested by GOJ, there is > £2 value for an essential health service.

The success of the strategy is critical, particularly with the introduction of Assisted Dying and the need to provide a high-quality alternative. The partnership has been flexible with debate and negotiation regarding targets and key performance indicators (KPIs). It has been part of a detailed planning exercise with other stakeholders on the EOL Partnership Group and reflects genuine partnership.

However, there needs to be consistency in the process particularly regarding inflation. JHC bore the cost of inflation as this was not included in previous contracts. Inflation is now covered for JHC but this needs to be consistent across the voluntary and third sector; it is unfair and inappropriate to expect these to cover inflation.

LV Care Group - Listening Lounge (LL)
CSh provided a verbal presentation and explained that the Listening Lounge began as a pilot in 2019 and was a collaborative piece of work with GoJ following identification of a gap in the market for early intervention in mental health. The service was launched successfully with clear, measurable outcomes and relieved pressure on Jersey Talking Therapies (JTT). Key points,

- The pilot (initially 1 year) has recently concluded and been through a full tender process. Again, this was felt to be very collaborative. LL approach is to be open and transparent, understand what is achievable, and the funding available to make this happen.

- Rising inflation posed a challenge to deliver same quality of service. However, the current experience is positive and facilitates building trust. The newly designed LL is slimmed down but not in terms of impact. LV is a Jersey Company founded by Islanders who have a desire to invest in the health of Islanders and improve their quality of life.

- Private sector is highly motivated with ethical people (as is GOJ) and there should be more trust between partners.

- KPIs and outcomes: there is a lot more that can be done to collate holistic data for the Island. The current data is small and could be so much better; this is a lost opportunity as there is potential for smarter working.

- Consistent messaging to facilitate planning. LV has invested over £60m in Jersey. If GOJ is looking for commercial entities to commit large sums of monies (as an example, LV has a large dementia facility that has received planning approval (cost of £35m) strengthened partnership are required to provide these entities with more confidence.

- Communication and mutual respect. Sometimes a feeling of 'them and us' but need to recognise that all partners have good ideas and valid opinions. There needs to be more collaboration and openness to achieve mutually agreeable outcomes.

CD stated the presentations were exceptional particularly referencing the choice of organisations to attend in terms of scale, type and funding model (private, wholly GoJ funded, partially GoJ funded). However, despite the difference between the organisations, there are consistent themes including inflation, consistency and fairness and trust.

CD commented that governments should not interfere in other sectors and there should be more collaboration. How to better collaborate and share to make better use of resource on a small Island is a worthy discussion that GoJ should either partner or lead.

Addressing CSh point regarding confidence, CD in agreement that any investment requires a return and therefore commercial entities need to be confident. As an example, the prior discussion regarding market intervention to allow private / community sector to flourish or direct provision, this requires direct and trusting conversations.

CD noted that the issue of inflation needs to be considered by the Board.

AM / AW invited to comment.

AM thanked PW, MP and CSh for attending and the feedback provided very much reflects the thoughts of the Associate Director of Improvement and Innovation and wider team. The process has been challenging but developed well over time. HCS is commissioning from a variety of providers of variable size and moving towards much more partnership work using partner expertise in service design. This is an exciting time to do more for the Island.

AM acknowledged the issue of inflation, and this requires further thought; it is also an internal issue for HCS. CD suggested that whilst consistency has been stressed as important, inflation may need to be approached differently depending on the size / scale of the provider.

AM signposted the Board to the paper on wider partnership working which provides context and update regarding JCC standards. In addition, it demonstrated the breadth of partnership working including Guernsey and the / UK.

AW thanked PW, MP and CSh and their openness regarding their experience, particularly the challenges. During AWs 2.5-year tenure to-date, the partnership board took time to launch and there have been inherent tensions around collaboration versus competition. A characteristic of some of the best partnerships now is the ability to have significant difference of view. AW reflected that he regularly disagrees with Police and a negotiation is required to navigate this, however, the end point is reached as a result of open honest dialogue.

DK noted this was a really interesting conversation, particularly as new to the health system. The issues struck a chord with a lot of issues seen in the private sector in the UK and are not unique to Jersey. Strengthening shared services and efficient implementation of shared service and partnerships is crucial moving forward. DK also noted the issue of inflation and there is little that can be done to negate the impact on partners.

MP advised that himself and PW belong to a group of charity CEO on Island that meet regularly and was keen to stress that their views today are not representative of all partners. CD sought to reassure MP / PW / CSh that this was understood, and they had not been invited to the Board to represent anyone but themselves.

CB thanked PW, MP and CSh and spoke about the importance of good commissioning rather than contracting and building relationships is critical and requires equal contribution from both parties. Despite challenges, it is working to ensure good outcomes for service users. CB was sympathetic to CSh's point regarding confidence and stated that the annual budget setting process provides little certainty for commercial entities, particularly in the long term. Regarding inflation there are also levels imposed on HCS (tertiary care providers) that exceed the inflationary uplift provided to HCS. CB concluded by recognising that the process may not be perfect across the Island and requires further work.

CD concluded this item has been of great value to the Board. Whilst the three partners were not considered representative of the Island, there is no doubt that those who do not have such a positive relationship, would have raised the same concerns. Whilst partners take out what they put in, HCS must continue to commit to listening constructively to partners and demonstrate collaborative behaviour.

8	**Finance Report Month 8 – August 2024**	**Action**

MQ, Deputy Head of Finance Business Partnering, introduced himself and advised the Board that he is in attendance on behalf of OH (see apologies).

Paper taken as read with following key highlights,

FY24 Month 8 Finance Position

- The Financial position for YTD Month 8 is an £18.9m deficit vs budget giving a headline monthly run-rate of £2.4m.

Underlying position and Run-rate

- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £2.2m.

FY24 year-end forecast

The current reported FY24 year-end forecast is £24m. However, this is after delivery of an additional £5.3m of savings that are required, over and above the FRP savings, to mitigate against further cost pressures identified and contain the overspend to the mandated £24.2m deficit funding. Without delivery of these additional mitigating savings the underlying forecast deficit is £29.5m. The £5.3m cost pressures for which additional savings are required include:

- Loss of income from closure of beds due to staff shortages and historic overbilling of LTCB income which has now been adjusted

- Increased costs of social care packages and mental health placements
- Reduction in surgical income due to loss of accommodation income from increased public activity and conversion of inpatient to day cases
- Increased costs in theatres consumables due to higher public activity but also in both surgical and medical services.
- Overperformance on acute care contracts in the UK, including our largest contract (Southampton) and inflationary impact at Oxford (Cardiology contract with tariff increase from April 2024).
- High-cost drugs pressures.

FRP savings delivery

FRP savings delivery YTD M8 is £5.4m vs £4.2m revised plan, made-up of £3.6m against original schemes and an additional £1.8m of mitigation schemes to recover slippage and additional cost pressures identified.

Forecast savings for FY24 are £7.1m vs plan of £5.2m, over-delivering by £1.9m. However, due to the £5.3m increase in the forecast deficit, a total of £11.9m of savings are required from additional FRP savings and Cobra actions. FRP over-delivery and additional Cobra actions are forecast to deliver £10.3m savings, leaving a further £1.6m of savings to identify. Financial Recovery COBRA group of the Executive Team has been leading delivery of these required savings.

Recovery Actions

Recovery actions being taken include:

- Financial Recovery Actions led by Cobra Executive Team – High impact mitigation actions to deliver £5.3m savings to reduce deficit to £24m. There is a £1.6m gap in the plan with 3-months to close.
- Intensive recovery support working with the Care Groups at the established Support and Challenge Meetings (SCMs)
- Service changes options- a list of options for service changes has been shared with the Advisory Board and MHSS for consideration to eliminate the forecast deficit. If approved this will require a quality impact assessment and a restructuring provision to be made available before implementation.
- Sustainable long-term funding – a paper has been submitted to Treasury and the MHSS for discussion which has been shared with the Advisory Board, making the case for a long-term sustainable funding settlement for HCS.

As Chair of the Finance and Performance Committee yesterday, CD invited JG to comment. JG reiterated that this is a challenging time and finding the savings required will require very hard work, however they must be found as overspend is not an option. This is indicative of the pressure on all heath systems currently with growth in demand. Investing in preventative measures whilst supporting ongoing operations is a challenge.

CD invited comments from DK and DK in agreement with JG's assessment of the current situation. The detail of transparency is good but with only three months to year-end, it is going to be difficult to close the gap. In addition, what is the impact on 2025, particularly as the FRP savings required are greater. CB advised that the 2025 budget setting process has commenced and a key figure will be the exit run-rate from 2024. Any major changes required to find the savings (to deliver £24m) will have an impact on the level (not quality) of service that HCS can provide. However, the FRP savings are positive, particularly the reduction in nursing agency costs which follows successful recruitment.

CD thanked JM for the work to achieve this and stated it highlights that with effort and focus, reducing agency / locum spend can be done. However, many of the pressures are non-pay (social care, contract costs, medicine costs) and HCS has limited ability to control some of these and require longer term strategies to address.

Noting the challenge ahead, CD advised that some difficult (immediate) decisions must be made which will impact provision of services. Reflecting on her other roles in the UK, CD stated this is a challenge in other organisations.

9	Quality and Performance Report Month 8 – August 2024	Action

Acute Services

- **Patients waiting for first outpatient appointment > 52 weeks:** An increase is noted, and this is related to key specialities. Key to note that these are patients waiting for routine appointments. There is confidence that the recovery plan in place for Ophthalmology will see a reduction in the waiting list. The recruitment in gastroenterology provides additional capacity for the end of 2024. The introduction of new software to the Clinical Genetics Service is also expected to yield reduction in the current waits by end 2024.

  The recruitment of a dermatologist will provide much needed capacity, especially as this is an area of higher risk. The Board received a paper at its last meeting describing the long-term plans for the service. An insourcing opportunity is being progressed with support from commercial services and CT confident that this will have a positive impact.

  There is a clinically led weekly PTL process to ensure that urgent patients are prioritised and confident that all urgent patients are seen within timeframe. There is balance to be struck between using the clinical capacity to review patients rather than conduct harm reviews, however, there is confidence that the current process is robust.

- **Patients on elective list > 52 weeks:** The greater the number of patients seen in outpatients, the greater the conversion rate to those waiting for treatment. Urgent patients remain the priority and consequently, those categorised as routine wait longer. A reduction in this cohort could be seen during the first part of 2024 and the slight increase over Q3 is due to loss of theatre capacity for planned annual maintenance.

- **Access to diagnostics:** this is a developing metric and a new monitoring tool. The variance is in line with the data development– monitoring performance and additional types of first diagnostics tests. This metric is used broadly in the UK and includes 15 key diagnostics.

- **New to follow-up:** This is monitored at specialty level. Exploring initiatives to reduce this.

- **Outpatient Did Not Attend (DNA) Rate (Adults only)**: The increase seen this summer is a pressure noted in previous years and is thought to be due to the holiday period. Towards the end of 2024 / beginning of 2025, individuals will be called to book their appointment (rather than receive a letter) – this will provide confidence that the allocated appointment suits the individual and therefore more likely to attend.

- **Elective Theatre Utilisation:** This is slowly improving although there has been on the day pressures due to equipment issues. Loan equipment should help to mitigate this.

- **% patients in the Emergency department > 12 hours:** Increase noted in the number of patients waiting > 12 hours. This is due to the availability of beds. However significant reductions in length of stay (LOS) can be seen in Acute Admission Unit (AAU) and Corbiere Ward.

- **% patients in the ED < / = 4 hours:** This benchmarks well with the UK. However, this will need to be managed through the winter period with a predicted increase in demand.

Noting the refence to patient initiated follow up, CB advised that from his experience, this is an initiative that has worked well elsewhere and asked whether this can be in place during Q1 2025? CT is confident of this and currently working with colleagues in Digital Services to progress this.

Referencing the success of nurse recruitment, CD asked why the recruitment of the Ophthalmologist has been delayed by four months, particularly as this is a pressured specialty. CT explained this is due to individual circumstances and locum staff are supporting in the interim. CD asked what impact this appointment will have if there are already locums in place. CT explained that the locum provides additional capacity and reductions should be seen in the cataract pathway.

Regarding individuals waiting for long periods of time on the waiting list, CD advised that whilst the Board is reassured that no one is experiencing harm, it would be useful for the Board to understand

how the harm analysis is undertaken (by who, for which specialities, methodology, actions taken and private / public split) to provide complete assurance.

ACTION: The Board to receive a deep dive of the harm review process including who undertakes these, in which specialities, the methodology, the management of those identified at risk or experiencing harm and the public / private split.

- **Delayed Transfers of Care (DTOC):** The DTOC position was lasted reported in detail to the Board in March 2024 and at this time there was an average of 28 individuals delayed. Whilst there has been a deteriorating position since March 2024, thankfully this is not to the extent of summer 2023 (average of 40-50 people delayed). The current position is 31 people delayed (21% of available capacity). The trend and reasons for the trend are significant. Of the 31,

    - 16 people waiting for a nursing home bed (do not need to be in hospital but cannot access a nursing home bed).
    - 6 people are waiting for specialist dementia provision in the community
    - 3 people waiting for a package of care. The discharge team have significantly accelerated access to packages of care and HCS continues to see a reduction in those waiting for home care – this has been helped by the brokerage system introduced with Customer and Local Services (CLS).
    - The remaining are either waiting for home adaptations, waiting for residential care or wait through choice until their preferred placement becomes available (do not accept alternatives).

    There have been bed closures at Sandybrook since October following a flood which required refurbishment. These beds will be opening in the next 2 weeks, providing additional nursing home capacity. However, across the Island there is increased reported reduction of nursing home capacity, particularly due to temporary closures and this is a contributory factor to the overall position. In response to this, a draft Discharge Policy has been developed to address the issue of choice i.e. when individuals choose not to leave the hospital. Work with CLS to look at the whole system (including commissioning and paying for community services) has almost concluded. However, the work to accelerate community care has resulted in a significant overspend on social care placements and packages of care (> £3m).

    Progress has not been made in creating additional specialist dementia care capacity, particularly those with additional complex needs. These individuals are those waiting the longest. Currently work at Rosewood House (St Saviours) which will provide some additional capacity, but this will not be completed until March 2025.

Noting the refence to the importance of a well delivered discharge policy and procedures, TH asked if AW had any thoughts on the capacity of the social work discharge team. AW responded that the capacity of the discharge team has been increased by one social worker and one assistant social worker. AW chairs a weekly meeting to review all those fit and nearly fit to leave the hospital - the current discharge team are able to identify what the issues are, it is the capacity issue that is the problem.

CD noted that in future years, sadly there will be more people with dementia, and it may only be possible to manage this through creating a market as the private and community sector either cannot afford or are not willing to do this themselves. The GoJ may have to intervene to create this as a longer-term objective. A priority of the proposed overarching integrated health and care system should be looking at where the market requires intervention. AW responded that these are actions in the dementia strategy published earlier this year, specifically redesign of the dementia care pathway and longer-term dementia care bed capacity. Support can be given to mainstream nursing homes where possible to manage individuals for longer. However, AW in agreement with CD that reached a point where state provision must be considered for those with most complex needs. Reflecting on the Learning Disability Services, CD stated this is an example of good, successful state provision, and GoJ should not be fearful of replicating this for other services.

CB echoed that market intervention is critical and highlighted the negative impact of DTOC for individuals who remain in hospital unnecessarily.

Mental Health

- **% of referrals to Mental Health Crisis Team assessed in period within 4 hours:** > 90% individuals who present in crisis are being seen face-to-face < 4 hours.

- **% referrals to Mental Health Assessment Team assessed in period within 10 working days**: 87% of all referrals are being seen within 10 working days which is excellent.

- **% adult acute discharges with a face-to-face contact from an appropriate mental health professional within 3 days**: This is an important safety metric for mental health services, and it is pleasing to see this performance sustained.

- **JTT % of clients waiting for assessment who have waited > 90 days:** There is an ever-increasing demand with 150 new referrals received during August 2024. 97% individuals are assessed well within the 90-day KPI but there is a lag on treatment – 43% people are waiting > 18-week standard for treatment. However, this is an improving position and will be sustained by successful recruitment.

- **Dementia Assessment Service**: The waiting time for dementia assessment has now reduced to 53 days, this is a terrific achievement on behalf of the service over recent months. This has reduced to 53 days and is almost within target.

- **Median wait of clients currently waiting for ADHD assessment (days):** This continues to rise and there is a specific paper later in this meeting (agenda item 12).

- **Access to specialist tertiary psychological therapies**: Whilst not included in this report, the waiting list for this is increasing and is predominantly due to vacancies where 50% of posts are vacant. However, active recruitment is underway which if successful will improve the current position.

- The LD service have done well to recover the position regarding those who have an annual health check. The social work team continue to exceed the performance target regarding assessments completed and authorised within three weeks.

CS drew the Boards attention to the maternity dashboard and the improvements made in access to service, timely intervention and outcomes for mothers and children. This is very different from last year and commended the work of staff in embedding these improvements. CD echoed the significant improvements in this area and congratulated all staff involved in this effort, noting it is team effort.

Quality indicators covered in the Chief Officer Report (agenda item 6).

Comfort Break

10	Workforce Report Month 8 – August 2024	Action

CD asked the Board to note that this report follows a differs format from previously and confirmed that ITe would share the reasons for this.

Before discussing the paper, ITe sought to highlight that there has been significant absence from key members of staff and acknowledged the support of the HCS Executive Directors and Chief People Officer GOJ for their support provided during this difficult time.

Secondly, ITe highlighted the relationship between nursing and HR in achieving the success in recruitment.

The workforce report was withdrawn from the previous Board meeting for a number of reasons. Firstly, ITe was relatively new in post and not had ample opportunity to undertake the due diligence on the data. Secondly, ITe wanted to avoid issuing a report with incorrect data (as previously).

This is the first report of what is anticipated will be an improvement in workforce data. The People Committee also receives this data. The main changes include the format (now a dashboard report), and it provides more information regarding where the data is derived from and what it means (data labels). Caveats include that the data is drawn from multiple sources, and this introduces risk of error, also discrepancies continue to exist between the finance and people ledgers – HR and finance continue to work to reconcile these.

New starters
This reflects the high level of recruitment since mid-2024. The decrease in August represents leave. Unfortunately, time to recruit has increased in 2024 compared to 2023 and this is thought to be due to the difference in the type of recruitment. Internal recruitment was the feature of 2023 whereas in 2024, much of the recruitment is external and this takes longer (DBS etc.). Whilst the metric has increased, this is in fact positive news.

Vacancies
The reduction in vacancies reflects the work in recruitment.

Turnover
Currently not able to express turnover specifically in HCS as the Connect system is GOJ wide and records the data as such. Working with business intelligence to establish HCS specific turnover.

Sickness
Sickness currently at approximately 6% and whilst this is not of specific concern, it will be continuously monitored. A review of all staff with long terms sickness has been undertaken, working with line managers to ensure that staff are properly supported.

Staff costs
The overtime spend is reducing in year but remains higher than previous years. The increase in basic pay reflects the increase in recruitment with the offset of reduction in agency spend. Reduction in agency spend has been significant and positively, many agency staff are looking to convert to a substantive contract.

Zero hours
Zero hours relates to bank staff, most of which are currently employed by HCS and do extra hours. However, there are staff that chose only to have a bank contract.

Connected performance
This relates to objective setting and mid-year reviews recorded on the Connect system. Completion rates are low and is an area that HCS needs to focus on. Contributory factors include competency in using the system and manager compliance.

My Welcome
My Welcome is the GOJ induction, rather than HCS specific induction. Work is needed to gather data regarding HCS and service-based induction.

A workshop has been held with representatives from other GOJ departments to review the data currently available and a series of workstreams developed to explore different data sets. As these workstreams deliver, this report will improve regarding the depth and breadth of information. This is not only important for the Board for assurance but also reporting at directorate and care group level, so managers are provided with the required information to allow them to manage operationally.

CD advised that there had been in depth discussions on the same report at the People and Culture Committee meeting yesterday. However, CD sought to highlight that this is the first time that the Board has received this quality of information and whilst there is still work to do, thanked ITe for the work involved in this.

CD described the data relating to appraisal as alarming, although recognised there may be staff having appropriate development / performance conversations and not recording them in the system, However, of the 19.3% staff that have completed the mid-year review, only 7.4% of managers have effectively responded to this. HCS must focus on improving this statistic. In

addition, the nursing appraisal data is very good, therefore this means that other areas are very poor.

In conclusion, whilst the system / administration of recording appraisal may be difficult, this does not mean that people are not having the appropriate conversations, however, there is no evidence to say they are.

CB in agreement and stated that Connect is the system to use (despite any difficulties) and the appraisal conversations must be recorded here. Difficulties in the Connect system were discussed and include competency and the inappropriateness for a clinical appraisal. Recognising that an appraisal process for the civil service is probably not appropriate for clinicians, the system should be flexible enough to allow for this difference. However, overall HCS must be improve.

PA confirmed that Doctors are not appraised through Connect system and use a different system due to regulatory requirements for revalidation. However, CD emphasised that when appraisal is a regulatory requirement, it is completed.

AW highlighted that 25.8% have completed the mid-year review and whilst cold comfort, this figure is 25.8% + 8%. AW supports receiving a more detailed report as reports for his portfolio indicate that managers are at 75-80% compliance.

ITe clarified that the Connect Performance data does exclude doctors but also manual workers (contract does not require them to have an appraisal). ITe confirmed he has requested reports that provide data at care group and service level, and this is underway. CD asked how manual workers have a development discussion with their line manager and ITe suggested they do not as this is a contractual arrangement. CD recognised that whilst it may be contractual, it is not contractual that they do not receive care from their line managers. ITe recognised that he is new to the manual workers contracts and in discussion with union representation and leaders of these staff groups, anything that looks like it may be an appraisal conversation is declined. CD asked whether they receive any development opportunities and ITe responded that they do but it will be carried out in an ad-hoc manner. CT sought to reassure that whilst there is no formal system, there is evidence of members of this staff group developing, having access to courses and progressing.

CD concluded that the report is moving in the right direction and thanked ITe.

11	**Out of Hospital Health and Care Services**	**Action**

Paper noted. TH advised that is an important issue for the Board, particularly regarding individuals receiving care in the right place and asked AW for an update on the work with Customer and Local Services (CLS).

AW advised the Board that there is a piece of ongoing work led by CLS to review arrangements around care packages, care in the community and how this is funded. HCS has been involved in this work, specifically the Chief Social Worker and it is near to completion. This will support thinking regarding standardised rates, need, and arrangements moving forward. However, on occasions, HCS could purchase much more expensive for individuals, but this would set a precedent around rate and manging demand which creates tension for HCS manging its own financial sustainability.

AW referenced earlier discussions regarding the work that needs to happen in terms of stimulating the market, particularly stimulating the market for the right group of people. For example, sometimes there are beds available, but they will not accept the people who need beds i.e. there is a clear unmet need for those with dementia and complex needs. This links a number of conversations that have taken previously at this Board morning and HCS needs to be clear about what it needs, how this is commissioned and how we engage with the market in delivery that is affordable.

12	**Neurodevelopmental Services Update – Attention Deficit Hyperactivity Disorder (ADHD) and Autism**	**Action**

Paper noted for information.

Firstly, TH asked if there is any work in other healthcare jurisdictions that could benefit Jersey and secondly, stated that updates on the work taking place regarding prescription of ADHD medication, potential joint working with private provider, introduction of electronic self-assessment tool and development of sessions with GP with special interest would be useful.

AW responded that regarding other jurisdictions, there has been a recent article in the Health Service Journal indicating waiting times of 7 years for outstanding mental health organisations with a longest NHS wait of 10 years (for an ADHD assessment). This is to emphasise the point that this is an international issue and Jersey is therefore in competition with all providers elsewhere who are seeking to solve this issue. For example, recruitment and specialist skill acquisition, there are many seeking to do this, making it more difficult. There is a piece of work being commissioned by NHS England, led by the Royal College of Psychiatrists exploring what can be done to address the ADHD waiting lists and AW pleased to report that the HCS ADHD Consultant is engaged with this work.

The issue of shared care remains unresolved. HCS could seek to commission private providers to undertake assessments (already being done in some areas in the UK). However, if HCS does this, there will be a consequential rise in the number of ADHD prescriptions required and there is no capacity to do this. Currently have 254 individuals who require monthly prescribing, and this has been worsened by the international shortage of ADHD medication. In conclusion, there is no easy solution. HCS will continue to work on the shared care arrangements as this would release capacity for the specialists to undertake assessments and provide specialist advice (rather than repeatedly write prescriptions). There is also a scrutiny review of the ADHD prescribing arrangement and HCS will await the outcome of this. HCS is also in conversation with a potential provider with an electronic self-assessment tool, but this is in very early stages.

13	**Board Committee Report**	**Action**

The People and Culture Committee and Finance and Performance Committee took place yesterday (25th Sept) and a written report will be provided at the Board meeting in November 2024.

Quality, Safety and Improvement
As Deputy Chair, TH raised the following from the meeting (in absence of the Chair, Dame Clare Gerada).

- Significant reduction in **pressure trauma** acquired in care which evidences real improvement.
- **Serious Incidents**: all open SIs have allocated investigators. Cross cutting themes have been identified from a review of multiple recommendations and where appropriate, recommendations are incorporated into improvement plans.
- **Central Alert System (CAS) Alerts**: The Committee is aware of the large number of overdue alerts currently but received assurance that the alerts are triaged on receipt and there are no serious issues not being addressed. PA advised that some temporary capacity has been allocated to this and significant progress has been made in addressing the backlog. Work is required to secure permanent resource to manage this.
- **Policies**: Approximately 50% of HCS policies are overdue for review and this is becoming a regulatory issue within Learning Disability (LD) Services. LD services are receiving recommendations for improvement as corporate policies are out of date.
- **Absence of a paediatrically qualified Designated Doctor:** JM explained that whilst the current Designated Doctor for Safeguarding is not paediatrically qualified, he does have the qualifications to undertake the role. Therefore, Jersey does have this role in place within safeguarding.
- **CAMHS Service**: There are currently 140 children held by CAMHS who should have transferred into adult ADHD services.
- **Pharmacy review** – makes recommendations which relate to Island wide issues and require other GOJ departments to engage in enacting change. Committee thanked those individuals in pharmacy that had the courage to speak up.

14	**Jersey General Hospital Pharmacy (External) Review: Update and Action Plan**	**Action**

CD explained that whilst this report has been published publicly, this is the first opportunity to review the action plan.

PA took the papers as read. The action plan continues to evolve, specifically how HCS will allocate resources to deliver the work. Culture work has already started. The structure of pharmacy will be reviewed as part of this work as the report commented on the difficulties of fulfilling the strategic / governance aspects of the service and the operational service within the current structure. Unique to Jersey, pharmacy has a regulatory function outside HCS i.e. the Chief Pharmacist is responsible for inspection of community pharmacies, responsibilities regarding medicines law and regulation and licensing within cannabis industry. The HCS SLT will be receiving a paper in the near future for a decision regarding proposed structural change. Regular updates will be provided to the Board.

TH commented the action plan is comprehensive and noting the reference to challenges in terms of resources to address the recommended improvements, sought assurance that the action plan will deliver. Noting that 59 recommendations were made, CD emphasised that the Board would need to receive assurance on the implementation / outcomes of the action plan and suggested that HCS concentrates on the recommendations that will make the most difference (taking into account the other review and action plans).

Regarding resources CB stated that the budget setting process for 2025 will need to consider whether HCS can implement some of the actions as they are unaffordable. The EPMA system has led to improvements in quality and safety. The recommendations may need to be prioritised.

PA highlighted that the approach to publishing this plan has differed from previously and the action plan would normally be developed before the report is made public. Consequently, HCS is unable to provide all the answers about how it will prioritise and proceed with implementation of the action plan. CD suggested it would be useful for the Board to receive the prioritised list of actions in November 2024 and in six months' time, receive the monitoring against the prioritised list. Noting the number of recommendations coming from all the reports, CD suggested a prioritisation approach is required for all.

ACTION: The Board to receive the prioritised list of actions in November 2024 and in six months' time, receive the monitoring against the prioritised list.

ITe advised the Board that progress has started regarding the structural changes and the required HR processes are being followed. Regarding weekend working (of pharmacists), ITe reminded the Board that pharmacists are on civil servant terms and conditions and there is no contractual requirement to work weekends – currently this is done out of good will. CD suggested that contractual adjustments may be required. ITe advised that he is in discussion with the Chief People Officer about how the States Employment Board (SEB) could support HCS to look at terms and conditions however, the renegotiation of a significant contract is a large piece of work. The Consultant contract is scheduled for renegotiation next year.

15	**Royal National Orthopaedic Hospital / Getting It Right First Time (GIRFT) Report and Action Plan**	**Action**

PA took the paper as read and explained that GIRFT are a nationally recognised programme running for over 20 years to help organisations improve productivity and efficiency (which in turn leads to safer care). The report made 36 recommendations which sit with the care group to deliver and embed as business as usual. GIRFT will continue to provide support and will return to evaluate progress made. PA is looking forward to being part of this and delivering some of the changes in the New Year.

Whilst there is no confirmed plan, HCS will ask GIRFT to review other services.

CB clarified that this review was not commissioned due to any concerns regarding quality of care. GIRFT is concerned with improving productivity, use of resources and efficiencies.

PA also asked the Board to note two areas of clarification. Firstly, there was a misunderstanding from the report that the MRI scanner does not have the capability to detect prostate cancer. It does, rather that HCS does not screen for prostate cancer. Secondly, the report incorrectly suggests high

levels performance management in CSSD, this should have stated sickness management. These are very different, and an apology has been made to CSSD for this error. CD noted there are many positives in the report, and it also provided solutions and different ways of working, specifically a review of contracts to remove any limitations to weekend / out of hours working. Regarding theatre utilisation and public / private work, CD stated that HCS must ensure that public patients are not deprioritised for private work, despite intention to maximise private productivity. TH reflected that it is worth emphasising that good organisations encourage reviews of its services.	

16	Board Assurance Framework	Action
Paper taken as read. EOC advised that following the most recent cycle of senior meetings and committees the levels of risk are, • Quality and safety remains at 20 • Patient experience remains at 8 • Operational performance (access) remains 20 • Finance increased to 25. • People and Culture: the People and Culture Committee concluded that the risk is higher than stated but this will be reviewed, along with the actions by the Director of Workforce.		

17	Declaration of Interest	Action
For information		

18	Questions from the Public	Action
Member A *"At the HCS Advisory Board meeting held on 30th May 2024, and subsequently captured in the published minutes on page 11, a member of the public asked if a zero-tolerance approach would be adopted for bullying, either generally and/or of whistleblowers, as it had already been publicly stated would be applied for instances of racism. Chris Bown "confirmed that HCS has a zero-tolerance of bullying". He continued with the following statement: "there must be evidence of bullying and upon investigation, it is not always the case that bullying has occurred".* *His last sentence is perfectly understandable, however, if, following the completion of an independent investigation executed in alignment with the applicable policy, certain and specific allegations of bullying are indeed upheld and fully substantiated, then what does the application of zero-tolerance actually mean in practice?* *If your interpretation of zero-tolerance does not support a 'one strike and you're out' approach, then what lesser approach is applied to the guilty employee, and does the Board believe that the cessation, preferably, or curtailment, the next best outcome, of bullying and harassment will be adversely impacted and diluted if confirmed bullies are allowed to continue benefitting from their employment with the Government of Jersey, and not seen to have been suitably disciplined and penalised whatsoever due to the fact that any actions recommended as part of the investigation are required, in accordance with the policy, to be kept confidential?* *That sounds to me very much like the bully winning again! It is absolutely imperative that when allegations of bullying are substantiated following the completion of either an internal or external investigation, suitable and swift action must not only be done, but must also be seen to be done."* **Response** CB responded that this appears to relate to matters detailed in email correspondence between CB and member A. Due process will take place and CB stated he is committed to this. The process and outcome of any investigation is reviewed by a disciplinary panel and the process will be followed through. CB stated he does not intend and never will discuss individuals publicly.		

CD thanked member A for the question and noted that the original question was asked by another member of the public and was answered by CB at the time. In terms of the wider implications, CD confirmed that the Board holds the view that bullying is inappropriate, unacceptable and harms performance. CD noted that CB has advised that due process will now follow, and this is required legally i.e. there must be an internal process between the employer and employee which will take place.

Member B (in writing)
CD stated that an email has been received this morning from an individual who cannot be here in person as is in hospital and asked for the statement to be read out.

"I would have attended your meeting at 09.30 today, were I not temporarily in the General so please can you use this email to put before the board today? Thank you!

Please use this email of my direct experience over the last 3 weeks to bring around change. Effective communication is essential and does not cost anything, but could this problem be as a result of pressure on your administrators as well as caring staff? Anyway, it does not need more money, just attention to the job in hand and training.

I have currently been at the General Hospital in Beauport Ward and now Plemont Ward, following a fall and under observation since Wednesday 4/9/24. I have had plenty of opportunity to observe how management of the Hospital operates and its part in bed blocking.

Firstly, I must give credit to extraordinary care and compassion I and my "roommates" have without fail received from the caring staff. They deserve every penny and more of their wages. The pressure they are under from not only the amount of work over long hours, but emotionally, cannot be under-estimated.

However as for Administration, the left hand does not know what the right is doing and that, from my observations has been a factor leading to the current bed-blocking of the 32 beds. I have not seen that listed as a contributory factor so far.

Example 1:
Last week, I was due to have an MRI scan "tomorrow": no timing or any indication of AM or PM, but I'm not going anywhere.

I did not dress that day as it is difficult for me and anyway, I needed to ensure I was not wearing metal, so no need to dress. I waited from 08.00 in anticipation until 12.15 when I dressed as I did not want to be in my nightie at lunch time. At 13.15 I was told I would have the scan at 14.00. So, I undressed (as usual with difficulty but I did not want to add to the staff's busy day and anyway I could do it myself). The porters came with a trolley at 13.45 when the junior doctor who had been in the ward all morning realised he had not inserted a cannula in me. This took 15-20 minutes. He could have done that at any time during the morning at leisure and not under pressure from the busy porters who chivvied him on. When we got to MRI, I was told they had been waiting for me and had been available earlier on, so their expertise and 2 porters had been wasted, and timely progress was interrupted.

Example2:
When I arrived on Portlet from Beauport on Saturday 15/9/24, there was a charming, bright roommate, about to be discharged that day. She told me after waiting during the day that they could not discharge as they had not got her prescription to the pharmacy by lunch time when it closed, so her discharge was delayed until Sunday. Everything at home had been arranged. On Sunday she was told the doctor had forgotten to sign her prescription, so she was delayed until a Monday. I don't know what happened on Monday, but she was eventually discharged on Tuesday PM, having been in the bed for an extra 3 1/2 days. Of course, it may be there were other reasons for her delayed discharge, but she was not told that.

Example 3:
Oh yes! Me! After 3 weeks under observation and being told I was due to have conductivity and EMG tests yesterday and setting great store by these tests for many days I was told yesterday morning that the list was too busy to accommodate me. I would be discharged today and wait for

the tests and their results as an outpatient. Why was I not booked in a few days after my arrival here as it was obvious I needed these tests?

So, after 3 weeks of observation at the hospital, I have no diagnosis or prognosis, and my untreated condition has worsened.

I also have observations on end-of-life care and am now a signed-up member of Assisted Dying, but I will keep that for another day, but please let me know if you want to share in the experience.

And of course, there was also someone denied the care that comes from my hospital bed!

Noting the poor coordination between different parts of the hospital, CD advised that the process should be agreed at day one and timetabled accordingly to expediate discharge. CD thanked member B for sharing her experience and highlighting these issues, noting it was written well and kindly. However, member B undoubtedly deserves an apology for her experience and JM will make contact with member B.

Member C
Following member B's experience, member C stated,

- She has been pointing the communication issues between departments for years.
- Member C also advised the Board that she is currently undergoing various investigations but will not receive results until December.
- Doubts data presented.
- Has a friend with a six-year-old son who broke his arm in two places and alleged that they waited for four hours in ED reception on a Friday night (not children's waiting room).

CT confirmed there is a paediatric area available in the ED and whilst there are more people being seen within 4 hours, there are also people who are not seen within 4 hours. However, work continues to reduce this as quickly as possible. CT offered support to individuals concerned to learn from their experience of care.

Whilst follow up is booked for December, CT stated she would not expect that member c would have to wait this long for the test results. Again, CT happy to discuss further with member c.

Member C suggested that these issues were only being reviewed as they were raised at the Board and stated that there must be similar experiences for others. CD reminded member c of the previous discussion (item 9) and the request for a deep dive regarding the prioritisation of the waiting lists. CD concluded these were points well made by member c and they reflect issues raised by member b.

	MEETING CLOSE	**Action**
CD thanked all for their participation in the meeting. Thanks were conveyed to CB for his work and contributions to HCS and looking forward to working with CB in his advisory capacity. CD also reiterated her thanks and best wishes to PA. **Date of next meeting:** Thursday 28th November 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	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	Sept 2024 ~~May 2024~~ ~~Feb 2024~~ ~~December 2023~~ ~~01/10/2023~~	25 July 2024 - OH advised this is not complete, feedback has been provided to the central team. There is still no confirmed date when budget holders will have access to budgetary information (through the Connect System). Remain OPEN. Update 28 March 2024 OH advised that Treasury have confirmed that budget holders should have access to the budget data by end April 2024. Remain OPEN. Update 6 Dec 2023 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. Update 4 October 2023 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			OPEN

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Feedback on issues raised at the previous HCS Advisory Board meeting – externally commissioned providers**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**4a**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation
Report Author:	Emma Polhill, Head of Transformation, Commissioning and Partnerships

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides the Health and Community Services (HCS) Advisory Board with an update from HCS Senior Leadership Team (SLT) following direction from the Chair at the meeting on 26 September 2024 to consider the impact of inflation on externally commissioned services.			
Summary of Key Messages:	The key message arising from this report is: HCS SLT agreed in principle to pass on non-pay inflationary funding received by HCS to contracted providers, subject to States Assembly approval of the proposed Government Budget 2025-28 and HCS budget setting agreement.			
Recommendations:	**The Board is asked to note the discussion and agreement in principle taken at HCS SLT in response to the matter raised at the last Board meeting.**			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	
Effective		SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	**x**
Responsive		SR 4 – People and Culture	
Well Led	**x**	SR 5 – Finance	**x**

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
HCS Senior Leadership Team	14 November 2024	Approved in principle

List of Appendices:
Nil

Health and Community Services

MAIN REPORT

Background:

Three providers (Jersey Hospice Care, My Voice and LV Care Group) were invited to present at the HCS Advisory Board Meeting on 26 September 2024 to share their experiences of commissioning processes and overall systems working. Whilst commissioning processes and partnership working were generally seen as positive, all three providers raised that inflation remains a challenge for them, particularly charities.

The Board agreed that the HCS commissioning team would review the position on inflationary uplifts and report back to the Board.

The commissioning team brought the topic for discussion to HCS SLT who recognised the challenges externally commissioned providers, in particular charities, are facing and acknowledged the valuable services those providers offer Islanders and the positive impact they are having on the overall health and care system.

In 2024, an inflationary uplift was added for some externally commissioned providers where no other arrangements for pay increase or increase in overall contract were applicable, however, it is recognised that this was less than what general inflation has been over recent years whilst external providers continued or even increased with their activity levels. The additional difficulties in raising charitable funds due to the overall economic position has contributed to this challenging position for charities.

HCS has also seen unprecedented cost pressures over the last years with a considerable forecast overspend for 2024 and key priority will be to provide services and maintain costs within the set budget for 2025. This will require HCS services to prioritise available resources and focus on opportunities for partnership working with the aim to maintain or increase capacity for health and care services whilst using funds in most efficient way.

Proposal to mitigate inflationary pressure for externally commissioned providers in 2025

In response to the Board discussions, HCS SLT considered the issue of inflation, and agreed in principle to the application of an inflationary non-pay uplift of 1.7% to externally commissioned providers in 2025 subject to States Assembly approval of the proposed Government Budget 2025-28 and the HCS budget setting agreement. Final confirmation of the position will be communicated to providers by end of the year.

Rationale:

An inflationary non-pay uplift of 1.7% for HCS services is currently included in the proposed Budget 2025-2028 (P.51/2024). Applying this to externally commissioned services supports an equal approach across the health and care system.

Charitable organisations provide good value for money as they part fund some services and provide in kind contributions. Passing on non-pay uplifts as received by HCS would support externally commissioned providers and contribute to the mitigation of inflationary cost pressures.

Sustainability of services

In view of the non-pay inflation increase being less than general inflation, to mitigate risk longer term with regards to externally commissioned services from charities, the Commissioning and Partnerships Team will review how externally provided services are budgeted from 2026 onwards and will discuss this at the Cross Government Commissioning Group to ensure a joined-up approach across Government departments. This would provide providers with a more consistent approach across Government commissioners and increase overall transparency and the ability for long-term planning.

The outcome of the discussion is expected to be shared with HCS SLT in Q2 2025 for inclusion in 2026 budget planning.

To ensure early sight of any financial challenges a provider may have that could impact on their ability to continue with the delivery of commissioned services, the Commissioning and Partnerships Team is keen to work with providers to support them in reviewing their operating model and financial position in relation to their whole business model rather than just the contracted activity. The recent experience of provider bankruptcy has provided valuable insights and learning points and the team is offering to share their expertise and support to external providers.

Summary

In summary, inflationary cost challenges as raised by externally commissioned providers have been acknowledged by HCS SLT and a decision in principle has been made to support providers by passing on non-pay inflationary funding received by HCS subject to States Assembly approval of the proposed Government Budget 2025-28 and HCS budget setting agreement.

Additional non-financial support is offered through the Commissioning and Partnerships Team for providers.

The Commissioning and Partnerships Team will also bring the topic to the Cross Government Commissioning Group for discussion.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Chief Officer's Report**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**6**

Executive Lead:	Tom Walker, Interim Chief Officer HCS
Report Author:	Tom Walker, Interim Chief Officer HCS

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion √
	This paper provides, • a summary of key activities for Health and Community Services (HCS), • an overview of HCS' performance since the last Board meeting, • a summary of key issues, some of which are presented in more detail through the relevant board papers.			
Summary of Key Messages:	The key messages arising from this report are: See below.			
Recommendations:	**The Board is asked to note the report.**			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	√
Caring		SR 3 – Operational Performance (Access)	√
Responsive		SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Nil		

List of Appendices:
Nil

MAIN REPORT

I am pleased to have joined HCS on 2 October as interim Chief Officer, just before the start of “HCS Appreciation Week”. Since my start, I have already had the opportunity to meet many HCS colleagues and to visit them in their services across various locations. It has been heartening to meet so many of the committed and talented people who look after the health of Islanders.

As Chief Officer, I have overall responsibility for the quality, effectiveness and safety of our services and am keen to ensure that HCS colleagues work together, as a team, to continue to deliver improvements. Living our public service values will be central to making improvements in a way that builds trust.

Over the coming months, I will be working with the Health Minister to help take forward proposals for a more integrated approach to health and care in Jersey. Working better together with other health and care providers will support our efforts to keep Islanders healthy and well in the first instance, help us intervene early when people need care and treatment, and help ensure the quality of services provided.

The New Healthcare Facilities Programme will also be something I will be helping to move forward, as work progress on the new Acute Hospital at Overdale, which is the immediate priority for the Programme, and the other two major sites – the Kensington Place Ambulatory facility and the St Saviour Health Village.

I would also like to take this opportunity to welcome Martin Carpenter, who joined HCS as Health Chief Information Officer in October, and to thank Chris Bown for all his good work and wish him a speedy recovery.

Key highlights from the last two months are summarised below.

OUR ORGANISATION, OUR STAFF

A comprehensive range of organisation development activities continues to be delivered across HCS.

Our Stars

On Friday 8 November 2024, over 300 Health and Community Services (HCS) colleagues gathered for the HCS “Our Stars” 2024 awards ceremony. The event recognised both, winners and those shortlisted for the HCS Our Stars programme. The event recognised the achievements of many HCS colleagues, taken from over 426 nominations received across the award categories, 18 winners and their achievements were acknowledged and celebrated by their colleagues.

Award	Winner
Customer Service Excellence	Halil Metushev, Community Catering Assistant
Employee of the Year	Oliver Leeming, Medical Education and Centre Manager
Manager of the Year	Becky Brawley, Team Manager Community Mental Health
Rising Star	Mara de Oliveira, Staff Nurse, Rozel Ward
Team of the Year	Intensive Care Unit
Embodying our Values	James Moulson, HCS Risk Manager

Award	Winner
Nurse/Midwife of the Year	Ashley Melling, Midwife
Allied Health Professional / Social Worker of the Year	Laura Foster, Head of Nutrition and Dietetics
Medic of the Year	Jesse Brown, General Medical Doctor
Healthcare Assistant of the Year	Michael Vieira, Healthcare Assistant
Non-clinical support Worker of the Year	Victoria Morel, Information Governance Manager
Achievement in Education & Learning	Gill Martin, Senior Lecturer (Mental Health)
Excellence in Leadership	Jenna MacKay, Lead Nurse Medical Services (now Head of Customer Feedback Team)
Multi-disciplinary team working	Janie du Feu, Ward Manager Rozel
Patient Experience	Maternity Team
Superstar	Mung Du, General Medical Doctor
Team Superstar	Oncology Team Paul Rendell & Adult Social Care

Appreciation Week

Appreciation Week was celebrated across HCS at the beginning of October and has been used as an opportunity to say thank you to HCS colleagues, and to take the time to reflect on all that our people do, day in day out, to deliver the best care to those that use our services. Activities included:

- stepping into the shoes of a colleague to understand what their days look like in various departments and wards
- breakfast with the Chief Officer for colleagues who were nominated by their peers for a significant achievement
- organisation of a dedicated Schwartz Round– 'Unsung Heroes of HCS – Stories of Appreciation'.

Achievements and Recognition

- Pride of Jersey awards recognised nurses Cate Goode, a finalist in the Angel of the Year category who was the recipient of a "special recognition award" for her work, and Isobel Hamon, who was named Community Champion of the Year for her efforts training student nurses and doctors.
- The HCS Maternity refurbishment project won a Jersey Construction Council Project of the Year award.
- The Jersey Private Patients team opened a new Sorel Admission Unit.
- The Lieutenant Governor visited the Oncology department at the General Hospital, and was provided an update on the progress being made in cancer care and how digital solutions are helping to transform the way we deliver care in Jersey.

Sharing our expertise

- The Help2Quit team promoted their stop smoking campaign 'Stoptober' and provided support to Islanders wanting to quit smoking.

- The HCS Resuscitation department launched a new internal e-newsletter so other departments could find out more about resuscitation, training, celebrations, education and more.
- The Chaplains department welcomed the 2nd Henry Penny Beaver Scout Pack to the General Hospital, to support them to complete their Faith Badge.
- HCS Mental Health Service put a spotlight on their services for World Mental Health Day.

Freedom to Speak Up

- We welcomed five HCS colleagues to the newly formed network of Freedom to Speak Up Champions.
- The Freedom to Speak up Guardian put a spotlight on listening up, visiting departments and offered training and Q&A sessions as part of October's 'Speak up Month', which focusing on the important part which listening plays in encouraging people to speak up.

QUALITY AND SAFETY

Ward Assurance

The Interim Chief Nurse continued the focus of visible ward leadership. This has been further supported by the monthly peer review process and weekly care rounds whereby all Senior Nurses working within the clinical areas focus on the fundamentals of care, including nutrition, hygiene, communication and patient experience.

To ensure daily oversight and prompt responses to emerging issues, the organisation has introduced a digital audit tool. The tool provides daily real time data which is monitored by ward managers and enables swift identification and resolution of potential issues.

Flu and Covid Vaccination

The Infection Prevention and Control (IPaC) service launched an internal Flu and Covid employee vaccination campaign, offering a range of dates and locations to encourage and support colleagues to get vaccinated.

Acting on patient and carer feedback - nutritional update

In response to patient and carer feedback, HCS has introduced 'snack rounds' across the inpatient wards. These rounds take place between standard mealtimes and patients are offered a range of nutritious snacks including fresh fruit.

Focus on falls and tissue viability

It is encouraging to report the sustained improvement in tissue viability and prevention of falls with harm against a background of increased patient activity. HCS has appointed a specialist nurse with expertise in falls and frailty management to continue supporting colleagues and patients with this improvement.

FINANCE

The financial position for year to date (YTD) Month 10 is a £24.7m deficit, giving a headline monthly run rate of £2.5m.

The FY24 year-end forecast is a deficit of £28.0m after delivery of additional savings to mitigate the underlying risk of £29.5 million deficit. The forecast has been updated following a further detailed review of the previously reported forecast deficit range of between £24.5m and £29.5m, from the net impact of additional savings delivery from the financial recovery programme (FRP) and Cobra actions of £2.8m vs target £5.3m, and continued significant non-pay cost pressures, particularly from steeply rising costs of social care and mental health packages, tertiary care contracts, and the impact of high cost drugs.

FRP savings delivery YTD M10 is £7m vs £4.3m plan, made up of £4.7m against original schemes and an additional £2.3m of mitigation schemes to recover slippage and additional cost pressures identified. Forecast savings delivery for FY24, including additional FRP and additional Cobra actions, are £8.1m vs plan of £5.2m which mitigates against the above cost pressures, reducing the underlying forecast deficit to £28.0m.

Budget Planning 2025 is underway with Care Groups and Directorates for budget sign-off and completion by the end of Dec-24, subject to States Assembly approval of the proposed Budget 2025-28.

WORKFORCE

Recruitment activities are continuing to be the focus, with the new nursing campaign having just gone live in the UK. Recruitment materials for medical staff are being reviewed and updated using specific campaign themes. The recruitment for pharmacy roles remains a priority and additional support has been sought from specialist agencies in the short term whilst developing a concerted new recruitment campaign.

Further information on workforce metrics is provided in the workforce Board report.

Connect Performance

Work has continued to ensure compliance with appraisal setting and reviews. Where issues were identified with recording appraisals in the Connect system, alternative methods were used, for example, individual electronic records or paper records. The workforce team is working closely with the Connect team to address any identified issues.

OPERATIONAL PERFORMANCE

Waiting List Initiative and New Consultants Update

A new consultant has commenced in Dermatology, which is positively impacting the waiting list in this specialty.

Positive impact, particularly in outpatient patient waiting list performance, has been delivered across the year from the outsourced and insourced recovery actions, such as ophthalmology, community dentistry and orthodontics as well as increased in-house activity.

Improvement has been observed again in the over 52 weeks key performance indicator for outpatient appointments and is further discussed within the Quality and Performance Board Report.

Acute Services

Emergency Department (ED) performance is noted as improving in month with increased flow. Further detail is provided in the Quality and Performance Board Report.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**HCS Annual Plan 2025 v1.0**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**8a**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation
Report Author:	Heide Smith, Acting Senior Business Planner

Purpose of Report:	Approval √	Assurance ☐	Information ☐	Discussion ☐
	This paper provides the Board with the final draft of the HCS Annual Plan for 2025.			
Summary of Key Messages:	The HCS Annual Plan 2025 provides the department and the Board with key objectives and actions for 2025 whilst outlining the overall connection to the Common Strategic Policy, ministerial priorities and Government values. The Annual Plan objectives and actions have been developed based on key themes arising from 2024 and through various workshops with colleagues. Wider staff feedback was gathered through a survey and has been incorporated in the tabled draft.			
Recommendations:	**The Board is asked to review and approve the draft Annual Plan 2025 prior to publication in December 2025.**			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	√
Caring		SR 3 – Operational Performance (Access)	√
Responsive		SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:

Meeting	**Date**	**Outcome**
HCS ELT Workshop	9 Sep 2024	Development of objectives
HCS ELT Workshop	16 Sep 2024	Development of objectives
HCS ELT Workshop	23 Sep 2024	Development of objectives
HCS ELT Workshop	30 Sep 2024	Review of objectives
HCS SLT	17 Oct 2024	Review of objectives
HCS Advisory Board Workshop	31 Oct 2024	Review of objectives and staff feedback
HCS SLT	14 Nov 2024	Final review before Board submission, SLT endorsed and approved the Plan operationally

List of Appendices:

MAIN REPORT

Consultation and development sessions have been held with HCS stakeholders including, the HCS Executive Leadership Team, the HCS Senior Leadership Team, the HCS Advisory Board and HCS Staff.

The workshops included the review of improvement themes from 2024 governance meetings, the 2025 Quality Account, and review of performance and quality and safety metrics. Lessons learnt from the development and content of the Annual Plan 2024 was also included in the workshops and informed the process and content of the Annual Plan.

Following this, the draft HCS Annual Plan 2025 has been produced for review and approval by the Board.

END OF REPORT














Health and Community Services

Health & Community Services

Annual Plan 2025

Version Control

Status	Version	Date	Changes
Draft	v1.0	28 Nov 2025	Final draft for approval.

Contents

Foreword by the Minister for Health & Social Services

Following several years of relative turbulence, Jersey's health system is at a crossroads. With four years to go until we have the benefit of an all-new hospital, we have just enough time remaining to improve our health service to mirror the standard of the new, forthcoming facility.

Whilst pockets of absolute excellence exist, moves to draw various health functions into central government, fractious relationships between various health bodies (Primary, Charitable and HCS etc.) and divisions between management and clinicians within HCS all suggest the need for a more collaborative style of leadership and a suitable structure within which all health sectors can work together efficiently.

With this in mind, we plan to establish an all-encompassing, unified, Jersey Health System. For the first time we will appoint a Chief Executive, charged with delivering a properly integrated service, guiding and overseeing the interaction of all health service providers (Primary Care, HCS, Charities, Care Homes, Home Care, Dental etc.).

This will involve the creation of a new 'stand-alone' health department. Separated from, but connected to government, it would encompass all health functions, including strategy, policy, legislation, public health, digital health, commissioning, procurement, and population data. Key advisory roles, such as a Chief Nurse Advisor and a Chief Pharmaceutical Advisor, would support this integrated approach.

Central to the proposal is the formation of a new Jersey Health & Care Partnership Board. Here, each health service provider will contribute equally. This structure would include Civil Servants serving in executive capacities alongside non-executive members representing private and charitable healthcare providers, ensuring a balanced and inclusive approach to governance.

Another key aspect of the proposal is the establishment of a single, central fund to manage all health-related finances, governed by appropriate terms and conditions. Collaboration with central government would be essential to build the autonomous internal framework for HR, finance, and procurement within the broader government system, along with Digital/IT which will receive particular attention.

Preventive health measures are a major focus of the proposal, including increased screening, vaccinations, health monitoring, and initiatives for healthier living from a young age. This proactive approach aims to address the root causes of health issues, thereby making the health budget more manageable in the longer term and improving the quality of life for residents.

Despite current funding constraints which limit certain of these longer-term ambitions, the proposal underscores the importance of not transferring fragmented services into the new hospital.

The plan also highlights the beginning of talks to develop a new health strategy, or action plan, both for the wider 'all island' service and for HCS itself. This initiative is expected to foster internal and external cooperation, improve morale, and initiate a much-needed culture change within the health system.

In conclusion, the plan stresses the need for maximizing operational efficiency whilst developing appropriate means by which additional funding might be achieved. It recognises Jersey's unique position as a wealthy island with a dedicated workforce and improving healthcare facilities, suggesting that with

appropriate investment and a willingness to embrace change, Jersey could become a model of best practice in health care.

This plan aims to provide a comprehensive overview of the proposed changes, and the strategic direction needed to achieve a unified, efficient, and effective health system for Jersey.

Deputy Tom Binet
Minister for Health and Social Services

Foreword by the Interim Chief Officer of HCS

To follow

The Health and Social Services Minister

Common Strategic Policy

On 21 May 2024, the States Assembly agreed the Common Strategic Policy (CSP) 2024 to 2026. In it, the Council of Ministers (CoM) identified 13 priorities where it believes it can deliver meaningful and measurable progress. The priorities aim to benefit patients and care providers as urgent improvements in the health services are delivered and the construction of the new Hospital at Overdale begins.

Preparations will be made for projected demographic changes, including an ageing population, falling birth rates and rising levels of disability, to ensure the sustainability of our health provisions and to protect economic prosperity into the future. The Common Strategic Policy can be found on gov.je, Common Strategic Policy 2024 to 2026.pdf

Ministers for Health and Social Services

Deputy Tom Binet
Minister for Health and Social Services

Deputy Andy Howell
Assistant Minister

Deputy Barbara Ward
Assistant Minister

Deputy Rose Binet
Assistant Minister

Our System

We know that supporting Islanders to live longer, healthier, and productive lives requires us to focus on preventing ill health and on supporting health and care services to work well together, so that we can make better use of the Island's skills, knowledge and resources.

Integrated Partnership Working

In 2025, we will focus on developing the systems that support integrated partnership working. It is proposed that, by the end of 2025, this will include:

Jersey Health Budget

Amending the law to provide that the Health Minister is responsible the Government's annual health and care services budget (which mainly funds government services) and the Health Insurance Fund (which mainly funds prescriptions and GP services). This will allow the proposed new Partnership Board to plan how to get best value from those monies.

Jersey Health and Care

Bringing together several of Government's health and care functions into a sngle department, with a Chief Officer who is responsible for working across the system to ensure planning and delivery of joined-up services (including whole system service commissioning and digital) and for delivery of Government's hospital, mental health, adult social care and community care services.

Partnership Board

Establishing a new Partnership Board, bringing together primary care, community care, public health, government services and the charitable sector to oversee development and delivery of whole-system strategy, to plan joined-up services and recommend spending priorities.

Services Board

Continuing to engage Non-Executive Directors in supporting Government to drive up the standards of Government's health and care services.

New Healthcare Facilities

The New Healthcare Facilities Programme will redevelop Jersey's healthcare estate over the next 10 years to meet the Island's future needs. The Programme proposes a plan to deliver healthcare services across multiple sites.

- **Enid Quenault Health and Wellbeing Centre at Les Quennevais** is a newly operational facility which is home to a range of therapies and services formerly located at Overdale.
- **Samarès Ward at St Ewold's** is a newly refurbished facility located at St Ewold's Residential Care Home, which includes rehabilitation services, overnight beds and therapies.
- **An Acute Hospital at Overdale** will include an emergency department, critical care, women and children's services, elective and emergency operating theatres, and all inpatient wards where an overnight stay is required.
- **Outpatients and Ambulatory facility at Kensington Place and Gloucester Street** will include a walk-in treatment centre, diagnostic testing, outpatient clinics and day surgery.
- **A Health Village in St Saviour** will include services such as mental health, rehabilitation and stepdown beds, and hydrotherapy and therapies.

Building the Acute Hospital at Overdale

A Planning Application for the Acute Hospital was submitted in September 2024, the outcome of which is expected in the first part of 2025.

The design will continue to develop internally, with further User Groups with clinical and non-clinical staff. This will include agreeing on the layout of individual rooms with equipment, furniture, and fixtures. There will also be wider consultation across Government and other stakeholders.

Building is due to start in 2025 with construction largely complete in 2028. Work is underway to define the Kensington Place Ambulatory and St Saviour's Health Village projects in greater detail, and there will be early physical works at both sites in 2025.

Our Services

What we do

HCS encompasses a range of Clinical and Professional Care Groups, some services are provided in partnership with our external partners. These include the provision of a wide array of hospital services, mental health, social care and support in the community, such as:

- hospital care including emergency care, intensive care and maternity services
- off-island care in the UK when needed
- social care services, and services in the community
- monitoring and improvement of the quality of all services
- the education and development of medical professionals
- the provision of a coordinated approach to mental health care
- offering free, private and confidential counselling services
- influencing and creating conditions that allow people to improve their health.

Services are delivered through the following Care Groups and key clinical services across HCS.

Adult Mental Health

Provides a wide range of mental health assessment, treatment and support services for adults of all age with mental health needs, both within the community and inpatient services. The mental health services work in close partnership with service users, carers and other agencies (including the police, children's services and social care) as well as with third sector and charitable partners.

Social Care

Provide social care assessment and support, as well as social work services and coordination of placements and care packages. The care group also includes a range of services for people with learning disabilities (including residential and community services) and our Safeguarding Adults team.

Community Services

The care group includes intermediate care, therapies (across hospital and the community), our telecare offer, Sandybrook nursing home, Samarès rehabilitation ward and the hospital discharge team.

Women's and Children's Care Group

Provides services throughout the hospital and community that relate to women, children and families, including functions such as maternity, gynaecology, assisted reproduction and the special care baby unit. The care group is responsible for gynaecology outpatient services offering an early pregnancy assessment, colposcopy, assisted reproduction clinics, termination of pregnancy service and other specialist clinics relating to women's health.

Surgical Services Care Group

Provides specialist hospital functions covering our inpatient wards, the Day Surgery Unit, the Operating Departments, and Intensive care. The Pain Service, Radiology Department, and Private Patient Services are also included.

Medical Services Care Group

Supports emergency care and medical speciality services. Includes the Emergency Department and Emergency Assessment Unit at the hospital as well as the medical inpatient wards and outpatient specialisms.

Non-Clinical Support Services

Support the provision and functioning of clinical services. Includes Estates, Pathology, Pharmacy, Patient Travel Office, Catering, Stores and Portering.

Commissioning and Partnerships

Commissioning in HCS is a process of continuously developing services and allocating the available resources to achieve the best health outcomes for Islanders. The commissioning process is repeated on agreed time cycles and comprises a range of activities including:

- understanding and assessing the Island's 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.

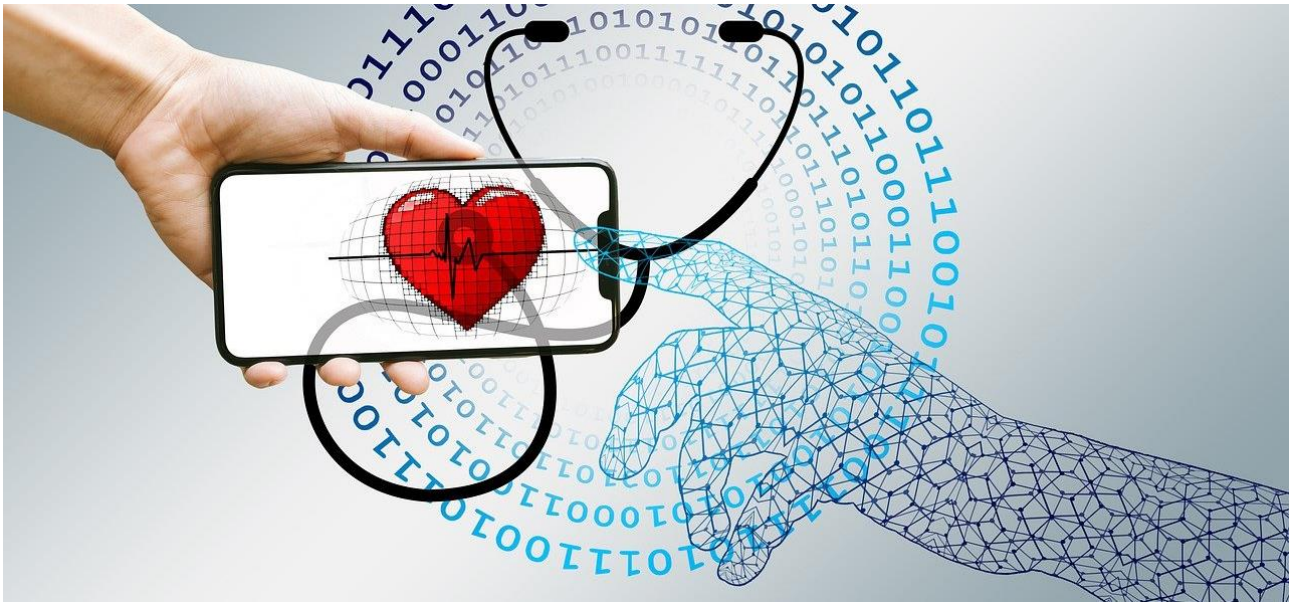
HCS works in partnership with other Government departments to commission from a range of providers. In 2025, HCS will be working across Government departments to develop a Cross-Government Commissioning and Partnerships Strategy for all future commissioned services.

Digital Health and Informatics

The Digital Care Strategy is a five-year programme, continuing in 2025 with the implementation of the Hospital Electronic Care Record functionalities and starting the process for a new electronic care record for our mental health and social care services. Digital system will support clinicians to deliver accessible, joined-up, person-centred care for our patients, clients and service users. The Health Informatics Team provides operational and performance data to inform decision-making and helps us to benchmark our services against other providers.

Corporate Support Functions

Includes Board Governance, Change and Improvement and Strategic Planning and Reporting.

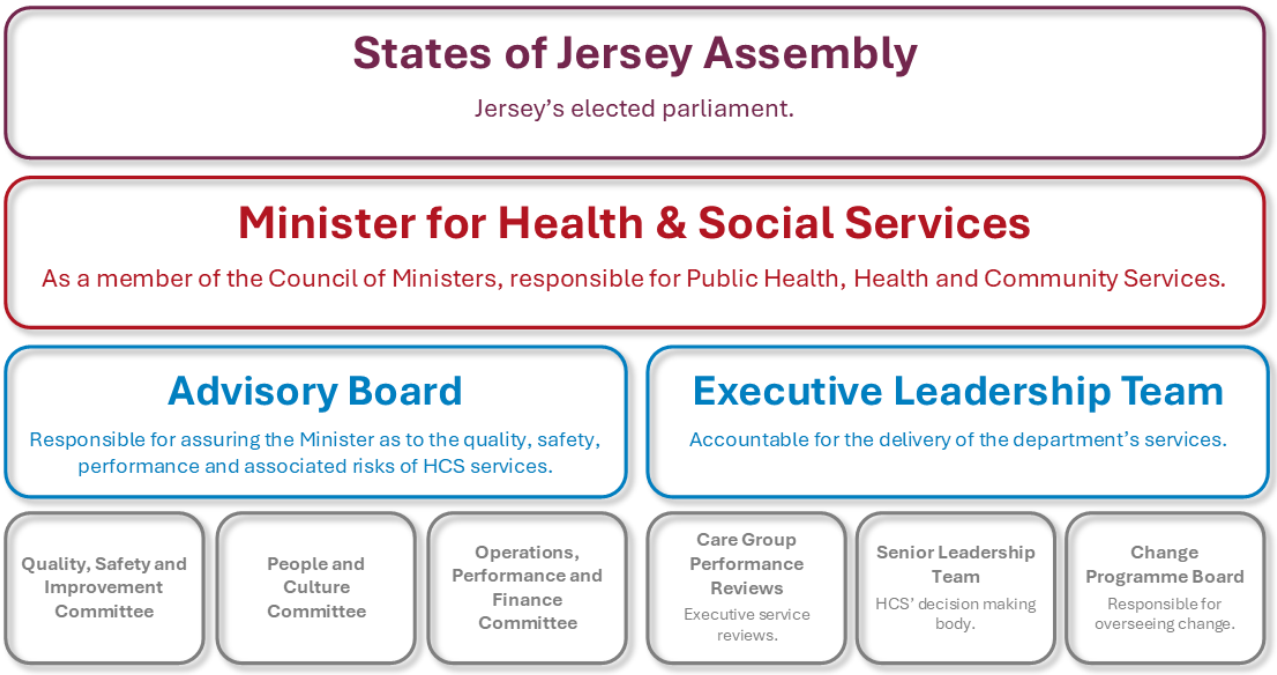


Structure and Leadership Team

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.

HCS's current corporate governance structure is outlined below but this may change during the course of 2025 with the establishment of a new Health and Care Partnership Board.



The Advisory Board Non-Executive Members

Carolyn Downs CBE
Dame Clare Gerada DBE
David Keen
Julie Garbutt
Tony Hunter CBE

The Advisory Board Executive Members (Executive Leadership Team)

The Executive Leadership Team (ELT) is comprised of the Chief Officer and Executive Directors. They are accountable for the delivery of the department's services.

Tom Walker	Chief Officer (Interim)
Andy Weir	Director of Mental Health, Social Care & Community Services
Dr Anuschka Muller	Director of Improvement & Innovation
Claire Thompson	Chief Operating Officer - Acute Services
Ian Tegerdine	Director of Workforce (Interim)
Jessie Marshall	Chief Nurse
Martin Carpenter	Director of Digital Health & Informatics
Obi Hasan	Financial Recovery Director (Interim)
Mr Patrick Armstrong MBE	Medical Director

Senior Leadership Team

The Senior Leadership Team (SLT) is comprised of the ELT members plus clinical and professional leaders. SLT is the decision-making body of the department.

Dr Caroline Jenkins	Chief of Service - Women, Children & Family Care
Dr Cheryl Power	Director of Culture, Engagement & Wellbeing
Debbie O'Driscoll	Acting Chief Pharmacist
Jo Poynter	Associate Managing Director - Improvement & Innovation
Kevin Smith	Acting Director of Pharmacy Services
Mark Queree	Deputy Head of Finance Business Partner
Dr Matt Doyle	Chief of Service - Medical Services
Paul Rendell	Chief Social Worker
Dr Simon Chapman	Chief of Service - Surgery
Mr Simon West	Deputy Medical Director
Sophia Bird	Head of Communications
Washington Gwatidzo	REACH Representative

Health and Community Services in Figures

41,223 emergency department attendances

199,491 prescription items dispensed in pharmacy

965 compliments received

781 maternity deliveries

210,864 attendances in outpatients

719,919 kg of washing processed by the laundry department

413 complaints received

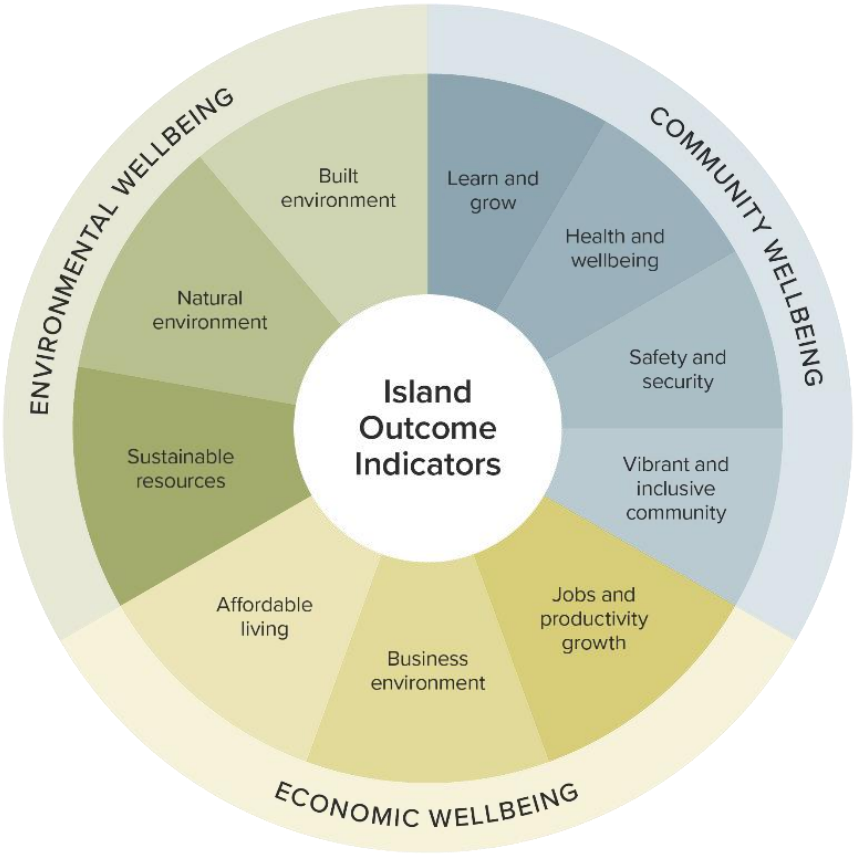
8,106 procedures carried out

16,094 inpatient admissions

Note: Laundry figures Jan-Nov 2024; all other figures 2023 total.
Source: Laundry team; Health & Social Care Informatics Team; Statistic Jersey (population data)

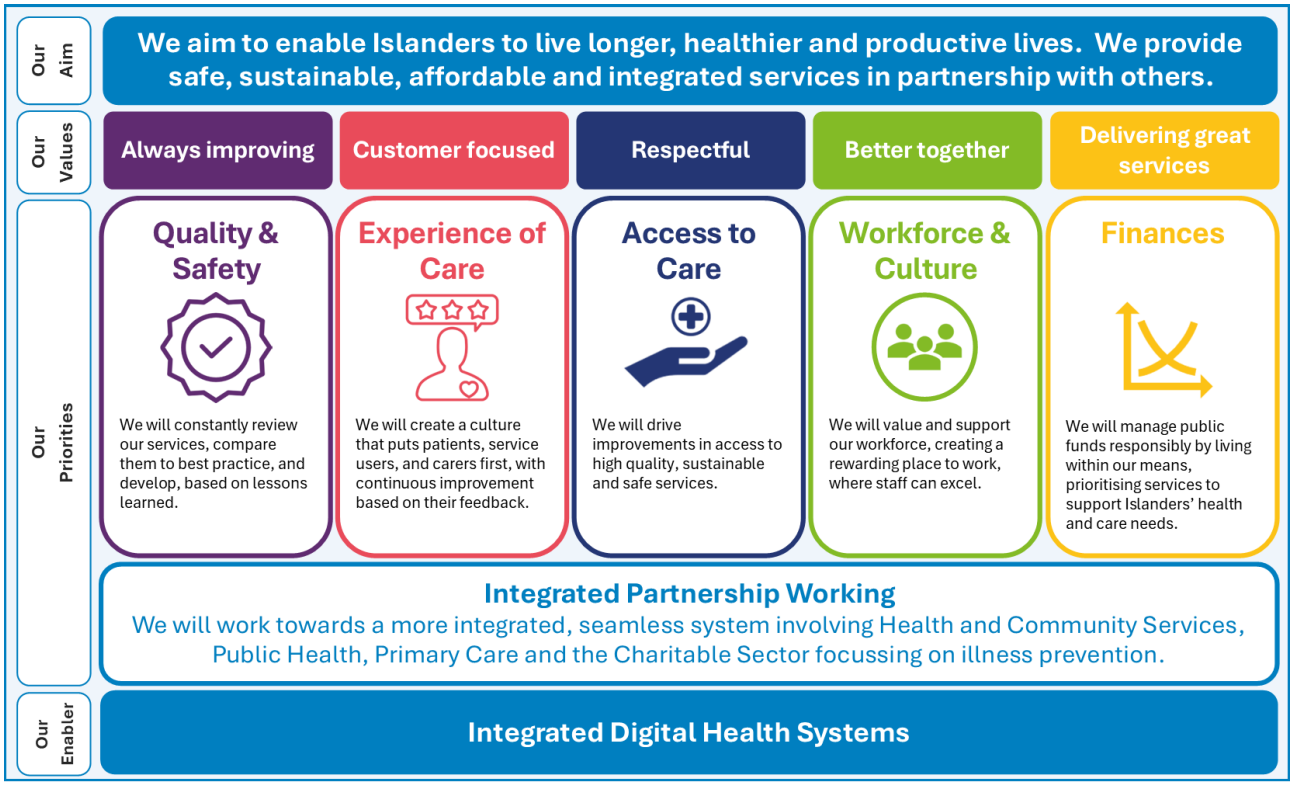
Island Outcomes

The long-term vision for Jersey's sustainable wellbeing was set out in the 2017 Future Jersey vision. It is based around 10 Island Outcomes which drive quality of life in Jersey. Based on long-term results, the Island Outcomes show how Jersey is progressing towards its Sustainable Wellbeing goals. They are divided into 3 themes of community wellbeing, economic wellbeing and environmental wellbeing. Each theme is made up of outcomes, each of which have a set of indicators to help measure progress.



The theme of Community Wellbeing is about the quality of people's lives. The work of Health and Community Services contributes to this theme, particularly towards the outcome of Health and Wellbeing. This outcome is about Islanders being healthy and, as a result, having the opportunity to live longer and active lives. This helps prevent the need for health interventions and ensures that healthcare and support can be targeted to those that need it most. It is also about ensuring that people can access the right treatment when they need it.

Our Service Objectives for 2025



Our Aim

In HCS, our aim is to enable Islanders to live longer, healthier, and productive lives by providing safe, sustainable, affordable, and integrated services in partnership with others**.** We also want to create a well-managed workplace that helps us improve care and outcomes by working with others.

We will ensure that we live within our means and deliver our services within the provided budget by identifying and implementing improvement and efficiency opportunities. This will also contribute to delivering, safe, effective and quality services to Islanders. It is vital that overall costs can be met from available government income.

We will continue to work with colleagues to develop and maintain a culture where staff feel safe, valued and work with collective values and aspirations.

Integrated partnership working and the use of digital systems are key enablers to achieving all our priorities.

The following pages show the details for each priority and how we will measure progress.

Priority: Quality and Safety

Objective 1.1

We will follow the Duty of Candour as a commitment to transparency, honesty and accountability to improve patient, service user and client safety.

Actions we will take.

- Update and implement a Duty of Candour Policy in line with the Regulation of Care (Jersey) Law 2014 and embed the process of Duty of Candour across HCS.
- Source training and commence training programme on Duty of Candour across HCS.
- Monitor Compliance with the statutory Duty of Candour in Care Group Governance Meetings.

Objective 1.2

We will deliver the best possible clinical / care outcomes to improve clinical effectiveness / care delivery.

Actions we will take.

- Provide an HCS wide National Audit Programme of work.
- Increased and timely participation in National Audits and National Confidential Enquiry into Patient Outcome and Death returns.
- NICE year-on-year effectiveness being evidenced by the result of re-audits and compliance against best practice standards.
- Ensure action plans are developed when HCS received National Audit reports that we have participated in, ensuring that the actions have owners, timeframes and are monitored through Care Group Governance Meetings.
- Implement and embed programme of ward based clinical audits on Tenable.
- Facilitate shared learning across HCS.

Objective 1.3

We will embed a culture of continuous quality improvement to improve clinical effectiveness / care delivery.

Actions we will take.

- Write an HCS Quality Improvement Strategy ensuring quality is everyone's responsibility by having a shared understanding.
- Establish and embed an HCS wide recognised methodology for Quality Improvement to support increased productivity and continuous improvement.
- Establish a Quality Improvement training plan for our staff.
- Set a Quality Improvement Agenda based on learning from Clinical Audit, Incidents (including Serious Incidents), Mortality and Patient Feedback.
- Facilitate shared learning across HCS reviewing performance at regular intervals.

Objective 1.4

We will review the surgical patient pathway to improve patient safety.

Actions we will take.

- Introduce e-consenting across HCS.
- Update the Health and Community Services Consent to Care and Treatment Policy.
- Standardise pre-operative checklists across HCS.
- Re-audit pre-operative pathway in six months.
- Audit compliance with World Health Organisation (WHO) checklists on a regular basis.
- Review WHO checklists.

Objective 1.5

We will improve the standard of clinical documentation across HCS in line with professional standards.

Actions we will take.

- Form a documentation working group.
- Audit documentation across HCS.
- Write and launch a Records and Document Management Policy.
- Monitor compliance with documentation through Peer Reviews and Care Rounds.
- Review the standards relating to documentation within the JCC Single Assessment Framework.

Priority: Experience of Care

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

Objective 2.1

We will regularly ask for feedback from patients, service users, clients, and carers and use it to continually improve their experience.

Actions we will take.

- Gather the evidence of actions taken because of service user and carer feedback.
- Carry out a formal review of the Patient's Panel to inform further development.
- Increase the number of clinical teams using at least 1 PROM (Patient Recorded Outcome Measure).
- Review patient feedback from the Picker survey, celebrate and learn from positive feedback and address areas of improvement.
- Gather patient, service user, client and carer feedback from Commissioned Services.

Objective 2.2

We will involve patients, service users and clients in their health and social care to ensure they and their carers feel informed and well cared for.

Actions we will take.

- Identify evidence of service user and carer involvement through agreed relevant service KPIs.
- Undertake a DNR (Do Not Resuscitate) audit.
- Gather and review patient feedback through the Picker survey in relation to patient involvement.
- Regularly seek feedback through the Patient Experience Survey through Tendable.

Priority: Access to Care

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

Objective 3.1

We will develop diagnostic testing pathways in emergency and planned care to ensure proper use of diagnostic testing services.

Actions we will take.

- Develop relevant pathways.
- Reduce the waiting times for diagnostic testing.

Objective 3.2

We will make outpatient services more efficient with better processes.

Actions we will take.

- Reduce the New to Follow Up Ratio.
- Reduce the waiting times for outpatients.
- Implement the Access Policy.

Objective 3.3

We will work with our partners to ensure patients, clients and service users have access to the right care in the right place at the right time.

Actions we will take.

- Reduce the number of Delayed Transfers of Care (DTOC) in the hospital.
- Reduce waiting times for elective care.
- Develop a Community Care Model.
- Implement a Patient Choice Policy.

Priority: Workforce & Culture

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

Objective 4.1

We will create an Organisational Development Strategy and a People & Culture Plan to ensure a well-led workplace where staff feel engaged, valued and safe.

Actions we will take.

- Using the Staff Engagement metrics in the Staff Survey to develop specific actions plans within each team.
- Produce and implement an Organisational Development Strategy.
- Produce and implement a People and Culture Plan.
- Develop and maintain the Culture Dashboard.

Objective 4.2

We will create a Workforce Strategy and plan to ensure we have a sustainable and suitable workforce.

Actions we will take.

- Produce a Workforce Strategy.
- Produce a Workforce Plan.
- Monitor changes to recruitment and retention.

Objective 4.3

We will improve our recruitment processes to make it faster and more effective.

Actions we will take.

- Improve the recruitment process.
- Reduce the recruitment time.

Objective 4.4

We will use detailed workforce data to support better people management.

Actions we will take.

- Increase the availability of Workforce Data Reports.
- Improve the confidence in Data Validity.

Objective 4.5

We will improve staff management by using e-rostering and job planning, while supporting their development through effective appraisals.

Actions we will take.

- Increase the coverage of Job Plans.
- Increase the effectiveness of e-rostering.
- Increase the number of Medical Appraisals.

Priority: Finances

We will manage public funds responsibly by living within our means, prioritising services to support Islanders' health and care needs.

Objective 5.1

We will provide the best service possible within our budget by balancing income and expenses, meeting prioritised needs, whilst ensuring we communicate and engage with staff.

Actions we will take.

- Produce Monthly Financial Recovery Plan delivery reports.
- Enable teams to have good control and visibility of financial and operational processes.
- Provide training and access to the right systems and tools for budget holders.

Objective 5.2

We will review and manage our provider and supplier contracts to ensure Islanders receive quality care, services, and products at good value.

Actions we will take.

- Negotiate off-Island contracts based on NHS tariffs in accordance with MOU and Reciprocal Agreement between the Government of Jersey and the UK Government.
- Develop and publish a Cross-Government Commissioning Partnerships Strategy.
- Develop outcome focussed partnership agreements with SLAs, deliverables and KPIs.
- Consolidate the number of suppliers.
- Ensure expenditure on products and equipment provides best value for money.

Objective 5.3

We will continue to identify and develop areas for income generation which will help us provide quality services for Islanders.

Actions we will take.

- Continue to develop areas for income generation through staff engagement.
- Expand and enable the choice of service provision to Islanders and attract skilled professional to Jersey, by enhancing the private healthcare offer.
- Recognise and promote the contribution made by private patients' services to our whole Island economy, supporting economic growth and improved productivity in the workplace.

Monitoring our Performance and Risks

Quality & Performance Report (QPR)

The Health & Community Services (HCS) Annual Plan sets the department's strategic and operational objectives. The HCS Advisory Board (the Board) monitors HCS' operational, quality and safety performance through the Quality and Performance Report (QPR).

The QPR provides a set of performance metrics that are also monitored through a wider set at the monthly performance meetings for clinical and care services. It includes patient and client safety, safeguarding, patient and client outcomes, service delivery productivity and efficiency.

The QPR is discussed at the Board and published monthly on Health and Community Services Quality and Performance Reports (gov.je).

Board Assurance Framework

The Board Assurance Framework (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 objectives, 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 HCS Advisory Board meeting.

Health and
Community Services

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Health and Community Services Quality and Performance Report 2025**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**8b**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation
Report Author:	Beverley Bissett, Head of Health and Social Care Informatics

Purpose of Report:	Approval √	Assurance ☐	Information ☐	Discussion ☐
	This paper provides the Board with an update on the work to review the indicators to be reported in the Quality and Performance Report in 2025			
Summary of Key Messages:	The key messages arising from this report are: • Key performance indicators for 2025 have been chosen to enable continuity of reporting from 2024 with new indicators where appropriate and relevant. Work will continue in some areas until the end of 2024 to identify and develop some new indicators. • Standards are set based on the assumption of continuous improvement and appropriate (e.g. NHS) benchmarks or standards from other jurisdictions. Standards shown in this document are provisional and will be reviewed once 2024 year-end data are available. • A new report layout has been proposed to address the HCS Advisory Board feedback on making data sources and standards more prominent in relation to the charts to enable interpretation.			
Recommendations:	The Board is asked to approve: • the selection of indicators, noting the work that is still ongoing to finalise these in some areas. • The new layout of the report providing adjacency between the charts and the metadata that sets out the data sources and standards			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	√
Effective	√	SR 2 – Patient Experience	√
Caring		SR 3 – Operational Performance (Access)	√
Responsive	√	SR 4 – People and Culture	√
Well Led		SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:

Meeting	Date	Outcome
HCS ELT	21 Oct 2024	Review of first draft
HCS Advisory Board Workshop	31 Oct 2024	Feedback provided on the layout of the report
HCS Senior Leadership Team	11 Nov 2024	No further changes, approved and endorsed for Board approval

List of Appendices:
Appendix 1: Quality and Performance Report Indicators v3

MAIN REPORT

Please see the attached draft Quality and Performance Report (QPR) metrics and standards for 2025 for approval along with a revised layout proposal.

END OF REPORT

Health and Community Services Quality and Performance Report 2025

Updated paper to take account of feedback from Board Workshop

Previous versions of this paper have been presented to:

- HCS ELT - 21st October 2024
- HCS Advisory Board Workshop – 31st October 2024

Introduction

The Health and Community Services (HCS) Annual Plan 2025 sets the department's strategic and operational objectives.

Each year, HCS reviews the list of key performance indicators (KPIs) that are monitored by the HCS Executive and the HCS Advisory Board through the Quality and Performance Report (QPR). This is part of the performance and governance arrangements of the department.

Indicators are reviewed on an annual basis to ensure they maintain currency. More frequent review is discouraged so that there is consistency and continuity of monitoring throughout the year. HCS has more granular performance reporting available at Care Group levels and through the Board Committees.

From 2025, Government of Jersey is no longer maintaining a central collation of the Departmental Service Performance Measures. Each department must publish its own progress against key performance indicators. The HCS Quality and Performance Report is the vehicle for this and is already being published on a monthly basis on gov.je (Health and Community Services Quality and Performance Reports).

The Report

In 2024 HCS introduced Statistical Process Control reporting instead of tabular reporting (with the exception of Maternity indicators). This reduces the risk that small positive or negative changes in a particular month will be over-interpreted by setting them in context. This is a well-established practice across health care internationally and is particularly important in Jersey, given the small numbers in many categories.

The change included a move to overall performance narratives being provided by the Executive Director responsible for each section with a commentary for escalations, instead of exception reporting at individual indicator level. This enables themes to be discussed and areas of positive performance to be highlighted as well as detailed review of areas for improvement.

Where needed, optional pages to allow further investigation or deep dive into certain areas are available – they are likely to be in arrears, given the tight timescales for reporting in month. Building

these into the Quality and Performance report enables all performance information to be in one place, thereby increasing transparency.

The reports have all been published on the GOJ website, both within the Board papers and also at: Health and Community Services Quality and Performance Reports

Feedback from the Advisory Board suggests that the metadata setting out the data sources and standards is not positioned with enough prominence in relation to the charts to enable interpretation. As such, for 2025, it is proposed to adjust the report layout as shown in Appendix 1.

The Indicators

The table below contains the proposed list of indicators for publication in the QPR 2025 and the proposed standards (where relevant). ***Standards are set based on the assumption of continuous improvement and appropriate (e.g. NHS) benchmarks or standards from other jurisdictions***.

The indicators are the same as those in the 2024 report to ensure consistency and continuity of reporting. The list will be finalised in line with the approval process of the Annual Plan.

A new section is proposed for Commissioned Services performance which will be reported quarterly.

Section	Subsection	Indicator	Provisional Standard for 2025*	Standard Source
Elective Care Performance	Elective Pathways	Patients waiting for first outpatient appointment > 52 weeks	0	HCS Elective Access Policy
		Patients on elective list > 52 weeks	0	HCS Elective Access Policy
		Access to diagnostics > 6 weeks	0	HCS Elective Access Policy
	Efficiency	Outpatient New to follow-up ratio	2.0	Standard set locally
		Outpatient Did Not Attend (DNA) rate (Adults only)	<=8%	Standard set locally
		Outpatient Was Not Brought (WNB) rate (Patients under 18)	<=10%	Standard set locally
		Elective Theatre List Utilisation (Main Theatres and Day Surgery, excluding Minor Operations)	>85%	NHS Benchmarking – Getting It Right First Time 2024/25 Target
		Number of operations cancelled by the hospital on the day for Non-Medical Reasons	NA	
Emergency Care Performance	Emergency Care Pathway	% of patients in Emergency Department for ≤ 4 hours	TBC	NHS Operational Standard in 2010 was 95%. NHS England achieved 72.14% in 2023/24 Quarterly-Annual-Time-Series.xls
		% of patients in Emergency Department for > 12 hrs	Not relevant – keep minimal	
	Patient Flow	Inpatient moves for non-clinical reasons > 22:00 and < 08:00	Not relevant – keep minimal	

		Total Bed Days Delayed Transfer of Care (DTOC)		Standard set locally Note: NHS England has discontinued this measure Statistics » (Discontinued) Delayed Transfers of Care
	Emergency Inpatients	Non-elective acute Length of Stay (LOS) (Days)	<8	Standard set locally based on historic performance – will be reviewed at year end
		Rate of Emergency readmission within 30 days of a previous inpatient discharge	<10%	Standard set locally based on historic performance – will be reviewed at year end
Maternity**		Total Births		
		Mothers with no previous pregnancy (Primips)		
		Mothers who have had a previous pregnancy (Multips)		
		Mothers with unknown previous pregnancy status		
		Bookings ≤10+0 Weeks		
		% of women that have an induced labour		
		Number of spontaneous vaginal births (including home births and breech vaginal deliveries)		
		Number of Instrumental deliveries		
		% deliveries by C-section (Planned & Unscheduled)		
		% Elective caesarean section births		
		Number of Emergency Caesarean Sections at full dilatation		
		Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)		
		Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)		

		Number of women in Robson Group 2b cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, caesarean birth prior to onset of spontaneous labour)		
		Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)		
		Number of deliveries home birth (Planned & Unscheduled)		
		Mothers who were current smokers at time of booking (SATOB)		
		Mothers who were current smokers at time of delivery (SATOD)		
		Number of Mothers who were consuming alcohol at time of booking		
		Number of Mothers who were consuming alcohol at time of delivery		
		Breastfeeding Initiation rates		
		Transfer of Mothers from Inpatients to Overseas		
		Number of births in the High dependency room / isolation room		
		Number of PPH > 1500mls		
		Number of 3rd & 4th degree tears – all births		
		% of babies experiencing shoulder dystocia during delivery		
		% Stillbirths >24 Weeks Gestation		
		Neonatal Deaths at <28 days old		
		Number of babies that have APGAR score below 7 at 5 mins		
		% live births < 3rd centile delivered > 37+6 weeks (detected & undetected SGA)		

		Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation		
		Transfer of Neonates from JNU		
		Preterm Births ≤27 Weeks (Live & Stillbirths)		
		Preterm Births ≤36+6 Weeks (Live & Stillbirths)		
		Neonatal Readmissions at <28 days old		
Mental Health	Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	<5%	Improving Access to Psychological Therapies (IAPT) Standard
		% of clients who started treatment in period who waited over 18 weeks	<5%	Improving Access to Psychological Therapies (IAPT) Standard
		JTT Average waiting time to treatment (Days)	≤177	Standard set locally based on historic performance – will be reviewed at year end
	Community Mental Health Services	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	>85%	Standard set locally by Care Group Senior Leadership Team
		% of referrals to Mental Health Assessment Team assessed in period within 10 working days	>85%	Standard set locally by Care Group Senior Leadership Team
		Median wait of clients currently waiting for Memory Assessment Service Assessment (Days)	NA	
		Median wait of clients currently waiting for Autism Assessment (Days)	NA	
!New		Number of clients waiting for ADHD Assessment	TBC	
		Median wait of clients currently waiting for ADHD Assessment (Days)	NA	
		Community Mental Health Team Did Not Attend (DNA) rate		Standard set locally based on historic performance – will be reviewed at year end

		% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	>80%	National Standard evidenced from Royal College of Psychiatrists
		% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	>80%	National Standard evidenced from Royal College of Psychiatrists
	Inpatient Mental Health	Mental Health Unit Bed Occupancy		
		Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards		
Social Care* **	Learning Disability	Percentage of Learning Disability Service 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)		
Quality & Safety	Mortality	Crude mortality rate (JGH, Overdale / St Ewolds and Mental Health) - % patients whose discharge outcome = death	NA	
	Safety	Patient Safety Events per 1000 bed days	NA	
		Number of Serious Incidents	NA	
		Number of falls resulting in harm (moderate / severe) per 1000 bed days	NA	
		Patient safety incidents with severe/major/extreme harm/death		
		Number of pressure ulcers present upon inpatient admission		
		Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days	<0.6	Standard set locally based on historic performance – will be reviewed at year end
		Number of medication errors across HCS resulting in harm per 1000 bed days	<0.4	Standard set locally based on historic performance – will be reviewed at year end

		% of adult inpatients who have had a VTE risk assessment within 24 hours of admission	>95%	NHS Operational Standard
		NEWS compliance		
	Infection Control	Healthcare Associated C. Difficile Infections	≤1	Standard set locally based on historic performance – will be reviewed at year end
		Healthcare Associated MRSA blood steam Infections	0	Standard set locally based on historic performance – will be reviewed at year end
		Healthcare Associated E. coli blood steam Infections	0	Standard set locally based on historic performance – will be reviewed at year end
		Outbreaks		
	Experience	Compliments received	Not relevant	
		Formal complaints received	Not relevant	
Commissioned Services Performance **(NEW section for 2025)******	Community Health	Palliative and End of Life Care - Inpatient bed occupancy - Referrals to specialist community team - Bereavement support sessions	 >75% >123 >358	
		Young People's Sexual Health - Number of visits	 >350	
		Adult and Child Community Nursing - District nursing referrals received - Rapid Response referrals accepted	 - -	
	Community Care	Day Care Activity Support -Provider 1 – People supported -Provider 2 – People attending per week (average) -Provider 3 – People supported -Provider 4 – People supported	 - - 725 -	

	Community Mental Health	Advocacy – Number of advocacy interventions Dementia Support – People supported Residential Drug/Alcohol Unit – Bed Occupancy Listening Lounge – Number of counselling appointments	>400 >14 >75% >909	

Notes

*Standards to be reviewed and finalised once 2024 year end data is available to ensure that they are set based on continuous improvement

**Maternity reporting uses the dashboard that was developed as part of the Maternity Improvement Programme. New indicators will become available once the implementation of the new Maternity EPR system is complete and embedded.

***Social Care indicators are being reviewed by the Team Managers and the Director for Mental Health and Social Care with a view to aligning and therefore benchmarking against the Adult Social Care Outcome Framework (ASCOF)

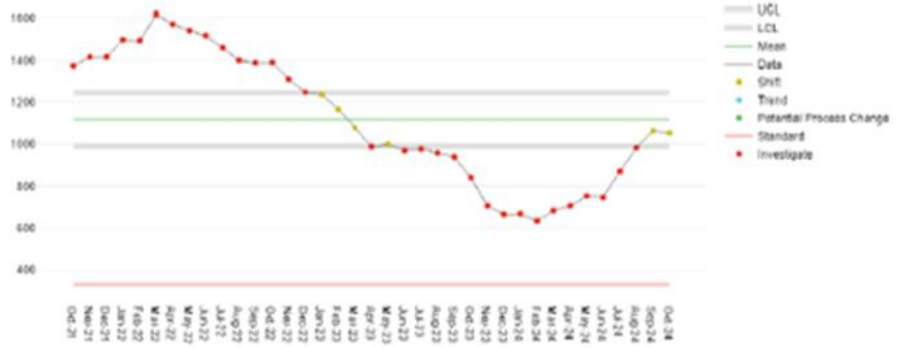
****Commissioned Services performance is a new section for 2025 and will be reported quarterly one month in arrears – e.g. Q1 data likely to be included in the M4 report

Appendix 1: Proposed Report Layout for QPR 2025

Elective Care Performance

Patients waiting for first Outpatient appointment Greater than 52 weeks

Latest value	Standard	Mean
1054	<333	1054

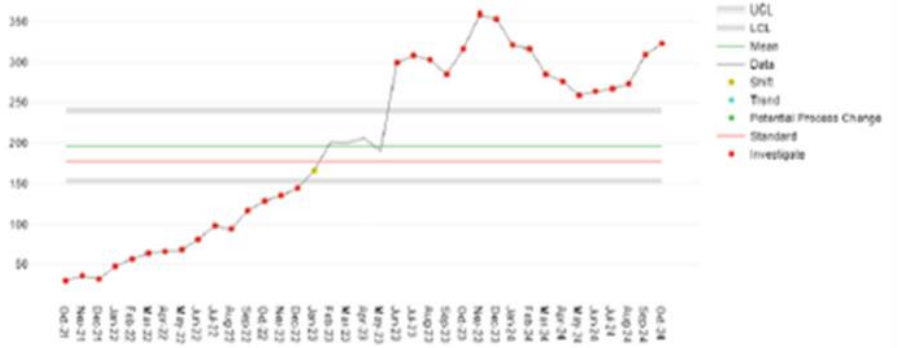


Definition
Number of patients who have been waiting for over 52 weeks for a first Outpatient appointment at period end

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

Patients on Elective list Greater than 52 weeks

Latest value	Standard	Mean
1054	<333	1054



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

Data Source	Standard Source
Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Standard set as 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

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Harm Review – Patient Tracking List Management Process**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**9**

Executive Lead:	Claire Thompson, Chief Operating Officer – Acute Services
Report Author:	Emily Hoban, Head of Access

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides the Board with assurance around the process for harm review for patients with extended waits.			
Summary of Key Messages:	The key messages arising from this report are: • Patients have experienced increased waits for an appointment because of Covid and subsequent reduction in elective capacity. • A process is in place to actively monitor patients who experience long waits, through administration and in some specialties, clinical validation. • The process is mainly used against our longest waiting patients over 52 weeks. • The impact of these actions has meant only one identified case of patient harm due to a long wait. The patient did not experience long term harm. • As HCS improves both capacity and utilisation, waiting lists will be reduced which will prevent harm. HCS has improved our performance on patients waiting over 52 weeks for first outpatient appointment and the position regarding those waiting for surgery for periods across 2024, although the rate of improvement has arrested over recent weeks due to capacity, equipment and estate issues.			
Recommendations:	The Board is asked to note the contents of the report and support the process of harm review for patients with extended waiting times.			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	√
Responsive	√	SR 4 – People and Culture	
Well Led	√	SR 5 – Finance	

Boards / Committees / Groups where this report has been discussed previously:

Health and Community Services

Meeting	**Date**	**Outcome**
Senior Leadership Team Meeting	14th November 2024	Noted

List of Appendices:
Non

Executive Summary

This report provides detail on the process by which patients with long waits are monitored on the elective waiting lists. There is a risk of patient harm being experienced (physical and psychological) whilst patients are waiting to be seen or treated. To reduce this risk, strategies are used by HCS which this report describes.

The paper does not provide detail on the Patient Tracking Lists (PTL) performance specifically, please refer to the current Quality Performance Report (QPR) papers for this detail.

As across the UK and worldwide, waiting lists for healthcare provision rose substantially during the pandemic due to significantly reduced elective capacity. As healthcare moved out of pandemic mode and back into business as usual, the transition to full capacity was slow meaning further growth in patients waiting for outpatient appointments or elective procedures.

Healthcare providers across the UK established a harm review process for PTL management whilst patients waited. This process included both administrative and clinical review. In England, the NHS devised a standard process which guided NHS Trusts on best practice for waiting list harm review.

HCS adopted some of the fundamental principles the NHS had developed and implemented these in those waiting lists which saw the highest number of patients waiting extended periods of time.

The standard processes HCS follow to monitor and manage PTLs are as follows:

1. Prompt clinical triage on receipt of referral.
2. 'Urgent' categorized referrals to receive appointment within four weeks.
3. 'Routine' categorized referrals placed on waiting list for next available slot.
4. Weekly monitoring of all patients on the waiting lists for outpatient and inpatient care through formalized Care Group PTL meetings.
5. Chronological booking principle alongside clinical priority grouping as described in the HCS Access policy.
6. Capacity and demand monitoring with interventions as required.
7. Clinical oversight of the longest waits with both administrative and clinical validation taking place where capacity allows. The regularity of review would be considered at weekly oversight PTL meetings if the recovery actions were not delivering access to care for patients and on advice of treating clinicians as their waiting lists are reviewed with waiting list managers/operational staff.
8. Monthly monitoring and reporting of patients waiting over 52 weeks HCS QPR.

Action point 7 has not been undertaken routinely on all outpatient PTLs other than dermatology, gastroenterology and Ear Nose and Throat (ENT) due to the lack of clinician capacity to undertake this review work. However, clinical review has been undertaken on the majority of inpatient PTLs of waits over one year with consultants ensuring their patients are able to remain on the waiting list without risk of harm.

Incident reporting and investigation through Datix happens when a patient has been identified as experiencing harm due to wait time. This has occurred once in 2024.

The impact of these actions show that clinical harm has not been experienced, in the main, by our longest waiting routine patients. Additionally, all urgent and suspected cancer patients are seen within the timescales expected to ensure a reduced risk of patient harm as demonstrated below in the clinical triage section.

Comparison with NHS data for benchmarking purposes is currently not possible.

Improvement work continues to be implemented as our systems and processes become more sophisticated over the next few months into 2025. Additionally, as interventions take shape, capacity is increased and utilisation improves across each specialty, long waits will be further reduced and eliminated.

Ultimately, the way to prevent harm is to reduce the waiting lists. Much work has been undertaken in this respect and further initiatives through 2025 will provide improved access to healthcare services for our Jersey residents.

Main Report

Managing patients on hospital waiting lists requires a systematic approach to ensure timely and appropriate care for all individuals with an emphasis of reducing potential harm. Extended patient waits can lead to various negative consequences, including increased patient anxiety, delayed diagnosis and treatment, and potential deterioration of their health condition. It is crucial that effective processes are used to manage harm while patients are waiting to be seen.

This report provides the HCS Advisory Board with assurance around the process for managing patient tracking lists (PTLs) and the extended waits some patients experience in some of the higher demand specialties.

To enable a systematic approach to management of waiting list, HCS has developed and published the Elective Patient Access Policy Policy Template HCS. This policy sets out the arrangements for the management of all elective referrals from any source, it establishes clear guidelines for managing waiting lists, including criteria for prioritising patients, details wait time targets, and procedures for monitoring and managing the elective pathways.

Management of waiting lists is crucial to ensure safe, efficient and equitable access to care for all patients. The list below provides the key strategies HCS has adopted to provide effective management of patients on our hospital waiting lists and to reduce the risk of harm to patients whilst they are awaiting their appointment.

Clinical Triage

Firstly, each referral is prioritized, through clinical triage by the receiving clinician, based on the severity of the referring condition. Currently patients are categorised as follows:

- Urgent
- Soon
- Routine

The use of the soon category is under review with the expectation this will be removed as HCS move to referral to treatment (RTT) standard, due to its ambiguity and ineffectiveness to manage. The removal of ‘soon’ is consistent with other jurisdiction healthcare organisations.

Triaging ensures those in urgent need of medical attention are seen promptly, while less urgent cases are managed accordingly. Urgent referrals are usually seen within four weeks with routine cases being appointed as capacity allows.

Table below shows the current urgent waits since 1st April 24.

Month-Year	Total Seen	Total Seen within 4 weeks	% Seen within 4 weeks
April-2024	1022	803	79%
May-2024	1120	888	79%
June-2024	1071	865	81%
July-2024	1095	885	81%
August-2024	963	763	79%
September-2024	966	855	89%
October-2024	883	870	99%
	7120	**5929**	**83%**

All urgent patients are seen within six weeks of referral, unless patient choice prevents this.

It is the routine cases where the longer patient waits are being experienced, but the physical risk of harm for this cohort of patients is low. Our current performance of over 52 weeks cohort as a proportion of overall waiting list size benchmarks well, however we still aspire to a performance position of zero patients in this cohort as part of our access standards.

Each triaged referral is visible on the live PTL by the responsible care group and the patient access and booking teams. Each referral is monitored on length of time they have waited on the waiting list with interventions being managed by care groups to support any necessary increase in capacity. These interventions can be through waiting list initiatives (finances allowing), additional patients being added on ad hoc basis to clinic templates, formal capacity and demand planning, job planning reviews or outsourcing initiatives. Improvement in efficiencies have been seen in reduction in 'did not attend' (DNAs), improved clinic utilisation and improved validation processes.

Patients who have been added to an inpatient waiting list for a surgical procedure will potentially experience further lengthy waits if their surgery is not deemed as urgent. Morbidity can deteriorate, for example, a patient waiting a hip replacement could experience increasing pain and reduced mobility. In this case, all long wait patients are reviewed by the TCI booking team in conjunction with their surgeon and at the weekly PTL meetings, with TCI prioritised based on clinical decision. Alongside the focus on urgent cases, HCS can evidence reducing in patient waiting list in those specialities where patients can face risk of deterioration such as lower limb elective in 2024.

Monitoring and Tracking

Each care group has a nominated waiting list manager whose responsibility it is to provide oversight of the waiting list status for each of the care group's specialties, providing escalation on issues which the care group needs to address to provide capacity to see and treat patients in line with the KPIs set out in the access policy.

Weekly PTL meetings are established for each care group. Attendees include the senior operational management team from the care group together with senior management from the centralised access team and the care group waiting list manager. The focus of these meetings are long waits, capacity and

demand needs, operational compliance with access policy and correct electronic management of patients on Maxims (data quality). As the organisation matures in its ability to manage its elective flow, implementation of referral to treatment (RTT) pathways will commence in 2025 with the weekly PTL meetings being further developed to include more complex KPI monitoring.

Dashboards and management information is provided through the informatics team, with data quality monitoring and oversight being managed by this team. This information provides graphical oversight and easy identification of potential future issues to enable care groups to provide interventions early.

Validation is the responsibility of all staff who manage patient pathways on Maxims. However overall validation sits with the waiting list manager for the care group. Validation is undertaken continuously to ensure our PTLs accurately reflect the status of the patients waiting on them. Validation provides the administrative oversite of potential patient harm and is the first point of identification when something does not look quite correct.

Capacity and Demand modelling

HCS has adopted the use of the NHS England Elective Care Improvement Support Team capacity and demand modelling tool which supports the business planning for specialties. Outputs enable the care group to plan their capacity requirements to mitigate potential short falls and manage their waiting lists effectively. Care groups are able to identify and shift available resources, based on these models, to where they are most needed thus supporting the reduction in patients long waits. This process once further developed and enhanced will, in the future, provide a mechanism whereby HCS can quickly identify future capacity constraints and establish plans to mitigate.

Management and oversight of clinic estate and clinic utilisation is undertaken by the waiting list managers for each care group, together with the assistant general manager (AGM) for patient access. Improvements in clinic utilisation supports reduction in patient waits.

Additional capacity is added to the core capacity at times of extended patient waits through out of hours working, evenings and weekends. This has significantly reduced patient waiting times, however unless capacity is improved, wait times will once again lengthen.

Clinical oversight

Responsible clinicians provide oversight of their waiting lists to ensure that patients are appropriately managed based on their clinical needs. Where extended waits are identified, waiting list managers request clinicians to review the waiting patients notes to gauge whether patients can continue to wait or require a more urgent appointment.

Currently there are different processes in the way clinicians document decisions when a review has taken place, in the main, a clinician will add notes to the patient record and if required, will ask for the patient to be expedited.

Incident reporting

Any incidents of patients coming to harm due to extended waits on waiting lists are required to be reported through the incident reporting system, Datix.

Depending on harm caused to the patient depends on the management of the incident. To date in 2024, only one incident has been identified and reported through Datix because of a patient long wait. The

investigation took place through the serious incident process. The patient did not suffer any long-term harm.

Improvements in place for the next 6 months

To further enhance oversight of PTLs, the following provides some of the additional work HCS is starting to design, implement and embed.

Standardised Referral Process

In collaboration with two key General Practitioners, HCS is standardising the referral process. This will support the required referral information to be easily accessible to the receiving triaging consultant to make improved informed decision on the patient's clinical priority thus reducing the potential harm of patients sat on waiting lists

Patient Initiated Follow-up (PIFU)

Traditional follow-up waiting list request the patient to attend an outpatient appointment at a time that is suitable for the clinician. Those patients with long term conditions, do not necessarily need to see their consultant at that time, but would prefer to see them when their condition has flared up. The introduction of PIFU will ensure clinic slots are not wasted by patients who do not need to see their consultant but provide quick access to their clinician at a time that is required.

Additionally, PIFU rules allow patients to take responsibility for their decision and advocate for themselves as required.

Technology and data management

The ability for patients to book appointments at a time suitable for them will support reduction in cancellations and DNAs and reduce wait times as clinic utilisation increases. The use of a digital patient portal or text messaging service will further enhance patient experience of waiting times. Both digital solutions are in early stages of development but will ultimately provide HCS and patients on waiting lists with enhanced communication tools and ability to manage their own care.

Technology will also support and educate patients about what to expect while waiting, including any signs or symptoms that would require immediate medical attention.

Over the coming months, a process of establishing a robust agreed patient referral management and communication standards with associated training will be rolled out to all staff who manage patient pathways.

Standardised pathways

The development of standardised and timed pathways will support the patient by knowing what is expected at each step of the pathway and approximate timescales these will be. It is likely timed standardised pathways would only be suitable for certain specialities but will prove supportive for those patients who are referred.

Collaboration Across Departments

Fostering collaboration among different departments to ensure a coordinated approach to managing waiting lists. This includes communication between primary care providers, specialists, and administrative staff. Additionally, HCS have been partnering with community organizations and other healthcare providers to share resources and improve access to care. This is a strategy which could be further enhanced.

Overall, proactive management of extended patient waits on our inpatient and outpatient waiting lists is being managed within the capacity, ability and technology currently available to HCS to reduce the risk to patient safety and well-being.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Winter Plan 2024**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**10**

Executive Lead:	Claire Thompson, Chief Operating Officer – Acute Services Andy Weir, Director of Mental Health, Social Care and Community Services
Report Author:	Claire Thompson, Chief Operating Officer – Acute Services Andy Weir, Director of Mental Health, Social Care and Community Services

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion ☐
	This paper provides the board with the steps being taken to respond to bed capacity pressures inherent with the winter season due to additional demand associated with respiratory illness.			
Summary of Key Messages:	The key messages arising from this report are: Healthcare providers annually consider the steps required to mitigate and reduce pressure for acute admission predominantly within acute medical services due to increased circulating respiratory disease. However, it is important to note that capacity issues can worsen due to further constraints in both home care and nursing home sector capacity due to leave of staff during school holiday periods. Health and Community Services (HCS) has considered the opportunity to increase our bed base (across acute and community care) to improve and stabilise emergency flow and elective access to maintain improvements made over 2024 with the inpatient waiting list. HCS winter planning therefore has focussed on increasing capacity for those patients requiring long term care due to dementia and other nursing needs and inpatient acute for medical admissions to respond to increase in respiratory activity, as well as planning a 'bridging' service to accelerate discharge where possible. Following a discussion as an Executive Leadership Team (ELT) on 14th October, it was recognised that additional capacity identified for the winter plan has already been utilised (namely Samares, Sandybrook). Therefore, a further discussion took place on the 22nd October about the management of capacity and demand and the ongoing impact on quality of care, operational performance and financial recovery. This has provided a framework for ongoing work in three areas, 1. Admission avoidance, 2. Pathway management (effective flow, discharge planning, senior review, red-to-green ((Red to Green (R2G) principles) 3. Delayed transfer of care (DTOC) / community provision. The overarching aim is to continue to improve length of stay and quality of care, evidencing the most efficient use of available capacity.			
Recommendations:	**The Board is asked to note the report.**			

Link to JCC Domain:		Link to BAF:	
Safe	√	SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	√
Responsive	√	SR 4 – People and Culture	
Well Led	√	SR 5 – Finance	

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Executive Leadership Team	14 October 2024	Further planning meeting planned
Senior Leadership Team	17 October 2024	Agreed for Committee reporting
Finance and Performance Committee	30 October 2024	Accepted for Board reporting

List of Appendices:
Nil

MAIN REPORT

HCS has considered a best practice framework to winter planning 2024/25 and is inherent in the subject headings below. Also, a reflection on the previous winter performance has taken place. HCS has worked with Public Health (PH) and other colleagues in acute physical, mental and community services to review and plan for this period. This commenced in August 2024.

Emergency Department (ED)
A room has been converted into an ambulance triage room (senior patient assessment and treatment) to reduce handover delays, improve patient experience and reduce risk of and from patients having to wait in a corridor. A rapid decant standard operating procedure (SOP) is in development for implementation pre-winter to support the need to maintain crucial resuscitation and majors' capacity. This has been developed as part of the review of the bed management policy HCS.

Same Day Emergency Care (SDEC)
Due to concerns raised regarding the physical environment, the previous location for SDEC service was closed. Throughout 2024, the Medical Care Group have explored the opportunity for this to sit within the Acute Admission Unit (AAU), but this has not been possible to maintain due to a corresponding loss of in-patient bed base. The provision of ambulatory care is being developed as part of the clinical vision of flow/acute care workstream with oversight at the Medical Improvement Group (MIG) meetings. However, the treatment room in AAU has been adopted to provide two physical reclining chairs for the assessment and treatment of patients within an ambulatory setting/pathway. A solution needs to be sought in relation to the procedures not able to be carried out in medical day unit (MDU) due to sluice availability. This is being actively worked through with Infection Prevention and Control (IPAC) and Estates. A solution will avoid elective medical patients having to be placed on AAU alongside the emergency take.

Frailty
HCS remains limited by the lack of on-site Geriatrician/Care of the Elderly Consultants to lead and provide admission avoidance and in-reach expertise to the acute medical and surgical bed base, although historically business cases have been developed but not received funding. The recent approval in principle of the Medical

Model by the Senior Leadership Team (SLT) will allow this service to be developed but will require prioritizing at budget setting 2025 for the medical care group with potential impact to other service provision in acute services without efficiency or growth being identified to provide a source of funding. Recent advertising for General Medical Consultants alongside those with interest and expertise in respiratory and elderly care has not been successful to date. Medicine care group (MCG) is presenting requests for a Geriatrician at the workforce control panel (WCP) and reviewing how Allied Health Professionals (AHPs) can support admission avoidance within the ED. Daily input from Rapid Response Team (RRT) via the Family Nursing and Home Care (FNHC) commission has been requested into ED and AAU as priority activity.

Inpatient flow and length of stay (acute)
As part of the medical model paper to SLT, reductions in acute length of stay were observed in some key areas notably AAU and Corbiere from 2023 to 2024. Continued focus on reducing length of stay and improving clinical effectiveness sits within the MIG with input from visiting Physician Dr Ian Sturgess supporting the Chief of Service and Clinical Directors. The ongoing work streams responding to the 19 recommendations from the Royal College of Physicians Review and the development of the clinical vision of flow are in place. Weekly 'over 7 days length of stay' (LOS) and DTOC meetings chaired by the Executive Director for Mental Health, Social Care and Community Services continue. Bed management function is being strengthened through a new model and ways of working which will support the Clinical Coordinators with additional capacity to input into the care of deteriorating patients and improving patient safety.

Community and Mental Health Care Group
The below actions are being delivered/developed by the Community Services Care Group to support the winter plan 2024/2025.

- Review of beds on Samares to increase capacity. More beds have been opened in October from 12 to 17. This is outside of the budgeted establishment and has been facilitated due to the ongoing pressure within the JGH with frequent periods of black escalation alongside deterioration of performance in the ED.
- Sandybrook (our only HCS provided nursing home) has also brought more capacity online in September/October from 20 to 24 beds.
- Review of beds on Beech ward to increase capacity (dementia care) is being undertaken by the mental health team. This needs to be further discussed to reach a conclusion, due to some concerns about the potential use of shared rooms and the longer-term impact on learning disability inpatient provision.
- Implement a bridging service to reduce delays for package of care (PoC).
- Identify single packages that could be initially supported by Red Cross / other agencies.
- Identify potential high cost / home first packages that could be provided (outside of agreed budget)
- Further work is needed to progress the implementation of Patient Choice Policy to reduce waiting times for community care beds when a suitable placement is available but being declined by patients or their families on personal choice.

Acute Respiratory and Inpatient Capacity
HCS currently has been able to secure respiratory consultants for Winter 24/25 although these are still non-substantive appointments. This has impeded the ability to develop a respiratory high dependency unit (HDU) in Bartlett ward although this has been provisioned within the ward refurbishment so remains an option to be developed resources allowing. Patient safety issues and staffing restrictions have led to the view to maintain the status quo of patients requiring higher levels of respiratory care being admitted to the Enhanced Care Area (ECA) or Critical Care (CCU) as required.

Cardiac and Respiratory Clinical Nurse Specialists are supporting admission avoidance in ED and in-reach into acute wards to support step down and discharge planning also.

At this time, HCS has 10 more acute medical beds open than during the same period last year.

A refurbishment of Bartlett (respiratory ward) will be complete in November 2024 which will allow Plemont ward to open to their full substantive establishment of beds (12 in total) and will increase the bed base by a further two.

At this point, the acute adult general and surgical inpatient capacity will sit at 152 beds (this excludes CCU, Maternity and Paediatrics and the private ward Sorel).

Paediatrics, Maternity and Jersey Neonatal Unit has a SOP for surge as required and works within a network to support tertiary transfer.

The physical environment in Plemont can provide additional winter surge capacity of 16 but is outside of funded budgeted establishment at this point. The medicine care group are reviewing as part of budget setting the ability to provision an establishment that incorporates an ability to surge without pressure in the future. For this winter, however, the ability to over-recruit at forthcoming interviews could provide a less costly approach to opening these beds with temporary workforce such as agency.

Bed management plan
A new structure has been developed to increase the clinical leadership of the bed management team and Clinical Coordinators. The bed management policy has been reviewed and HCS is developing a maximum capacity ED/rapid ED decant process alongside potential boarding policy to support this. ED will have an ambulance handover room in place to reduce handover delays at time of bed pressures and poor flow out of ED.

Vaccination plan
The Flu and Covid vaccine programme has commenced with the aim of increasing uptake across clinical and non-clinical staff groups to support responding to circulating viruses and maximize staffing available to provide care and protect vulnerable patients within acute wards from non-symptomatic staff.

Adult Mental Health
The adult mental health team are able to flex to increase crisis and home treatment capacity should a surge of referrals occur. There is also capacity within the new Orchard Ward to increase acute admission bed capacity in an emergency.

Finance / workforce implications

Planning well for winter minimises financial risk due to the need to avoid surging capacity at short notice and reliance on agency workers as an emergency response. In addition, this allows healthcare providers to take management decisions to respond to higher demand for services and maintain performance and quality of care through mitigating actions. Winter workforce is being maximised through agency conversion, reduction in overall vacancies and improved take up of bank shifts. Opportunities to over recruit are being actively explored. Good workforce planning will reduce staffing gaps which will support both staff and patient experience. Development of the medical model has continued following a paper to SLT which was accepted in principle but requires resource allocation via budget setting. This will delay any potential recruitment to impact Q1 2025 and winter periods although key roles are being presented at WCP for consideration e.g. frailty consultant to support admission avoidance.

Risk and issues

Both inpatient acute and mental health capacity remains challenged. JGH acute capacity is observing high periods of occupancy and frequent occurrences of black and red escalation status. ED performance metrics have been impacted alongside elective activity. There has been a rise in DToC specifically relating to people waiting for nursing home beds and specialist dementia placements. This creates a specific risk in terms of increased DToC / reduced flow and capacity, particularly given that we have very little ability to influence how community capacity is used in these areas.

CCU has a SOP for surging if the requirement for cubicle delivered care exceeds the two side rooms in CCU although this would impact elective activity by affecting physical space in theatres/recovery.

Further and current surge is outside of substantive financial envelope for 2024 although opportunity to address this is being considered at budget setting 2025.

In year loss of the physical environment of SDEC/SDAC is a current issue that is being reviewed to attempt to ensure we can maximise our ability to manage demand via ambulatory model to reduce the need for acute admission where it is clinically appropriate to do so. Alongside this, Medical Services Care group are looking to find an adequate solution to the estate constraints in MDU regarding no sluice and the impact on the types of patient treatment that cannot be placed there, further impacting the demand for acute admission or placement elsewhere.

The recent notification of the closure of the out of hours opening of a community pharmacy is being discussed with Public Health and Primary Care to see what mitigation measures can be taken to reduce any compounding impact to HCS ED.

Recommendation

The board is asked to note the following:

- Additional acute, rehabilitation and nursing bed capacity has been put in place compared to the same period 2023.
- A further two beds in medicine will be operational by the end of November with a newly refurbished respiratory acute care environment improving patient experience and infection prevention and control. A mitigation plan is in place to facilitate ambulatory care.
- The opportunity to surge into Plemont ward with an additional 16 beds to respond to demand is subject to additional staffing that is outside of budget and current year end forecast. The Chief Nurse is leading HCS approach that considers over recruitment to limit agency premium. Other roles including medics, AHPs and nonclinical support will also be required to operationalise.
- The medical care group are not able to commence recruitment until budget setting is finalised which contains key roles for supporting continued improvement of length of stay (as evidenced in HCS wards with substantive and senior Consultant leadership) and frailty.
- Ongoing discussion and timeline for decision making regarding the potential Beech Ward repurposing to provide increased dementia care capacity. This work is being led by the Director for Mental Health, Social Care and Community Services and the Chief Nurse.

HCS needs to consider for subsequent winter plans opportunities such as:

- Local enhanced services and directed enhanced services which could impact the need for hospital admission through primary care intervention into clients within nursing home capacity particularly during winter periods. This could feature within the system wide discussions supported by the Minister for Health and Social Services (MHSS) proposed integrated structure for health and care.

- Development of frailty services and admission avoidance.

- Virtual ward and the development of outreach oversight of clinical pathways

- Development of future dementia care models (across hospital, nursing / residential care and home) in line with the published dementia strategy.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**M10 Workforce data report**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**12**

Executive Lead:	Ian Tegerdine Director of Workforce
Report Author:	Ian Tegerdine Director of Workforce

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides the Board with regular information on the status of the workforce.			
Summary of Key Messages:	The key messages arising from this report are: We continue to work with Government of Jersey (GoJ) People Services on these reports, at the request of the People and Culture committee we will withdraw the domains relating to workforce finance as they are drawn from different data sources and may cause confusion when compared with the workforce data in our finance reports. This action has not yet been completed. We have outstanding actions on the data on new starters as the Connect data differs with our manual recruitment tracker this month and the Connect performance data remains differs with our manual data on the number of appraisals and reviews completed. Putting aside these new data challenges, which we are addressing in our workforce data workstream, then the following conclusions may be drawn (with the normal data warnings about how we have to compile reports from multiple sources): • The number of live vacancies may be related to the data issue on new starters and is under investigation. • Turnover remains stable. • Sickness levels remain stable. The Board will note that the report does not give the assurance on staffing that is needed, and further work is needed in order to provide the Board and its committees (and the departments and teams in HCS) with the data required to effectively manage its workforce. The Health Chief Information Officer (CIO) and Director of Workforce (DoW) are meeting with the People Services team to further review the data flows and reporting on workforce.			
Recommendations:	**The Board is asked to note the report and note the actions in train to develop a fit for purpose report.**			

Health and Community Services

Link to JCC Domain:		Link to BAF:	
Safe	X	SR 1 – Quality and Safety	X
Effective	X	SR 2 – Patient Experience	X
Caring		SR 3 – Operational Performance (Access)	X
Responsive	X	SR 4 – People and Culture	X
Well Led	X	SR 5 – Finance	X

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
People and Culture Committee	30 October 2024	

List of Appendices:
Appendix 1: Workforce Data M10

PLEASE NOTE THE BELOW BEFORE USING THE PEOPLE DASHBOARD

Methodologies and Pre-Filters:

The data in this dashboard includes all permanent and fixed-term employees, as well as employees on variable contracts.

The data exclude any employee or staff with a pay group of 'non-payroll' (such as contingent workers, interims and agency staff) and 'non-states workers' (such as States Members and staff in JOIC and Jersey Overseas Aid).

With the exception of the Zero Hour page, the data also excludes employees who are solely on zero hour / bank contracts.

Metric specific methodologies are shown on each page as applicable.

The Overview page uses a snapshot of the metrics from the pages that follow. Specific methodologies for each of those figures are shown on the applicable page(s).

Overview

October 2024

Workforce Profile

2,529.22
Actual FTE

2,676
Actual H/C

365
Starters in Last 12 Months

Turnover

176
Leavers in Last 12 Months

6.8% ✓
Same Period Last Year: 7.4% (-0.6%)

Leaver Category	Leavers	Turnover	Same Period Last Year
Retirement	17	0.7% ↓	1.4%
Involuntary	31	1.2% ↓	1.6%
Voluntary	130	5.1% ↑	4.3%
Total	**176**	**6.8%** ↓	**7.4%**

Sickness

33,421.7
Sickness Days Lost

Av. Days Sick Per Employee

13.0 !
Same Period Last Year: 11.18 (+1.8)

Main Reasons for Absence

Reason for Absence	%
Cold, Cough, Flu - Influenza	26.8%
Gastrointestinal problems incl. D&V	15.1%
Anxiety/Stress	11.6%
Headache / migraine	7.3%
Chest & respiratory problems	5.7%
Surgical Procedure	4.9%
Musculoskeletal prob. excl back incl	4.0%

Staff Costs

Monthly Staff Costs

£15,425,172 ✓
Same Period Last Year: £15.6M (-0.84%)

Monthly Overtime

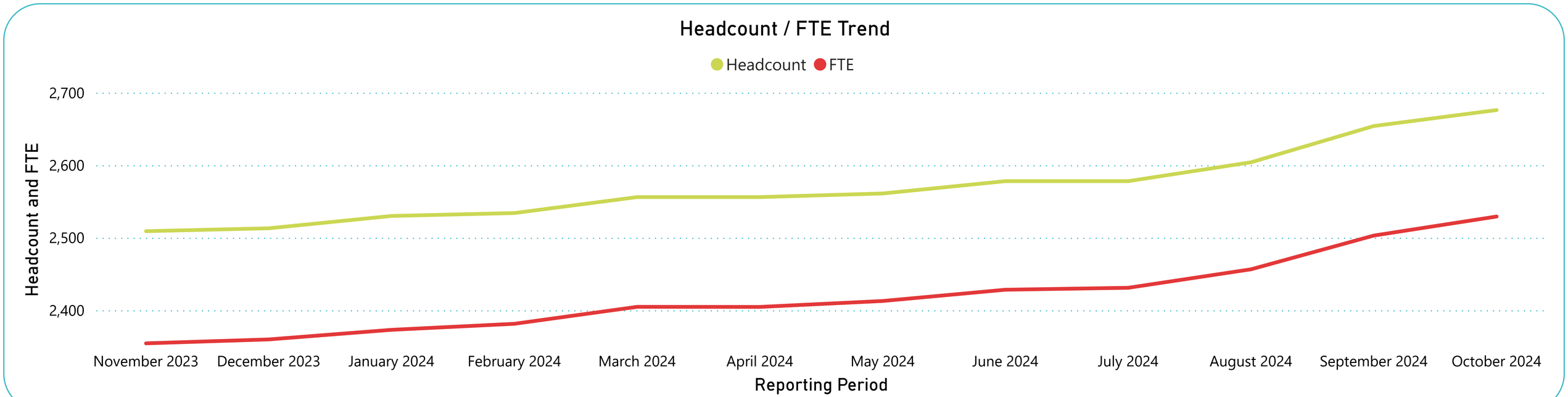
£301,431 ✓
Same Period Last Year: £446,592 (-32.5%)

Main Pay Excl. Basic Pay

Pay Code - Categorised	% of Total Pay
Shift Allowances	37.4%
Skill Related Payments	25.9%
Overtime	16.8%
Ad Hoc Payments / Supplements	13.5%
Benefits	4.5%

Headcount

October 2024



Department	Total	FTE
Health and Community Services	2,676	2,529.22
Total	**2,676**	**2,529.22**

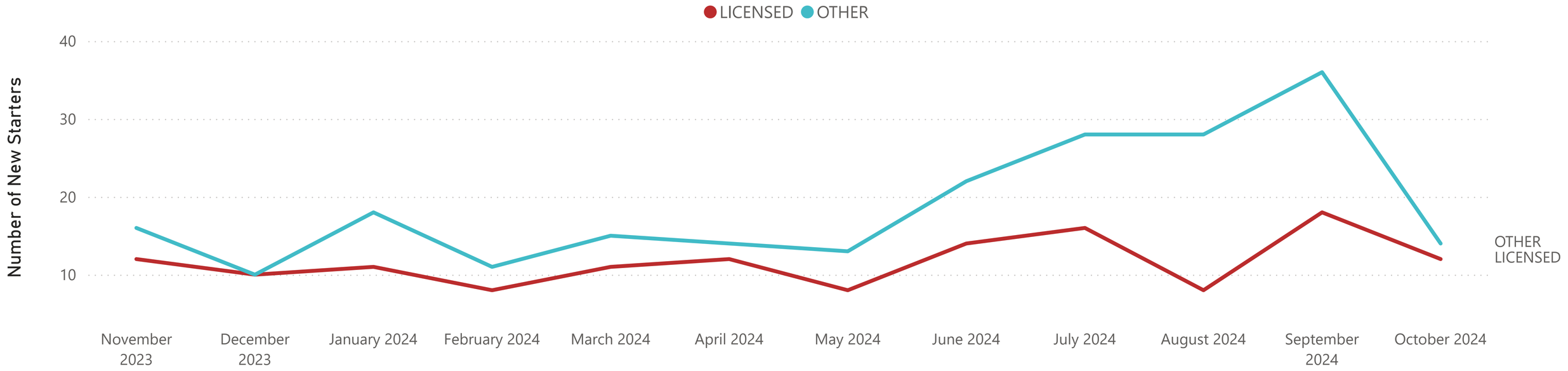
Methodology:

Total headcount includes all permanent and fixed-term employees, as well as employees on variable contracts. The data excludes employees who are solely on zero hour / bank contracts, as well as any staff showing as 'non-payroll' (such as contingent workers, interims and agency staff) and 'non-states workers' (such as those in JOIC and Jersey Overseas Aid).

Each employee is counted once, per department they work in. If an employee holds multiple roles (other than zero hour contracts) they are counted once per area they work in. The employees total Full-Time Equivalent (FTE), for all roles held in any area, are counted in the FTE column.

New Starters

October 2024



Department	LICENSED	OTHER	**Total**
⊞ Health and Community Services	140	225	**365**
Total	**140**	**225**	**365**

Methodology:

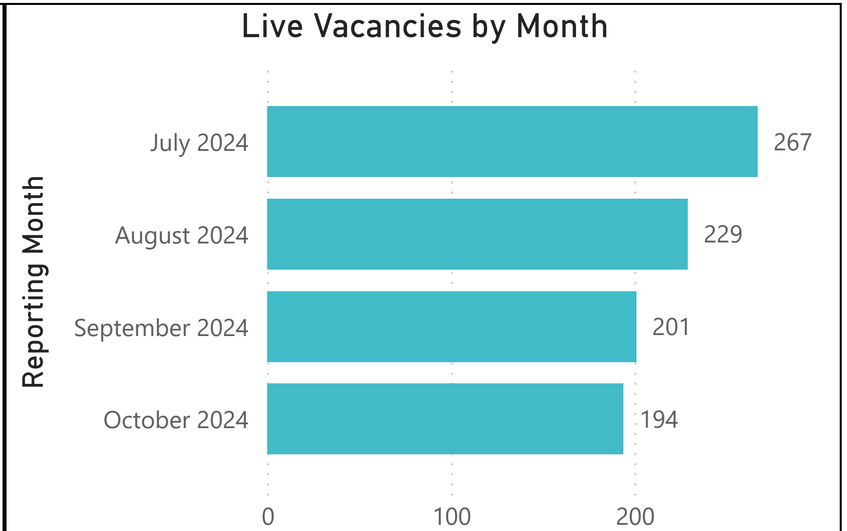
Starters are split to highlight the number of Licensed employees who have joined in the last 12 months, compared to those with other Jersey Residency Statuses.

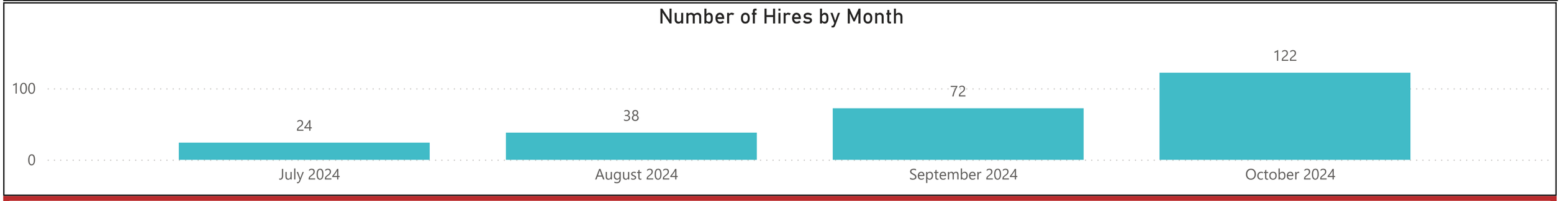
Data is based on Continuous Service Start Dates in Connect People. If an employee joins one area, and subsequently moves to another within the 12 months period, they are counted once per area with the grand total only counting them once.

Live Vacancies in Recruitment

October 2024

Department	No Stage	Interview	Offer and Contract	Clearances	Total
Health and Community Services	81	30	26	57	**194**
Total	**81**	**30**	**26**	**57**	**194**





'Live Vacancies in Recruitment' is different to 'vacant posts' in Connect People and Establishment. There may be several budgeted posts currently not being recruited for, and as such are not included in these figures. Vacancy figures are only displayed from July 2024, when the Talent Acquisition (TA) module in Connect was fully live and previously used systems closed down.

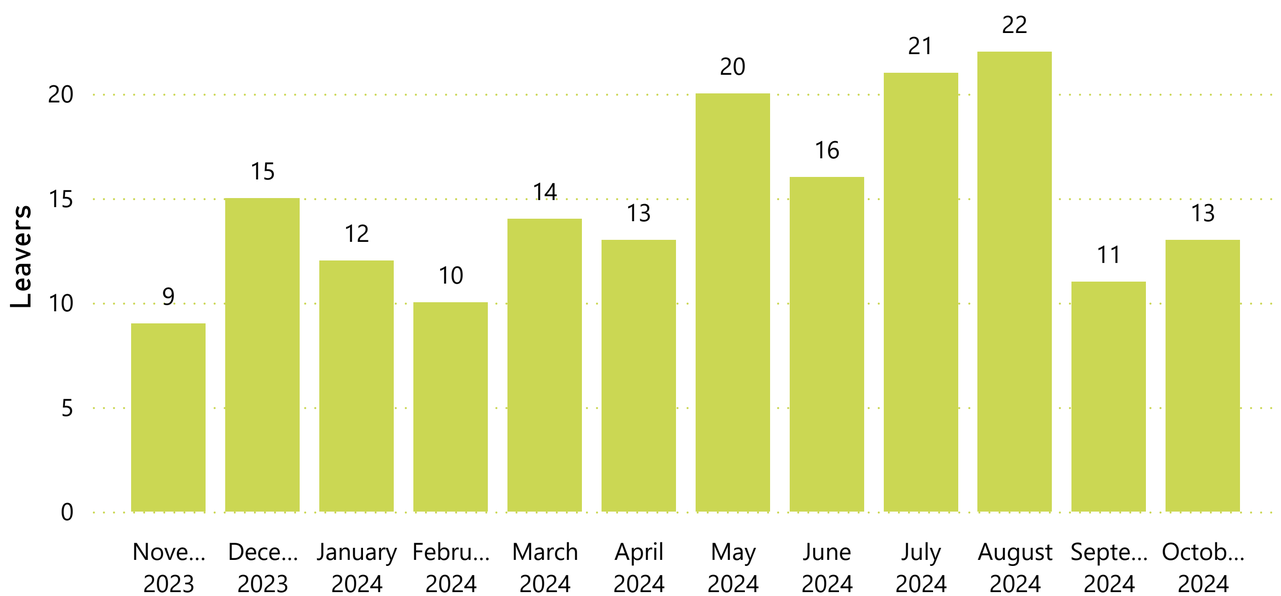
Figures are taken as a snap-shot in time; the last day of each month. Therefore, they do not include any vacancies which were hired or which closed down earlier in the month. Figures exclude Evergreen campaigns.

Figures shown here include any vacancies in TA that haven't been closed down, and which are not showing as 'Hired'. The table is broken down into the candidate status of each role currently in Recruitment.

As from 5th August 2024, a recruitment freeze for non-essential roles was implemented at the Government of Jersey. As such, Live Vacancy figures will progressively get lower as previously advertised non-essential posts are either filled or closed down. **As at 30 September 2024, 84% of all GoJ live vacancies were approved prior to the recruitment freeze.**

Turnover

October 2024



Methodology:

Turnover % is calculated as Permanent, Fixed-Term of Variable Contract Employees who leave Government employment as a whole. It does not include those who leaves one department for another, i.e. an internal transfer. It does not include employees who leave a substantive post but retains or moves to a zero hour / bank position, as they are still in Government employment.

Metrics for internal movers and substantive -> zero hour role movers are in development.

Permanent leavers with less than 12 months continuous service

Department	Leavers
⊞ Health and Community Services	19
Total	**19**

Department	Involuntary	Retirement	Voluntary	**Total**
⊞ Health and Community Services	31	17	130	**176**
Total	**31**	**17**	**130**	**176**

Leaver Category	Leavers	Turnover	Same Period Last Year
Retirement	17	0.7% ↓	1.4%
Involuntary	31	1.2% ↓	1.6%
Voluntary	130	5.1% ↑	4.3%
Total	**176**	**6.8%** ↓	**7.4%**

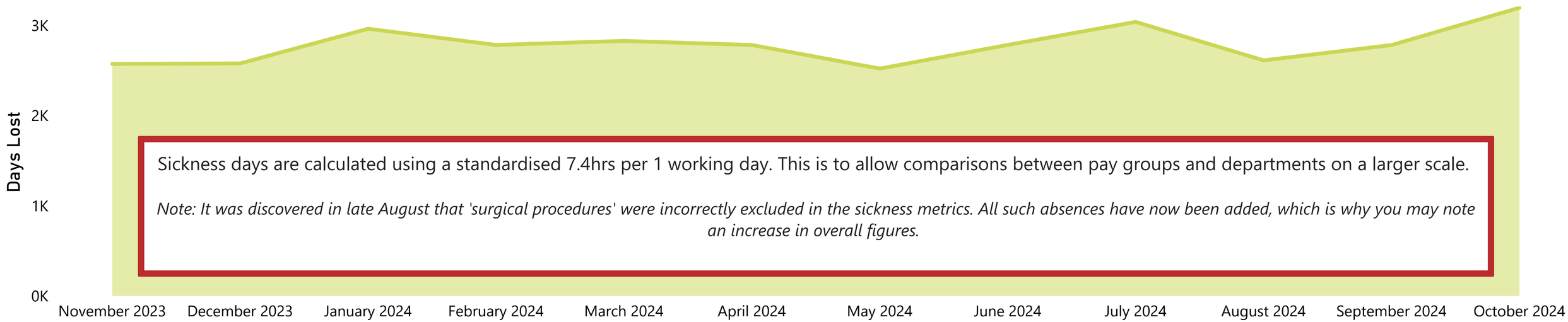
Sickness Term

All

Mental Health Related

Sickness

October 2024



Sickness days are calculated using a standardised 7.4hrs per 1 working day. This is to allow comparisons between pay groups and departments on a larger scale.

Note: It was discovered in late August that 'surgical procedures' were incorrectly excluded in the sickness metrics. All such absences have now been added, which is why you may note an increase in overall figures.

Sickness Analysis - Nov-23 - Oct-24

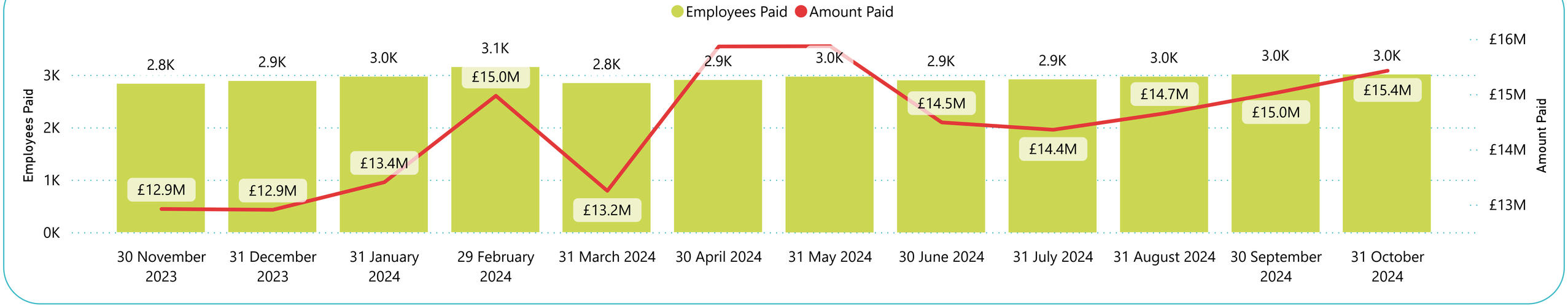
Department	Sickness Hours	Days	Instances	% Working Days Lost	Av. Days Sick Per Employee*	Av. Days Same Period Last Year
⊞ Health and Community Services	247,320.3	33,421.7	6,310	6.2%	13.0 ↑	11.18
Total	**247,320.3**	**33,421.7**	**6,310**	**6.2%**	**13.0** ↑	**11.18**

*Compared to same period last year

Absence Reason	Number of instances
Cold, Cough, Flu - Influenza	1,693
Gastrointestinal problems incl. D&V	956
Anxiety/Stress	735
Headache / migraine	462
Chest & respiratory problems	362
Surgical Procedure	309
Musculoskeletal prob excl back incl neck	254
Back Problems	247
Injury, fracture incl bruising/cuts	224
Depression/other psych	167
Genitourinary & gynaecological disorders	162
Benign and malignant tumours, cancers	155
Pregnancy related disorders	73
Eye problems	61
Dental and oral problems	58
Total	**6,310**

Staff Costs

October 2024



Payment Type	£
	£19,442.7
Ad Hoc Payments / Supplements	£241,175.3
Basic Pay	£13,635,615.8
Benefits	£80,416.3
Business Expenses	£4,080.7
Exclusions	£4,400.0
Other Time Payments	£14,488.9
Total	**£15,425,171.6**

Basic Pay YTD

£129,981,425.0

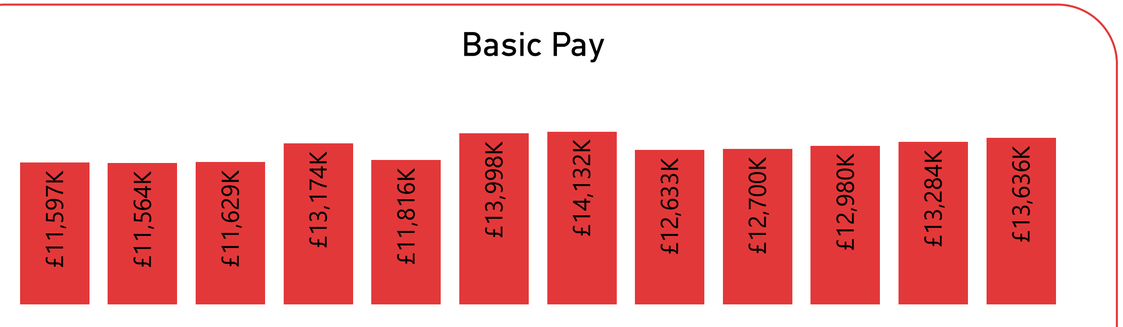
YTD Last Year: £110,555,050.7

(+17.57%)

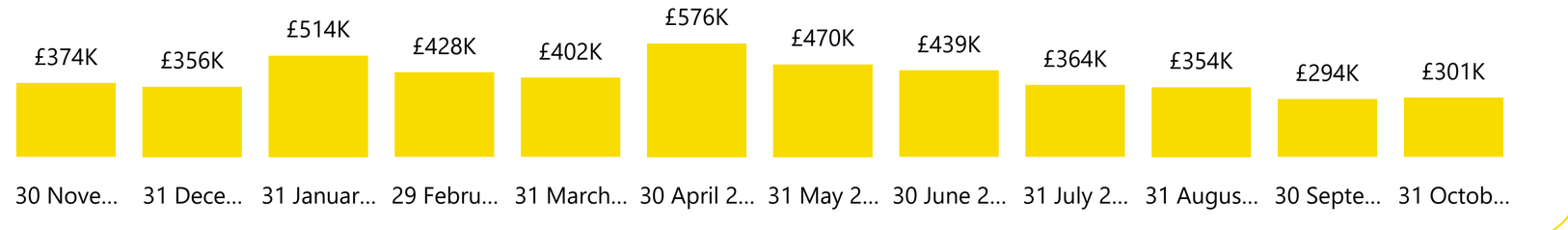
Overtime YTD

£4,143,911.3

YTD Last Year: £4,038,954.4 (+2.6%)



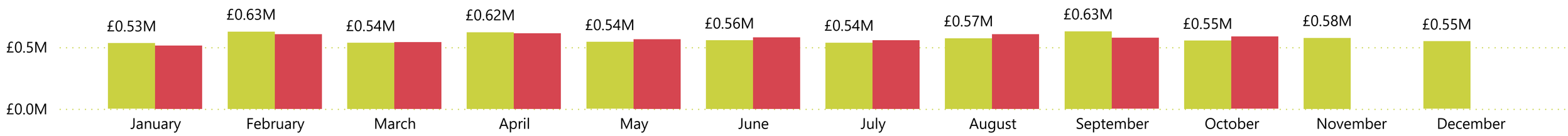
Department	£
⊟ **Health and Community Services**	**£15,425,171.6**
⊞ Chief Nurse	£873,340.7
⊞ Hospital and Community Services	£13,682,010.0
⊞ Improvement & Innovation	£173,628.2
⊞ Medical Director	£696,192.7
Total	**£15,425,171.6**



Zero Hours

October 2024

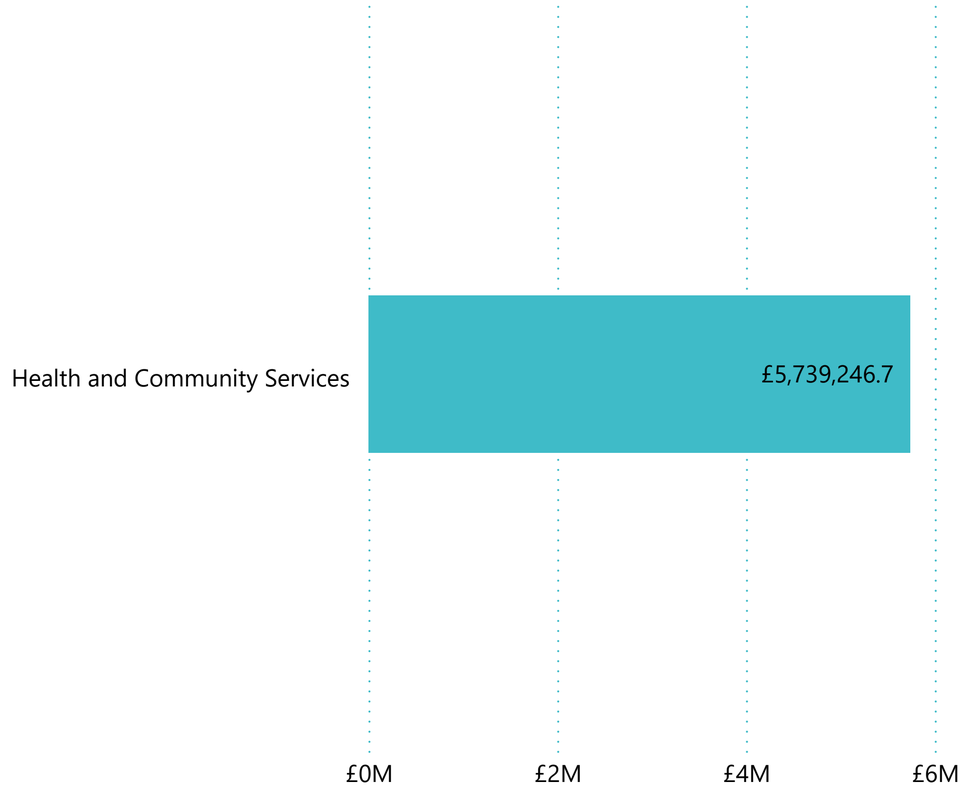
Zero Hour Spend



Department	Has a PM / FTC Role	Unique ZH Role	**Total**
⊞ Health and Community Services	1,096	713	**1,809**
Total	**1,096**	**713**	**1,809**

Department	Not Worked in Last 12 Months	Worked in Last 6 Months	Worked in Last 7 - 12 Months	**Total**
⊞ Health and Community Services	823	952	127	**1,809**
Total	**823**	**952**	**127**	**1,809**

YTD Zero Hour Spend



Connected Performance

October 2024

40.3%	14.1%	5.5%	38.1%	1.39%	0.60%
Objective Setting	Mid Year Self-Review	Mid Year Manager Review	Year End Self Rerview	Year End Manager Review	Connected Performance Complete

Connect Performance

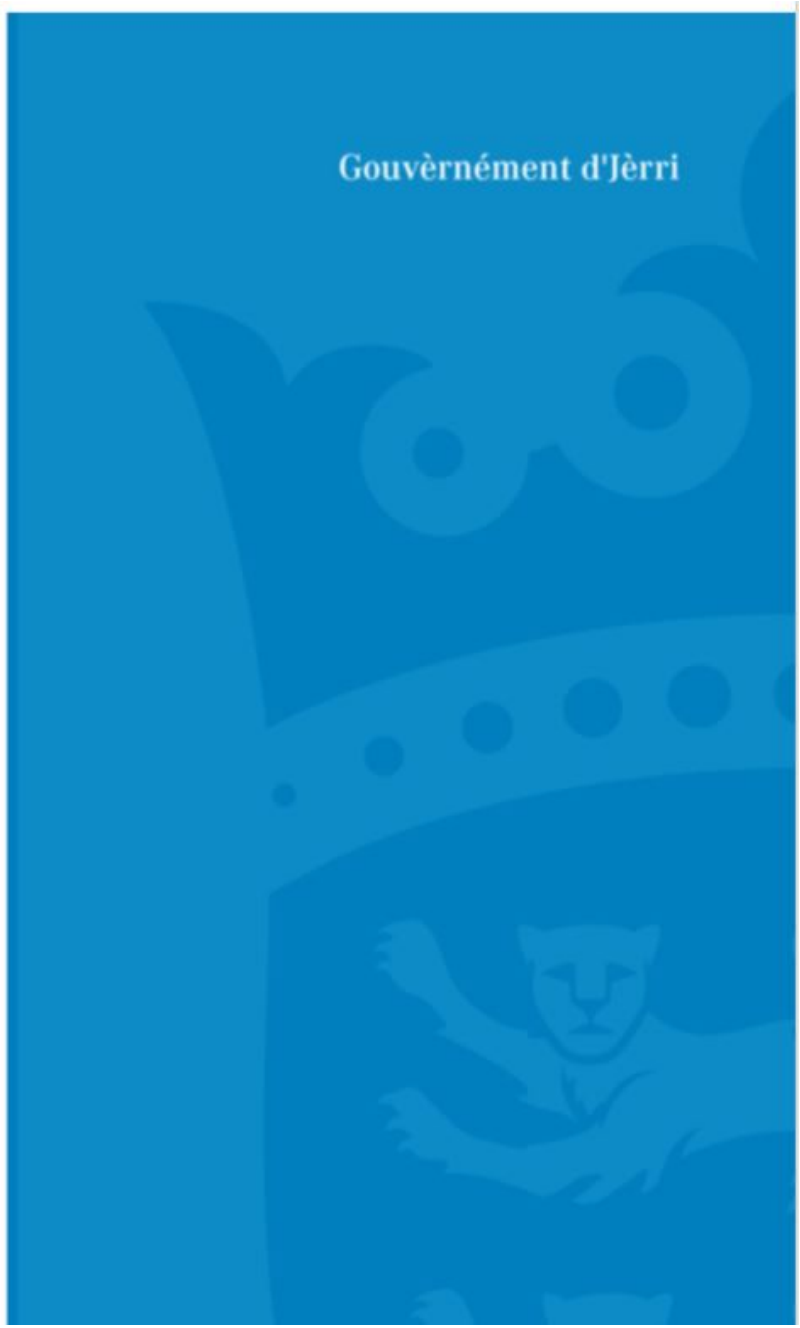
Department	Objective Setting	Mid Year Self-Review	Mid Year Manager Review	Year End Self Review	Year End Manager Review	Connected Performance Complete	**Total**
⊞ Health and Community Services	870	304	118	822	30	13	**2,157**
Total	**870**	**304**	**118**	**822**	**30**	**13**	**2,157**

The total column shows the number of forms that have been issued for each area, as not all Government of Jersey employees are enrolled on to the Connect Performance appraisal programme.

Each stage (column) shows the completion figure / percentage of where employees "sit" in the process. For example, if the 'Objective Setting' column is showing a figure of 12, it means that 12 employees in this area have yet to set their start of year objectives. A figure of, for example, 18 in the 'Mid Year Manager Review' column means 18 employees' managers have not approved / completed the mid-year review.

Health and Community Services

Quality and Performance Report
October 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

Patients waiting over 52weeks for 1st OPA

October was the first time since June 2024 where the number of patients waiting over 52 weeks have fallen, this is a direct result of increase in capacity within dermatology outpatients; commencement of the 2nd consultant dermatologist and the start of a short waiting list initiative.

Patients waiting over 52 weeks for their elective procedure

October, once again saw a small rise in the number of patients waiting over 52 weeks for their procedure. Mainly within orthopaedic and general surgery specialties. This small rise, as in previous months, is a direct result of equipment breakdown and bed availability together with additional unplanned theatre maintenance.

Access to Diagnostics over 6 weeks

Diagnostic waits remain static. Further validation of the waiting list particularly within MRI and CT is required to ensure the reported position is not over inflated.

Elective Care Performance

The waiting list initiative for Echo cardiology completed in September. The project was successful and delivered 1742 additional echo capacity resulting in the waiting list reducing from a wait of over 14 months to a current wait of approximately 4 months. Ongoing sustainability for the service is now being planned with an additional physiologist being planned for the new year.

New to Folow-up ratio

The new to follow-up ratio has fallen in month and remains within an acceptable range to overseas peers.

DNA and WNB rates

The DNA and WNB rates have dropped in month because of improved booking and validation processes. Further work continues as we get more sophisticated in our administrative processes.

Elective theatre utilisation

Theatre utilisation remains significantly below the required standard. There are multiple reasons for this including the availability of equipment and unexpected theatre maintenance. A new lead has been appointed to drive theatre process improvement and improvement into November has been observed in reduction of late start minutes.

On the day theatre cancellations remain high as a direct result of theatre and equipment breakdowns. Cancellations due to beds have reduced.

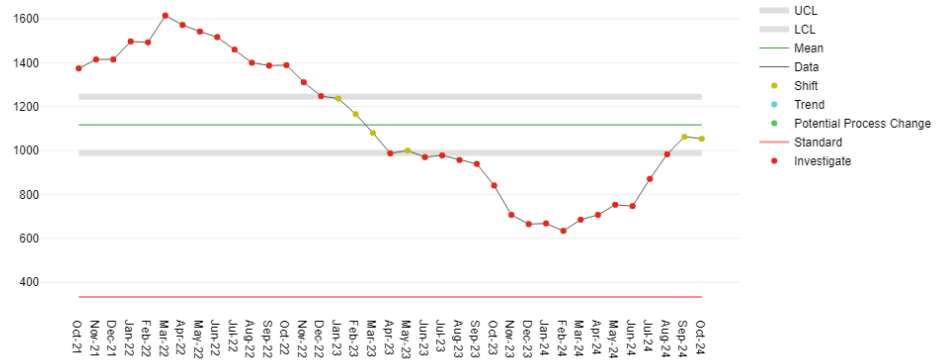
Escalations

No Escalations

Elective Care Performance - SPC Charts

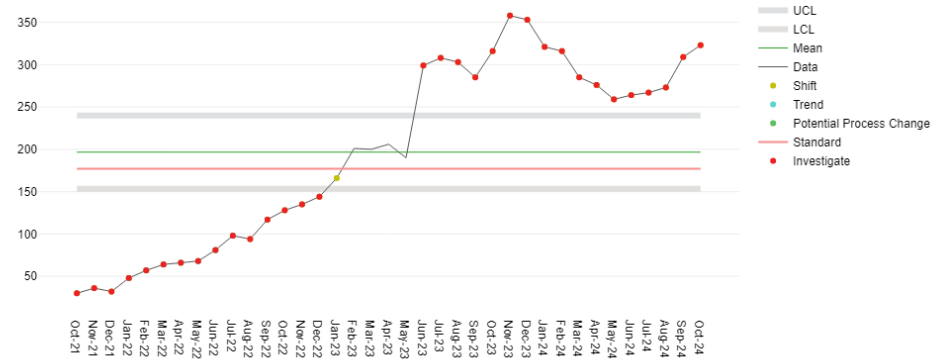
Latest value	Standard
1054	<333

Patients waiting for first outpatient appointment Greater Than 52 weeks



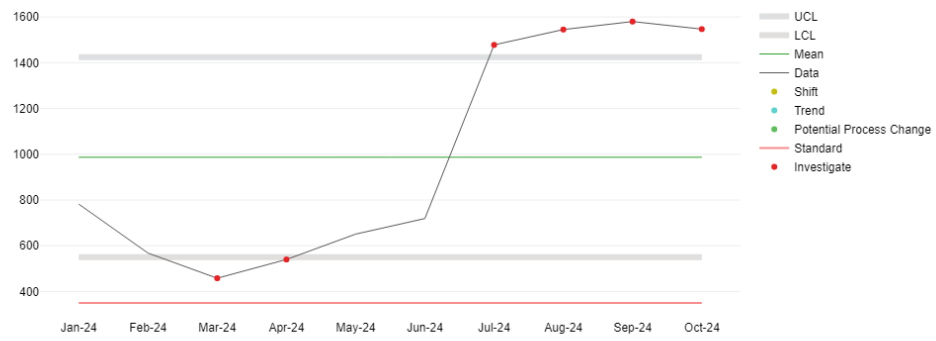
Latest value	Standard
323	<177

Patients on elective list Greater Than 52 weeks



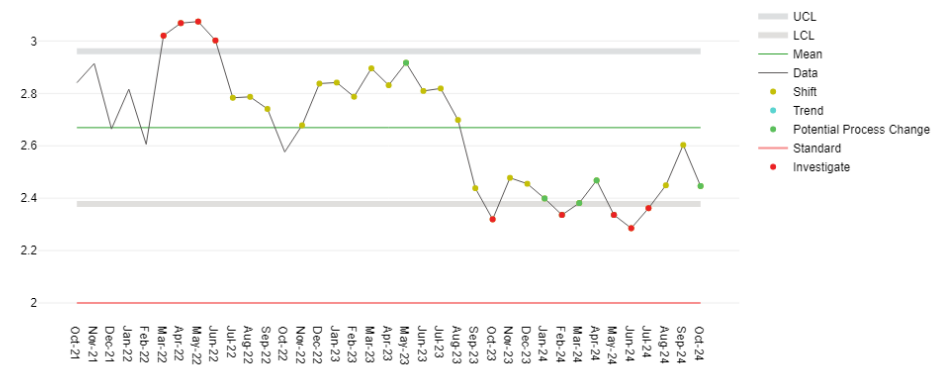
Latest value	Standard
1547	<350

Access to diagnostics Greater Than 6 weeks



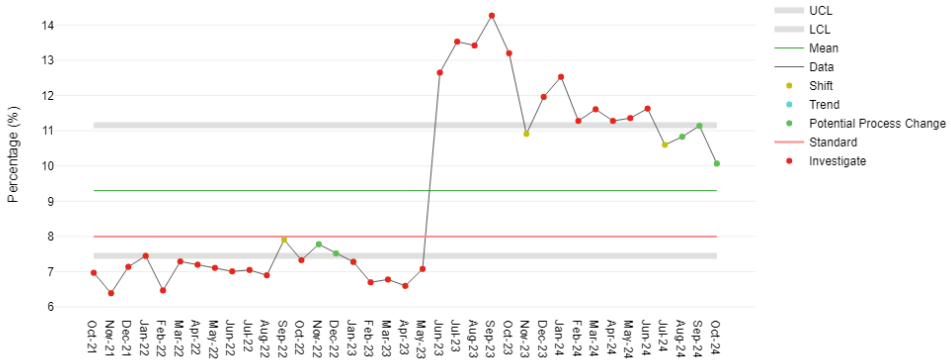
Latest value	Standard
2.45	2

New to follow-up ratio

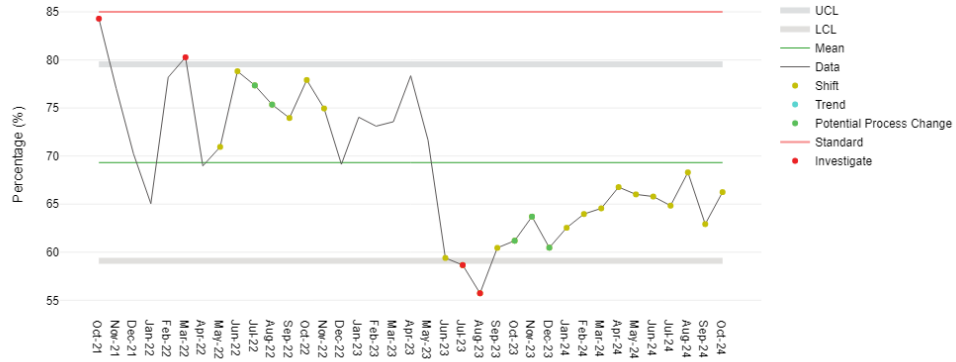


Elective Care Performance - SPC Charts

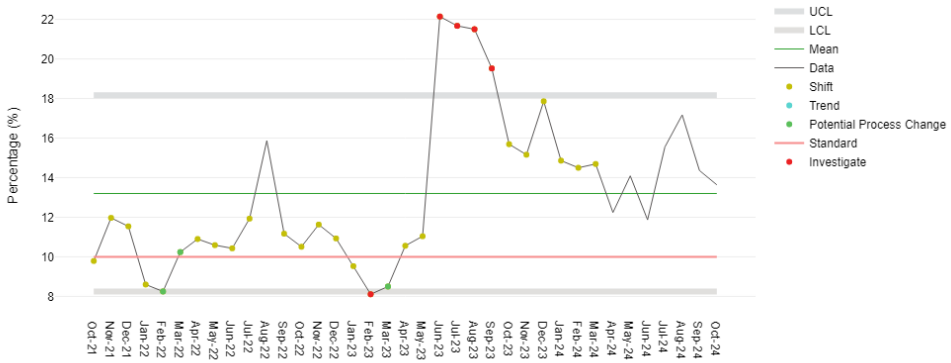
Latest value	Standard
10.1 %	<=8%



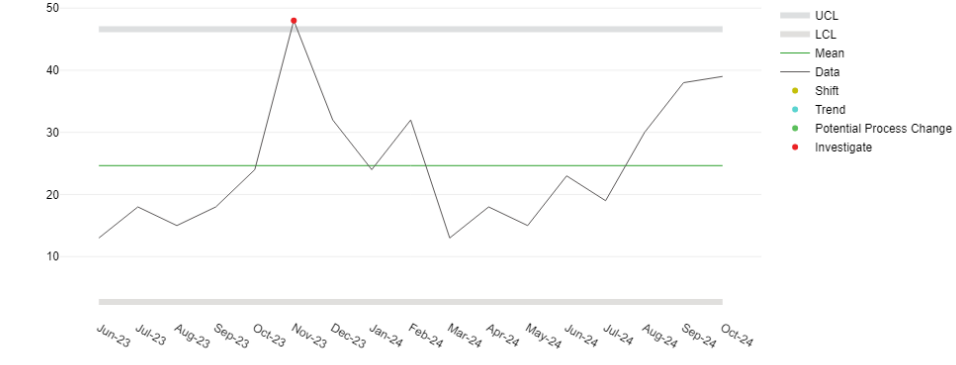
Latest value	Standard
66.3 %	>85%



Latest value	Standard
13.6 %	<=10%



Latest value	Standard
39	NA



Elective Care Performance - Indicator & Standard Definitions

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

Emergency Care Performance

Section Owner

Chief Operating Officer – Acute Services

Performance Narrative

In the month of October, we had 3,750 attendees through the Emergency Department which is slight increase on September. The number of patients seen within target time (<4 hours) increased to 75%. 95% of the minor's activity was patients seen and treated within 4hrs which is an improvement in this area of activity. We also saw an increase in the major's patient cohort, with 75% meeting the 4-hour standard. We are benchmarking higher than that reported as achieved in England currently.

A decrease was seen in the number of patients who were in ED for >12 hrs (2.6%). 14.4% were admitted which is a decrease on the previous month. It is noted that the number of emergency episodes in October nearly 450 patients, compared with October 2023 and was higher than any of the Winter months in 2023/24.

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

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

There is an insignificant increase to the emergency LOS rate this month and is this being actioned through our response to the Royal College of Physicians' report and Operational flow work stream. It is important to note the indicator definition in that monthly performance in this metric could be representative of the in-month discharge of a patient with a significant LOS due to requiring alternative discharge arrangements e.g. a nursing or residential bed. This metric is also affected by acuity and patient management. Further work in regard to the RCP Acute Medicine and Clinical Productivity workstream is showing considerable reductions in acute LOS at a ward level specifically AAU, Corbiere and Rozel wards.

A slight increase in the rate of readmission is noted this month at 13.1% of patients being readmitted within 30 days.

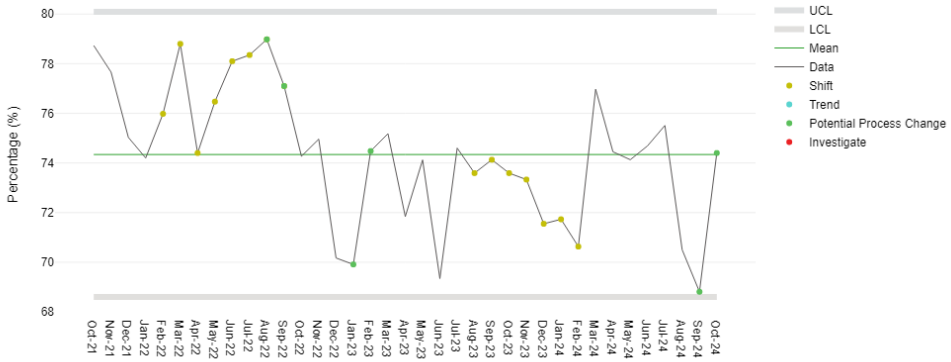
Escalations

October shows an improved performance from ED, although as we enter the winter months, we anticipate facing 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, line by line before each bank holiday & length of stay activity in Clinical Productivity workstream supported by the external physician leading a clinical flow improvement strategy which will be implemented shortly.

Emergency Care Performance - SPC Charts

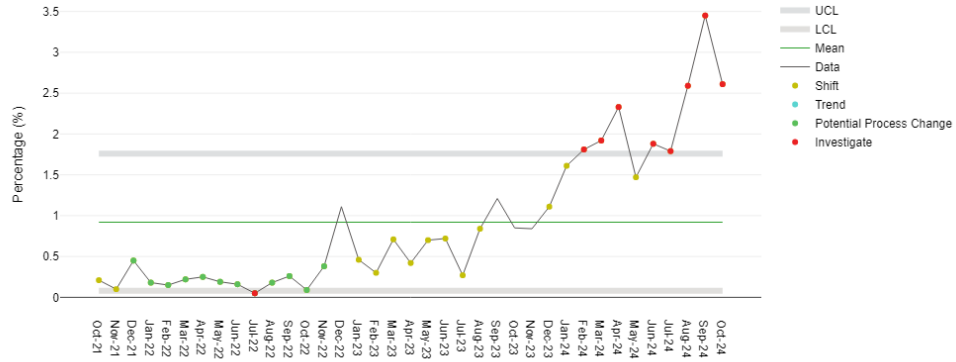
Latest value	Mean
74.4 %	74.3 %

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



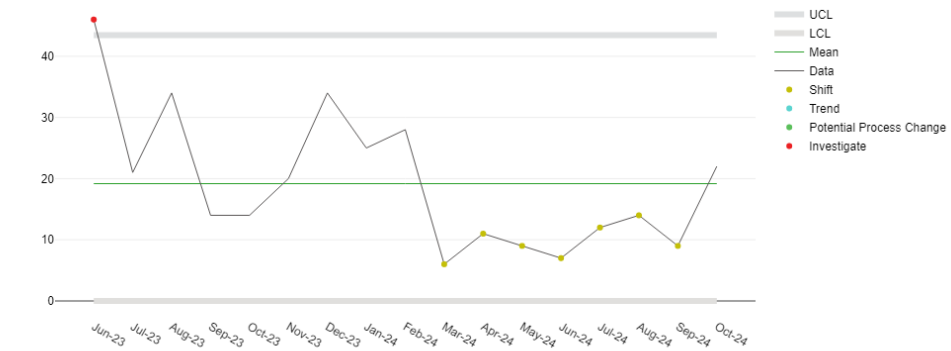
Latest value	Mean
2.6 %	0.9 %

% Patients in Emergency Department for more than 12 Hours



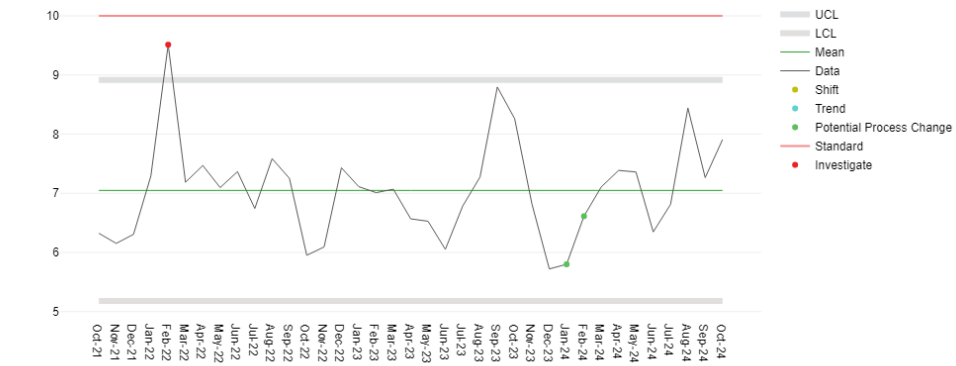
Latest value	Mean
22	19.18

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



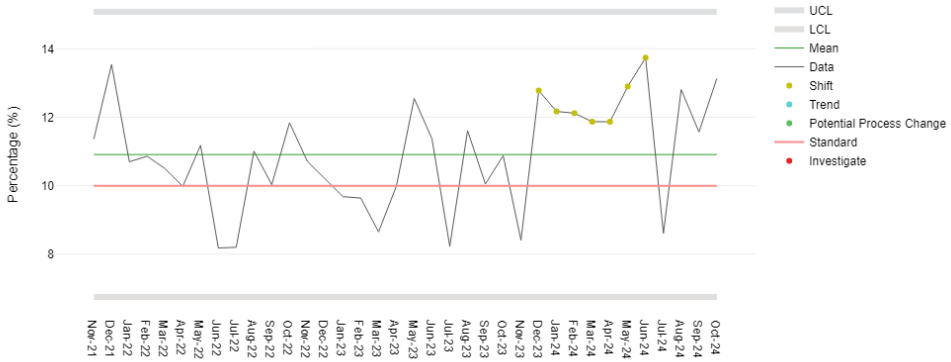
Latest value	Mean
7.91	7.05

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



Emergency Care Performance - SPC Charts

Latest value	Mean
13.1 %	10.9 %



Emergency Care Performance - Indicator & Standard Definitions

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

Maternity

Section Owner

Chief Nurse

Performance Narrative

Our caesarean rate in month has again seen a slight decrease to 46.15% (30/67), with 33.85% being elective. Biggest cohort this month being in relation to the Robson Criteria group 2b, women who are primigravidae (first time mothers) with single pregnancy, at least 37 weeks' gestation who had a caesarean section prior to onset of labour. Patient choice continues to play a key part with our caesarean section rate which is in line with both UK national and international trends. There were no caesarean births at full dilatation and 4 (7.46%) from Robson Criteria Group 1 which are primigravida women.

Our induction rate remains consistent month on month but has seen a slight increase in month to 38.46%, but we continue to ensure we are offering induction at the correct gestation due to the presenting clinical picture.

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

In month we had 3 transfers of women off island for care in the UK, all being cared for at Southampton Hospital. We have daily calls with the team there when any of our women are transferred. They were due to presenting with a clinical picture requiring care outside Jersey i.e labour prior to 30 weeks' gestation for 2 and 3rd was a complex case which required care in a unit with radiology intervention theatre due to placental accreta.

An increase in the number of babies born less than the 3rd centile over 37+6 weeks, but these are managed appropriately and reviewed through the datix system. This is also due to the improvements in detection of growth restriction.

Escalations

Outcome of which maternity specific EPR system is expected to be decided this month.

Maternity - Key Performance Indicators

Indicator	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	YTD
Total Births	58	66	59	68	51	58	56	53	69	59	62	53	67	596
Mothers with no previous pregnancy (Primips)				24	15	20	16	20	34	22	27	26	31	235
Mothers who have had a previous pregnancy (Multips)				26	19	30	28	24	25	30	32	25	27	266
Mothers with unknown previous pregnancy status				18	17	8	12	9	10	7	3	2	9	95
Bookings ≤10+0 Weeks				6	3	7	8	8	9	7	4	9	6	67
% of women that have an induced labour	17.24%	30.77%	38.98%	30.16%	24%	31.58%	22.22%	16.67%	19.4%	28.07%	18.33%	28.3%	38.46%	25.96%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	21	18	11	25	13	22	10	19	19	12	22	17	10	169
Number of Instrumental deliveries	5	5	4	7	3	5	2	3	7	4	6	4	6	47
% deliveries by C-section (Planned & Unscheduled)	46.55%	49.23%	45.76%	36.51%	54%	40.35%	66.67%	50%	52.24%	61.4%	51.67%	47.17%	46.15%	50.35%
% Elective caesarean section births	22.41%	27.69%	28.81%	23.81%	32%	15.79%	37.04%	27.08%	29.85%	35.09%	40%	26.42%	33.85%	30.14%
Number of Emergency Caesarean Sections at full dilatation	1	2	0	2	1	1	1	1	0	4	0	1	0	11
Number of women in Robson Group 1 cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, spontaneous labour)				2	3	0	8	2	7	7	0	4	5	38
Number of women in Robson Group 2a cohort (Nulliparous, single cephalic pregnancy, at least 37 weeks' gestation, induced labour)				4	3	5	5	1	4	4	2	3	3	34
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)				3	3	2	5	3	7	4	6	2	7	42
Number of women in Robson Group 5 cohort (Previous caesarean birth, single cephalic pregnancy, at least 37 weeks' gestation)				4	6	5	6	4	4	10	10	9	5	63
Number of deliveries home birth (Planned & Unscheduled)	3	3	0	2	3	1	1	1	1	3	0	1	0	13
Mothers who were current smokers at time of booking (SATOB)	4	3	2	7	7	3	4	6	2	3	3	4	6	45
Mothers who were current smokers at time of delivery (SATOD)	0	0	0	0	0	2	0	2	2	3	6	3	3	21

Maternity - Key Performance Indicators

Indicator	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	YTD
Number of Mothers who were consuming alcohol at time of booking	2	0	3	1	1	2	0	0	0	0	0	0	0	4
Number of Mothers who were consuming alcohol at time of delivery	0	1	0	0	0	1	3	3	6	4	5	6	2	30
Breastfeeding Initiation rates	74.1%	75.8%	72.9%	77.9%	74.5%	65.5%	73.2%	69.8%	71%	79.7%	67.7%	79.2%	65.7%	72.32%
Transfer of Mothers from Inpatients to Overseas	0	2	1	0	3	1	1	0	1	0	1	2	3	12
Number of births in the High dependency room / isolation room	0	0	0	1	1	0	0	0	0	0	0	1	1	4
Number of PPH Greater Than 1500mls	6	6	3	2	2	1	6	0	1	3	1	0	1	17
Number of 3rd & 4th degree tears – all births	2	1	0	2	2	1	0	0	0	0	0	1	1	7
% of babies experiencing shoulder dystocia during delivery	1.72%	0%	1.69%	0%	0%	0%	1.79%	0%	4.35%	0%	0%	0%	2.99%	1.01%
% Stillbirths Greater Than 24 Weeks Gestation				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Neonatal Deaths at Less Than 28 days old				0	0	0	0	0	0	0	0	0	0	0
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	9.09%	5%	3.45%	0%	3.7%	7.41%	3.85%	7.14%	2.78%	5.13%	2.56%	2.5%	6.67%	4.12%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	2	2	0	1	0	0	1	2	0	1	0	0	5
Transfer of Neonates from JNU	0	1	1	1	0	0	1	0	1	0	1	0	0	4
Preterm Births ≤27 Weeks (Live & Stillbirths)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	7	1	2	1	1	8	1	2	2	3	4	1	4	27
Neonatal Readmissions at Less Than 28 days old				11	4	4	5	5	6	4	5	9	5	58

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)	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.
Breastfeeding Initiation rates	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT1A) & Maxims Maternity Report (MT001))	Not Applicable	Number of babies whose first feed is from the mother's breast

Maternity - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Transfer of Mothers from Inpatients to Overseas	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of mothers out of Maternity inpatient wards to an off-island Healthcare facility.
Number of births in the High dependency room / isolation room	Maxims Deliveries Report (MT005)	Not Applicable	Number of births which took place in the High Dependancy Room / Isolation Room
Number of PPH Greater Than 1500mls	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Number of deliveries that resulted in a blood loss of over 1500ml
Number of 3rd & 4th degree tears – all births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Not Applicable	Number of women who gave birth and sustained a 3rd or 4th degree perineal tear
% of babies experiencing shoulder dystocia during delivery	Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Not Applicable	Total number of babies experiencing shoulder dystocia during delivery divided by the total number of births
% Stillbirths Greater Than 24 Weeks Gestation	Hospital Electronic Patient Record (Maxims Maternity Report (MT001))	Not Applicable	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
Neonatal Deaths at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Demographics Report (MP001DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of deaths during the first 28 completed days of life
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Percentage of live births with a gestational age lower than the 3rd centile (3% of babies born at same gestational age will have a lower birth weight than them) delivered after 37 weeks and 6 days of pregnancy.
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Not Applicable	Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation
Transfer of Neonates from JNU	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility.
Preterm Births ≤27 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born at or before 27 weeks
Preterm Births ≤36+6 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born before 37 weeks (less than or equal to 36+6 gestation)
Neonatal Readmissions at Less Than 28 days old	Hospital Electronic Patient Record (Maxims Discharges Report (IP013DM) & Maxims Maternity Report (MT001))	Indicator is for information only	Number of babies that were readmitted to Hospital within 28 days of their delivery date

Maternity

Additional Commentary / Deep Dive

We have commenced using the NICHE PPH/MOH tool so we can review all using this tool, so we are able to identify good practice and learning. This is fed back to staff at the weekly maternity risk meeting. We are now further exploring this to make this an ongoing audit into 2025 as a Quality Improvement initiative, so we continue to capture themes, or any learning required.

Mental Health

Section Owner

Director Adult Mental Health & Social Care

Performance Narrative

Access to mental health services remains well above target – with 92% of crisis referrals being seen in 4 hours, and 96% of routine referrals seen within 10 working days

Waiting times for diagnostic services ; dementia and autism assessment waiting times remain improved, whilst the ADHD waiting list and waiting times continue to grow.

Jersey Talking Therapies: Referrals and the waiting list for JTT have both reduced in the month. 95% of people are waiting less than the target 90 days for assessment; however, wait for treatment remains higher than target, with 52% of people waiting over 18 weeks. Two new staff have been recruited, and a further two are being recruited to.

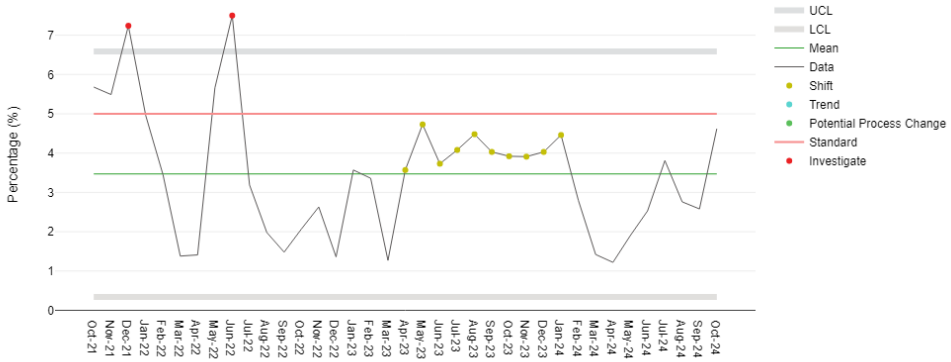
Escalations

Waiting times for ADHD and psychological therapies remain key challenges for the care group, particularly influenced by availability of staffing & increasing demand.

Mental Health - SPC Charts

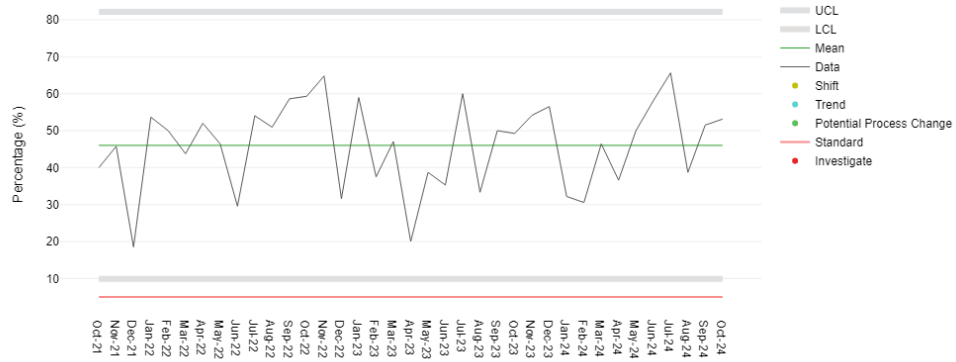
Latest value	Mean
4.6 %	3.5 %

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



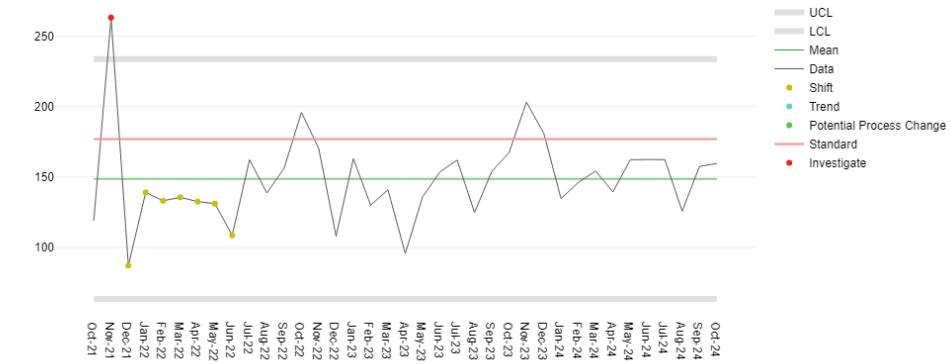
Latest value	Mean
53.1 %	46 %

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



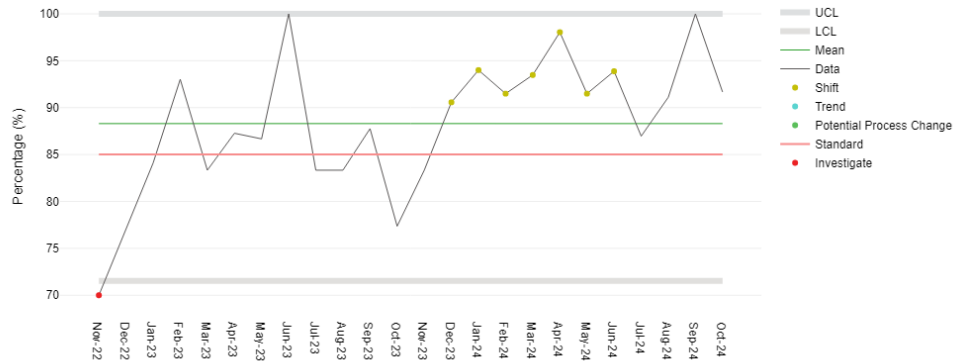
Latest value	Mean
159.61	148.54

JTT Average waiting time to treatment (Days)



Latest value	Mean
91.7 %	88.3 %

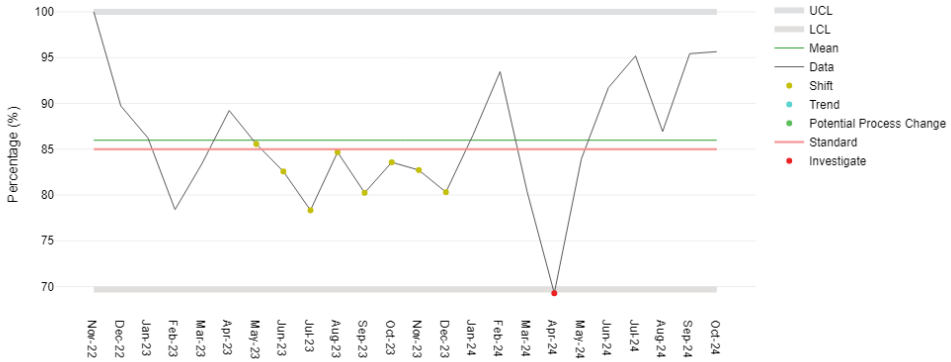
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



Mental Health - SPC Charts

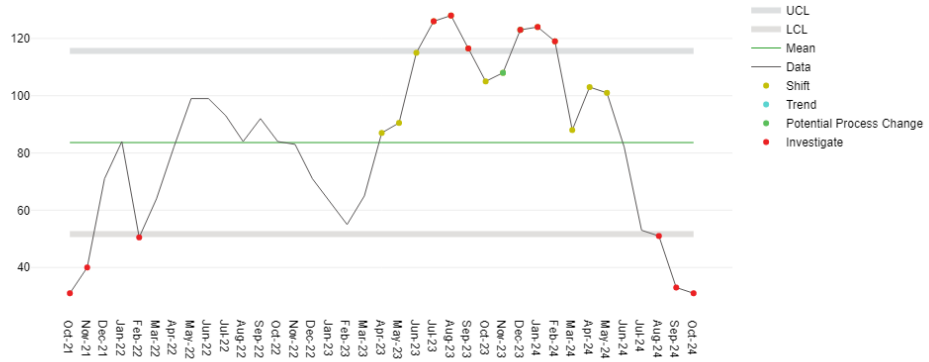
Latest value	Mean
95.7 %	86 %

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



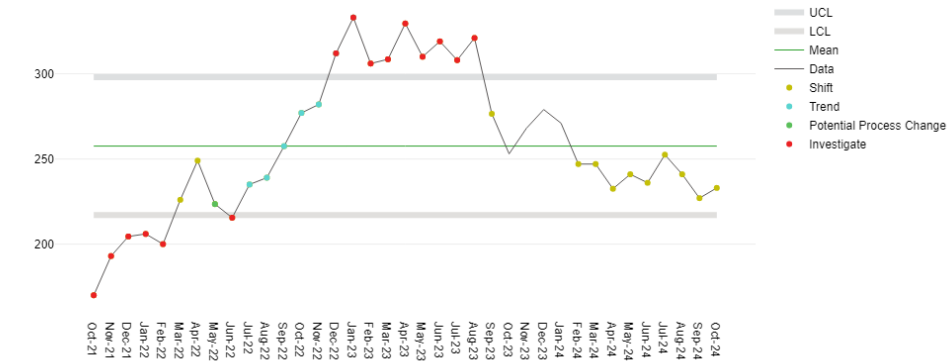
Latest value	Mean
31	83.64

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



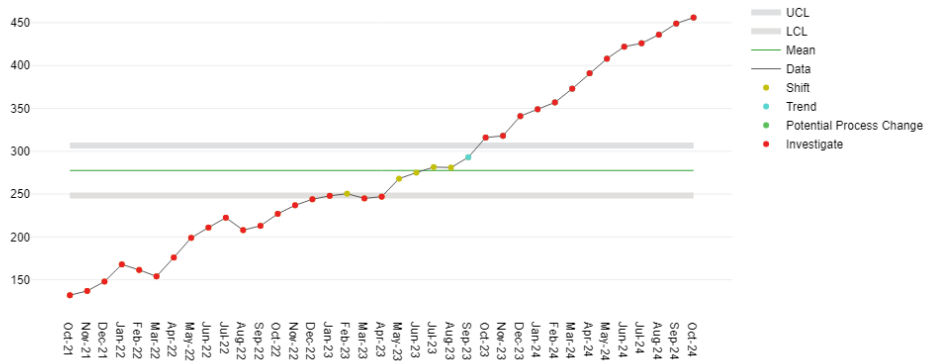
Latest value	Mean
233	257.55

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



Latest value	Mean
456	277.54

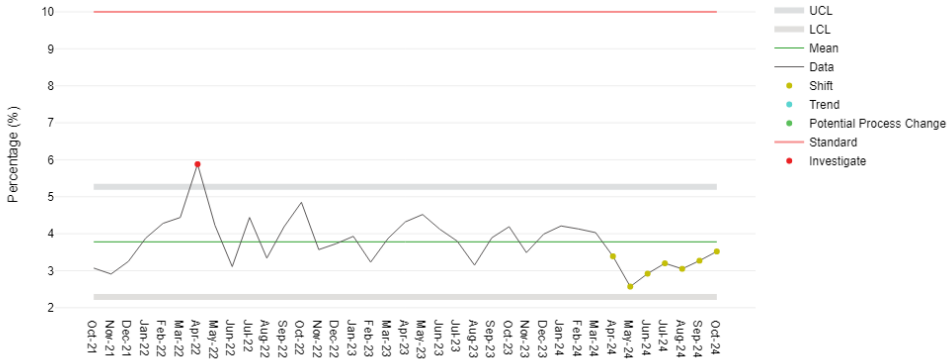
Median wait of clients currently waiting for ADHD Assessment (Days)



Mental Health - SPC Charts

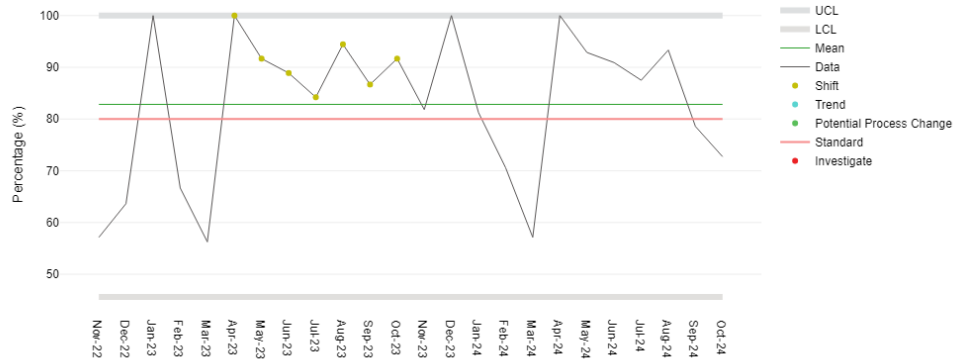
Latest value	Mean
3.5 %	3.8 %

Community Mental Health Team Did Not Attend (DNA) rate



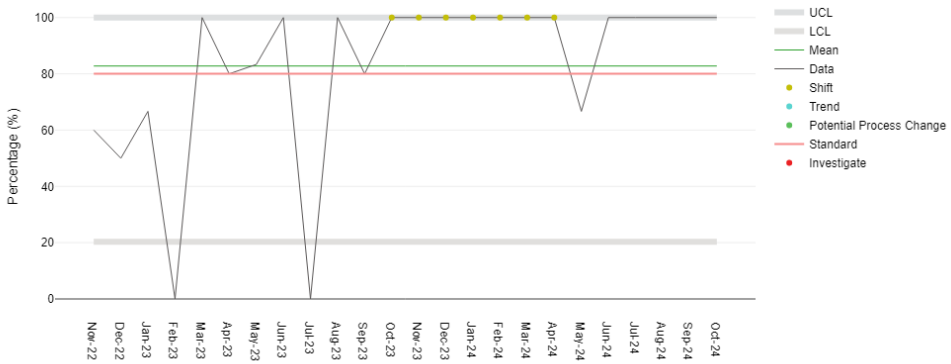
Latest value	Mean
72.7 %	82.8 %

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



Latest value	Mean
100 %	82.8 %

% 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

Rates of physical health checks for people with a learning disability have improved but remain just below target. Plans for 2025 are currently being developed to ensure target is consistently met.

The % of social care assessments completed and authorised within 3 weeks has declined dramatically. A decline was expected due to unforeseen and exceptional circumstances around staffing in the senior team. This is being compounded by difficulties obtaining community nursing beds. A full review is planned for week commencing 18.11.24 to ensure there are no other issues concerning data management that are affecting this information, and to develop and implement a recovery plan.

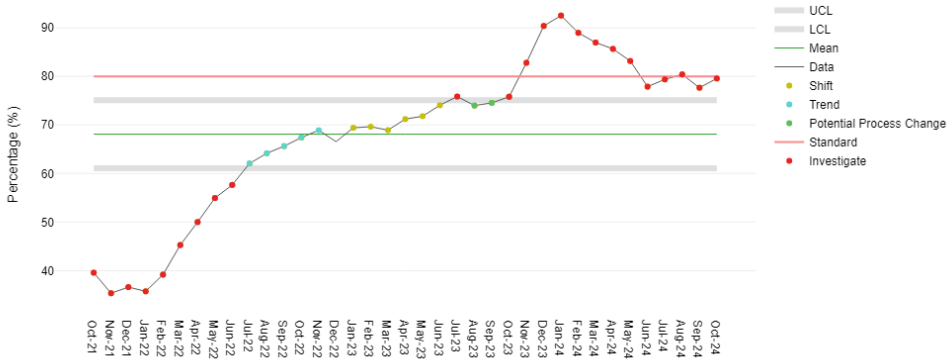
Escalations

No Escalations

Social Care - SPC Charts

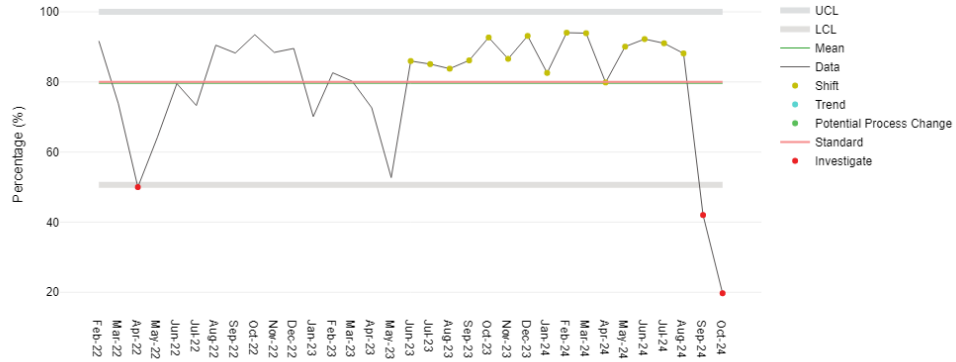
Latest value	Mean
79.6 %	68.1 %

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



Latest value	Mean
19.7 %	79.6 %

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



Social Care - Indicator & Standard Definitions

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

Quality & Safety

Section Owner

Medical Director / Chief Nurse

Performance Narrative

Patient Experience

Complaints

In October, 23 new complaints were received across Health and Community Services. Each complaint was systematically categorised to support efficient tracking, prompt resolution, and the identification of potential trends for improvement. No consistent themes or specific areas of concern were noted. This structured approach ensures a timely response, with each complaint assigned to the relevant department for investigation and resolution, aligning with our commitment to continuous quality improvement and excellence in patient care.

Compliments

In October 2024, 150 compliments were logged in the Datix system, a substantial increase from the 100 compliments recorded in October 2023. This positive trend reflects our teams' dedication to providing high-quality, compassionate care. Collaboration with wards and departments ensures that all patient and family compliments are documented in Datix, providing valuable feedback and well-deserved recognition for staff.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) saw a significant rise in engagement, with logged interactions increasing from 48 in October 2023 to 113 in October 2024. This growth highlights PALS' effectiveness in supporting more patients and families, promoting open communication, and addressing concerns promptly. The increased interaction levels demonstrate the team's critical role in enhancing patient experience and trust across our services.

Infection Prevention & Control Update

Healthcare-Associated Infections (HCAIs)

In October 2024, three cases of Clostridioides difficile (C. difficile) infection were identified within the hospital. Year-to-date, there have been 17 cases, a slight increase from the 15 cases recorded during the same period last year. In response, enhanced infection prevention and control measures have been implemented, including comprehensive root cause analyses to identify and mitigate contributing factors.

No cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Klebsiella, Escherichia coli (E. coli), or Pseudomonas bacteraemia were recorded in October. This positive outcome reflects the continued success of our stringent infection control practices in minimising the risk of bloodstream infections across these key organisms.

Our Infection Prevention & Control team remains vigilant, actively monitoring infection trends and reinforcing robust protocols to safeguard patient health.

Quality & Safety

Pressure Ulcers Acquired in Care

In October, six pressure ulcers were acquired during care episodes, and the following breakdown provides an overview of these cases:

* 4 x Category 2 Pressure Ulcers

* 1 x Category 3 Pressure Ulcer – This case was assessed as unavoidable given the patient's unique clinical needs, which required careful, personalised care planning and ongoing education to address risk factors.

* 1 x Mucosal Membrane Device-Related Ulcer – Resolved successfully during the care episode.

Admissions with Pre-existing Pressure Ulcers

A total of 27 pressure ulcers were noted among patients admitted from home or other care settings, with most of these cases (20) classified as Category 2 ulcers. Our team ensured continuity of care and implemented protective measures to prevent further deterioration.

Ongoing Prevention Efforts

The monthly Pressure Ulcer Task Group remains instrumental in our proactive prevention and management strategies. This collaborative forum, attended by ward managers, lead nurses, and specialist nurses, focuses on case reviews, best practices, and evidence-based approaches to reduce the incidence of pressure ulcers. This united effort highlights our commitment to delivering high-quality patient care and continuously enhancing our strategies for pressure ulcer prevention and management.

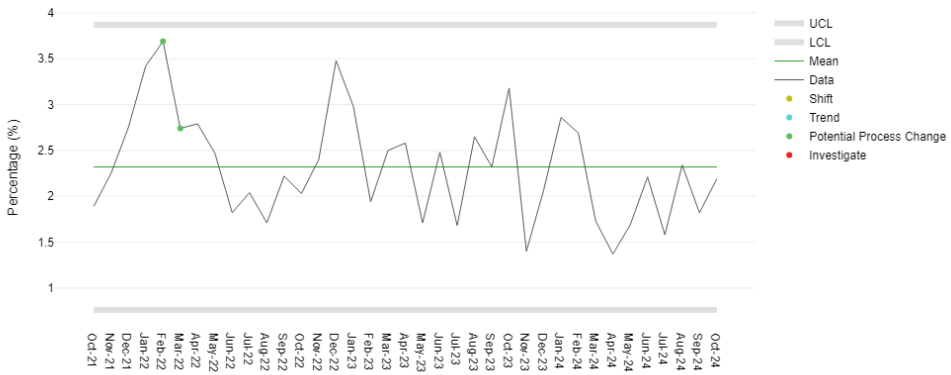
Escalations

No Escalations

Quality & Safety - SPC Charts

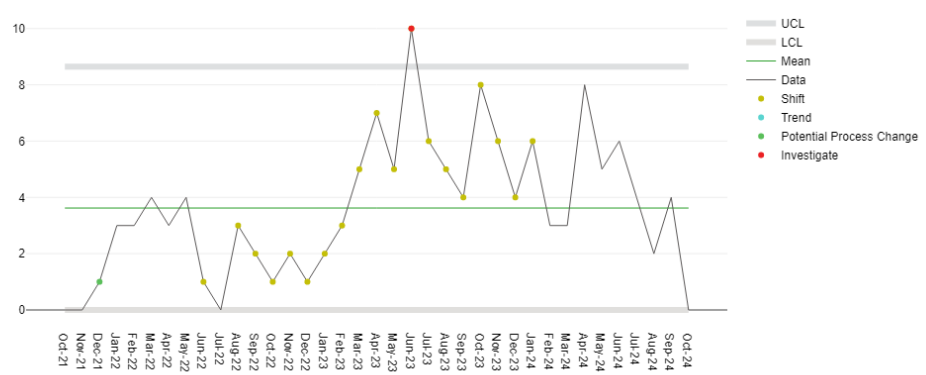
Latest value	Mean
2.2 %	2.3 %

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



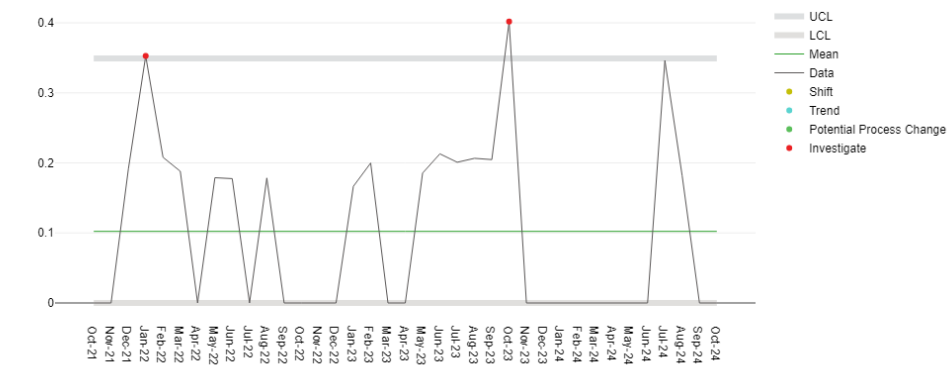
Latest value	Mean
0	3.62

Number of serious incidents



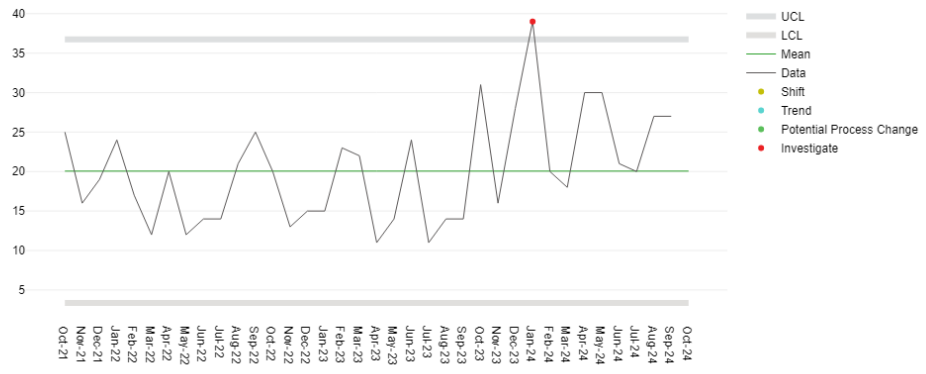
Latest value	Mean
0	0.1

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



Latest value	Mean
	20.06

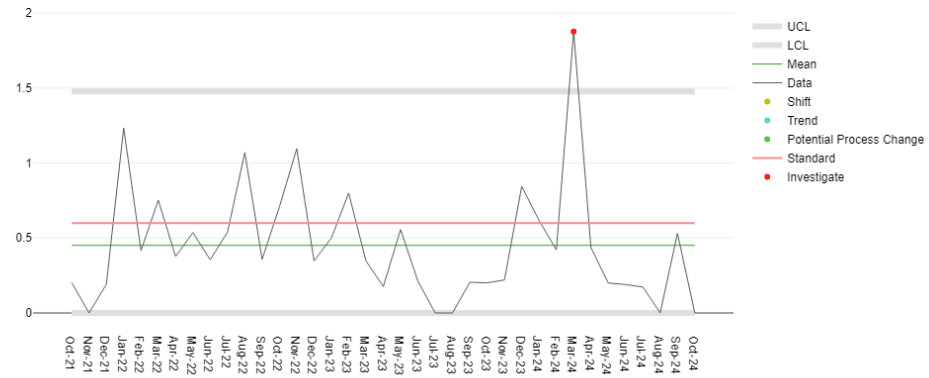
Number of pressure ulcers present upon inpatient admission



Quality & Safety - SPC Charts

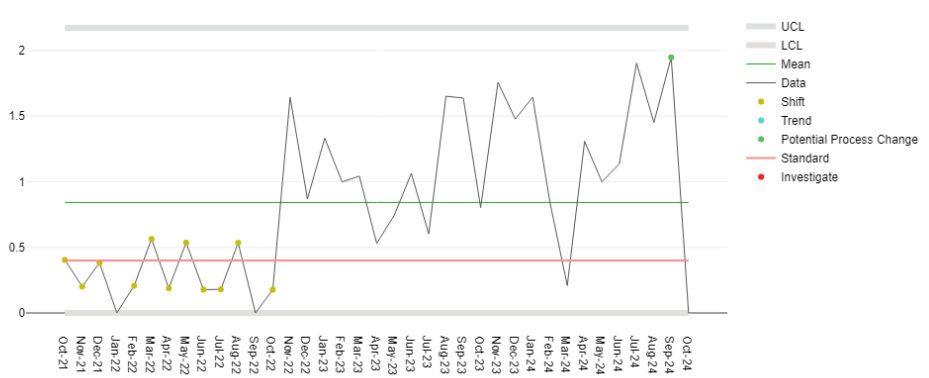
Latest value	Mean
0	0.45

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



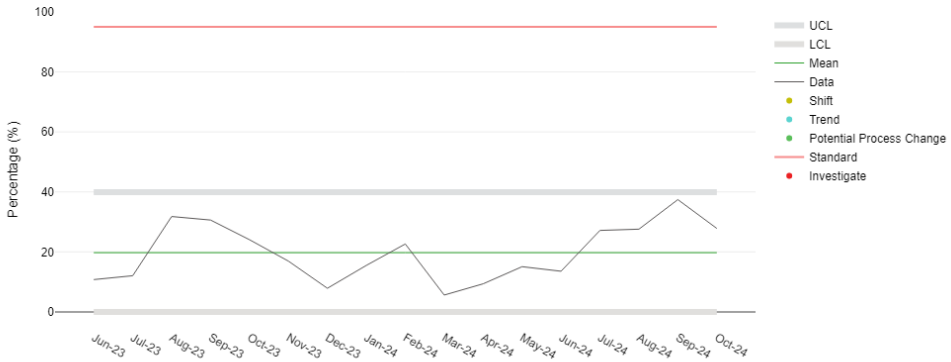
Latest value	Mean
0	0.84

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



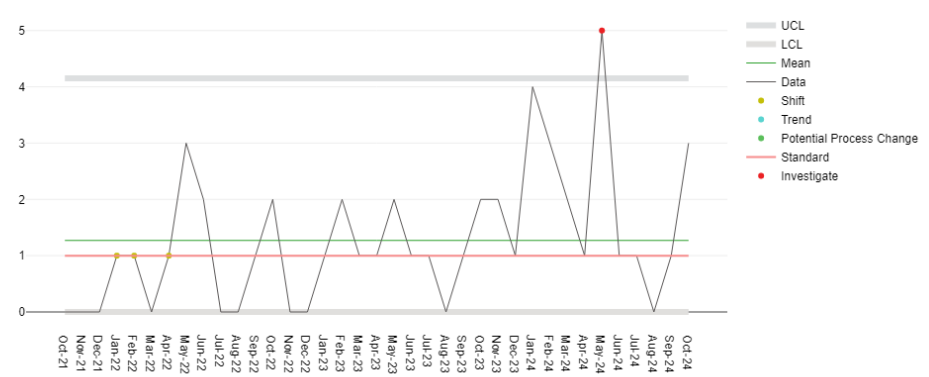
Latest value	Mean
27.8 %	19.8 %

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



Latest value	Mean
3	1.27

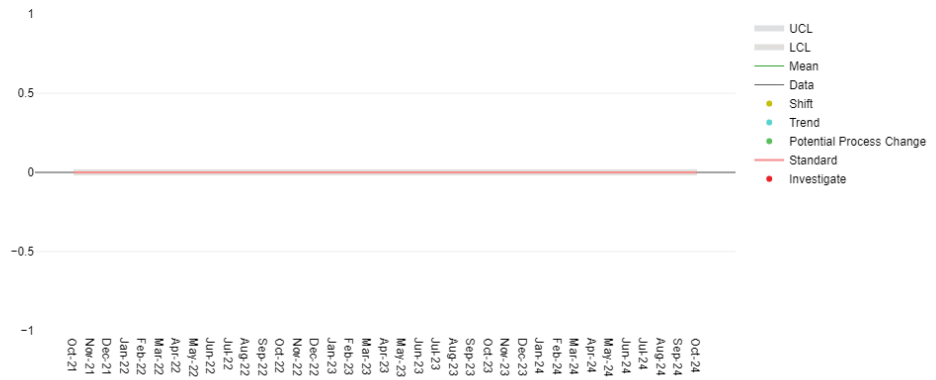
C-Diff Cases - Hosp



Quality & Safety - SPC Charts

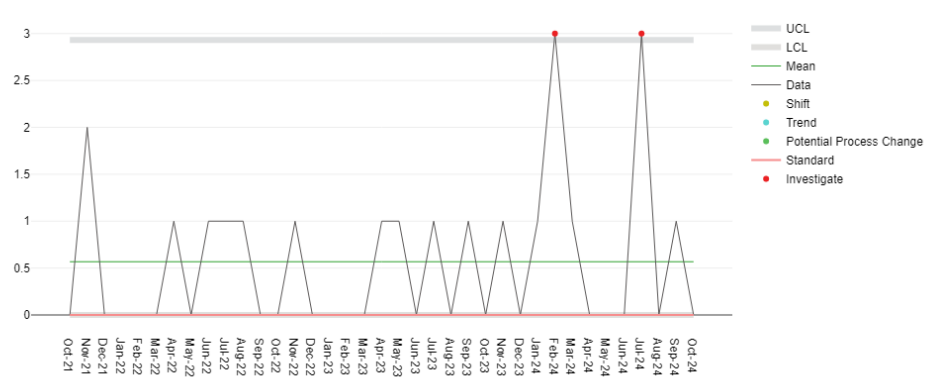
Latest value	Mean
0	0

MRSA Bacteraemia - Hosp



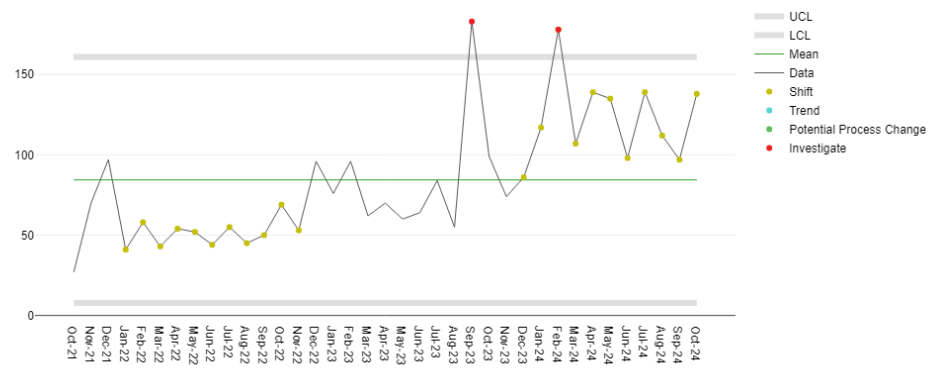
Latest value	Mean
0	0.57

E-Coli Bacteraemia - Hosp



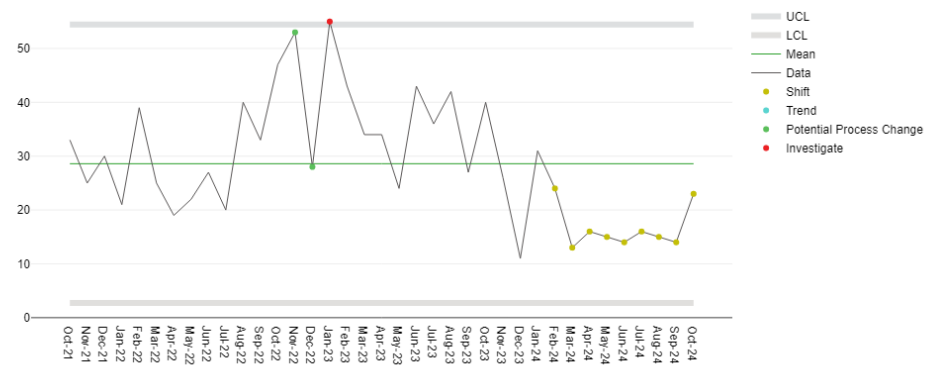
Latest value	Mean
138	84.41

Number of compliments received



Latest value	Mean
23	28.59

Number of complaints received



Quality & Safety - Indicator & Standard Definitions

Indicator	Source	Standard Source	Definition
Crude Mortality Rate (JGH, Overdale, St Ewolds and Mental Health)	Hospital Electronic Patient Record (TrakCare Inpatient Discharges Report (ATD9P) Maxims Inpatient Discharges Report (IP013DM))	Not Applicable	A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted.
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
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

Report to:	Health and Community Services Advisory Board		
Report title:	**People and Culture Committee Report**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**14a**

Non - Executive Lead:	Carolyn Downs CB, Chair of the People and Culture Committee
Report Author:	Carolyn Downs CB, Chair of the People and Culture Committee

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the People and Culture Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The People and Culture Committee met on Wednesday 25 September and 30 October 2024. Each meeting was chaired by Carolyn Downs CB. • The Committee received a written account from a staff member regarding their experience of speaking up. • Additional agenda items include, - A deep dive into recruitment, an update on other workforce priorities, workforce dashboard, employee relations (ER), case management, cultural improvement work, staff communications, health and safety, pharmacy action plan and job planning.			
Recommendations:	The Board is asked to note the report.			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	
Effective		SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	
Responsive		SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
N/A		

List of Appendices:
Nil

MAIN REPORT

Summary of key actions, discussions and decision-making arising in the committee meetings.

Staff Story

The committee received a powerful written account from a staff member regarding their experience of speaking up, specifically why staff should speak up. The committee noted a number of themes and suggested that elements of this experience could be shared more widely across HCS (whilst maintaining the anonymity of the staff member).

The committee noted that staff are hesitant to attend the committee to share their experiences and concluded that the aim is to create a culture where staff feel safe to share their experiences and see this is a part of their job regarding learning and culture improvement.

Recruitment Deep-Dive

The committee continues to receive a deep dive at each of its meetings regarding one of the agreed workforce priorities. During September and October, this covered recruitment and workforce data.

The deep dive into recruitment was specifically requested in response to issues raised through previous staff experiences. Key elements covered include time to recruit (non-medical recruitment), agency costs, medical recruitment, the recruitment team, revisions to recruitment processes and recruitment campaigns. The committee requested a full update on accommodation and relocation at a future meeting (scheduled January 2025). Importantly, the members of staff who attended the committee to share their experience are to be provided with feedback and action to-date.

Workforce Priorities

As a monthly standing agenda item, the committee continues to receive an update on the remaining workforce priorities,

1. Medical staff management
2. HCS Workforce Strategy
3. HCS People Plan

Workforce Data

The committee has started to receive the new workforce dashboard and welcomed this improvement. The committee noted the caveat that as the report continues to be drawn from multiple sources this increases the risk of error. A deep dive into workforce was received at the October meeting.

The workforce report will align to the proposed Jersey Care Commission (JCC) key lines of enquiry (KLOE) and will continue to develop and include elements such as professional registration and Disclosure Barring Service (DBS) compliance. However, the Director of Workforce will be working with newly appointed Director of Digital Health and Informatics to ensure that the data foundation is robust before expanding the report.

It was concluded that work must continue to ensure the provision of workforce information that is timely, reliable, comprehensive and suitable for committee and board use.

The recorded completion of Connected Performance (appraisal) was noted as a key concern for the committee and will be subject to a deep dive in its meeting in January 2025. Additional improvements and monitoring mechanisms have been introduced and concluded that it will most likely take a further reporting cycle (2025) to see these improvements.

The committee did not note any significant changes from month 8. Sickness absence was discussed, and the committee was appraised of the work that has been done to ensure the appropriate active management of long-standing sickness cases. Focus has now moved to short-term sickness i.e. patterns of sickness. In addition, the level of absence due to stress and anxiety was considered and the committee discussed a number of actions that may help to reduce this including ensuring all staff have an appraisal.

Employee Relations

The committee receives a monthly report and notes that activity in this area is very high for an organisation the size of HCS. Contributory factors were discussed with the proposed actions to reduce this including, development of a People Plan and providing the appropriate staff with the skills to manage such issues.

The committee requested that ER data is aligned with the culture work and care groups to build an understanding of where the 'hot spots' are in the HCS workforce.

Culture Improvements

The Committee continues to receive an overview of the ongoing activities to address and improve culture and agreed that it is important to now understand the impact of this work.

The committee reviewed the first draft of the culture dashboard and agreed this is a positive development. Regular reviews will allow the identification of trends and 'hot spot' areas of concern for appropriate management.

The committee noted that the results of the BeHeard Survey results are currently being cascaded through the organisation for staff to review. Areas will be supported to develop action plans in response to the results.

Health and Safety

The committee received the Health and Safety report for both Q2 and Q3 2024. The reports include the analysis of activity, trends and action to provide the committee with assurance. Topics include incident reporting, health and safety training, health and safety management system, fire risk assessment and prevention and prevention and management of violence and aggression.

The committee concluded that HCS is doing well regarding health and safety management.

Pharmacy Action Plan

The committee has received the external report, and the action plan developed by HCS to meet the recommendations. Noting the high number of recommendations, the board requested HCS initially prioritises actions to those that will have the most positive impact.

As a key element, culture is a particular focus for the committee. Specifically, the need to balance confidentiality regarding individual performance issues with feeding back to staff who have raised concerns. Pharmacy staff continue to be provided with ongoing wellbeing and workforce support.

The committee will receive regular progress reports.

Board Assurance Framework

The Committee reflected on the discussions and concluded that the key areas of concerns have been discussed or planned for discussion on a future agenda. Risk score remains at 20.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Finance and Performance Committee Report**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**14b**

Non-Executive Lead:	David Keen, Chair of the Finance and Performance Committee
Report Author:	David Keen, Chair of the Finance and Performance Committee

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the Finance and Performance Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The Finance and Performance Committee met on 25 September and 30 October. The meeting on 25 September was chaired by Julie Garbutt. Mr David Keen, Non-Executive Director (for Strategic Finance) is the chair from October 2024. • Agenda items include financial performance, performance indicators, commissioning and partnerships and estates and facilities.			
Recommendations:	**The Board is asked to note the report.**			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	
Effective	√	SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	√
Responsive		SR 4 – People and Culture	
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Nil		

List of Appendices:
Nil

MAIN REPORT

Summary of key actions, discussions and decision-making arising in the committee meetings.

Performance Indicators

The committee reviewed the performance indicators and had detailed discussions regarding elective waiting times (dermatology and clinical genetics), outpatient waiting time, delayed transfers of care (DToC), mental health and social care.

The committee noted the paucity of social care indicators and received reassurance that the care group is exploring outcome-based indicators (current ones are more enablers). In addition, discussions are also being held regarding the inclusion of patient reported outcome measures (PROM) within the Quality and Performance Report (QPR) which will provide consistent service user outcome views.

The waiting list initiative to address the long waits in dermatology were discussed in detail and improvements are anticipated by end 2024.

Winter Plan

The committee received a paper detailing the steps being taken to respond to bed capacity pressures inherent with the winter season due to additional demand associated with respiratory illness.

The paper was approved for onward presentation to the board in November 2024.

Finance Report

The committee continues to receive the monthly financial position, most recently reviewing the M9 position. The progress and impact of the financial recovery programme (FRP) is also included. The forecast deficit range is between £24.2m and £29.5m and additional savings are required to reduce this gap with M10 results providing more clarity on the most likely outturn position. The Committee discussed the drivers of the deficit, specifically tertiary care contracts and social care placements which are key areas of risk.

As the newly appointed non-executive director for finance, David Keen requested a deep dive into finance during the October meeting. Specific areas addressed include,

- The plans to reduce the financial overspend
- The risk that these plans introduce to delivery of services
- The effect of this overspend on the 2025 budget

An extraordinary meeting has been scheduled for the beginning of December 2024 for the committee to understand the 2024 year-end position.

Commissioning and Partnerships

The Committee received a paper detailing the externally commissioned services including service of each provider and the contract values against each service category.

The focus is now very much of partnership working and providing services through a commissioning framework. All contracts for commissioned services have performance reporting requirements and related measures specified within them. To strengthen the focus on outcomes in performance reviews, an

outcomes-based accountability (OBA) approach is being used for contracts going forward. This is a methodology which links performance measures to strategic/island wide outcomes and service level outcomes, focussing on the three key areas, how much is being done? How well is it being done? Is anyone better off? As the outcomes metrics are longer terms measures of performance, activity metrics are used more regularly.

The recent Comptroller and Auditor General (CAG) report was discussed which was positive regarding the approach taken by HCS, particularly the establishment of the cross Government of Jersey (GoJ) commissioning group and the Commissioning Academy.

Estates and Facilities

The committee received comprehensive reports regarding both estates and facilities covering activity, finance and associated risks. The non-executive directors found this particularly useful as the structure of these functions differs from other healthcare jurisdictions.

The Committee will continue to receive 6-monthly reports.

Board Assurance Framework

The Committee reviewed the relevant sections of the Board Assurance Framework (BAF) and agreed that the current levels are an accurate representation.

1. **Operational Performance (Access)**: 20

2. **Finance**: 25

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Quality, Safety and Improvement Committee Report**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**14c**

Non-Executive Lead:	Dame Clare Gerada DBE, Chair of the Quality, Safety and Improvement Committee
Report Author:	Dame Clare Gerada DBE, Chair of the Quality, Safety and Improvement Committee

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides assurance to the HCS Advisory Board on the work of the Quality, Safety and Improvement Committee and escalate issues as necessary.			
Summary of Key Messages:	The key messages arising from this report are: • The Quality, Safety and Improvement Committee met on Wednesday 31 October 2024. The meeting was chaired by Dame Clare Gerada. • Agenda items include quality indicators, clinical governance, serious incidents, clinical audit, safeguarding, infection prevention and control, safeguarding, freedom to speak up, improvement plans and the work of subcommittees.			
Recommendations:	**The Board is asked to note the report and the following,** **Medicines Optimisation**: Good direction of travel but the committee was unable to gain adequate assurance regarding **prescribing practice** due to requirement for additional information regarding hospital, community and private prescribing practices. However, the legislative changes to support this are progressing.			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	√
Effective	√	SR 2 – Patient Experience	√
Caring	√	SR 3 – Operational Performance (Access)	
Responsive	√	SR 4 – People and Culture	
Well Led	√	SR 5 – Finance	

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
N/A		

List of Appendices:
Nil

MAIN REPORT

Summary of key actions, discussions and decision-making arising in the committee meeting.

Quality Indicators

The committee discussed the plans in place to address the four areas in which there are the longest waits: **dermatology**, **ophthalmology**, **gastroenterology** and **clinical genetics**.

The committee concluded that the waiting times are improving (or have plans in place to improve) and future risks have been anticipated. Outcomes expected in performance reporting for M11 and M12.

Patient experience / complaints: There are 14 open complaints currently. A high proportion of concerns are coming through the Patient Advisory and Liaison Service (PALS) team and these are resolved at the point of contact. Noting the 67.4% decrease in complaints compared to 2023, the committee understood this is largely due to the early resolution by the PALS team and how this was previously recorded. The complex complaints are the complaints that take longest to resolve and there is now a senior nurse in post to manage these. Areas from which complaints arise is captured to help identify if there are any 'hot spots' and instigate targeted actions as required.

Incidence of **pressure ulcers** acquired in care remains low when compared to the UK: a total of nine during September 2024.

Quality / Clinical Governance Framework Report

Incident Reporting: Overall incident reporting has decreased during September, but this is not considered a significant decrease.

Serious Incidents (SI): Close monitoring continues through weekly meetings with investigators. Training in SI investigation is being provided during November and December and 20 members of staff have enrolled. A thematic review of SIs has resulted in the identification of ten themes and each of these will have executive oversight to ensure progress and closure of recommendations.

Central Alert System (CAS): This has been a significant area of concern and was escalated to the board in September 2024 following the previous committee meeting. Addition of temporary resource has seen the closure of 153 alerts (of 163) demonstrating that significant progress can be made when one person is overseeing and reviewing each CAS alerts. One alert has been reopened to provide additional assurance

regarding appropriate actions taken. The committee concluded that additional assurance is required regarding the process for managing CAS alerts.

Infection Prevention and Control (IPaC)

The committee received a report detailing activity for the period January to September 2024 with a focus on hospital acquired infection (HAIs) (reported in Quality and Performance report). The committee was advised of the ongoing audits supported by IPaC champions in wards and departments. The staff winter vaccination campaign continues.

Safeguarding Report Mid-Year 2024

The Committee received a report detailing the work of the Safeguarding subcommittee. Safeguarding training is under review with levels one and two already complete. There has been a steady increase in adult safeguarding referrals over the last three years (mirroring national trends) and increased awareness is thought to be a major contributing factor.

Improvement Plans

The committee received updates on progress of the key improvement plans. Of note was maternity, particularly as the service improvements triangulate well with the Picker Institute Survey results.

Board Assurance Framework

The Committee reflected on the discussions and considered whether there was any material impact on the BAF risk. The committee concluded that the current scoring is an accurate representation of key risk.

1. **Quality and Safety**: 20.
2. **Patient Experience**: 8

Matters to be escalated to the HCS Advisory Board

The Board is asked to note the report and the following,

- Medicines Optimisation: Good direction of travel but the committee was unable to gain adequate assurance regarding prescribing practice due to requirement for additional information regarding hospital, community and private prescribing practices. However, the legislative changes to support this are progressing.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Medicine Improvement Plan**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**15**

Executive Lead:	Claire Thompson, Chief Operating Officer – Acute Services
Report Author:	Senior Change Manager / Medicine SLT approved

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides the Health and Community Services (HCS) Advisory Board with assurance regarding the progress of the Medicine Improvement Plan as discussed at the Quality, Safety and Improvement Committee on 31 October 2024. Whilst the Quality, Safety and Improvement Committee provides scrutiny on behalf of the Board, the Board requested regular updates until confident regarding the progress of actions to meet recommendations.			
Summary of Key Messages:	The key messages arising from this report are: - The Quality, Safety and Improvement Committee noted the progress made during its meeting on 31 October 2024.			
Recommendations:	**The Board is asked to note the report.**			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	√
Effective	√	SR 2 – Patient Experience	√
Caring	√	SR 3 – Operational Performance (Access)	√
Responsive	√	SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Quality, Safety and Improvement Committee	31 October 2024	Progress for noting at the Board meeting on 28 November 2024.

List of Appendices:
Appendix 1: Medicine Improvement Plan

Health and Community Services

Appendix 1

Report to:	Quality, Safety and Improvement Committee		
Report title:	**Medicine Improvement Plan**		
Date of Meeting:	31 October 2024	**Agenda Item:**	**9c**

Executive Lead:	Claire Thompson, Chief Operating Officer – Acute Services
Report Author:	Senior Change Manager / Medicine SLT approved

Purpose of Report:	Approval ☐	Assurance X☐	Information X☐
	This paper provides information and update on the Medicine Improvement Plan.		
Summary of Key Messages:	The key message arising from this report is the ongoing progress of the Medicine Improvement Plan.		
Recommendations:	The Committee is asked to note the content of the report and acknowledge the ongoing progress of completion.		

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 - Quality and Safety	√
Effective	√	SR 2 - Patient Experience	√
Caring	√	SR 3 - Operational Performance	√
Responsive	√	SR 4 - People and Culture	√
Well Led	√	SR 5 - Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Medicine Improvement Plan Monitoring Meetings	Weekly since 03/11/2023, fortnightly since August 24	Ongoing scrutiny of progress by HCS Executives
HCS Change Programme Board	02/10/2024	Noted
HCS Advisory Board	26/09/2024	CG commented that despite the absence of outcomes, the improvement work continues. CG escalated the issue regarding the funding for the Consultant posts for the full implementation of the medical model which is critical to the Medicine IP
HCS Change Programme Board	04/09/2024	Noted
HCS QSI Committee	29/08/2024	Noted
HCS Change Programme Board	07/08/2024	Noted
HCS Advisory Board	25/07/2024	Noted. CG commented that despite the absence of outcomes, the improvement work continues. CG escalated the issue regarding the funding for the Consultant posts for the full implementation of the medical model which is critical to the Medicine IP.
HCS Change Programme Board	03/07/2024	Noted

HCS QSI Committee	27/06/2024	Noted
HCS Change Programme Board	05/06/2024	Noted
HCS Advisory Board	30/05/2024	Noted. Confirmed to be reported to HCS Advisory Board and Quality, Safety & Improvement Committee for ongoing oversight of progress.
HCS Change Programme Board	03/04/2024	Noted
HCS SLT	14/02/2024	Noted
HCS Advisory Board	29/02/2024	Noted
HCS Advisory Board	25/01/2024	Noted
HCS Advisory Board	06/12/2023	Noted
HCS ELT	11/2023	Noted
HCS ELT	09/2023	Noted
HCS ELT	06/2023	Noted

List of Appendices:
202410 – Medicine Improvement Plan – Monthly Poster – Approved 20241022
20241031 – HCS QSI Committee – Medicine Improvement Plan – Exception Report
20241022 – Medicine Improvement Plan

MAIN REPORT

1. 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:

1. Royal College of Physicians Invited Service Review 18 – 20 June 2014
2. Royal College of Physicians (RCP) in 2022 Letter
3. Royal College of Physicians Invited Service Review 3 – 4 November 2022
4. Royal College of Physicians Invited Service Review 28 June 2023
5. Dr Rob Haigh Review 21 - 24 August 2023
6. Serious Incidents

The recommendations have been collated and consolidated, totalling 56 recommendations to become embedded as part of the business-as-usual processes of the organisation.

Since the last QSI Committee, the following progress has been made:

- Ongoing support from External Physician Advisory Support for development of SDAC (Same Day Acute Care) service strategy and patient flow model.

- Confirmed further 7 recommendations complete with robust evidence, which include compliance to handwashing, recruitment to Clinical Director posts with management training to be provided, roll out of electronic prescribing and medicine administration (EPMA) and additional support for patients diagnosed with cancer, which has been implemented through the Cancer Strategy Delivery Plan.

- During ongoing delivery of the Medicine Improvement, some recommendations were identified which are outside of the scope of the Medicine Care Group to deliver. These recommendations have been transferred out of the Plan, to be appropriately monitored and delivered in the applicable service area. These recommendations are:

Rec.ID#	Topic	Moved to
006	Development of nurses for emergency and advised nurse practitioners and nurse prescribing	Chief Nurse office
017	Local and National Audits	Medical Director office, Quality & Safety
022	Guideline review process	Medical Director office, Quality & Safety
030	Clerking of patients using standardized proforma	Medical Director office
034	Morbidity and Mortality meetings	Medical Director office, Quality & Safety
063	Venous thromboembolism (VTE) policy	Medical Director office
077	Enema training	Chief Nurse office
065	Diabetes education	Chief Nurse office

- In conjunction with the Culture, Engagement and Wellbeing team, a communication and engagement plan for the Medical Services Care Group regarding the Medicine Improvement Plan and cultural improvement elements in the Care Group has been established, to ensure there is continuous engagement with staff and lead into a series of culture and engagement modules. Current progress of the Medicine Improvement Plan is shared through a monthly poster, attached as an appendix. It is noted to date that the Medicine Improvement Plan has been shared with staff through Consultant Meetings and Inset Days and with senior clinical leaders at the Medicine Strategy Day held in June 2024.
    - 09-27 September - Government Be Heard survey
    - 04 – 30 October – Confidential listening sessions to identify current challenges and areas for improvement. Events held to gathering staff views, opinions and voice in relation to how they feel at work. Thematic analysis to be undertaken on this to help drive forward evidenced based initiatives to support positive change.

- Commencement in post of second Clinical Director, who is supporting the delivery of the Medicine Improvement Plan.

- Finalisation of the overarching Medical Care Group Strategy (Clinical Vision of Flow), to be submitted through approval process, date to be confirmed.

- Finalisation of plans to launch the Same Day Acute Day (SDAC) service as part of the Plan-Do-Study-Act (PDSA) cycle, to identify and implement continuous improvements to the service, with the aim to develop a robust and definitive service model.

- Rec.ID#004 Full acute medicine consultant recruitment.
    - 6 further Consultant posts were approved in principle by HCS SLT in November 2023. An updated paper was provided to HCS SLT in July 2024, which was rejected due to the financial pressures within HCS. The Medicine Care Group re-submitted the Medical Model to HCS SLT on 02 October which was approved, and further review is underway to confirm funding of model.

- A review was undertaken of the outstanding recommendations within the Medicine Improvement Plan, with the aim to establish a priority for completion. This identified several recommendations that are organisation wide, and which have been transferred out of the Plan. The review categorised the remaining recommendations into quick win, urgent and monitor, enabling the service to focus on the quick win items. The service will aim to complete all “quick win” items by the end of 2024. Details of these items can be found in the attached exception report.

- Ongoing refinement and embedment of referral pathway, alongside the review of current contracts with Southampton and Portsmouth regarding endoscopic retrograde cholangiopancreatography (ERCP), to improve KPI's and accountabilities.

Key actions for next period:

- Ongoing development of the communication and engagement plan of the Medicine Improvement Plan and culture elements across the service. To consider for inclusion asking staff four key questions, Executive and Senior Leadership Ward Visits, Diagonal Slice Meetings and listening sessions.
    - November – Have your say survey. Questions within the survey will be based on the findings from the 2023 and 2024 Be Heard survey to ensure we are addressing the areas we score poorly on in order to make improvements.

- Ongoing refinement and embedment of referral pathway, alongside the review of current contracts with Southampton and Portsmouth regarding ERCP, to improve KPI's and accountabilities.

- Quick win recommendations – approval of endoscopy pre-admission procedure through governance process, high-risk drug Shared Care Agreements uploaded to MyStates, transfer of HCS wide mixed/single sex policy to appropriate owner and commencement of HCS wide communications for Clinical Vision of Flow.

Progress to date

Currently 17 out of 56 recommendations have been identified by Medicine Care Group as complete (up from 9 in August), of which 16 have been confirmed as having robust evidence/business-as-usual process. 1 is under review to ensure robustness of evidence and sustainability of any business-as-usual processes prior to approval by Medicine Care Group Senior Leadership Team. High level progress to date can be found below:

	August QSI Committee	**September** Advisory Board	**October** QSI Committee
Total Number of recommendations	**67**	**67**	**56**
Complete signed off	7	7	16
Complete	3	3	1
Green	8	11	5
Amber	47	44	28
Red	1	0	0
Escalate	1	2	6

A detailed breakdown of escalated recommendations can be found in the attached exception report.

2. Finance / workforce implications

The following recommendations have identified finance and workforce implications:

- Rec.ID#004
- Ongoing recruitment to 4 Consultant Grade posts.
    - Stroke – Post offered and awaiting candidate to accept.
    - Renal – Substantive post vacant since March 2023 due to retirement. Post is covered by

Locums until 13/11/2024, post will go out to advert ASAP whilst we are awaiting confirmation from Portsmouth on contract.
    - Respiratory x2 – One Acting Consultant in place from 01/08/2024. One role currently being filled by Locum until 31/10/2024 and post out to substantive recruitment.

- Ongoing review of funding for further recruitment as detailed within the Medical Model.

- Rec.ID#026 - Nursing Workforce Planning
    - Following approval of ECA Standard Operating Procedure, a training needs analysis is to be conducted for Doctors and Nurses to ensure correct workforce skill set and model are adequately supported, which may have financial implications.

3. 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 Senior Leadership Team. To mitigate this, additional resource has been sourced to include an External Physician Advisory Support, Governance Support. Extra capacity has been sourced within the Care Group including extending Medicine Improvement Plan meetings to Clinical Fellow, Ward Managers, and newly recruited to Clinical Directors. A monthly newsletter is circulated, which hopes to identify further resource within the Care Group to support the plan.

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 Plan (FRP) due to risk of agency premium. It is hoped that the ongoing HR re-design will provide the service with more HR capacity, to support timely recruitment processes and establishment of a recruitment package.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Maternity Improvement Plan – Phase 2**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**16**

Executive Lead:	Patrick Armstrong MBE, Medical Director
Report Author:	Senior Change Manager / WACs SLT approved

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides the Health and Community Services (HCS) Advisory Board with assurance regarding the progress of the maternity improvement plan as discussed at the Quality, Safety and Improvement Committee on 31 October 2024. Whilst the Quality, Safety and Improvement Committee provides scrutiny on behalf of the Board, the Board requested a biannual update.			
Summary of Key Messages:	The key message arising from this report is: • Ongoing assurance of completion of recommendations within the Maternity Improvement Plan and Strategy.			
Recommendations:	**The Board is asked to note the report. The Quality, Safety and Improvement Committee on 31 October 2024 noted the overall improvements to the service as significant.**			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	√
Effective	√	SR 2 – Patient Experience	√
Caring	√	SR 3 – Operational Performance (Access)	√
Responsive	√	SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Quality, Safety and Improvement Committee	31 October 2024	Significant service improvements to be noted at the HCS Advisory Board

List of Appendices:
Appendix 1: Maternity Improvement Plan – Phase 2, as presented to the Quality, Safety and Improvement Committee on 31 October 2024.

Health and Community Services

Appendix 1

Report to:	Quality, Safety and Improvement Committee		
Report title:	**Maternity Improvement Plan – Phase 2**		
Date of Meeting:	31 October 2024	**Agenda Item:**	**9d**

Executive Lead:	Patrick Armstrong MBE, Medical Director
Report Author:	Senior Change Manager / WACs SLT approved

Purpose of Report:	Approval ☐	Assurance X	Information X
	This paper provides information and update on the Maternity Improvement Plan Phase 2.		
Summary of Key Messages:	The key message arising from this report is: • Ongoing assurance of completion of recommendations within the Maternity Improvement Plan and Strategy.		
Recommendations:	The Committee is asked to note the content of the report and acknowledge the ongoing progress of completion and assurance of embedded practice.		

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 - Quality and Safety	√
Effective	√	SR 2 - Patient Experience	√
Caring	√	SR 3 - Operational Performance	√
Responsive	√	SR 4 - People and Culture	√
Well Led	√	SR 5 - Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Maternity Improvement Plan Monitoring Meetings	Weekly from 24/05/2023 to 09/10/2024	Agreed to be monitored monthly through Care Group Governance
HCS Change Programme Board	02/10/2024	Noted
HCS QSI Committee	29/08/2024	Noted
HCS Change Programme Board	07/08/2024	Noted
HCS Change Programme Board	03/07/2024	Noted
HCS Change Programme Board	05/06/2024	Noted
HCS Advisory Board	30/05/2024	Noted
HCS Change Programme Board	01/05/2024	Noted
HCS Advisory Board	25/04/2024	Noted
Scrutiny Report	15/04/2024	Noted
HCS Change Programme Board	03/04/2024	Noted
HCS Advisory Board	28/03/2024	Noted
HCS Change Programme Board	06/03/2024	Noted
HCS Advisory Board	29/02/2024	Noted

HCS Change Programme Board	07/02/2024	Noted
HCS Change Programme Board	03/01/2024	Noted
HCS Advisory Board	06/12/2023	Noted
HCS Change Programme Board	04/12/2023	Noted
MHSS Hearing Pack	16/11/2023	Noted
HCS Change Programme Board	06/11/2023	Noted
HCS Advisory Board	01/11/2023	Noted
HCS Advisory Board	04/10/2023	Noted
HCS Change Programme Board	02/10/2023	Noted
HCS Change Programme Board	06/09/2023	Noted
Shadow Health Board	23/08/2023	Noted
HCS Change Programme Board	02/08/2023	Noted

List of Appendices:
20241023 – Maternity Improvement Plan – Phase 2

MAIN REPORT

1. Executive Summary

The Maternity Improvement Programme was established on 28th June 2023, the purpose of the programme was 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, with clear assurance and accountability, totalling 127 reported recommendations. The Service have been dedicated in progressing these recommendations, ensuring that the responses became part of the embedded business-as-usual governance process of the organisation.

During Phase 1 of the Maternity Improvement Plan, the service co-designed their Maternity Services Strategy 2024-2026 with the Jersey Maternity Voices Partnership, widespread public engagement including the hard-to-reach groups, Family Nursing and Home Care, midwives, nurses, health care assistants, consultants and community providers. It is envisioned that the Strategy will ensure sustainability of the completed recommendations within the Maternity Improvement Plan and see the completion of the outstanding recommendations. On completion of Phase 1, the Service have achieved 102 out of 127 recommendations.

Phase 2 (business-as-usual) of the Maternity Improvement Plan commenced on 16th July 2024. The aim of this phase is to:

1. Ensure the sustainability of the completed recommendations from Phase 1
2. See the completion of the outstanding recommendations from Phase 1
3. Implement the Maternity Services Strategy 2024-2026
4. Enable the framework of continuous improvements for the Maternity Service from future internal and external reports of relevance.

Since the last QSI Committee, the following progress has been made:

- New substantive Chief of Service appointed.
- Commencement in post of the substantive Risk Midwife and WAC's Care Group Governance Lead.
- Culture Improvement Plan sessions continue on Psychological Safety at Work and additional dates are being added to ensure all staff across maternity have attended. It is recognised that culture change is ongoing and maternity services, with support from the Director of Culture,

Engagement and Wellbeing, are continuing to implement the culture improvement plan for the service.

- Following evidence of sustainability of improvements within the service, and in line with transferring the Maternity Improvement Plan to business-as-usual, it was agreed to align reporting of the Maternity Improvement Plan with business-as-usual structures, with the Maternity Improvement Plan Monitoring Meeting concluding and reporting to commence monthly to the Care Group Governance Meeting.
- Ongoing follow-up reviews for Phase 1 of which 101 out of 102 recommendations have completed 30-, 60-, 90-, and 120- day follow-up reviews, evidencing ongoing embedment of recommendations (up from 95 in September).
- Re-commencement of support from Senior Change Manager to ensure embedment of Phase 2 outstanding report recommendations (total 25 recommendations).
- Review of working book structure to align with Strategy years for delivery, enabling focused working within the spreadsheet and accurate reporting.
- Progress of outstanding report recommendations including approval of the Perinatal Mental Health Standard Operating Procedure, ongoing refinement of competency skills tracker, finalisation of the Maternity Catheter guideline and venous thromboembolism (VTE) guideline appendices to be included within the HCS guidelines (under review) and ongoing training and development of Leads for championing fetal monitoring.
- The Strategy has now become 'business as usual' for the service following its publication in July. A three-year delivery plan of the strategy is in place, with the service providing feedback to the executive team through the monthly Care Group Governance meeting.

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 next month:

- The culture improvement plan for the remainder of 2024 includes specialist mediation, 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.
- Benchmark service against the recently published National review of maternity services in England 2022 to 2024 - Care Quality Commission.
- Following finalisation of comparison dashboards, to benchmark 2024 service dashboard.
- To continue to refine the 2024 Maternity dashboard.

Phase 2 Report Recommendations - Progress to date

Currently 6 out of 25 have been confirmed as complete/business-as-usual with robust evidence by the Care Group Senior Leadership Team. 1 recommendation is under review to ensure sustainability of any business-as-usual processes. High level progress can be found below:

	August	September	October
Total Number of recommendations	25	25	25

Complete signed off	2	2	6
Complete	2	5	1
Green	15	13	15
Amber	6	5	3
Red	0	0	0
Not Started	0	0	0

Phase 2 Strategy Recommendations - Progress to date

The service is focusing on the recommendations to be commenced in 2024, following the publication of the three-year Strategy. Currently 3 out of 36 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	October
	36
Complete signed off	0
Complete	3
Green	13
Amber	16
Red	0
Not Started	4

Maternity Improvement Plan - transfer to business-as-usual

As each recommendation is approved by Women and Children's Senior Leadership Team, 30-, 60-, 90- and 120-day reviews are completed 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 Care Group Governance Meeting.

2. Finance / workforce implications

Workforce:

- Maternity Services are continuing with recruitment to substantive posts across the department.

3. Risk and issues

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.

Phase 2 of the maternity improvement plan is the delivery of the maternity strategy across the next 3 years. We are presently reviewing all aspects to ensure that the plan is owned, delivered and maintained by the

care group. Current engagement opportunities are in place to ensure all staff are included in this, including a weekly “Time to Chat” sessions with the Director of Midwifery and monthly updates 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.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Pharmacy Action Plan – Prioritised Actions**		
Date of Meeting:	30 October 2024	**Agenda Item:**	**18**

Executive Lead:	Mr Patrick Armstrong MBE, Medical Director
Report Author:	Mr Simon West, Deputy Medical Director

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion ☐
	This paper provides the HCS Advisory Board with the prioritised actions.			
Summary of Key Messages:	On the 26 September 2024, the Health and Community Services (HCS) Advisory Board noted >50 recommendations made in the report and asked the HCS Executive to identify priority actions which would have greatest impact.			
Recommendations:	**The Board is asked to support the report.**			

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 - Quality and Safety	√
Effective	√	SR 2 - Patient Experience	√
Caring	√	SR 3 - Operational Performance	√
Responsive	√	SR 4 - People and Culture	√
Well Led	√	SR 5 - Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Senior Leadership Team meeting	17 October 2024	For further discussion at the People and Culture Committee 30 Oct ahead of the HCS Advisory Board during Nov2024.
People and Culture Committee	30 October 2024	Discussion at Board 28 Nov

List of Appendices:
Nil

MAIN REPORT

Following the HCS Advisory Board meeting during September 2024, an action was requested regarding the pharmacy action plan as it was felt that there were too many actions to be effectively and successfully completed.

ACTION: The Board to receive the prioritised list of actions in November 2024 and in six months' time, receive the monitoring against the prioritised list

The request was to review the action plan and determine which actions would successfully kick start the process of improving all aspects of pharmacy as described under the various subheadings in the review report.

The Deputy Medical Director and the interim Director of Pharmacy met and reviewed the action plan and propose the following actions to commence the pharmacy improvement program with progress tracked and monitored through weekly 1:1 sessions.

The original report was divided into the following subheadings,

1. Culture
2. Workforce
3. Workload
4. Education and training.

To kickstart the program, the team have selected four actions that upon completion would have the biggest impact on the domain which they cover and/or crosscuts many of the other domains in order to address the 59 separate actions described by the original review team in their report.

The actions have been categorised according to the headings from the original report.

1. Culture

Establish a series of listening events, either in groups, teams or 1:1, to understand the cultural issues in pharmacy and establish a programme of change informed by those discussions.

This is already in progress.

The Director of Culture, Engagement and Wellbeing, the Director of Pharmacy and the Deputy Medical Director (DMD) met and discussed the process for conducting the above on the 24th of September 2024.

The review report talks extensively of the cultural issues that are evident through all areas of pharmacy. The decision was made to conduct a series of listening events to allow the pharmacy workforce a safe space to set out their individual or group concerns which will inform the development of a charter for behaviour in Pharmacy.

The success of this intervention, which is seen as key to the delivery of a safe and improved workplace for all pharmacy staff will need to be assessed to ensure the interventions put in place have the proposed impact on cultural improvement.

This will require interval assessment, and also re-assessment via the original survey from the pharmacy review as well as other suitable assessment tools. The proposal would be that this occurs as a minimum at 6, 12, 18 and 24 months to ensure that there is improvement and sustainability.

The proposal will be covered fully in a paper to the next board.

2. Workforce

***Establish a regular workforce planning meeting at the Director of Pharmacy 1:1 with the workforce team to ensure traction on vacant posts and any new appointments*.**

Many of the workforce challenges relate to vacant posts and/or an inability to recruit to these with a degree of drift and a reliance on temporary transient locum workforce.

This workforce never firmly embeds in the department and can leave gaps as their requirement to give notice of absence as agency staff is not the same as substantive staff. This in turn feeds into the cultural issues experienced by staff.

Both the DMD and Director of Pharmacy are aware that recent high levels of absence, as well as further resignations leading to a depleted workforce.

To maintain traction on temporary absences it has been agreed with the Director of Workforce that medical staffing can expand the agency pool that supply agency staff. This was seen as a key issue effecting the ability to recruit effective longer-term locums. It is also felt that weekly direct review of the workforce issues will ensure an “eyes on” approach and allow areas where there is blockage to be escalated sooner with the Director of Workforce.

This overarching action has been selected to therefore address the vacancies and ensure that recruitment to vacant post is closely monitored and any impediments are addressed and unblocked on a weekly basis.

In addressing workforce, it is believed that there will be improvements in culture as feedback from pharmacy suggested that the burden of workload in itself is a contributor to the cultural aspects.

3. Workload

A. Reduce workload in outpatient pharmacy - explore option of dispensing NEW scripts from outpatient appointments only and discontinue prescription of over-the-counter meds.

A significant part of the dispensary workload is the supply of scripts from outpatients as well as medication that is available over the counter.

The pharmacy review recognised three areas where workload could be reduced: outpatient scripts, over the counter medications and private prescriptions.

Work has already been undertaken on private prescriptions. Whilst some private prescriptions would always require dispensing from the hospital pharmacy, this change has already had an impact in the dispensary function.

A proportion of all medications dispensed are from the prescribing of established patient medications rather than new scripts.

This was recognised as an opportunity to reduce workload on the dispensing team by the pharmacy review team. A focus for outpatient scripts would be to only dispense new scripts commenced at the outpatient appointment and no longer supply existing medication so long as it is available in the community. Over time, this should translate to the delivery of take home medicines (TTOSs) from the ward as well. This action will require discussion and an assessment of impact.

For over-the-counter medications, the pharmacy should no longer supply these.

This would require communication to all clinicians and align with the approach of other jurisdictions to reduce both demand at dispensaries as well as financial burden.

B. Explore with SEB/ MHSS as a matter of urgency contract arrangements for On-Call/ Out of Hours work in pharmacy for nights and weekends.

The review report recognised that there is inequity in a number of areas for out of hours and emergency work.

Whilst similar to all other AHP's, there is no formalised on-call rota for pharmacy and the system relies on good will and professionalism to supply an on-call rota to HCS for pharmacy.

Staff are "repaid" with time in lieu in the week, however this further compounds the staff numbers in the week and at times staff do not take this time in lieu to make up the numbers.

The Director of Pharmacy is concerned that the numbers of staff within the "on call" pool is diminishing pushing the burden to an ever-lower number of people.

To address this, the establishment of a formal paid on call rota is suggested that should work for all, and as such is equitable both financially and personally.

This action was again seen to have an impact on culture and equity within the department but is a longer-term action given the discussions required.

This will require both staff and States Employment Board (SEB) discussion.

4. Education/ Training

Establish the Pharmacy Head of Education and Workforce and define reporting structure and function to support the recommendation of the pharmacy review from both an operational and a strategic island wide perspective.

This post exists and has now been recruited to establishment. However, the role is not properly defined with respect to the time spent between operational and strategic arms of pharmacy.

The majority of the recommendations around education and training suggest improvements to education and training provision are required and as such will inevitably improve the culture within the department.

The impact of this change will be measurable in the face of delivery of education in the department, ability of and attendance at educational events demonstrable through workforce appraisal.

This one action is felt to deliver the highest impact in this subsection.

Finance / workforce implications

- A reduction in reliance on agency and temporary workforce will improve the financial position in pharmacy and for HCS.

- A reduction in the dispensing of medication would improve the financial position of the pharmacy budget reducing overall costs as well as improving the intensity of work for the workforce in dispensary and with the possibility of cultural improvement.

- Establishment of a formal on call rota will incur cost and would require agreement in SEB as well as formal change to contracts. This will require consultation with workforce as well as SEB. HCS is encouraged during 2025 to review short term investment to the on-call structure to effect immediate change as the longer-term options are explored.

- The establishment of regular training programmes may require additional investment.

Risk and issues

The recommendations were accepted by the senior leadership team on 14 November 2024. The recommendation around outpatient prescribing may raise concerns but is in line with other jurisdictions.

Recommendation

The HCS Advisory Board is asked to discuss and support the proposed priority actions (noting that some will require a Ministerial briefing ahead of implementation).

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Board Assurance Framework**		
Date of Meeting:	28 November 2024	**Agenda Item:**	**19**

Executive Lead:	Executive Leadership Team
Report Author:	Emma O'Connor Price, Board Secretary

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides the Board with key strategic risks to the achievement of the annual strategic objectives 2024.			
Summary of Key Messages:	The key messages arising from this report are: Following the Committee meetings held at the end of October 2024, the following was agreed, - **Quality and Safety**: remains at 20. - **Patient Experience**: remains at 8 - **Operational Performance (Access)**: remains at 20 - **People and Culture**: increased to 20 - **Finance**: remains at 25			
Recommendations:	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.			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	√
Caring		SR 3 – Operational Performance (Access)	√
Responsive		SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Each Committee	October 2024	As above

List of Appendices:
Appendix 1: Board Assurance Framework

MAIN REPORT

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.

BAF Review

Quality and Safety: The Quality, Safety and Improvement Committee met on the 31 October 2024. The Committee reflected on the discussions and considered whether there was any material impact on the BAF risk. Agreement that the agenda items and discussions covered the main areas of risk, and the level remains 20.

Patient Experience: The Quality, Safety and Improvement Committee met on the 31 October 2024. Agreement that the level of risk remains 8.

Operational Performance: The Finance and Performance Committee met on the 30 October 2024. The current level of risk remains at 20.

Workforce and Culture: The People and Culture Committee met on 30 October 2024. The current level of risk remains at 20 (reflecting the increase last month).

Finance: The Finance and Performance Committee met on 30 October 2024. The current level of risk is 25.

New Risks Recommended for Inclusion in the BAF
No new risks have been added to the BAF.

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 September 2024.

Review Date
The BAF is reviewed bi-monthly by the Board and the committees of the Board. The next review date is scheduled for January 2025. Following this the BAF will be aligned to the 2025 Annual Plan objectives.

END OF REPORT

Health and Community Services

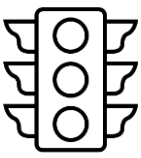
Board Assurance Framework

2024

The content of this report was last reviewed as follows:

Quality, Safety and Improvement Committee	October 2024
People and Culture Committee	October 2024
Finance and Performance Committee	October 2024
Executive Team	October 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** 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** **Chief Nurse**	**Quality, Safety, and Improvement**	**20**	↔
2	**Experience** 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**	**8**	↔
3	**Operational Performance** 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** **Director of Improvement and Innovation**	**Finance and Performance**	**20**	↔
4	**Workforce and Culture** 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** **Director of Culture, Engagement and Wellbeing**	**People and Culture**	**20**	↑
5	**Finance** 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**	**25**	↔

Risk Management

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

Impact

Likelihood	Negligible 1	Minor 2	Moderate 3	Significant 4	Severe / Catastrophic 5
Very Likely 5				People and Culture	Finance
Likely 4					Quality and Safety Operational Performance
Possible 3					
Unlikely 2				Patient Experience	
Very Unlikely 1					

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**	31 October 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	0	0.24	
Number of Serious Incidents completed in timeframe	11	15	5	
Number of patients who have had a VTE risk assessment completed within 24 hours of admission	14.5%	12.7%	30.6%	
Number of medication errors resulting in harm / per 1000 bed days	0.90	1.14	1.77	
Number of organisational never events	1	0	0	
Number of cat 3/4 pressure injury & deep tissue injury acquired in care / 1000 bed days	0.97	0.27	0.24	

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. 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**	31 October 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	**8 (2 x 4)**
Tolerable risk	6
Direction of travel	N/A

Relevant Key Performance Indicators

	Q1	Q2	Q3	Q4
Number of Compliments received	402	372	343	
Number of Complaints received	68	45	45	

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	Completed
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.	Patient and Users Panel	Completed

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**	30 October 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	685	747	1063	
Patient on elective waiting list > 52 weeks	285	264	309	
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	Chief Operating Officer – Acute Services,	TBC

			monitor compliance and understand impact		Director of 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	**Date last reviewed**	30 October 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. 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	**20 (5 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.	32 wc 12 TRiM	33 wc 9 TRiM	53 wc 38 TRiM	
Staff offered wellbeing support.	32	33	53	
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 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. 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.	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	Complete
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. Review education and development needs accompanied by the development of a skills review exercise.	Head of Nursing, Midwifery and AHP Education. Chief of Service – Medical Education	Oct 2024 Not Achieved at deadline CF to 25
Limited resource to deliver culture intervention/organisational development	Review resource required for targeted service areas	Director Culture, Engagement & Wellbeing	May- June 2024 Not Achieved at deadline CF to 25
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 Not Achieved at

	with HCS Directors and their managers for e-learning		deadline CF to 25
Continued staff exposure to violence and aggression by service-users	Review of Violence and Aggression in the workplace policy Cross agency working group with SoJP established to agree procedures following violence. Continue review of Datix reports of violence and aggression	Director of Mental Health Services and Adult Social Care	May – June 2024 Not Achieved at deadline CF to 25
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	Complete
An immature restorative and just learning culture	Review of safety huddles post incident. 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 Not Achieved at deadline CF to 25
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 Not Achieved at deadline CF to 25
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 Not Achieved at deadline CF to 25
	Dedicated recruitment campaigns for specific services / Developing dedicated nurse cohort recruitment campaigns in QTR 2 Provisional planning of events, discussions with specialist recruiting companies and cost estimates to be set against the Recruitment Budget. 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	Complete

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**	30 October 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	**25 (5 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%	9.1%	9.3%	
FRP Delivery	£1.853m	£3.557m	£6.504m	

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: • Gaps in applying PO controls causing payment delays. 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