Health and Community Services

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

26 SEPTEMBER 2024

Government of Jersey

Health and Community Services

AGENDA

MEETING: Part A - Health and Community Services Advisory Board
DATE: 26 September 2024
TIME: 9:30am – 12:30pm
VENUE: The Grand Suite, Grand Jersey Hotel, Esplanade, St Helier, Jersey JE2 3QA

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 (TEAMS)	**DK**
Executive Board Members (Voting):		
Chris Bown	Chief Officer HCS	**CB**
Patrick Armstrong MBE	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 Services, Adult Social care and Intermediate 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 (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**

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** *Verbal*	For **Information**	Chair	**9:30pm**
2	**Declarations of Interest** *Verbal*	For **Information**	Chair	
3	**Minutes of the Previous Meeting** *Verbal*	For **Decision**	Chair	
4	**Matters Arising and Action Tracker** *Verbal*	For **Decision**	Chair	
5	**Chair's Introduction** *Verbal (include arrangements for CB;s cover)*	For **Information**	Chair	**9:40am**
6	**Chief Officer's Report** *Paper*	For **Information**	Chief Officer	**9:50am**
7	**Partnerships in the Health and Social Care System** *Paper*	For **Discussion**	Director of Improvement and Innovation	**10:10am**

	Presentation from invited partners			
8	**Finance Report Month 8 – August 2024** *Paper*	For **Assurance**	Strategic Head of Finance Business Partnering	**10:40am**
	Comfort Break			**11:00am**
9	**Quality and Performance Report Month 8 – August 2024** *Paper*	For **Assurance**	Executive Directors	**11:10am**
10	**Workforce Report Month 8 – August 2024** *Paper*	For **Assurance**	Director of Workforce	**11:20am**
11	**Out of Hospital Health and Care Services** *Paper*	For **Information**	Director of Improvement and Innovation and Director of Mental Health, Social Care and Community Services	
12	**Neurodevelopmental Services Update – Attention Deficit Hyperactivity Disorder (ADHD) and Autism** *Paper*	For **Information**	Director of Mental Health, Social Care and Community Services	**11:30am**
13	**Board Committee Reports** **Quality, Safety and Improvement** – *Paper* **People and Culture** – *Verbal* **Finance and Performance** - *Verbal*	For **Assurance**	Committee Chairs	**11:40am**
14	**Jersey General Hospital Pharmacy (External) Review: Update and Action Plan** *Paper*	For **Assurance**	Deputy Medical Director	**11:50am**
15	**Royal National Orthopaedic Hospital / getting It Right First Time (GIRFT) Report and Action Plan** *Paper*	For **Assurance**	Deputy Medical Director	**12:00pm**
16	**Board Assurance Framework** *Paper*	For **Assurance**	Board Secretary	**12:10am**
17	**Declaration of Interests Register** *Register*	For **Information**	Board Secretary	
QUESTIONS FROM THE PUBLIC (Relating to Agenda Items Only)				
	Questions		Chair	**12:15pm**
	MEETING CLOSE			**12:30pm**

Health and Community Services

	Date of next meeting: Thursday 28 November 2024	

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

Health and Community Services

Date: 25 July 2024	Time: 9:30 – 12:30pm	Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL

Non-Executive Board Members (Voting):		
Anthony Hunter OBE - **CHAIR**	Non-Executive Director	**AH**
Dame Clare Gerada DBE	Non-Executive Director (Item 8 onwards)	**CG**
Julie Garbutt	Non-Executive Director	**JG**
Executive Board Members (Voting):		
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Obi Hasan	Head of Strategic Finance HCS	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Emily Hoban	Head of Access deputising for Claire Thompson, Chief Operating Officer – Acute Services	**EH**
Andy Weir	Director of Mental Health Services, Adult Social Care and Intermediate Services	**AW**
Jo Poynter	Associate Director of Improvement and Innovation deputising for Dr Anuschka Muller, Director of Improvement and Innovation	**JP**
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**
Professor Peter Bradley	Director of Public Health and Medical Officer for Health (Item 7 only)	**PB**
Dr James Grose	Chair of the End-of-Life Care Partnership and palliative Care Consultant (Item 8 only)	**JGr**
John Gavey	Health and Safety Manager (Item 11 only)	**JGa**

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

AH welcomed all to the meeting. EOC provided some housekeeping information including location of fire exits, comfort break arrangements and minimising distractions during the meeting.

Apologies received from:

Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Carolyn Downs CB	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director (late arrival)	**CG**

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

No declarations

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

The minutes of the meeting held on 30th May 2024 were agreed.

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

ACTION 123: EH confirmed that both the inpatient elective and outpatient new referral waiting lists are fully validated and this is a continuous process of validation. Agree **CLOSE**.

ACTION 114: AW advised a paper will be presented in Sept 2024. The Quality and Performance Report for Month 6 demonstrates a plateau as a consequence of the work to review the waiting lists and reprioritise referrals. In addition, the clinical team are changing the pathway for assessment. Remain **OPEN**. **ACTION 76**: AH explained that the policy required for Article 36 has been prioritised ahead of progressing the Prosecution Policy and provided a preliminary delivery date of 2 -3 months. Remain **OPEN**. **ACTION 31**: 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**.	

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

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. Firstly, JG suggested that the Dementia Strategy could be presented at a future Board meeting with invites extended to key stakeholders. Secondly, JG welcomed the introduction of the Florence Nightingale Foundation Leadership Course for nurses and asked what training opportunities are available to doctors moving into or looking to further develop leadership skills. CB responded that senior staff across all Government of Jersey (GOJ) departments have been invited to attend the Cohen Brown Leadership training and this includes those in medical leadership roles. In addition, PA explained that the Faculty of Medical Leadership and Managers (FMLM) provided multiprofessional training (Doctors, Lead Nurses and General Managers) approximately 18 months ago. ACTION: Medical leadership training opportunities suggested for inclusion on the People and Culture Committee agenda.	

7	**Public Health**	**Action**
AH welcomed Professor Peter Bradley (PB), Director of Public Health and Medical Officer for Health, and emphasised the need for the Board to understand the importance of Public Health in Jersey and how HCS can contribute and support this agenda. The population of Jersey is getting older and as people get older, they live more years in poorer health; the ambition must be to make people well for longer in their lives and reduce the period of poorer health. This will also reduce the burden on the healthcare system. PB presented a series of slides (addendum to these minutes). AH thanked PB for the presentation and highlighted the linkage with HCS and the vision of the Minister for Health and Social Services (MHSS) for health, quality of life and prevention in Jersey and the range of services that will support this transition. JG thanked PB for the interesting and thought-provoking presentation, in particular the reference to 61.4 years for females in good health and 23.7 years in poorer health. Also, that the estimated cost of lost productivity to the Jersey economy due to preventable ill health has been estimated to be nearly £108m per year. JG echoed AH's observation that this Public Health agenda reflects the MHSS vision for the need of an integrated health system and the part that prevention, health promotion and wellbeing has in this. Healthy people are happy people, happy people are productive people and productive people contribute more to the economy that can be reinvested in health services. JG asked how HCS (which is predominantly engaged in the provision of services for the unwell) can support Public Health to move progress their agenda. PB responded	

the main issue is advocacy for investment as services are not currently well-developed, particularly when compared to other health jurisdictions (Jersey spends approx. 1/5 to a 1/4 of that seen in other jurisdictions). In addition, strengthen existing services such as vaccination to ensure efficiency. JG noted that the need to double fund services i.e. fund the prevention and wellbeing services at the same time as funding the ill health services. This is a debate that needs to occur with both the GOJ and the public to understand how this can be progressed as it is critical to establishing a healthy population and funding healthcare in the future. CB advised the Board that he meets regularly with PB and PA to discuss the issues described above. In addition, CB noted that governments in most other healthcare jurisdictions have difficulty with the issue of double funding and that HCS will support as much as possible. AH thanked PB for his attendance and advised that work will continue to align HCS with the Public Health agenda. PB thanked Dr Matt Doyle, Chief of Service and Sarah Evans, General Manager for Primary and Prevention, Therapies and Community Dental for their contribution to this morning's presentation.	

8	**Update on the implementation of 'A Palliative and End of Life Care Strategy for Adults in Jersey'**	**Action**
Dr James Grose (JGr), Chair of the End-of-Life Care Partnership and Palliative Medicine Consultant was welcomed to the meeting. JP provided an introduction including the funding of the service and the development of the strategy. Key factors to the provision of a good service for everyone in Jersey include increasing community awareness, early identification of those on an end-of-life pathway to support them to have a good death and supporting preferred place of death (see paper). To deliver against the strategy, a partnership group has been set up. JGr thanked JP for the introduction and thanked the Board for the opportunity to talk about the progress of the strategy. The Board was asked to recognise that there has never been a Palliative and End of Life (EOL) Care Strategy for Jersey and the publication of this in November 2023 was a huge advancement in terms of provision of service for this cohort of people. It recognises and benchmarks against International frameworks the key quality criteria to resemble a good palliative care service i.e. delivery of patient centred care, understanding patients expressed wishes, equal provision of service for non-cancer disease, and meeting physical symptom needs in addition to psychological, spiritual and social needs. The EOL Partnership Group was formed shortly after the publication of the strategy with strong representation across all stakeholders (HCS, Jersey Hospice Care (JHC), Family Nursing and Home Care (FNHC), Jersey Care Federation (JCF), Jersey Ambulance Service (JAS), patient representatives and charities including MacMillan and Age Concern). This recognises that there is no single organisation in Jersey that can meet all holistic needs for this groups of patients. The partnership set about to explore priority aims against the strategy and concluded that the core of what needed to be delivered must be based on knowledge (clinical, medical, scientific) and well-grounded evidence to support quality in the service. The first workstream focussed on education and a robust education strategy has been produced by the partnership group that identifies the key areas in which education and dissemination is core. The well-developed specialist palliative care team is a finite resource that looks after individuals in their final stage of the disease journey or those with complex symptoms prior to being at EOL. A gap was identified for those individuals who are not in the final stages of life or do not have complex symptoms but have a life-limiting illness – these patients still have needs. The second workstream's focus is looking at how we make sure that those patients who do not currently fulfil the criteria for specialist palliative but equally have needs from a palliative care service, have the right coordinated care. Key roles in supporting this group of patients have been identified as navigators, or 'care coordinators'. These individuals are professionals from a nursing background who can guide patients through a complex system of multiple stakeholders providing all different types of supportive services for patients with life limiting illness who do not meet the	

threshold to be under specialist palliative care team care. One of the roles of this coordination service is to look at access to care and making sure that mechanism for funding is in place to rapidly increase a package of care for someone with a life-limiting illness who is starting to deteriorate at home. In addition, rapid access to equipment and mediation as these are often factors that can limit patients from being able to maintain their care at home.

The importance was noted of making sure that patients have the opportunities through skilled professionals to have conversations about their wishes when it comes to EOL and the role of care coordinator to make sure these wishes are documented and importantly, shared and disseminated (to increase the chances of these wishes being met).

JGr advised the Board that he is proud to Chair the partnership group and the investment in Palliative Care in Jersey is world class and exemplary. JGr noted he has never worked in an area (whether NHS or wider) that has invested and recognised the worth and importance of caring for those with complex specialist palliative care needs and also those with life limiting illness without complex needs who are currently missed in many jurisdictions. JGr is proud to be part of this work with all the stakeholders who are doing incredibly good things to realise this strategy. JGr thanked the Board for opportunity to share this.

Noting the reference to improvements in technology to facilitate better integration between services, CB asked JGr if an integrated care record would improve the coordination of EOL care across Jersey. JGr agreed and noted that digital infrastructure would support the dissemination of care plans. Having a well-educated workforce with the skills, knowledge and ability to have difficult conversations with patients about their wishes when it comes to dying is of limited benefit if these wishes cannot be communicated across services: the whole pathway falls. Positively, progress has been made with the electronic dissemination of 'do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions and there is now a pathway to communicate DNACPR decisions electronically to the hospital. However, there is further work to explore how the wider decision making of patients is communicated.

CS commended JGr for the work of the group and asked JGr if he was confident that the strategy is reaching hard to reach groups. JGr recognised that there is a need (as part of the access workstream) to understand what is being done to support BAME groups in terms of access as currently there is under representation. The message must be that the specialist palliative care team and the partnership group will provide general palliative care regardless of ethnicity, religion or background. This work is not part of a current workstream, but it will be part of a future workstream.

Noting that much of the palliative care would be provided in the community until such time as specialist palliative care services are needed, CG asked if the community representation of the partnership needed to increase. JGr responded that it is important to recognise that everyone provides palliative care, and the partnership group represents a core group of people that attend regular quarterly meetings; additional invites are sent when appropriate. AH suggested that JGr and CG could meet to discuss further outside of this meeting if required.

AH extended the Boards thanks to JGr for his attendance and presentation.

9	**Patient and Service User Charter**	**Action**

JM advised she is presenting the Charter on behalf of Carl Walker, Chair of the Patient and User Panel. The Charter represents the work of the panel. The HCS Senior Leadership Team has approved the Charter for presentation to the Board.

AH noted the Board's appreciation to Carl Walker and the Panel in producing this.

AW noted that HCS includes a range of community and social services and commented that the language may need to be changed to reflect this. CB extended his thanks to the Patient Panel and whilst the SLT is supportive recognised the point made by AW to ensure the language is appropriate for all services across HCS. It is then important to ensure the Charter is communicated across all sites and services in HCS.

CS sought to clarify that the voice of the child is included in the development of a children's / young person's charter and JM confirmed that this will be a collaborative piece of work. The Board approved the Charter in principle.	

10	Outcomes of the Ward Based Peer Reviews	Action
JM took the paper as read and verbally summarise the key points detailed in the paper, including areas of good practice and areas for ongoing improvement. The Quality, Safety and Improvement Committee will be receiving quarterly assurance reports. CS noted the regular (weekly) visibility of senior nursing leadership is very important. These reviews provide real-time information and allow for real time improvements where indicated. The reviews form a critical part of continuous improvement. AH noted this represents a robust process of assurance and is open regarding the improvements that must be made. As a new member of staff within HCS, ITe endorsed and supported this process, stating this approach is not often seen. As an advisor to CQC inspections, ITe is aware of different practices, and this is one that a provider would be congratulated for. Specific areas highlighted include the senior nursing leadership and the multiprofessional approach to these reviews.		

11	Health and Safety Q1 2024 Report	Action
John Gavey, Health and Safety Manager for HCS, was welcomed to the meeting and took the paper as read. In addition, • The approach to Health and Safety is that of risk control and mitigation (rather than compliance). This is how the Health and Safety team are led and engage with all staff across HCS: the ability to mature Health and Safety culture is owned by Managers and Team Leaders in the operational teams. • The Health and Safety team in HCS delivers specific training interventions which is unique to HCS. • The Health and Safety Management System refers to the way in which HCS manages health and safety throughout the estate, and how it can demonstrate its due diligence of an effective implemented approach (rather than a software system). It is based on Plan, Do, Check, Act or HSG 65 from the health and Safety Executive. This risk entry is the collective of the other twenty-seven risks identified. • >10,000 training certificates were issued for Health and Safety in HCS during 2023. • 2,204 hours of face-to-face training were delivered by the Health and Safety Team. • 91 HCS specific sample audits were completed. • Whilst the report refers to Q1, during Q2 a Corporate audit (classed as external) of radiology against the Ionising Radiation Minimum Standard and achieved 100%. It is very rare to achieve 100% and JGa asked the Board to note the work of the radiology department in achieving this. Further detail will be provided in the Q2 report. This achievement has also been included in the report to the States Employment Board (SEB). AH thanked JGa, particularly for reminding the Board that health and Safety is the responsibility of all employees. CG asked for clarification regarding the risk of violence and aggression and who it relates to i.e., against staff, between staff. JGa explained that this relates to incidents as described by JGa and also includes members of the public and visitors as HCS has a duty to non-employees under the Health and Safety Law. The risk is representative of HCS as a whole but there will be different across services. It is concerned with the provision of tools to manage all types of abuse, not just physical / assault.		

CB advised the Board that he meets regularly with the JGa and that a steady trajectory of improvement continues within HCS. HCS is seen as an exemplar across GOJ with a maturing culture and thanked JGa and his team for their work.

In response to JG's questions, risk turns green below 4. However, in Health and Safety risk management, the mitigations often reduce the likelihood but not the impact. Therefore, it is unlikely that a 'green' will ever be achieved.

EOC confirmed that People and Culture Committee will receive future Health and Safety reports with the Q2 2024 scheduled for September 2024.

ITe thanked JGa for his report, noting the intelligent and thorough approach to Health and Safety. The Unions have raised the issue of violence and aggression in their regular meetings with HCS and suggested it would be beneficial for ITe and meet ahead of the People and Culture Committee to prepare. CP reminded the Board that an audit had been completed last year with a subsequent programme of improvement.

12	**Royal College of Radiology Report including a Review of Mammography Service**	**Action**

Before progressing to the key areas from the report, PA noted the following,

- Apologies to all patients and their relatives who have been affected by this report. Whilst the number of people affected is not large, this is not acceptable to any individual.
- Thanked Mr Simon West, Deputy Medical Director, who has led this piece of work.
- There are two parts to this work – firstly, the Review by the Royal College of Radiology and the Review by the British Society of Breast Radiologists. The review was commissioned following a concern raise through the Freedom to Speak Up Guardian regarding the performance of a Radiologist.

The Royal College of Radiology Report focussed on five different areas: patient safety, service planning and delivery, team working, clinical governance and managing concerns. There has been a focus on the team-working / relationships within Radiology and improvement work is ongoing. The reference is to some members of staff, it is not universal. Of most concern is the description that young, female doctors were not spoken to professionally and one doctor was told not to go to the department. PA assured the board that this incident was managed in the expected manner.

Tensions between different professional groups are not unique to Jersey or Radiology. PA suggested that HCS are behind the curve in supporting nurses and Allied Healthcare Professional in working to the top of their registration and moving away from the medical model in Jersey would help culture. In addition, this would provide improve retention and provide resilience to many services.

There are gaps in clinical governance however, item 11 highlighted some very good practice. It is important to note that the report did not state that there was no clinical governance, rather that improvements in clinical governance are needed. Radiology is a highly regulated area.

There is a programme of action to address the recommendations, all of which are detailed in the report.

The British Society of Breast Radiologists report led to the development of an action plan and all recommendations made have been accepted. Whilst avoiding focussing on individuals, PA highlighted that the Radiologist concerned has acted in an exemplar manner following concerns regarding their practice. It is important to note that this relates to one area of practice and HCS has good evidence that the same individual performs very well in other areas of radiology.

The review did not recommend a mass review / recall on the basis that many patients had already been seen and would likely be seen over the ensuing few months. However, HCS took the view that this period (5 months) was too long and commissioned an external review of patients. Key findings from this,

- Of circa 3,500 patients, 650 had already been rescreened. Therefore circa 2,800 mammograms were reviewed. Of the 2,800, 23 needed to be recalled – 3 had already been seen which left 20 patients. In addition, a delay in diagnosis was identified for 14 patients and a duty of candour has been undertaken.

In summary, this has been a distressing time for patients and staff. PA assured the Board that the findings of the reports have been acknowledged and HCS will implement any required improvements.

AH thanked PA for the report and stated that the Board and the public will require ongoing assurance of the improvements delivered. AH noted the importance of the Freedom to Speak Up Guardian for all staff.

CG stated she was unclear as to the level of harm to the 34 individuals affected. In addition, this represents a very low error rate (0.4 – 1%) and asked if the error rate for this service is known. In addition, did the initial concern raised through the FTSU refer to skill or behaviour? Thirdly, the frequency of screening (yearly) appears to be more than the UK which is every 3 years. Is the cumulative effect that the public are being worried unnecessarily?

PA responded that the error rate is low and, in all probability, falls within what could be considered a normal range. However, the issue is that concerns within Radiology had been raised over a three-year period and had not been acted upon. The BSBR has not been published as it contains personal information that would be inappropriate for the public domain. However, HCS acknowledges that no screening programme can provide 100% assurance, but HCS had a duty to act upon the concern raised. In response, CG suggested that concerns raised in the future could be brought to the Quality, Safety and Improvement Committee to discuss and decide how these should be managed; context is important.

CB re-emphasised the key point that the concerns had been raised for three years within Radiology but had never been escalated from Radiology to senior management. The FTSU Guardian provided the opportunity to raise concerns through the system. The culture that fostered this failure to escalate is being addressed with all other recommendations. CB echoed PA's earlier point that behaviours do not relate to all staff within Radiology and the difficulties across professions are reflected elsewhere, for example within Maternity Services. However, HCS has a duty to manage all these issues head on, and despite a range of error, one patient harmed is one too many. HCS had to undertake the review (with expert opinion) to establish the number of patients involved. Whilst acknowledging that context is important, the report has raised significant issues that must be addressed and t is important to get an external view, particularly for small departments.

Following the outcome of the reviews, CP advised that a Psychological Safety in Healthcare Teams Programme has been developed, particularly for managers to provide them with the skills to have difficult conversations and foster a culture where people feel safe to speak up.

JG asked when the new mammography units are expected. EH suggested it is Q4 2024 but will confirm.

AH thanked PA for the report and advised that the Board will require assurance of the improvement delivery.

CG wished to emphasise that the public cannot be given the impression that the healthcare has a zero-error rate.

13	**Rheumatology Update**	**Action**

Reflecting on item 12, AH stated that it is difficult to strike the balance between addressing concerns with an appropriate and proportionate response. However, this should not indicate complacency, rather realism.

PA advised this is an update for the Board, primarily regarding the review of deceased patients. The focus will be on the improvements made within the rheumatology service. PA stated it is

important to acknowledge and apologise to those patients and relatives who have been impacted by what has happened in this service. It is hoped that this report demonstrates the steps that HCS has taken to improve the service. PA also sought to acknowledge the tremendous effort of the staff in the rheumatology service for the improvements made in the service – this is now an exemplar service within HCS.

- The review of patients has been approached in different tranches and all previous audits have been completed. The most recent tranche has focussed on those patients who had been under the care of the rheumatology service and have died for any reason during the period Jan 2019 to Jan 2022. This period has been extended to patients who have died more recently.
- From Jan 2019 to-date, 190 patients were identified for review and 120 have been completed. The process includes the use of an audit tool to decide whether there are concerns regarding the care they received. Concerns existed for approximately one third of patients. These patients were subject to a Mortality Learning Review (Structured Judgement Review in the UK) followed by a panel review consisting of an independent general physician, a GP, an independent rheumatologist, Chief of Service Medicine and the Deputy Medical Director to establish if there was a possible or definite link between the care they received and their death. Under Jersey Law, HCS must notify the Police if further investigation may be required.
- In discussion with the Police and Viscount, it has been agreed that patients will be referred to the Viscount. HCS's part in the process ends here.
- To-date, 20 such referrals have been made.
- Of the 190, the remaining patients will be reviewed, and the Viscount has asked HCS to look back as far as possible. It is therefore likely that this process will take a long time (years).
- A Duty of Candour has been undertaken and they will be informed if there relative has been referred to the Viscount.
- All patients under the care of the service in recent years have been written to inform them that there is a process to establish whether they have come to harm as a result.
- 33 patients have been identified where it was felt that care has fallen below expected standards and may have resulted in possible medical harm.
- The medico-legal recourse remains under discussion and a pilot scheme is being piloted.

The following improvements have been made,

1. Commence an audit of those patients currently on biologics to assure their diagnosis is secure – **complete**
2. The recommendations made regarding the two Doctors involved – **complete**
3. Share the RCP report with the executive team and minister for health and social services, with oversight of an action plan by a Non-Executive Board member - **complete**
4. Appoint consultants on the specialist register, specialist nurses and access to physio, OT, podiatry, pharmacy and psychology services. Secretarial and administrative support in order to provide a sustainable, contemporary rheumatology service - **complete**
5. Introduce job plans for Rheumatology consultants and clinical nurse specialists - **complete.**
6. Review processes for personal and professional development of the rheumatology service staff, including weekly teaching sessions and annual appraisals - **complete**
7. Embed MDT working into everyday practice and establish links with a mainland modern rheumatology centre **- on track**
8. Ensure all patients starting a biologic have a documented biologic assessment, an objective assessment of disease activity and infection risk, documentation of relevant co-morbidities and vaccination status, and confirmation that prescribing is in line with NICE/European guidelines – **complete**
9. Service should adopt a more holistic approach with the involvement of therapies - **on track**
10. Review the frequency of follow up - **on track**
11. Implement a standardized written correspondence template – **complete**
12. Arrange a regular rheumatology MDT meeting with clear Terms of Reference. Record the MDT discussion and outcome in the patient's notes, with a copy sent to the GP and the patient - **on track**

13. Discourage the sole reliance on pharmaceutical companies for drug information and training – **complete**
14. Review the arrangements for the prescribing of biologics; incorporate processes for challenge and be more proactive in providing regular updates on rheumatology prescribing - **on track**
15. Improve data collection and analysis in relation to dispensing rheumatological medications in order to assure patient safety prior to dispensing medication, maintain a record of the biologic therapy dispensed for audit purposes - **on track**
16. Hold a clinical governance meeting at least quarterly, including complaints, concerns, incidents, activity, staffing issues, audits and use of biologics. Document attendees and discussions, and report into the HCS clinical governance structure - **on track**
17. Regularly audit biologic therapies prescribing – **complete**
18. Use NICE guidance as part of the Rheumatology governance framework – **complete**
19. Foster relationships between primary and secondary care to develop more robust monitoring and develop shared care guidelines - **on track**
20. Support electronic prescribing and monitoring systems **- complete for rheumatology**
21. Appoint a pharmacist for high-cost drugs, to understand the usage and cost of biologic drugs and produce prescribing protocols – **complete**
22. Enrol in a regular rolling audit programme to provide reassurance about the activity and outcomes for patients and the use of expensive resources such as biologic therapies - **on track**

PA hopes that this reassures the Board and the public that a huge amount of work has been undertaken to realise these improvements.

Whilst acknowledging the distressing nature of this, AH stated it is now right to focus on the actions and continued assurance regain the service. CG gave her thanks for the improvements being made. CB highlighted that the Quality, Safety and Improvement Committee will continue to monitor the assurance regarding the improvements. In addition, CB provided an apology to all patients and relatives who have been harmed in any way. The distress to staff was also acknowledged and support is being provided. However, this is a powerful example for the need for strong clinical governance, the need for following evidence-based guidance, participation in National Audits and linkage with a tertiary centre to ensure modernisation and sustainability in services.

14	**Medicine Improvement Plan**	**Action**
As the Medicine Improvement Plan (IP) is monitored by the Quality, Safety and improvement Committee, AH invited CG to comment. 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.		

15	**2024 HCS Annual Plan - Q2 Progress Report**	**Action**
AH took the paper as read.		

16	**2025 Annual Business Planning Approach**	**Action**
AH took the paper as read.		

17	**Quality and Performance Report Month 6**	**Action**
AH invited exceptions only. No exceptions to highlight.		

18	**Dermatology Sustainability**	**Action**
EH advised the Board that the paper provides a very brief summary of the current service. CB highlighted that a second dermatology Consultant has been appointed and EH confirmed they		

will be taking up the post before end 2024. Following this, the Consultant will consider how to progress the service.

CG commented that her understanding is that the existing Consultant will only see pigmented lesions, and this means that the new Consultant will be overwhelmed with the large number of patients currently on the waiting list (circa 1500). The development of new care pathways has been requested although recognised that this will involve moving budgetary resource and empowering primary care practitioners. More can be done (in addition to recruitment) and if done well, there will be learning for other services. EH in agreement but CG advised this must be done as a matter of urgency due to the length of the waiting list. EH responded that work is ongoing to recruit to other vacancies and there are two GPs with specialist interest, one of which already works in the department and the other due to start January 2025. The use of teledermatology is also being explored.

19	**Finance Report Month 6**	**Action**

Key headlines from the finance report (month 6).

- FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. This is a deterioration on previous months. Drivers include tertiary care contracts (experiencing a 50% increase in tariff), mental health placements and social care, recharge from the accommodation service and medicine 9oncology and medical day care).
- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- Recovery actions include intensive recovery support, further cost reduction actions and sustainable long-term funding.

OH highlighted that the HCS Ministerial meeting have been very supportive while trying to work through this.

CB advised that the Executive Leadership Team (ELT) met yesterday to explore additional actions to further mitigate the risks. Weekly meetings have been scheduled to ensure delivery of these plans and monitoring current spend. Other measures include reviewing management costs and management of overtime more effectively. The aim is to ensure that the current forecast deficit does not increase.

CG asked if it is possible to obtain a comparison of the department based on tariffs available. Whilst costs are higher in Jersey due to economies of scale, significant differences would be evident. OH stated that this is possible, and work has been going on regarding the patient level information costing system (PLICS) – the cost base for 2022 has been completed. CG stated that understood that doctors and nurses are not routinely coding activity meaning that the data is not available – is there a way of mandating coding? OH responded that the issue is one of resource – there are not enough coders. CB advised the Board that historically this is a skilled but low paid, in addition, these are not licensed posts and staff require intensive training. Consequently, this is a hard to recruit area.

AH advised that the Board would require continued assurance of the risks and implications of any additional savings. CB reassured the Board that quality impact assessments (QIAs) would be completed. In addition, could any of the increased pressures have been reasonably foreseeable. OH responded that HCS is well aware of where the pressures are coming from, it is the size of the pressure. Whilst HCS can enter negotiations regarding tertiary care contracts, there is not much bargaining power as Jersey has limited alternatives.

CS emphasised the benefits of substantive recruitment and in addition to saving money, permanent staff are more invested in the organisation and deliver good care. The Board heard that there are pockets of increasing recruitment.

20	Proposed Future Workforce Report Structure	Action
AH noted that this was covered in the Chief Officer report. ITe advised the Board that the paper details the five priorities for ITe. In addition, the proposal for the workforce report is aligned to the Jersey Care Commission (JCC) domains which will provide the Board with information against these criteria.		

21	Committee Reports	Action
The Committee reports were taken as read. The Quality, Safety and Improvement Committee noted some escalations for the Board, 1. **Medical Model** - previously discussed under item 14. 2. **Central Alert System** – the lack of a central purchasing system leading to probable overspends and inability to manage safety alerts effectively. OH responded that a key action for the FRP is that HCS has its own central buying team – the aim is to have this set up in the next three months. CB echoed this and does not feel assured that HCS can be assured regarding safety alert management. 3. **Cannabis prescribing** – the prescribing of cannabis in the private sector is impacting the public sector due to the rise in mental illness and the lack of governance etc. CG will provide feedback to the Committee.		

22	Board Assurance Framework	Action
EOC took the paper as read and informed the Board that following review of the risks by the relevant committee, there had been some movement in risk level (detailed in report). Each Committee will continue to draft its agenda according to the key assurance to ensure these are effective.		

23	Questions form the Public	Action
Member A: Member A commented that it is very good that the areas requiring improvement are becoming apparent. However, why was this information not available previously – for example by the Pharmacy Department (cost of biologics) and Medical Director. PA responded that the issues are now being exposed. Radiology was actioned as soon as it was highlighted. In addition, as soon as the Rheumatology issues were raised with PA, these were acted upon. The culture is beginning to change and HCS is being open and transparent (as it should be). CB commented that these are 'old issues coming out in a new environment'. In part, the transparency has also been enhanced by the creation of this Board and its way of operating. CB referred to Professor Hugo Mascie's Review as to why Jersey faced these problems. AH commented that whilst it is distressing when incidents occur, it is important to generate confidence by managing these effectively i.e. acting appropriately and proportionately. However, it remains critical the issues are exposed – this is the open and accountable culture that that Board aims to foster. It is good that HCS is addressing historical problems in this open way. CS commended the Medical Director and Chief Nurse for managing the issues that have surfaced, noted it is work in progress and putting clinical governance systems in place meets resistance. However, patient needs must be placed in the centre of everything. Further support was provided by a member of the public who stated that changes had been implemented as a result of feedback. **Member B**: Member B used his own experience as a service user to highlight the following issues: lack of challenge amongst Doctors (resulting in expensive use of external), lack of recognition of previous medical history, treated with disregard and disrespect and unfounded		

diagnoses / reports. In addition, perceived unreasonable questioning of taking photographs during the Board meeting. AW responded that whilst it is reasonable for the Board to expect to have their photograph taken, it is not reasonable for members of the public attending the meeting to have their photograph taken without their consent. Member B sought to reassure the Board that members of the public were not in any of the photographs. AW advised that the repeated concerns specified are complicated, but AW will meet with member B outside this meeting to discuss. **Member C**: Member C stated whilst there are people in the room that are trying to help manage individual concerns, a culture of keeping issues hidden continues. **Member D**: Noting the Advisory nature of the Board, there are seven items for information, two for a decision, one for discussion, two for approval, ten for assurance and zero for advice to the Minister for Health and Social Services – why is this? CB / EOC advised that the agenda provides a balance of agenda items that would typically be seen in other healthcare jurisdictions and promotes accountability in an open and transparent manner. The MHSS meets regularly with the NEDs and will be advised where necessary during these meetings. AH noted the benefits of these debates occurring in public.	

	MEETING CLOSE	**Action**
AH thanked all those in attendance and closed the meeting. **Date of next meeting:** 26th September 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											
5	144	30-May-24	14	Maternity Improvement Plan	Progress against the Maternity Strategy to be monitored by the Board every six months.	Patrick Armstrong	Nov-24				Nov Agenda
6	143	30-May-24	14	Maternity Improvement Plan	Maternity feedback to be included in the next culture report to the Board	Dr Cheryl Power	~~01/07/2024~~ ~~Sept 2024~~	Next Pand C Committee			Sept Agenda
7	141	30-May-24	10	Workforce Report Month 4	The results of the Pulse Surveys to be presented to the Board	Dr Cheryl Power	Nov / Dec 2024	Superseeded by GOJ Beeadr survey - results circa Nov 2024			TBC
8	129	28-Mar-24	9	Workforce Report (Month 2)	Invest to save options to speed up the recruitment process to be explored and brought back to the next meeting (April 2024).	O. Hasan	Apr-24	Close			OPEN
9	127	29-Feb-24	14	#BeOurBest Programme - Annual update	CP to present the culture dashboard at a future Board meeting.	C. Bown	~~01/06/2024~~ Sept 2024	Update 28 March 2024 CP confirmed that the culture dashboard will be presented to Board in June 2024. Remain OPEN.			Sept Agenda
10	125	29-Feb-24	13	Mental Health External Review Implementation	CD asked for an update on the work to join up Mental Health Services and Acute Services as it progress (timescale to be determined)	A. Weir	Apr-24	Update 28 March 2024 AW confirmed that meetings have taken place between Mental health And Acute Services. A summary of this can be presented to the board in April 2024. Remain OPEN			OPEN
11	114	25-Jan-24	7	Quality and Performance Report	AW to provide a paper on neurodevelopmental services in May 2024.	Andy Weir	~~01/05/2024~~ Sept 2024	25 July 2024 - AW advised a paper will be presented in Sept 2024. The Quality and Performance Report for Month 6 demonstrates a plateau as a consequence of the work to review the waiting lists and reprioritise referrals. In addition, the clinical team are changing the pathway for assessment. Remain OPEN.			Sept Agenda
12	96	06-Dec-23	6	Chief Officer's Report	The board to receive a report indicating progress on increasing the number of ACPs (March 2024).	Jessie Marshall	~~01/03/2024~~ Sept 2024 Nov 2024	Update 28 March 2024 The number of ACP's is to be increased – currently there a small number in post however a Project Lead has been appointed with start date 1st July to the position of Practice Development, Advanced Practice and Independent Prescribing who will support the further development of Advanced Clinical Practice across HCS in line with new NMC regulations due 2025/26. Anticipate an update after July 2024. Remain OPEN.			Sept Agenda
13	76	1st Nov 2023	4	Management of Incidents of Racial Abuse	Prosecution Policy to be presented to the Board (link to action 70).	Andy Weir	~~01/02/2024~~ ~~May 2024~~ Nov 2024	25 July 2024 - AH explained that the policy required for Article 36 has been prioritised ahead of progressing the Prosecution Policy and provided a preliminary delivery date of 2 -3 months. Remain OPEN.			Nov Agenda
14	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 including weekly meetings with the care groups and the care group			OPEN

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Chief Officer's Report**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**6**

Executive Lead:	Chris Bown, Chief Officer HCS
Report Author:	Chris Bown, 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

Getting It Right First Time (GIRFT) and Pharmacy Report / Action Plan

Following publication of these two reports by the MHSS, this is the Board's first opportunity to consider formally the content and action plans.

The recommendations from both reports have been accepted and following this, action plans have been agreed and implementation started.

The GIRFT recommendations are being tracked in the Surgical Care Group and the Pharmacy Review will be supported and tracked through the Medical Director's Office. The HCS Advisory Board will be sighted on progress through the Quality, Safety and Improvement Committee.

Cultural Change (including Staff Engagement)

The nomination platform for the Government of Jersey (GoJ) Public Service awards was launched in July 2024. With two weeks to go before it closes, HCS has received a total of 315 nominations. The number of nominations entered provide us with an indicator of employee engagement. It is important to note that when comparing 2024 nominations with last year, (183) it reflects a 42% uplift and a significant improvement in employee engagement within HCS. Of particular interest is the medical engagement metric that shows medics being nominated more than any other professional group.

The GoJ Be Heard survey was launched on the 9 September and runs for three weeks. The anonymous survey provides employees with a voice and feedback on what is working well in HCS and what needs to improve. Results from the survey will help us focus on where improvements need to be targeted across HCS.

Targeted programmes of organisational development in departments with specific challenges continue within identified service areas and include improving psychological safety and respecting and responding appropriately to cultural differences.

A number of staff achievements were recognised within HCS including,

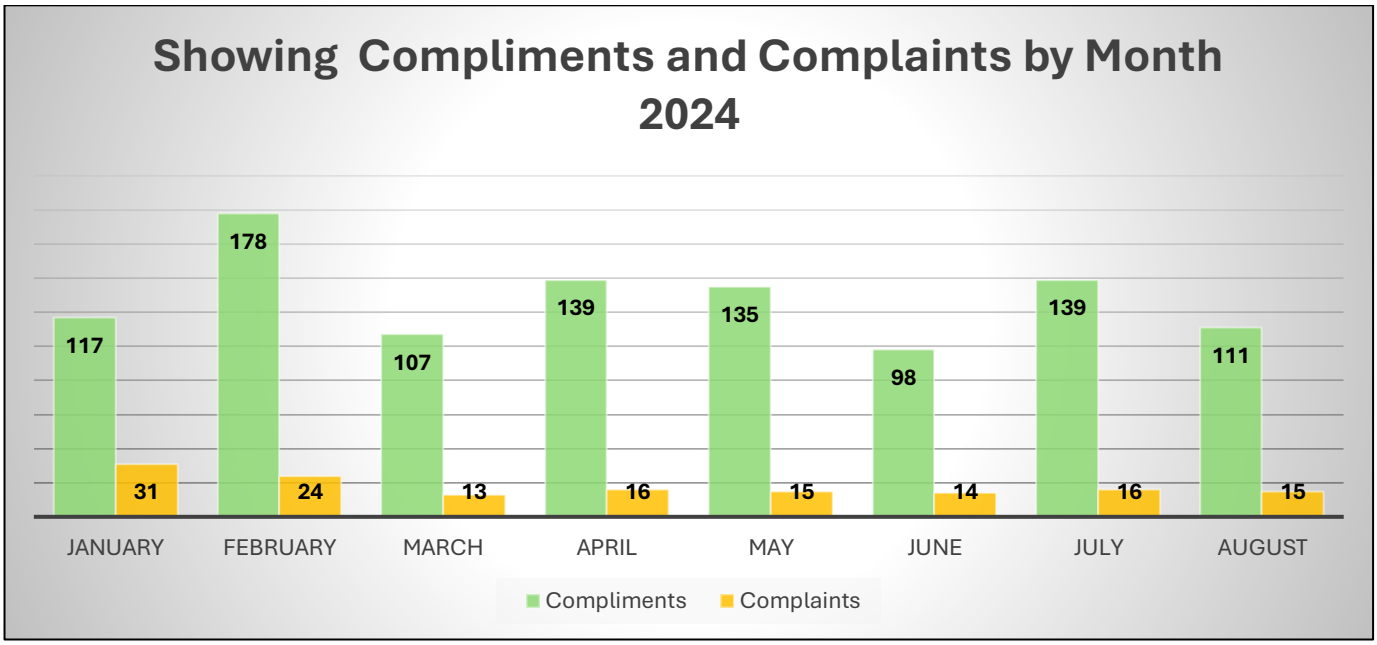
- A colleague from the Assisted Reproduction Unit (ARU) was awarded a University of Oxford scholarship.
- The HCS Learning Disability Service held a number of community engagement events/pop-ups.
- A new initiative was launched by our colleagues in Thyme Out and Beresford Street Kitchen to support Islanders with learning disabilities and/or Autistic people.
- HCS colleagues were involved in launching Jersey's first Dementia Strategy and implementation plan.
- HCS welcomed a new head chef, who has previously worked in luxury venues across the Island.
- HCS welcomed a new lead for Advanced Practice, Independent Prescribing and Practice Development.

- The Help2Quit team supported local construction workers at ROK with their respiratory health.
- A new cohort of Foundation Year One doctors started at HCS.
- Colleagues from the Dental and Oral and Maxillofacial Department participated in a lipreading and managing hearing loss session, delivered by an employee from the Audiology department, to improve patients experience.
- The Jersey Heart Team launched JeFF: Jersey Fighting Failure project.
- Employees were involved with the launch of the Neuroinclusive Jersey three-year strategy survey to capture Islanders feedback.
- Employees completed a two-year project to overhaul medical records and works began on the next phase.

Quality and Safety

The Patient Experience Team, encompassing Feedback, Patient Advice and Liaison Service (PALS), and Senior Nurse, continues to enhance patient interactions and support across Health and Community Services (HCS). Since the full launch of the PALS service in July 2024, this has become a key component of this effort. PALS staff are now easily identifiable in uniform, providing a more approachable and visible presence for patients.

A robust awareness campaign, incorporating social media, information leaflets, and posters displayed across HCS sites, has resulted in a 300% increase in PALS contact since its launch. This reflects the success of the team's efforts in promoting accessibility and support for patients. Below is a chart illustrating the positive impact of the team's efforts, particularly the steady decrease in complaints since January. These complaints are meticulously logged and monitored through our incident reporting system. While capturing compliments presents more challenges, as it relies on staff to input data into the system, the team remains dedicated to accurately reflecting the positive feedback received. This progress highlights the ongoing dedication of the Patient Experience Team to improving the quality of care and patient experience across HCS.



Throughout the year, we have seen a marked increase in compliments for our maternity services, (112 formally recorded) a positive reflection of the implementation of the maternity improvement plan. This upward trend emphasises the success of our continuous efforts to enhance patient care and satisfaction within the service and I would like to thank the team for all their efforts.

Student Nurses

This month sees the ongoing commitment to the growth of local talent as the Faculty of Health Education welcomes 14 Student Nurses, 3 Student Midwives and 1 Student Operating Practitioner to Health and Community Services. Their programmes of learning are delivered in collaboration with our university partners, and I was able to meet with the students and wish them every success as they embark on this exciting start to their healthcare careers.

Infection Prevention and Control

Healthcare-Associated Infections (HAIs)

Despite a very busy summer period with high numbers of admission, we are continuing to deliver good care evidenced by the HAI rates.

In August 2024, the hospital reported the following in relation to healthcare-associated infections:

- **Clostridium difficile (C. difficile)**: There were no cases of C. difficile identified during this period.
- **Methicillin-resistant Staphylococcus aureus (MRSA)**: No cases of MRSA bacteraemia were reported in August.
- **Methicillin-sensitive Staphylococcus aureus (MSSA)**: One case of MSSA bacteraemia was identified, and a thorough investigation is currently underway to determine the cause and implement necessary preventive measures.

The infection control team continues to maintain rigorous monitoring and response protocols to ensure the highest standards of patient safety and care.

In addition, physical environmental improvements have been delivered to the current estate to supporting infection control, health and safety standards/compliance alongside patient and staff experience through the annual improvement healthcare standards estate refurbishment programme. This has seen Plemont, Beauport & currently Bartlett wards restored and brings onto line additional bed capacity now and for Winter 2024.

Finance (including FRP)

- The Financial position for YTD Month 8 is an £18.9m deficit vs budget giving a headline monthly run-rate of £2.4m. Adjusting for one-off items and non-recurrent costs the underlying run-rate is £2.2m.

- 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.
- FRP savings delivery YTD M8 is £5.4m vs £4.2m plan over-delivering by £1.2m.
- FRP 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 what we have designated as '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 is chaired by the Chief Officer has been leading delivery of these required savings.

Recovery actions being taken include:

- High impact mitigation actions to deliver £5.5m savings to reduce deficit to £24m
- Intensive recovery support working with the Care Groups at the established Support and Challenge Meetings (SCMs)
- Service change 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.
- Sustainable long-term funding – a paper has been submitted to Treasury and the MHSS for consideration.

Workforce

The workforce team is working with reduced resources due to long term sickness and other non-availability of key staff at a time of very high levels of activity. People and Corporate Services (PCS) have been very supportive and have seconded additional staff to the HCS workforce team.

Organisation, improvement, restructuring and change continue to create high demand for workforce team support in multiple departments including Pharmacy and Central Sterile Services Department (CSSD).

Recruitment continues apace with high numbers of staff moving though clearances allowing us to exit further agency staff. We are also launching our autumn nursing recruitment campaign '*Our Island takes time to care'* with a focus on mental health nursing. Our HCS recruitment team (seconded from central people services) have settled in and now have a team leader seconded over and are working systematically though the candidates in train. We are also working up new more efficient tailored recruitment SOPs for our local team, all of which is improving our recruitment effectiveness.

We are concerned about the high level of Employee Relations (ER) activity which is now more visible to us with the development of ER reports by the central workforce team. This underlines the

need for us to focus further on our culture and organisational development strategy and plan. To support this work, I have agreed that the Director of Culture, Engagement and Wellbeing will work to the Director of Workforce from October to jointly develop our ‘People Strategy’.

I am pleased to see that we have made progress in improving our workforce reporting and look forward to the incremental improvements that are planned in this area.

I am conscious that the workforce team have adopted the workforce improvement work that is described in the Financial Recovery Plan, and we have not been able to continue the additional HR resources that was previously in the change team. Hence, we are reviewing timelines and objectives in light of the workforce resources available.

We have revisited and refreshed our plans and activity in medical workforce planning and will deliver comprehensive job plans for 2025 by December. The issue of job planning coverage for 2023 and 2024 will also be completed by this date within the additional budget that we made available for this. We are moving forward with medical appraisal with our new contract with the Wessex Deanery.

We now have a combined workforce ‘tactical’ plan for HCS; however, these plans are only part of the development of a wider workforce strategy and plan, and we are discussing shared resources with the New Healthcare Facilities team to look at future plans fully taking into account the impact of the new Hospital.

Waiting List Initiative and New Consultants Update

Since March 2024, we have successfully provided cataract treatment to almost 200 patients within our partner ophthalmic provider near Southampton. This initiative will continue to March next year, and we anticipate almost 500 patients to have received cataract surgery by the end of the contract.

Over 1000 patients have received their ECHO diagnostic test since the end of May 2024 as part of the increase in diagnostic capacity initiative.

Our cancer services team have now implemented in Jersey a UK wide Somerset Cancer Registry to ensure all suspected and confirmed cancer patients are managed in line with national standards. This also enables our multidisciplinary teams (MDT) to collaborate with other cancer specialists across the UK.

In collaboration with Improving Cancer Journey Jersey (ICJJ), we are now able to provide cancer patients with holistic needs assessments to support their ongoing cancer treatment.

We are currently in discussion to engage with an external provider for insourcing dermatology capacity to support the extended patient waits times for both our new referrals and our long-term follow-up patients. It is anticipated this contract will be finalised during Q4 2024 with an immediate start thereafter.

Resource has been purchased to support the clinical genetics service. Patients are currently waiting extended periods of time for breast cancer genetic screening as HCS are unable to provide the service on Island and referrals are being managed in the UK. This new process enables HCS

to manage the screening process and any further complex screening only being managed off Island.

A new Gastroenterology consultant has commenced which has increased our capacity for endoscopy diagnostic testing, this increase will, over the next few months, enable us to bring down waiting times for Gastro referrals and colonoscopy.

A new stroke consultant who commenced earlier this year enabled our Stroke and transient ischaemic attack (TIA) service to see and treat patients much quicker ensuring the best possible outcomes for patients who experience these events.

We are pleased to have recruited a highly regarded dermatology consultant from London who will commence in October 2024. This will provide additional support to our patients, the current lone consultant and the wider dermatology team to improve the sustainability of the on island public dermatology provision.

Care Group structures

As a result of urgent operational and capacity pressures, I have made a number of interim changes to our Care Group Leadership structures.

- Primary Care and Therapies and Intermediate Care have merged into a new single Community Services Care Group. The Community Services Care Group is under the Executive leadership of Andy Weir.
- Dr Adrian Noon will now focus increasing time on the organisation's response to the Royal College of Physicians (RCP) Report on Rheumatology, the subsequent audits and Mortality Learning Reviews, whilst continuing his role as the Medical Director for Primary Care and as the Primary Care Responsible Officer.
- The Medical Services Care Group will be led by Dr Matt Doyle as interim Chief of Service.

Article 36 Suite

A new facility for islanders detained by the police due to mental health concerns opened at Clinique Pinel on 9 September 2024.The Article 36 suite offers a "place of safety" where patients detained under Mental health (Jersey) Law can be held for up to 72 hours to receive crisis care and assessments.

New Hospital Facilities

Good progress is being made with the delivery of new healthcare facilities (NHF) with the Planning Application for the Acute Hospital at Overdale being submitted to the Government of Jersey Planning Portal at the start of September. This follows extensive engagement with Health and Community Services colleagues: since the start of the year, there have been more than 70 meetings between the NHF team and Clinical User Groups to ensure the new Acute Hospital plans align with the needs of our teams and departments. This has been key in ensuring clinicians and

healthcare workers have a voice in the design of the new Acute Hospital and that the building offers the best possible clinical solution.

All documents will be available on the GoJ Planning Portal following validation by Planning and Regulation. Islanders will then be able to express their views on the proposals. The team will be encouraging all stakeholders, including HCS colleagues to provide supportive comments, although understandably, it can also be anticipated that some parties will also use the opportunity to describe impacts of the scheme on them. Feedback from Islanders has shown strong support for the scheme overall with an overarching sentiment from respondents to “get on with” delivery of the hospital.

The next steps for the Planning Application require the Minister for Environment to review the information and determine the Planning Application process. Notwithstanding, we hope to see a determination to the Application early next year, and we remain on track to fulfil the Common Strategic Policy of starting the new Acute facility in 2025, especially with demolition nearing completion on the Overdale site.

Securing the full funding for the first phase of the programme is another important workstream and this has been supported by the development of an Outline Business Case. This business case which is an evolution of the Strategic Outline Case produced last year, will not be published in full to maintain commercial tension but a summary has been made available to all Islanders. This will help to inform them of the justification for the scheme, as well as the financial implications. The cost plan, refreshed for the business case following concept design and supporting information indicates that the scheme can be delivered within the capital financial envelope of £710m and that the running costs will be increased but mainly as a function of the growth of the facility which is required because of the anticipated growth in demand for healthcare services over the medium to long term.

With HCS support, a positive planning determination and funding, the NHF team hope to be able to procure the best possible deal for the construction of the new acute facility – their attention will turn to this important task in the coming months as well as progressing the concept designs for the Kensington Place Ambulatory and St Saviour Health Village sites.

Commissioning Academy Event

As part of a cross-Government 2024 commissioning academy programme, HCS Commissioning Team joined up with other Government Commissioning departments to deliver an interactive workshop on 16 September on delivering the best outcomes for Islanders. This was done in collaboration with the Public Service Transformation Academy and aimed at developing and embedding commissioning as a way of working in Jersey. This workshop was open to all Government employees and non-Government organisations and charities and facilitated a valuable exchange of ideas and experiences.

This workshop was well attended with approximately 70 attendees, close to 40% of which were non-Government organisations/charities.

HCS presented an excellent example of partnership working with a commissioned provider, Silkworth, who also presented back on their experiences of working with the Government and

shared insights into their experiences, including both positives and challenges. Following this, they presented on the draft Commissioning Framework and detailed discussions took place around the strengths of using such a framework and the barriers to using this and how to overcome these. The workshop concluded with a call to action, encouraging participants to apply what they learned and reconsider their approaches.

Carbon Literacy Training

Following the introduction of carbon literacy training in Government of Jersey, an Endoscopy Technician in HCS introduced an initiative to firstly reduce the number of plastic jugs in use in the hospital and secondly, sought new ways to source sterile water washrooms. As well as a considerable reduction of the carbon footprints of these products, this has also saved just over £9000 per year.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Partnerships in the Health and Social Care System**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**7**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation
Report Author:	Jo Poynter, Associate Director Improvement and Innovation

Purpose of Report:	Approval ☐	Assurance x	Information x	Discussion ☐
	This paper provides assurance and information.			
Summary of Key Messages:	The key messages arising from this report are: Jersey's health and care system is supported by a diverse network of partnerships to deliver high quality patient/person centred care to Islanders. These partnerships include charities, private entities, and government bodies. This paper explores the current arrangements in place to meet the Jersey Care Commission (JCC) Standards for Health and Community Services, particularly focusing on the "well-led" Standard 33, which emphasises the importance of partnerships and collaboration. The report categorises partnership activities into three levels: operational, system-wide, and strategic. Operational partnerships focus on the day-to-day delivery of services, ensuring immediate community needs are met. System-wide partnerships involve broader collaborations across multiple stakeholders to deliver coordinated and integrated care, addressing complex health and social care issues. Strategic partnerships extend beyond Jersey's borders, leveraging international expertise and aligning the island with best practices in health and social care. Jersey is currently developing its partnership arrangements with some good partnerships in place, including contracts with a total value of circa £18million with 14 local organisations, collaborations with cross-government groups, and partnerships aimed at improving specialised services such as mental health, end-of-life care, and safeguarding. In addition, strategic partnerships with organisations such as the Wessex Deanery and Higher Education Establishments (HEE) enhance professional development and service quality. While Jersey has established a strong foundation of collaboration, there are ongoing opportunities to improve the effectiveness of these partnerships, ensuring they continue to meet the needs of the community and adapt to future challenges. This approach promotes comprehensive patient-centred services.			
Recommendations:	**The Board is asked to note the report**			

Link to JCC Domain:	**Link to BAF:**

Health and Community Services

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	23 September 2024	noted

List of Appendices:
Appendix 1: Channel Island Alliance for Health and Social Care – progress report

MAIN REPORT

In Jersey a diverse range of organisations—including charities, private entities, and government bodies—provide health and care services across the island. These organisations collaborate effectively, often working in partnership and always supporting each other to deliver high-quality care.

In preparation for the Jersey Care Commission (JCC) Standards for Health and Community Services and Jersey Ambulance Service, and in particular standard 33 within the *well led* category which focuses on partnerships and communities, this paper explores the current arrangements and opportunities to improve Jerseys partnership working.

The JCC well led standard 33 states that:

> *We understand our duty to collaborate and work in partnership with others across the island and off the island. This way, our services work well for people. We share information and knowledge with our partners and collaborate to continuously improve.*

By adhering to this standard, we aim to ensure that Islanders can say:

- *I benefit whenever care providers team up with others across the island and beyond to improve my healthcare experience.*
- *I will have access to specialist care and treatment provided off island when I need it.*

Health and Community Services (HCS) and the wider government currently have processes in place to meet the JCC Universal Requirements (JCCUR), but recognise there are many opportunities to enhance the current arrangements: Microsoft Word - Single Assessment Framework - Consultation April-May (carecommission.je).

Current Partnership and Communities Activities fall into three categories:

1. Operational
2. System wide
3. Strategic

Operational partnerships refer to collaborations and relationships formed to manage and deliver specific services or programs effectively. These partnerships are focused on day-to-day operations and the delivery of services on the Island. The partnerships are tactical and designed to meet immediate needs and deliver

specific services. These operational partnerships involve local organisations collaborating directly to provide services to the community, manage local resources, or address specific local needs.

HCS currently directly commission £18 million with 14 local organisations and elements of HCS to deliver care services to the community. These include:

- Age Concern
- Brook Jersey
- Communicare
- Coop
- Dementia Jersey
- Family Nursing and Home Care
- Good Companions Club
- Headway Jersey
- Jersey Doctors on Call
- Jersey Hospice Care
- Listening Lounge
- Mind Jersey
- My Voice
- Silkworth
- HCS – overnight nursing

There are robust mechanisms in place to work alongside these commissioned organisations such as, monthly/quarterly meetings, with standardised documentation, looking at key performance criteria, finance and space to explore opportunities to improve and adapt the service provided. In addition, action logs are in place with each provider. JCCUR 33.1.1 - 33.1.2. and 33.1.7 – 33.1.9

Work is currently underway within the operational HCS departments to ensure similar arrangements are in place for off island tertiary contracts.

Operational partnerships in Jersey are crucial for the efficient and effective delivery of services that directly impact the daily lives of residents and the functioning of the community.

System-Wide partnerships refer to collaborations that involve multiple organisations and stakeholders working together to achieve shared goals across an entire health and care system. These partnerships are characterised by their broad scope and aim to deliver coordinated and integrated services across the Island of Jersey. Unlike operational partnerships that focus on specific services or projects, system-wide partnerships encompass a wider range of organisations, including those not bound by formal contracts, to ensure a cohesive approach to service delivery, policy development, and community engagement.

There are several Jersey System wide partnerships, including:

1. **Cross-Government Commissioning Group**: This group involves various government departments working together to commission services that span multiple sectors. Their goal is to ensure that resources are allocated efficiently and that services are integrated to meet the needs of the whole population. JCCUR 33.1.3

2. **Health and Care Partnership Group (HCPG)**: A collaboration between health and social care providers aimed at improving the delivery of integrated care services. This partnership focuses on aligning efforts across the healthcare system to provide seamless care, reduce duplication, and enhance patient outcomes. JCCUR 33.1.1, 33.1.4

3. **HCS Patients and Users' Public Engagement Panel**: A forum for engaging patients and individuals that access HCS services in discussions about healthcare services and policies. This partnership ensures that the voices of those who use the services are heard and considered in decision-making processes. JCCUR 33.1.5 and 33.1.10. In addition, work has started to hear the voice of children accessing services.

4. **Community Forum**: A platform that brings together care home and home care providers as required to discuss and address local issues. This forum promotes collaboration to identify needs and develop solutions that benefit the entire island.
5. **End of Life Partnership Group**: A collaboration focused on improving end-of-life care across Jersey through the implementation of the Palliative and End of Life Care Strategy for Adults. This group includes healthcare providers, social services, charities, faith organisations, funeral directors, community organisations and patients and their families working together to ensure that people receive compassionate and appropriate care at the end of their lives. JCCUR 33.1.6
6. **Mental Health Strategic Partnership Board**: A partnership that brings together stakeholders from across the mental health system, including healthcare providers, social care services, charities and people with lived experience. This board works to develop and implement strategies to improve mental health services and support for the population. JCCUR 33.1.6
7. **Safeguarding Partnership Board**: This board includes representatives from various sectors, such as health, social care, education, and law enforcement, working together to protect vulnerable adults and children from harm. The board coordinates efforts to ensure effective safeguarding practices are in place across the island.
8. **HCS and Primary Care Board Group**: A collaboration between HCS and primary care providers to improve coordination and integration of healthcare services. This group focuses on enhancing communication, sharing best practices, and developing joint initiatives to improve patient care. JCCUR 33.1.5
9. **Customer and Local Services (CLS) Cluster Groups**: A series of groups bringing together specific focussed services including: JCCUR 33.1.3 and 33.1.5

    - Learning Disability (LD), Autism and Disability Cluster
    - Equality, Diversity and Inclusion Cluster
    - Children's Cluster
    - Homelessness Cluster
    - Older Persons Cluster
    - Cancer Support Network

System-wide partnerships in Jersey play a critical role in ensuring that services are delivered in a coordinated, efficient, and patient-centred manner, addressing the needs of the entire population and enhancing overall system performance.

Strategic Partnerships are high-level collaborations focused on ensuring that Jersey aligns with internationally recognised best practices and standards. These partnerships are designed to enhance the island's capabilities, drive long-term improvements, and foster innovation across sectors by leveraging expertise, resources, and networks beyond Jersey's borders.

Strategic partnerships involve forming alliances with external organisations, such as international bodies, educational institutions, and cross-jurisdictional groups, to achieve broader goals that go beyond immediate operational needs. These partnerships are aimed at fostering excellence, driving innovation, and ensuring that Jersey remains at the forefront of international standards in health and social care.

There are a number of these partnerships currently including:

1. **Jersey-Guernsey Health Alliance**: A partnership focused on aligning health services across the Channel Islands to optimise resources, share best practices, and improve patient outcomes. See appendix for the recent progress update report.
2. **Partnership with Wessex Deanery and UK Universities:** Collaborations with Wessex Deanery to enhance medical practices, along with partnerships with UK universities to offer Nursing and Social Work degree courses, ensure that Jersey's healthcare

workforce receives top-tier training and is well-equipped to meet the evolving needs of the population.

3. **The Jersey Commissioning Academy:** In partnership with the Public Services Transformation Academy, represents a significant strategic collaboration aimed at enhancing the commissioning capabilities and overall effectiveness of public services in Jersey. This partnership focuses on leveraging the expertise and best practices worldwide to drive improvements in Jersey's public service delivery. This strategic partnership also supports the island's ability to adapt in response to changing needs and challenges.

Conclusion:

The range of operational, system-wide, and strategic partnerships in Jersey reflects the island's commitment to collaboration in delivering high-quality health and care services. These partnerships ensure that care is coordinated, innovative, and aligned with best practices. By continually enhancing these relationships, Jersey can better meet the needs of its residents, improve patient outcomes, and remain adaptable to future challenges. The commencement of the cross-government commissioning group, the further development of the commissioning academy and the ongoing focus on collaboration, as guided by the Jersey Care Commission's standards, positions the island's health and care system for sustainable success.

Appendix

Channel Island Alliance for Health and Social Care – progress report

Briefing Note

Channel Island Alliance for Health and Social Care

Update on joint working activities between Jersey and Guernsey

January to July 2024

Contents

Purpose of the report

1. The report provides an update on the progress and activities undertaken on matters relating to health and social care across the Bailiwick of Jersey and Bailiwick of Guernsey.
2. The report is a joint report presented to the Minister for Health and Social Services, the Council of Ministers, Jersey and the Health and Social Care Committee, Guernsey.

Introduction

The Channel Island Alliance for Health and Social Care was formally established in February 2024[1] to provide shared opportunities for joint working in matters relating to health and social care across the Bailiwick of Jersey and the Bailiwick of Guernsey. The Alliance for Health and Social Care is a complementary Alliance to the Guernsey and Jersey Public Health Alliance.

Since its inauguration, the Alliance has identified, and officers have progressed, a range of opportunities for joint working and shared learning. This report provides a summary of the key areas covered between January and July 2024.

Activities

Opportunities for joint working were identified across the following areas:

Nursing Associate Training Programme

Guernsey currently offers a well-established Nursing Associate training programme in collaboration with a UK university. The Dean for Nurse Education in Jersey is in discussion with their counterpart in Guernsey to explore the possibility of joint collaboration, aiming to deliver the same programme in Jersey through the same university.

Commissioning

Health & Care Commissioners have met and shared information to understand respective

- Commissioning Strategies
- Registers
- Pipeline of work

[1] Jersey and Guernsey commit to work together on health and care challenges (gov.je)

The initial phase of work focuses on developing an understanding of different commissioning models and structures and related resources in both jurisdictions including identifying what works well and what could be done differently.

Guernsey colleagues have been invited to join the Jersey Commissioning Academy 2024 programme and we are aiming to develop a joint Commissioning Academy programme for 2025.

Contract reviews

Tertiary Care

A review was undertaken to understand the Islands' range and scope of tertiary care activity with NHS trusts in the UK. This has identified a range of opportunities with the potential for further joint work, for example, the consolidated use of NHS hospital providers for specialist services such as renal, oncology and cardiology services; NHS provider tariffs and their adherence to the reciprocal health agreements with the UK.

GAMA contract

Jersey and Guernsey are working closely together to extend the current contract for air ambulance services, currently provided by GAMA. The initial contract period is due to expire May 2025 and the intention is to synchronise activities so that the extension and process is aligned. Work on the joint procurement has started and the next step is for a bilateral meeting to take place to review a draft commercial appraisal project plan, including joint project objectives and to discuss any key challenges.

Non-clinical support services

Following a visit to Princess Elizabeth Hospital in 2023, officers from both jurisdictions have sought to continue sharing best practice and seeking opportunities for collaborative working. This includes the alignment of support services for visiting Consultants and overseas treatment, particularly in commissioning and contracting patient travel services. Joint capital procurement could also bear fruit allowing greater buying power and alignment of equipment spares and consumables. Shared infrastructure is also an opportunity with examples including commercial laundry, CSSD, and path labs, though assurance on inter-island logistics needs more work.

Private Patient Services

The private patient services management teams from both jurisdictions have agreed to compare the current private patient services in order to identify any learning to improve services for patients and consultants.

Ophthalmology waiting list initiative

Jersey developed a waiting list initiative for ophthalmology patients to be treated at a specialist facility in the UK. The extensive service specification and procurement documentation were shared with Guernsey colleagues who are now actively working on a similar initiative for autumn 2024 with the same provider.

Emergency Planning and Resilience

Work started at the end of 2023 on establishing mitigations for a UK coastguard strike (the risk of a strike has now been resolved). Guernsey and Jersey joined up to discuss options with French colleagues, including the Regional Health Agency Normandie and the University Hospital in Caen. The aim is to formalise emergency support with France in case the Channel Islands were unable to transport patients to the UK (for example, due to weather conditions or unavailability of transport to the UK). A visit of the French delegation and Guernsey colleagues to Jersey is planned for September to visit local emergency arrangements and to start identifying required processes and policies for a formal arrangement that supports bilateral resilience around health and social care.

Financial Improvement Programmes

Work is being shared on financial challenges and financial recovery programmes. The above projects on contract reviews are part of identifying means to provide services more efficiently.

Digital Health

Electronic Patient Record System Replacement. Both digital teams have frequently met and exchanged information, knowledge and expertise over the past 18 months as Guernsey is also replacing their EPR system with IMS MAXIMS EPR System. The exchange has been valuable and included sharing Jersey's journey to Go-Live in May 2023 and the subsequent implementation support processes.

Wider digital technologies. In addition to the collaboration on the EPR initiative, on-going discussions are in place between the two digital teams on Digital Health improvements, technologies deployed and possible synergies. This has established strong professional relationships over the last two years which has proven to be beneficial operationally and in planning ahead.

Mental Health and Learning Disabilities

The Director of Mental Health and Social Care visited Guernsey colleagues in August which has resulted in the identification of possible joint working opportunities, including the review of off-island placements. It has been agreed to continue to explore these joint opportunities.

Strategic Health Policy

Policy officers from both jurisdictions have met to discuss ongoing policy initiatives. Currently there is no active joint work but it has been agreed that:

- at the inception of new policy initiatives, officers will make contact to discuss and identity potential opportunities for joint working;

- where appropriate new legislation should be 'future proofed' to allow it to be adopted, whether in whole or in part, in both jurisdictions (for example, the Regulation of Care (Jersey) Law, in establishing the Jersey Care Commission, allowed for the Commission to operate in Guernsey as and when Guernsey determined it was appropriate to do so).

Pharmacy and Medicines

Guernsey and Jersey's Chief Pharmacists work collaboratively to promote effective working on pharmaceutical and medicines optimisation matters between Chief Pharmacist teams in Guernsey and Jersey.

An alliance is due to be established to:

- share best practice, experience and learning to improve efficiency
- act as critical friends to improve the quality of medicines optimisation policies
- work collaboratively on medicines governance and safety practices
- jointly commission work to increase value for money
- jointly develop training opportunities and professional development across the Islands
- share resources and improve efficiency
- work collaboratively on matters related to medicines and pharmacy legislation and regulation

An inaugural meeting is due to take place on 13 September to finalise terms of reference.

Joint working has started on in a number of areas, for example:

- Plan for community pharmacy inspection framework and delivery, working jointly with the General Pharmaceutical Council
- Support for medicines shortages, working jointly with the Southwest region in the UK for mutual aid support
- Contingency planning for operational services, including the pharmacy aseptic (sterile) unit which prepares chemotherapy for cancer patients
- Support for medical gas quality control testing across the Islands
- Collaborative working around the use and handling of controlled drugs including cannabis, working jointly with the UKHO
- Support and sharing of medicines optimisation policies with Guernsey and the Isle of Man

Adult Safeguarding

Both Safeguarding teams met in Jersey to share and compare working practices. The visit also enabled Guernsey officers to meet with other Jersey teams, including the Quality & Safety team, Safeguarding Adults team, Children and Family Hub, and Jersey Care Commissioners.

Acute Healthcare Facilities

There has been no active joint work over the last six months, however, the hospital project teams have met several times over the last years and relationships are well established.

Public Health

Regular updates on the activities in the Public Health Alliance are being provided at the meetings by the Directors of Public Health.

Operational practices and processes

Jersey colleagues will visit Guernsey in September to discuss and progress a range of topics. The visit will also include the attendance of operational meetings for shared learning and improvement.

For reference, the appendix provides details of the work undertaken in the Guernsey and Jersey Public Health Alliance. The Director of Public Health from each jurisdiction

are members of the Channel Island Alliance for Health and Social Care and ensure information is shared regularly between the two groups.

Appendix – Public Health Alliance

The Guernsey and Jersey Public Health Alliance was launched on 28th March 2023. This provides a brief overview of their progress to date.
Since our launch joint working has started on a number of topics, including:

- Mental health strategy – Jersey are represented on the Guernsey Mental Health and Wellbeing (MHWB) Steering Group which has resulted in the launch of a new MHWB Strategy in Guernsey. Jersey is also updating their strategy and sharing of expertise and experience has been very valuable;
- Food and nutrition/healthier weight strategy – ability to share work and looking at new approaches in partnership with Cambridge University;
- Infectious disease management – Develop plans for the management of individual infectious diseases more efficiently e.g. Tuberculosis;
- Health protection – Guernsey established a Health Protection Forum in 2022 – Jersey is represented on this and their input has been greatly appreciated;
- Environmental hazards, particularly PFAS and glyphosates; This includes learning for both islands from the newly established international scientific panel looking at PFAS in Jersey
- Pandemic virus plans – both islands are currently considering updated Pandemic Frameworks, focusing of the route of transmission rather than a causal event;
- Vaccination policy – sharing experience with the commissioning and implementation of vaccination programmes;
- Substance use – both islands are looking at vaping policies / legislation and sharing ideas and initiatives is of benefit to both jurisdictions. Also included is work on alcohol ;
- Migrant health – this included developing protocols and health approaches that are consistent, as far as is possible, across both islands;
- Threats from nuclear hazards – French Nuclear facilities as a joint Channel Island Team and have jointly commissioned a review of our nuclear risk through the UK Health Security Agency. The results of this was considered by a joint sitting of the individual islands Radiation Advisory Groups and then presented to the political representatives from both islands. The Comms teams from both islands are working on joint messaging to ensure a consistent approach to very sensitive topics;
- The Directors of Public Health are working together to consider the use of Artificial Intelligence in geographically islated locations.

- Typically this topic specific joint work includes:
- Sharing initial policy documents, plans and strategies to save time (but still allowing for island-specific recommendations);
- Organising one set of meetings, hosted by one island to save time and avoid duplication;
- Joint commissioning of external reports to reduce cost and improve quality (we have already jointly commissioned a review of our nuclear risk);
- Joint advocacy to other jurisdictions and organisations to facilitate external expertise such and access to UK committees;
- Comparative analysis of data to gauge the size of public health problems and to monitor progress by comparative benchmarking – the aim is to develop a pan-islands public health outcomes framework so we can analyse our population-based health outcomes in an island context;
- Sharing best practice, knowledge & innovation
- Offering peer support for those training in public health.

The joint working and collaboration that we have through the Alliance is highly valued by both Public Health Teams and is helping us deliver very larger mandates of work in the most effective and cost-effective way we can.

End of Report

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Finance Report Month 8**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**8**

Executive Lead:	Chris Bown, Chief Officer HCS
Report Author:	Obi Hasan, Finance Lead Change Team, Interim Lead of Finance Business Partnering HCS

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion √
	This paper provides an update on the Month 8 Financial position for 2024 and future funding. To discuss the financial position noting the risks and mitigations and recommendations for future funding.			

Summary of Key Messages:

The key messages arising from this report are:

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.

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.

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.

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
- 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.

Conclusion

- FY24 YTD M8 deficit is £18.9m giving a headline monthly run-rate of £2.4m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £2.2m.
- 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.
- 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.
- Recovery actions being taken include:
    - Cobra Actions led by Executive Team – to deliver additional £5.3m savings
    - 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. • 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.
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	√
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	12 September 2024	Committee and Board Reporting
Finance and Performance Committee	25 September 2024	

List of Appendices:
Appendix 1: HCS Finance Report M8 August 2024

MAIN REPORT

FY24 Month 8 Finance Position

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	18,889	18,746	148,359	150,671	(2,312)	225,120	229,368	(4,248)	(1.6%)	(1.9%)
Non Pay	8,725	10,621	71,538	86,787	(15,249)	108,406	123,994	(15,588)	(21.3%)	(14.4%)
Income	(2,562)	(1,989)	(17,962)	(16,667)	(1,295)	(28,975)	(24,802)	(4,173)	(7.2%)	(14.4%)
Grand Total	25,053	27,378	201,935	220,790	(18,855)	304,551	328,560	(24,009)	(9.3%)	(7.9%)

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

The key drivers are:

Year-to-date (YTD) position is a £18.9m deficit:

- **Staff Costs £2.3m overspend** is made up of an agency overspend of £10.1m (no. of agency staff: 133 (31 doctors and 102 Nurses, AHPs and Other), an overtime overspend of £2.5m, and a budget pressure of £1.0m, offset by a substantive underspend of £10.2m (no. of vacancies: 511 FTE). The underlying factors driving these cost pressures are recruitment issues and dependency on temporary staffing, and a £0.9m year-to-date impact of additional PAs paid following doctors' job planning. The Care Groups/Directorates accounting for this Staff Costs overspend are Medical Services £2.0m, Surgical Services £1.3m, Women and Children £0.9m, Chief Officer's Dept £0.8m, and Mental Health £0.2m. All other areas are underspent on staffing. £0.6m of the Surgical Services overspend relates to doctors' job planning impacts, with £0.3m in Medical Services.
- **Non-Pay £15.2m overspend** includes significant overspends in Medical Services £3.5m in relation to consumables and Oncology and Medical Day Care drugs, Social Care £2.9m mainly in relation to domiciliary care packages, Tertiary Care £1.5m in relation to acute hospital referrals to the UK, Surgical Services £1.4m in relation to consumables, £1.2m in Mental Health due to placements, and an overspend of £0.9m in Estates and Hard Facilities Management mainly in relation to utilities and maintenance. There is also an overspend of £1.8m in Chief Officer's Dept, which includes £1.1m in relation to the opening budget pressure aligned here as part of budget setting for 2024, and a £0.7m cost pressure from the recharge of Accommodation Service income 'voids' for Q1 and 2 2024 (in discussion to resolve).
- **Income under-achievement £1.3m** includes under-achievements in Surgical Services £1.8m, where additional income generation is targeted through the Financial Recovery Programme, and in Non-Clinical Support Services £0.3m with reduced recovery of income in Catering through the ending of an SLA with CYPES for school meals, and also an under-recovery of Laundry income from external customers. There is an underachievement of Long-Term Care income of £0.5m between Community Services and Mental Health, following a detailed view of amounts billed, and reflecting a closure of 5 beds at Sandybrook. These under-achievements are offset by Health Education income received for Apr-23-Mar-24 with a £0.8m overachievement in Medical Director. All other Care Group income variances are currently less that £0.3m under or over budget.
- **Underlying position and run-rate** - Adjusting for the non-recurrent one-off items, budget phasing, over-accruals and recharge, the underlying deficit at M8 is £17.2m or an average monthly run-rate of £2.2m.

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.

FRP Delivery and Development Tracker – FY24 Savings Delivery

FRP Savings Plan by Workstream

Workstreams	Projects	Scheme RAG	Revised 2024 Planned Savings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2024 Forecast Saving	Revised Plan YTD	YTD Actual Saving	Revised YTD Plan vs Actual Savings	Revised FYE Plan vs Forecast Savings	Remaining FYE 2025 Planned Saving	Total Saving Forecast
Delivery Tracker				Actual								Forecast										
Clinical Productivity	Theatres Efficiency		-	-	-	-	-	-	-	-	-	10	10	10	10	40	-	-	-	40	749	789
Workforce	Clinical - Medical		800	72	88	78	77	56	118	118	179	101	101	101	101	1,190	432	787	355	390	791	2,202
	Clinical - AHPs		700	13	13	13	69	69	69	94	132	134	134	134	134	1,008	365	474	109	308	619	1,746
	Clinical - Nursing		400	-	-	-	-	24	39	41	87	101	140	202	185	820	168	191	23	420	2,719	3,539
	Workforce Savings		516	-	-	-	-	78	87	83	79	83	83	83	83	656	221	326	105	140	417	1,073
	Pay Controls (WCP)		215	-	-	-	36	34	36	34	18	15	13	11	12	208	120	157	37	-6	113	321
Non-Pay and Procurement	Non-Pay Controls (NPCP)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Centralised Buying Function		170	19	19	74	25	33	17	6	35	13	13	13	13	281	107	228	121	111	158	439
	Commissioned Services		100	9	9	9	9	9	9	9	9	9	9	9	9	109	67	73	6	9	-	109
	Governance & Contracting Procurement		295	65	65	65	-	-	-	17	17	17	17	17	17	295	228	229	1	0	100	980
	Medicines Management		600	25	30	37	36	58	64	56	59	61	61	61	61	609	375	366	-9	9	164	838
	Other Non-Pay		-	-	-	-	2	2	2	2	2	2	2	2	2	15	-	9	9	15	5	20
Income	Other Income Opportunities		490	65	68	68	30	28	32	36	32	32	32	32	32	486	417	359	-58	-4	-	649
	Private Patients		885	28	30	30	30	29	31	170	66	128	142	142	142	969	323	415	92	85	1,484	2,695
Care Groups and Non-Clinical Directorate schemes	£3m in 3 months		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,914
Total schemes currently in delivery			5,171	297	322	375	314	421	504	664	716	705	754	816	800	6,687	2,823	3,613	790	1,517	7,318	17,314
Development Tracker																						
				Planned																		
Workforce	Clinical - Medical		-									-	-	-	-	-	-	-	-	-	216	216
Non-Pay and Procurement	Centralised Buying Function		-									2	10	10	10	32	-	-	-	32	53	85
	Commissioned Services Governance & Contracting Procurement		-									13	13	13	13	50	-	-	-	50	404	454
			-									-	-	-	-	-	-	-	-	-	411	411
Income	Other Income Opportunities		-									-	3	3	3	9	-	-	-	9	1,455	1,464
	Private Patients		-									69	69	69	69	278	-	-	-	278	1,127	1,405
Total Schemes being prepared for delivery			-	-	-	-	-	-	-	-	-	84	95	95	95	369	-	-	-	369	5,506	5,875
TOTAL FRP SCHEME SAVINGS			5,171	297	322	375	314	421	504	664	716	788	849	911	895	7,056	2,823	3,613	790	1,886	12,824	23,189
				Actual								Forecast										
Other budget pressures	Identified mitigating budget measures		1,440	-	-	953	257	218	174	162	49	58	58	58	58	2,047	1,363	1,813	450	607	-	2,047
	COBRA unidentified mitigating budget measures		4,158	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-4,158	-	-
	COBRA identified mitigating budget measures		1,142	-	-	-	-	-	-	-	16	69	337	347	382	1,150	16	16	-	8	2,438	3,588
TOTAL EFFICIENCY SAVINGS TO BALANCE BUDGET			11,910	297	322	1,328	571	638	678	826	782	915	1,245	1,316	1,334	10,253	4,202	5,442	1,240	-1,657	15,262	28,824

- The FRP Programme over the three years has identified savings of £29m with a risk-adjusted value of £23m, which are phased to be delivered over FY23 £3m, FY24 £5m, FY25 £8m and FY26 £9m.

FY24 Year-end Forecast

- The current reported FY24 year-end forecast has remained at £24m. However, this is after delivery of an additional £5.3m of savings that are required, over and above the FRP £5m savings, to mitigate against further cost pressures identified that impact the year-end position. 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
    - Further overperformance on tertiary care contracts at Southampton and inflationary impact at Oxford
    - High cost drugs pressures.

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

- **Staff Costs £4.2m forecast overspend** due to a £14.5m overspend on agency locums (total

forecast spend £21.4m), and £1.2m from negative budget pressures, partially mitigated by a £11.5m underspend on substantive staffing due to vacancies.

The net impact above is made-up of:

- Net overspends due to agency/locums and substantive costs in Medical Services £4.0m, Women and Children's Services £1.5m, Surgical Services £0.8m, Chief Officer's Department £0.8m, which are mitigated by substantive pay underspends of £2.7m in other Care Groups.
- £1.2m re the full year impact of doctors' back-pay from job planning.

- **Non-Pay overspend £15.6m** with the main forecast overspends in Medical Services £4.4m, Social Care £3.6m, Surgical Services £2.2m, Tertiary Care £1.8m, Estates £1.4m, Medical Director £1.0m, Mental Health £1.0m, Improvement and Innovation, Non-Clinical Support Services, Community Services and Patient Access all £0.2m, and Women and Children's £0.1m.

- **Income under-achievement £4.2m** is due to the current forecast shortfall in Surgery private patient income of £3.7m, due to levels of private throughput not reaching targeted levels, with COBRA mitigating actions being developed to offset this. The forecast will be updated in Q3 to recognise the impact of mitigations. There is a forecast underachievement of £0.9m for Long Term Care Benefit income across Mental Health and Intermediate Care, partly due to bed closures at Sandybrook £0.4m, and the remainder due to correction of historical invoicing back to 2021, which has now been reconciled with CLS. Further work is being done with Social Care and CLS around potential improvements to the Long-Term Care income in this area. There is also a £0.5m under-achievement in Non-Clinical Support Services, mainly due to delays in the increase in laundry income, which is now improving, and the cessation of school meals provision to CYPES. These pressures are offset by non-recurrent over-recovery of Health Education England income in Medical Director £0.9m.

Recovery Actions

The following recovery actions are being taken:

- **Financial Recovery Actions led by Cobra Executive Team** – High impact mitigation actions to deliver £5.3m savings to reduce deficit to £24m
- **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.

Recommendation

The Board is asked to note:

- FY24 YTD M8 deficit is £18.9m giving a headline monthly run-rate of £2.4m. Adjusting for one-

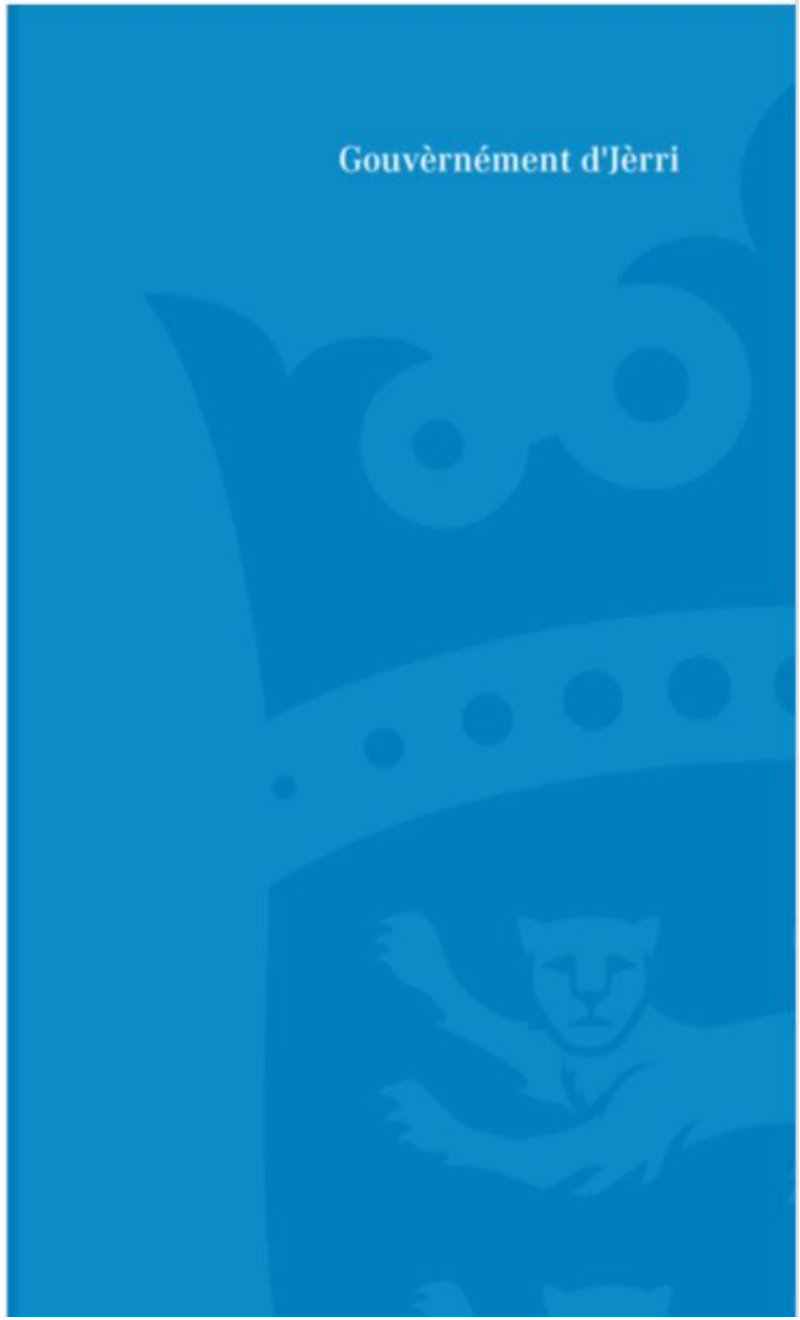
off items and non-recurrent costs the underlying monthly run-rate is £2.2m.

- 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.
- 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.
- Recovery actions being taken include:
    - Cobra Actions led by Executive Team – to deliver additional £5.3m savings
    - 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.
    - 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.

END OF REPORT

Health and Community Services

Quality and Performance Report
August 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

Patient Waiting over 365 days for first appointment

Patients waiting over 365 days for their first outpatient appointment, in the main, are within four specialities; dermatology, gastroenterology, ophthalmology and clinical genetics.

Each of these services has a developed plan to support the reduction in wait times with the expectation that Gastro and Clinical Genetic long waits will be significantly reduced by end of Q4.

Ophthalmology extended waits is as a direct result of lack of medical staff over the summer in this specialty with a locum who was due to commence in August, now not commencing until January. The contract to outsource cataract patients remains in place and continues to support ophthalmic capacity.

Within dermatology, the service is planning the procurement of an insourcing company to enable additional capacity to be delivered over a 24-week period

for routine dermatology referrals.

Patients waiting over 365 days for treatment

A slight increase in patients waiting over a year for surgery is as a direct result of planned theatre closure over the summer period for mandatory maintenance. With all theatres now fully operational again and the continued improvement in theatre capacity utilisation, it is anticipated additional activity will mitigate the lost sessions.

Access to diagnostics greater than 6 weeks

We continue to review the capacity within our diagnostic provision with a view to understanding how we can improve performance against this metric. The June to July movement is due to the addition of diagnostic modalities into data capture due to the development of system connectivity. As per our Data Improvement agenda, we are now able to include waiting times for a broader range of diagnostic tests. From July (month 7) the indicator now includes additional data for radiology imaging diagnostics, previously unable to be robustly reported (CT, MRI, Ultrasound) .

MRI has a developed and approved business case to increase capacity with recruitment well underway. The increase in wait times observed over spring and summer have now started to reduce again and waits on average for routine tests sit at 18 weeks.

Elective Care Performance

DEXA and Endoscopy diagnostic services both have fully developed plans to increase the capacity, with an anticipated reduction in patient waits being seen in Q4.

Further work is being undertaken within CT to develop the additional capacity required to meet the service demand.

Was Not Brought Rate

The WNB rate has significantly climbed over the summer months. Some of this increase is due to patients being away for holidays.

A planned change in process of the way patients are booked into clinics is being developed and should be implemented over the coming months. This will enable patients to choose a suitable appointment time rather than allocated a time suitable to HCS. This should have a positive impact on clinic utilisation by reducing DNA and WNB rates. It will also have a positive impact on patient experience.

Elective Theatre Utilisation

The theatre improvement work is starting to show an impact on utilisation with a significant utilisation rate increase over recent months. It is anticipated this improvement will continue and work is underway to increase the pace of improvement.

Cancellations on day of surgery

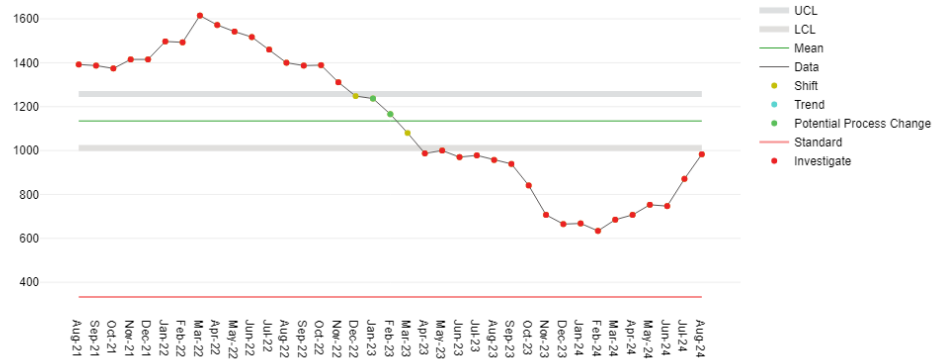
The rate of on the day cancellations has increased in month as a direct result of the breakdown failure of key ophthalmology equipment on a single day.

Escalations

Elective Care Performance - SPC Charts

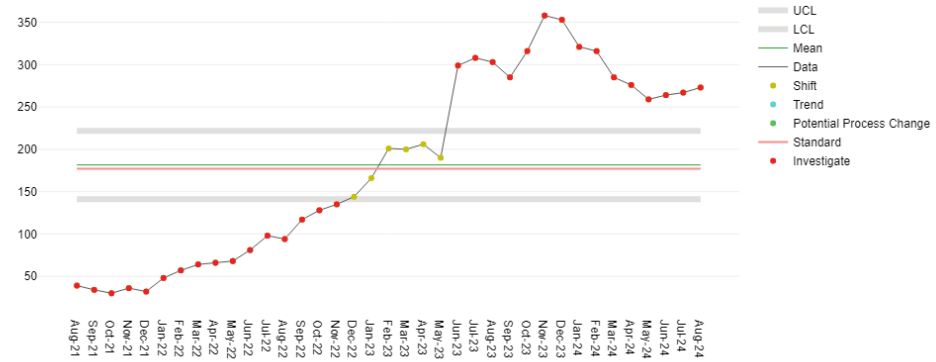
Latest value	Standard
983	<333

Patients waiting for first outpatient appointment Greater Than 52 weeks



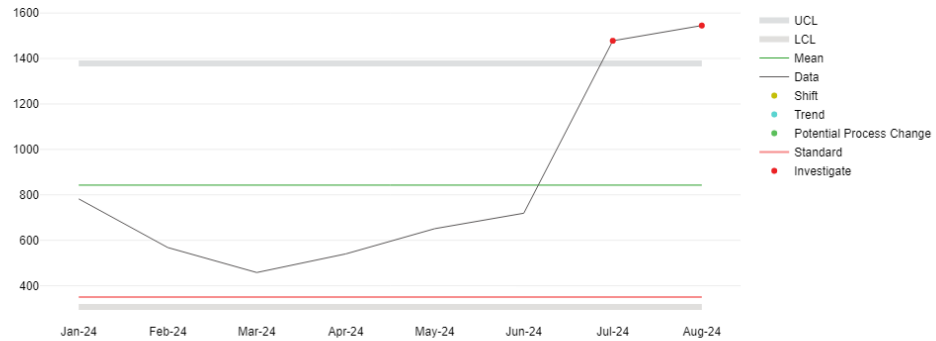
Latest value	Standard
273	<177

Patients on elective list Greater Than 52 weeks



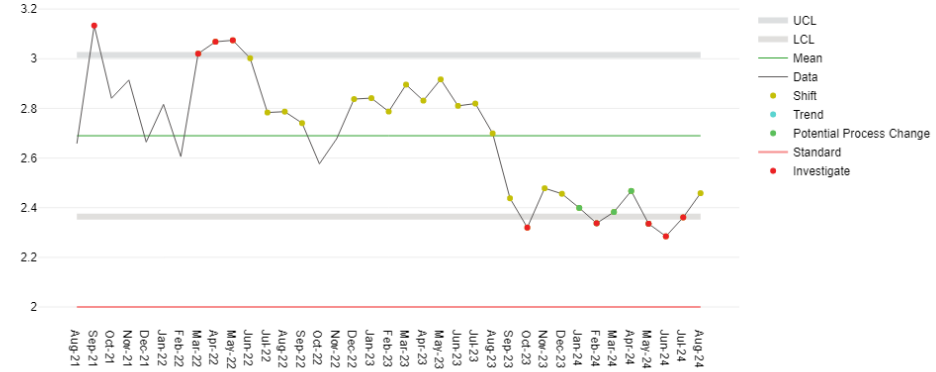
Latest value	Standard
1545	<350

Access to diagnostics Greater Than 6 weeks



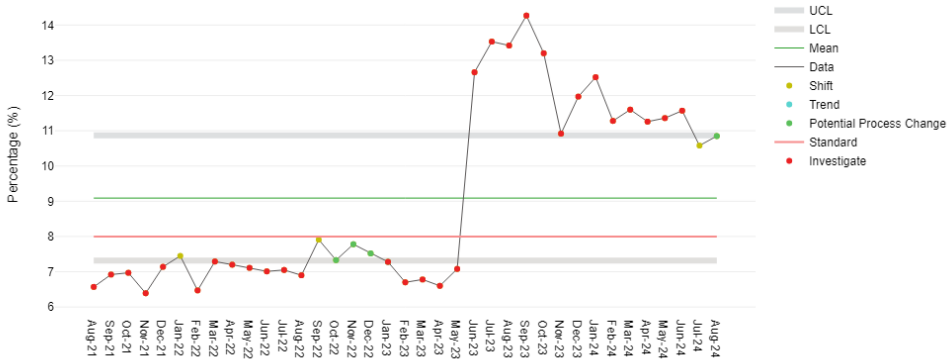
Latest value	Standard
2.46	2

New to follow-up ratio

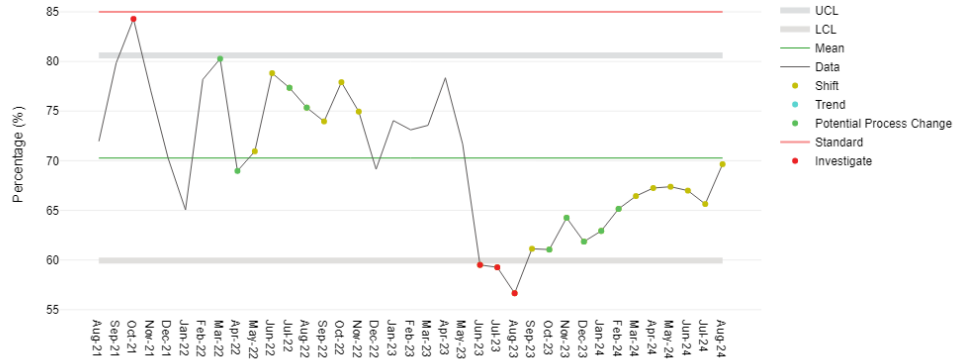


Elective Care Performance - SPC Charts

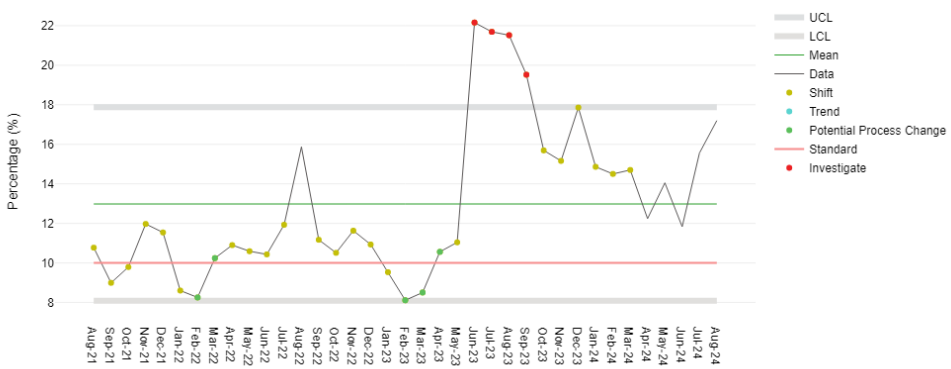
Latest value	Standard
10.8 %	<=8%



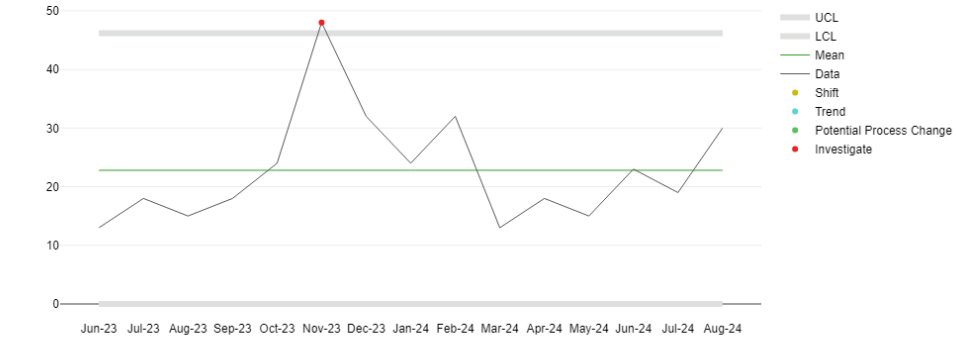
Latest value	Standard
69.7 %	>85%



Latest value	Standard
17.2 %	<=10%



Latest value	Standard
30	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 August, we had 3,854 attendees through the Emergency Department which is static. 70.5% of these patients were seen within target time (<4hrs) this made up of 91.7% of the minor activity with patients being seen and treated within 4hrs but within the major patients was equivalent to 68.3%. Major patients take more resources, onwards referrals and care which takes time to organise. We are benchmarking slightly higher than that reported as achieved in England currently.

2.6% (100) of the patients were in ED for >12 hours. This unfortunately is an increase on July and specific bed capacity was an issue. 14.2% were admitted, we continue to embed Red 2 Green (R2G) principles to assist with flow.

Inpatients movement out of hours for non-clinical reasons continue to remain below average at 14 compared to the average 19.67 and we will continue to work on this. 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.

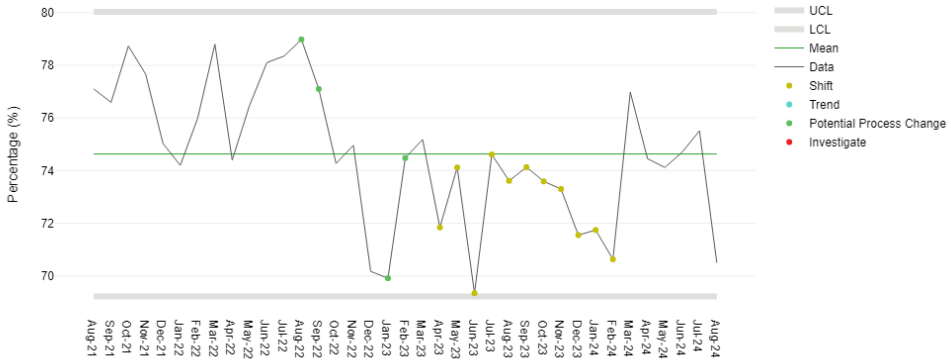
Minimal upwards change is noted to the emergency LOS rate this month and is being addressed through our response to the Royal College of Physicians' report and Operational flow work stream. It is important to note the indicator definition in that monthly performance in this metric could be representative 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 regards 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.

Minimal deviation to current performance regarding rate of readmission is noted (less that 1% increase)

Emergency Care Performance - SPC Charts

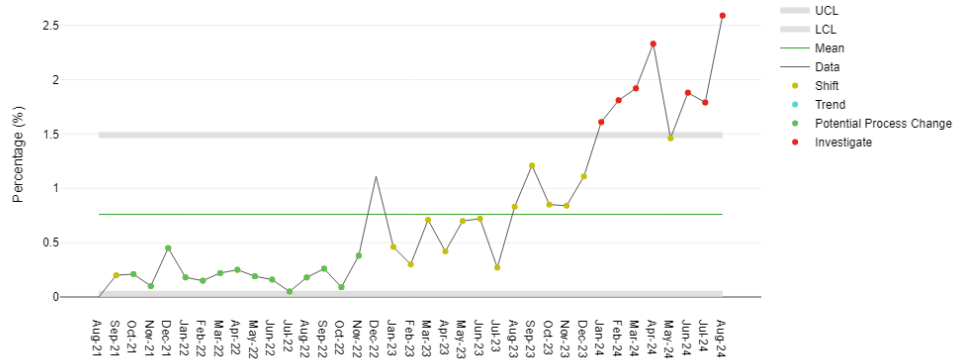
Latest value	Mean
70.5 %	74.6 %

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



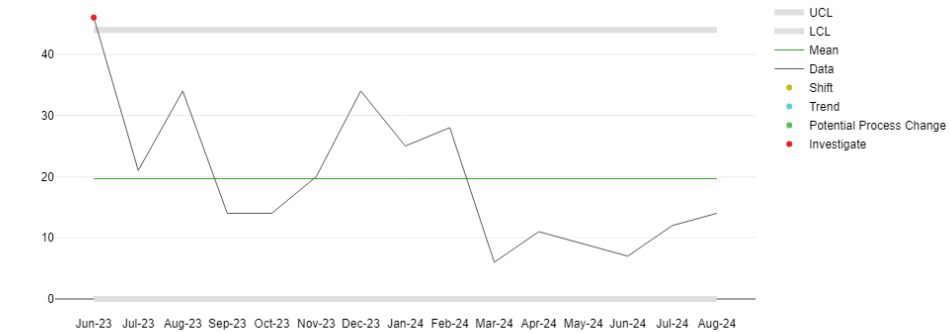
Latest value	Mean
2.6 %	0.8 %

% Patients in Emergency Department for more than 12 Hours



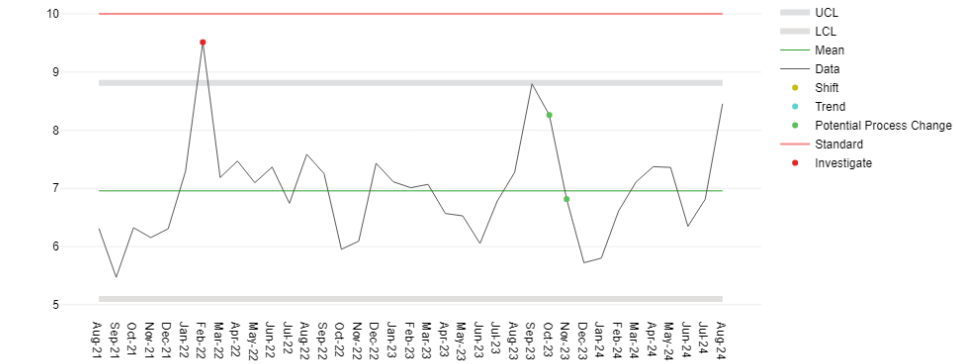
Latest value	Mean
14	19.67

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



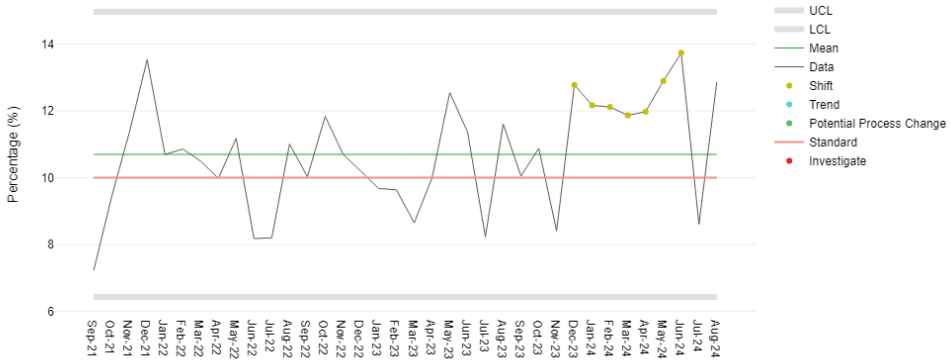
Latest value	Mean
8.45	6.96

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



Emergency Care Performance - SPC Charts

Latest value	Mean
12.9 %	10.7 %



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 was 51.7% (32/62), with 40% being elective. Biggest cohort continues to be in relation to the Robson Criteria group 5, women who had previous caesarean birth, single cephalic pregnancy and were at least 37 weeks' gestation. 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 0 caesarean births at full dilatation or any with the Robson Criteria Group 1 which are primigravida women that went into spontaneous labour meaning all delivered vaginally.

Our induction rate remains consistent month on month but there was a drop to 18.33%, but we continue to ensure we are offering induction at the correct gestation due to the presenting clinical picture.

Apgar score (Appearance, Pulse, Grimace, Activity & Respiration) of below 7 at 5 minutes; there were 9 recorded on the dashboard in month which is a jump since beginning on 2024 (total 15 in year so far). All cases reviewed and in fact none were below 7 at 5 minutes they all had a score of either 9 or 10. Therefore this is a human input error, and all staff have been reminded of the importance of data entry on to Maxims where we get our indicators from monthly. This is an issue that will be resolved with the new EPR system that will be implemented in maternity in 2025.

There have been no major obstetric haemorrhages in month, all PPH discussed at weekly risk meeting; all well managed and good practice identified.

Escalations

Outcome of which maternity specific EPR system was planned for Friday 16th August but was put on hold as medical colleagues had not had any input and hadn’t attended either of the demos therefore hadn’t reviewed either system. Meeting was arranged with consultants and now a demo is being arranged and a site visit to units in UK that use the systems so a live demo can be undertaken. This has and will cause a delay to the replacement of a maternity specific system from Maxims.

Maternity - Key Performance Indicators

Indicator	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	YTD
Total Births	72	67	58	66	59	67	51	58	56	53	69	59	62	475
Mothers with no previous pregnancy (Primips)						24	15	20	16	20	34	22	27	178
Mothers who have had a previous pregnancy (Multips)						26	19	30	28	24	25	30	32	214
Mothers with unknown previous pregnancy status						17	17	8	12	9	10	7	3	83
Bookings ≤10+0 Weeks						6	3	7	8	8	9	7	4	52
% of women that have an induced labour	28.17%	31.25%	17.24%	30.77%	38.98%	30.16%	24%	31.58%	22.22%	16.67%	19.4%	28.07%	18.33%	23.9%
Number of spontaneous vaginal births (including home births and breech vaginal deliveries)	24	23	21	18	11	25	13	22	10	19	19	12	22	142
Number of Instrumental deliveries	12	4	5	5	4	7	3	5	2	3	7	4	6	37
% deliveries by C-section (Planned & Unscheduled)	45.07%	37.5%	46.55%	49.23%	45.76%	36.51%	54%	40.35%	66.67%	47.92%	52.24%	61.4%	51.67%	51.1%
% Elective caesarean section births	22.54%	21.88%	22.41%	27.69%	28.81%	23.81%	32%	15.79%	37.04%	27.08%	29.85%	35.09%	40%	30.04%
Number of Emergency Caesarean Sections at full dilatation	1	1	1	2	0	2	1	1	1	1	0	4	0	10
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	29
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	28
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	33
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	49
Number of deliveries home birth (Planned & Unscheduled)	4	2	3	3	0	2	3	1	1	1	1	3	0	12
Mothers who were current smokers at time of booking (SATOB)	0	1	4	3	2	7	7	3	4	6	2	3	3	35
Mothers who were current smokers at time of delivery (SATOD)	0	0	0	0	0	0	0	2	0	2	2	3	6	15

Maternity - Key Performance Indicators

Indicator	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	YTD
Number of Mothers who were consuming alcohol at time of booking	1	1	2	0	3	1	1	2	0	0	0	0	0	4
Number of Mothers who were consuming alcohol at time of delivery	0	0	0	1	0	0	1	6	4	3	6	4	5	29
Breastfeeding Initiation rates	76.4%	77.6%	74.1%	75.8%	72.9%	79.1%	74.5%	65.5%	73.2%	69.8%	71%	79.7%	67.7%	72.63%
Transfer of Mothers from Inpatients to Overseas	0	0	0	2	1	0	3	1	1	0	1	0	1	7
Number of births in the High dependency room / isolation room	0	1	0	0	0	1	1	0	0	0	0	0	0	2
Number of PPH Greater Than 1500mls	2	3	6	6	3	2	2	1	6	0	1	3	1	16
Number of 3rd & 4th degree tears – all births	1	2	2	1	0	2	2	1	0	0	0	0	0	5
% of babies experiencing shoulder dystocia during delivery	2.78%	1.49%	1.72%	0%	1.69%	0%	0%	0%	1.79%	0%	4.35%	0%	0%	0.84%
% Stillbirths Greater Than 24 Weeks Gestation						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
Number of babies that have APGAR score below 7 at 5 mins	0	1	0	1	0	0	1	0	1	1	1	2	9	15
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	0%	0%	9.09%	5%	6.9%	0%	3.7%	7.41%	3.85%	7.14%	2.78%	5.13%	2.56%	3.92%
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	0	0	0	2	2	0	1	0	0	1	2	0	1	5
Transfer of Neonates from JNU	0	0	0	1	1	1	0	0	1	0	1	0	1	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)	2	2	7	1	2	1	1	8	1	2	2	3	4	22
Neonatal Readmissions at Less Than 28 days old						11	4	4	5	5	6	4	5	44

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
Number of babies that have APGAR score below 7 at 5 mins	Hospital Electronic Patient Record (TrakCare Maternity Reports (MAT23A & MAT1A) & Maxims Maternity Reports (MT005 & MT001))	Indicator is for information only	Number of live births (only looking at singleton babies with a gestational length at birth between 259 and 315 days) that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
% live births Less Than 3rd centile delivered Greater Than 37+6 weeks (detected & undetected SGA)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Percentage of live births with a gestational age lower than the 3rd centile (3% of babies born at same gestational age will have a lower birth weight than them) delivered after 37 weeks and 6 days of pregnancy.
Number of admissions to Jersey Neonatal Unit at or above 37 weeks gestation	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Not Applicable	Number of births requiring admission to the Jersey Neonatal Unit at or above 37 weeks gestation
Transfer of Neonates from JNU	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Deliveries Report (MAT23A), Maxims Admissions Report (IP013DM) & Maxims Deliveries Report (MT005))	Indicator is for information only	Number of transfers of babies out of the Jersey Neonatal Unit to an off-island Neonatal facility.
Preterm Births ≤27 Weeks (Live & Stillbirths)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Indicator is for information only	Live babies born who were born at or before 27 weeks
Preterm Births ≤36+6 Weeks (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

Work commenced on the smoking in pregnancy work stream to ensure we have accurate data for women. Presently we are showing you data for 'Mothers who are currently smokers at time of booking (SATOB)' and 'Mothers who are currently smokers at time of delivery (SATOD)' but these are different cohorts of women (women who have just booked against women who have just delivered). To get a true reflection we should be look at the women who are delivering within month and reviewing this against the information we hold in relation to these women at the time of booking; i.e. did they stop during pregnancy. This is the same for consuming alcohol and we will address this also within this work stream.

Mental Health

Section Owner

Director Mental Health, Social Care & Community Services

Performance Narrative

Our mental health access KPI's remain above target (91% of all crisis referrals seen within 4 hours, and 87% of all referrals seen within 10 working days).

100% of all patients discharged (both working age and older adult) had a follow up contact within 3 days.

In relation to Jersey Talking Therapies (JTT), 97% of people were assessed within the target 90 days. 42% of people waited over 18 weeks for treatment – this is an improved position on recent months, with an associated reduced waiting time for treatment. The service received 150 new referrals in the month. Further recruitment is underway to support reduced waiting for treatment times.

Escalations

Waiting time for dementia assessment has now reduced to 53 days; this is a terrific achievement on behalf of the service over recent months.

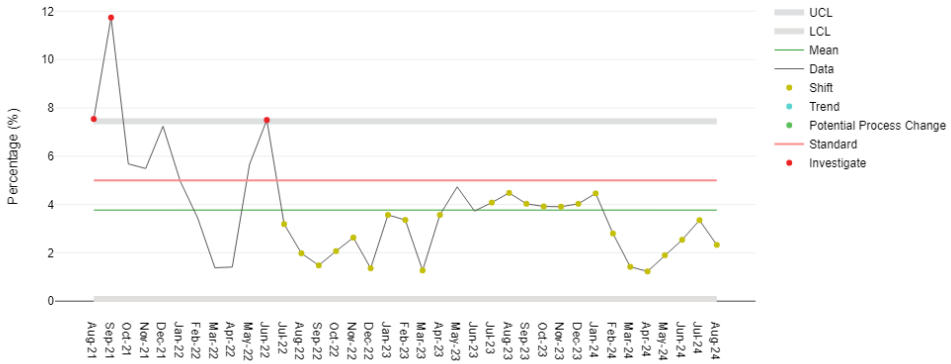
The waiting time for ADHD assessment continues to rise; this is addressed in a specific paper to the Board this month.

The waiting list & waiting time for specialist psychological assessment and treatment (not reported in the QPR, and predominantly due to vacancies) is a concern for the service; a meeting has been arranged with the service to explore this and develop a plan to address it.

Mental Health - SPC Charts

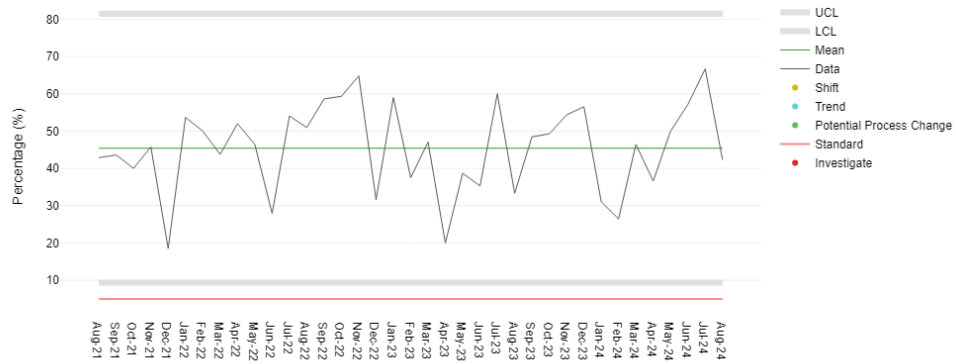
Latest value	Mean
2.3 %	3.8 %

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



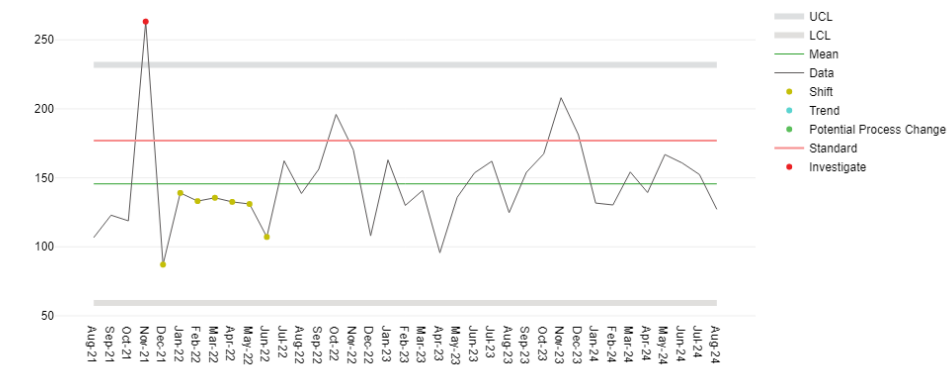
Latest value	Mean
42.3 %	45.4 %

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



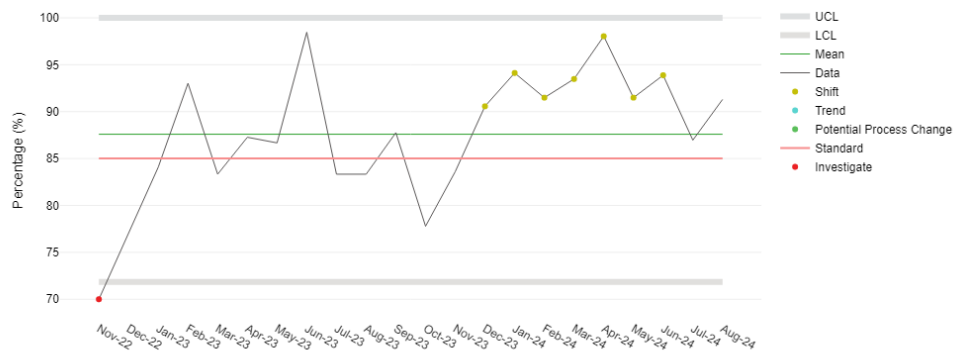
Latest value	Mean
127.2	145.62

JTT Average waiting time to treatment (Days)



Latest value	Mean
91.3 %	87.6 %

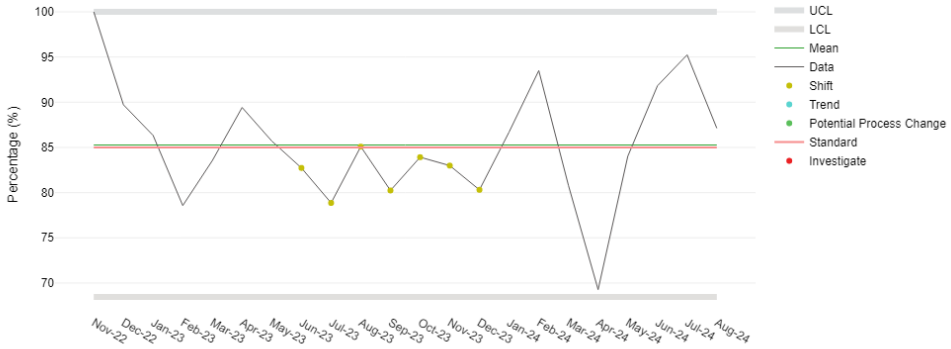
% of referrals to Mental Health Crisis Team assessed in period within 4 hours



Mental Health - SPC Charts

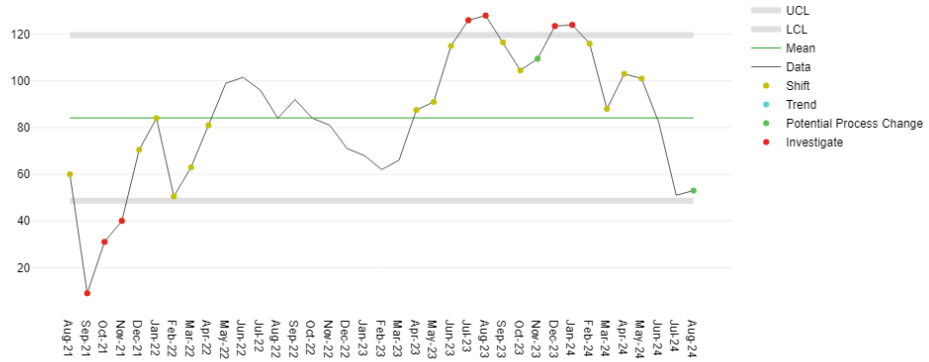
Latest value	Mean
87.1 %	85.3 %

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



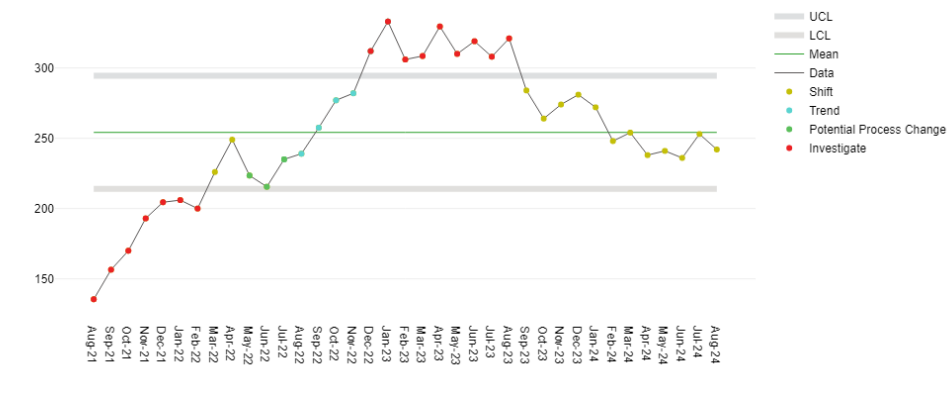
Latest value	Mean
53	84.14

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



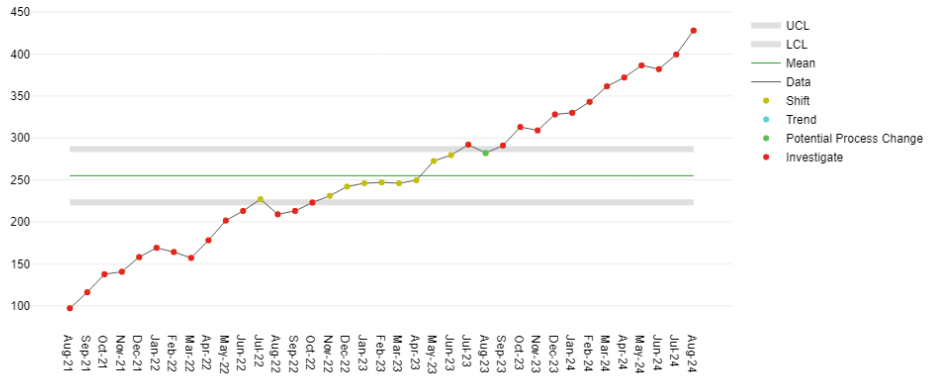
Latest value	Mean
242	254.16

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



Latest value	Mean
428	254.99

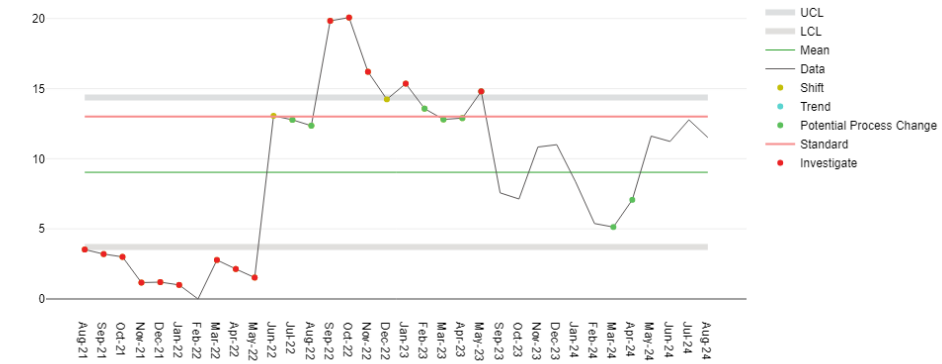
Median wait of clients currently waiting for ADHD Assessment (Days)



Mental Health - SPC Charts

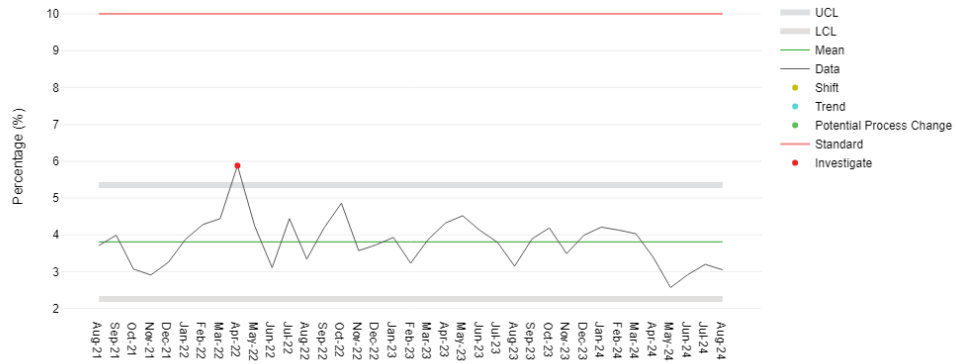
Latest value	Mean
11.52	9.03

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



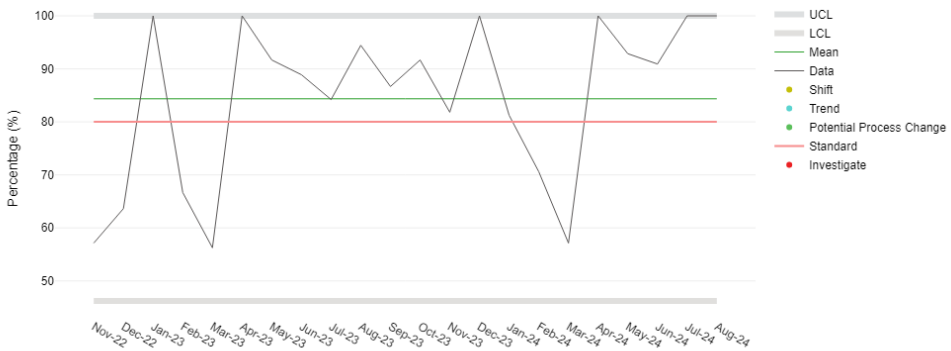
Latest value	Mean
3.1 %	3.8 %

Community Mental Health Team Did Not Attend (DNA) rate



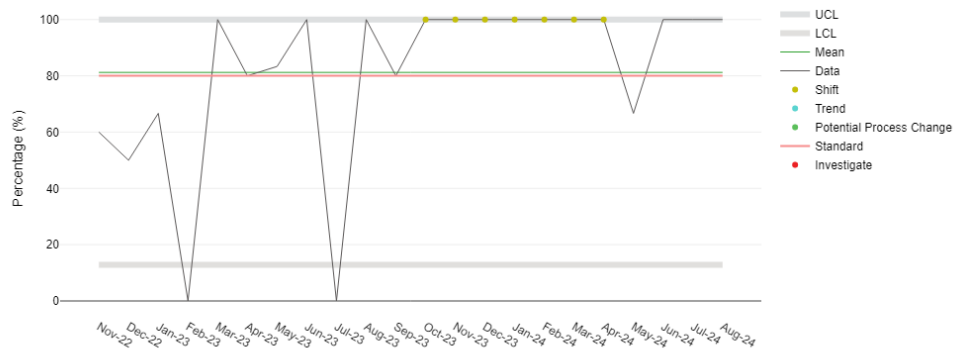
Latest value	Mean
100 %	84.4 %

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



Latest value	Mean
100 %	81.2 %

% 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
Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	Hospital Electronic Patient Record (TrakCare Current Inpatient Report (ATD49) & Maxims Current Inpatient Report (IP020DM))	Generated based on historic percentiles	Average (mean) number of Mental Health inpatients marked as Medically Fit For Discharge each day at 8am
% 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 Mental Health, Social Care & Community Services

Performance Narrative

Learning Disabilities Clients Physical Health Checks

In month position of 80.5% achievement is a positive increase from previous month returns to compliance against target (80% of service users having an annual health check). Work is ongoing to further improve the position (with some of the previous month's position relating to staff absence).

Assessments Authorised and Completed within 3 weeks (ASCT)

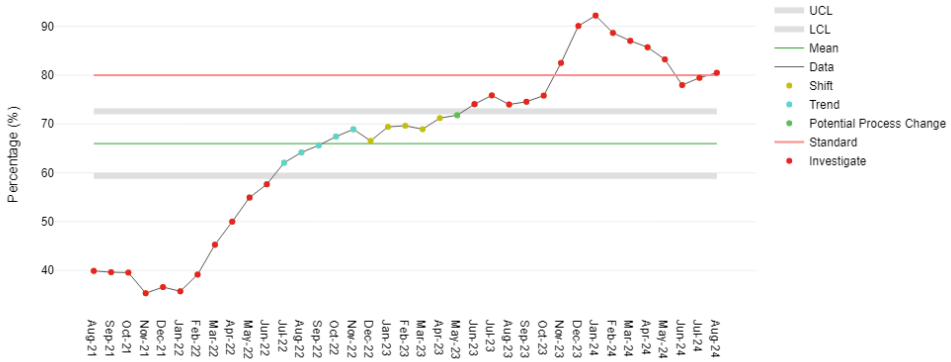
Achievement of 88% remains well above the target of 80%, indicative of good customer care for clients who have care and support needs.

Escalations

Social Care - SPC Charts

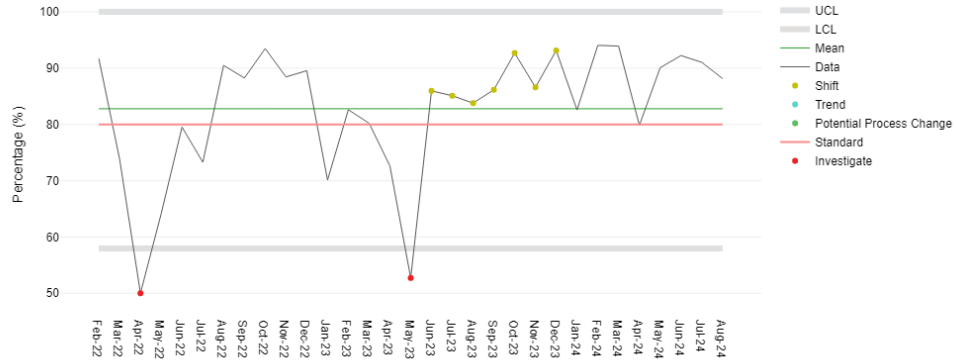
Latest value	Mean
80.5 %	66 %

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



Latest value	Mean
88.1 %	82.8 %

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

Complaints:

In August 2024, 15 new complaints were received across all care groups, a 65% decrease from August 2023 (43 complaints). The team continues to encourage de-escalation at the ward level, working directly with patients and relatives to resolve concerns before they escalate to formal complaints.

Compliments:

A total of 111 compliments were recorded in August 2024, marking a 101% increase compared to August 2023 (55). Efforts are ongoing to ensure that all compliments from patients and relatives are captured in Datix, ensuring relevant staff receive recognition.

PALS:

The Patient Advice and Liaison Service (PALS) relaunched in June 2024 with a media campaign, leading to a significant rise in interactions, from 22 in July 2023 to 144 in July 2024 (a 554% increase).

Tissue Viability

In August 2024, there were 6 reported incidents of hospital-acquired pressure damage within our care.

Of these, 3 were confirmed as category 2 pressure ulcers. Notably, 1 of these ulcers resolved (healed) during the same hospital admission, with no reported deterioration in the remaining 2 cases.

The other 3 incidents relate to one patient. A thorough root cause analysis revealed that these incidents were unavoidable due to the patient's complex comorbidities and non-concordance with the recommended care plans and risk reduction interventions. The patient continues to be closely monitored and supported by a multidisciplinary team.

Quality & Safety

Infection Prevention & Control

In August 2024 Healthcare Associated Infections:

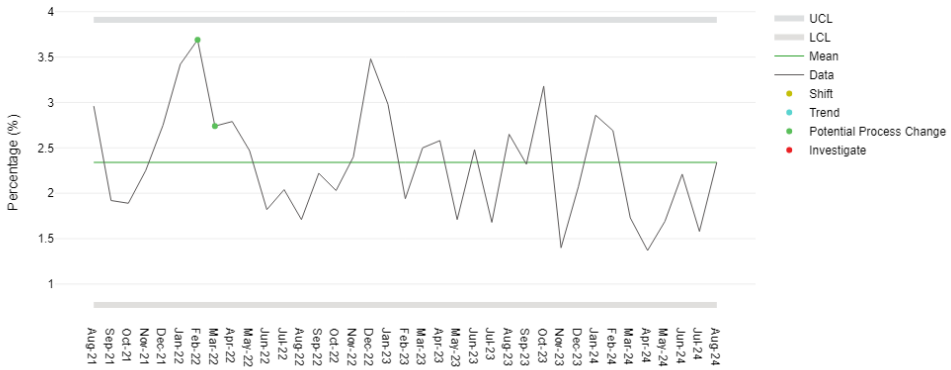
There have been no cases of C. difficile infection identified in the hospital in August. There have been 13 so far this year in comparison to 15 last year. Enhanced infection prevention and control measures and root cause analysis have been implemented for each case.

There have been no MRSA bacteraemia's and one MSSA bacteraemia in August, investigation underway.

Quality & Safety - SPC Charts

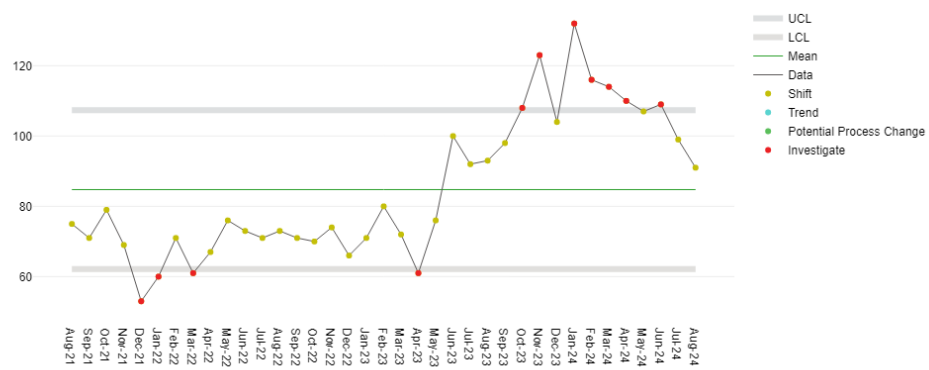
Latest value	Mean
2.3 %	2.3 %

Crude Mortality Rate (JGH, Overdale and Mental Health)



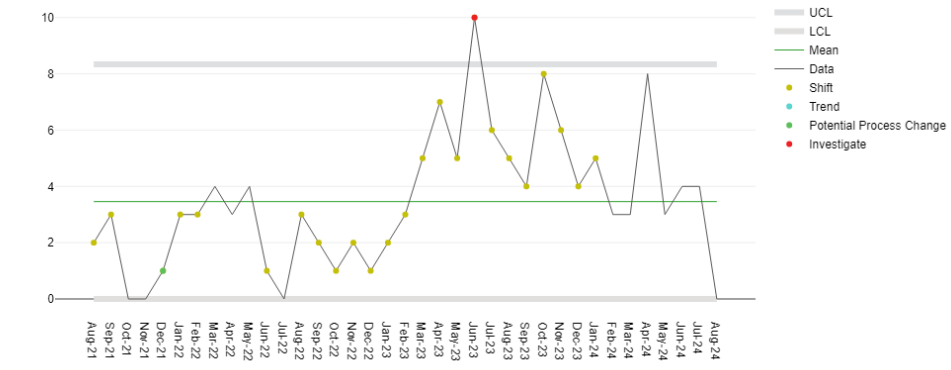
Latest value	Mean
91	84.76

Patient Safety Events per 1000 bed days



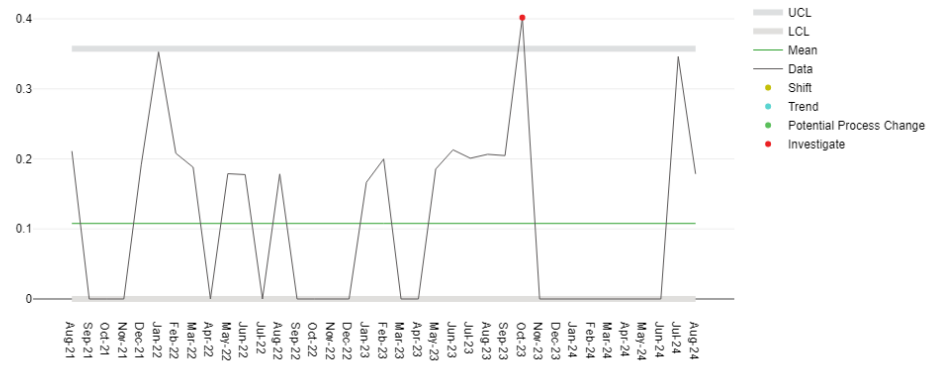
Latest value	Mean
0	3.46

Number of serious incidents



Latest value	Mean
0.18	0.11

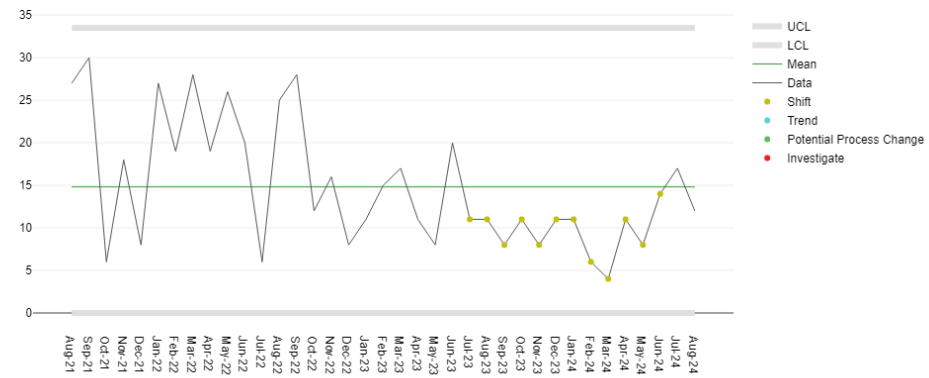
Number of falls resulting in harm (moderate/severe) per 1,000 bed days



Quality & Safety - SPC Charts

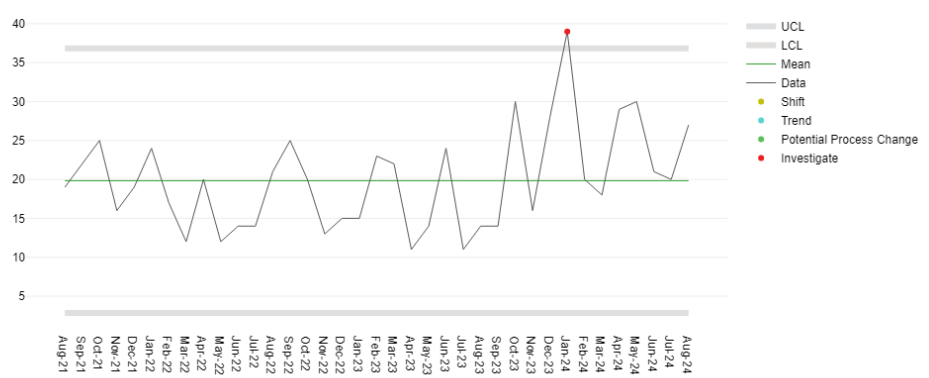
Latest value	Mean
12	14.81

Patient safety incidents with moderate/severe harm/death



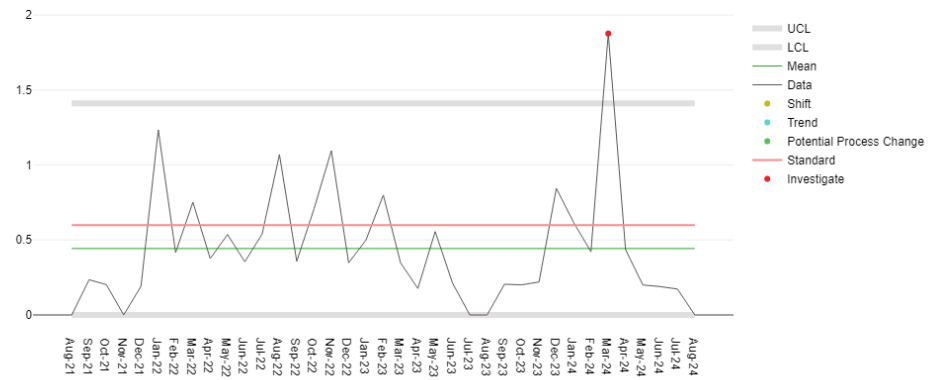
Latest value	Mean
27	19.84

Number of pressure ulcers present upon inpatient admission



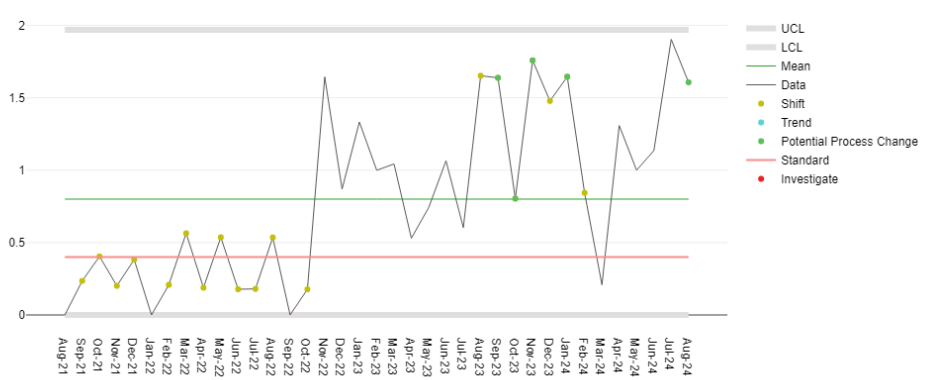
Latest value	Mean
0	0.44

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



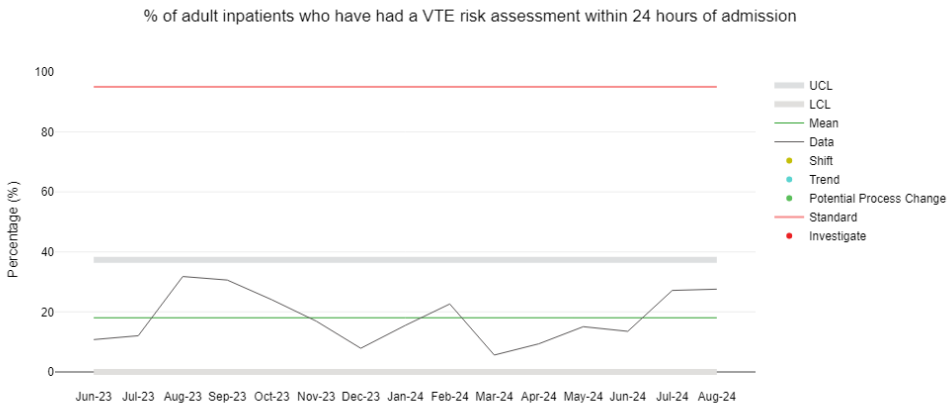
Latest value	Mean
1.61	0.8

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

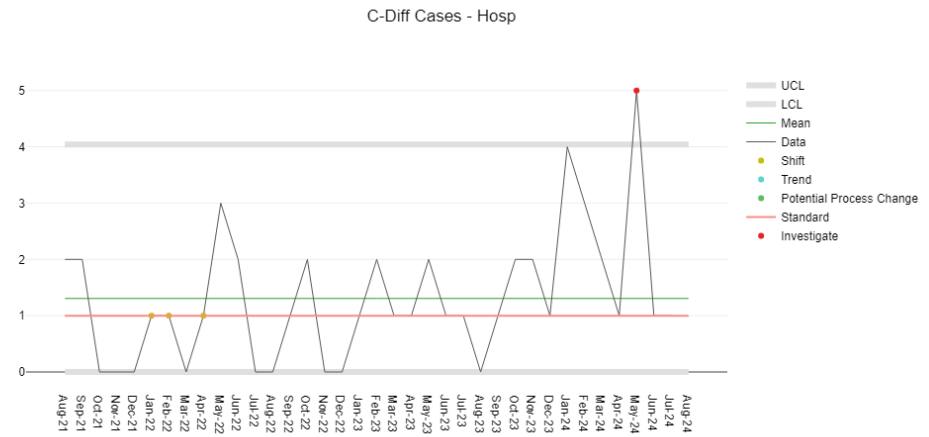


Quality & Safety - SPC Charts

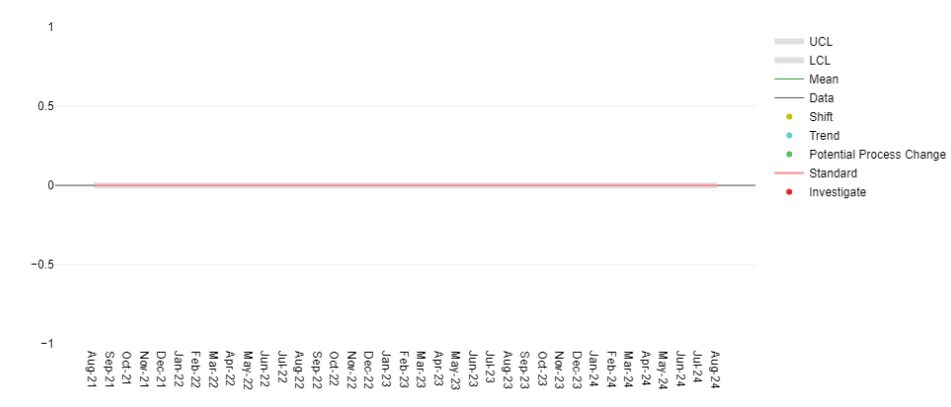
Latest value	Mean
27.6 %	18.1 %



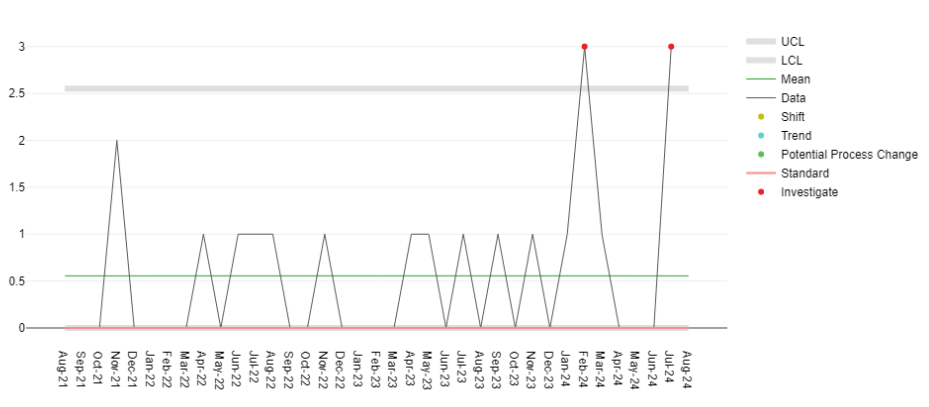
Latest value	Mean
	1.31



Latest value	Mean
	0

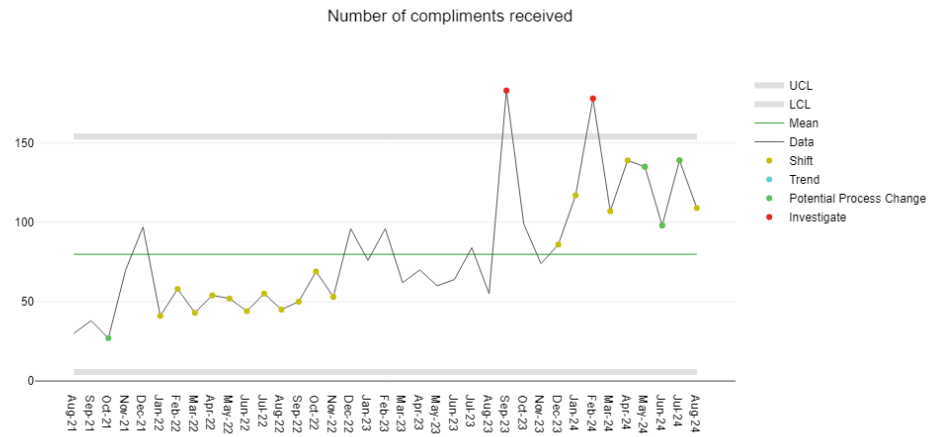


Latest value	Mean
	0.56



Quality & Safety - SPC Charts

Latest value	Mean
109	79.81



Latest value	Mean
15	29.16

Quality & Safety - Indicator & Standard Definitions

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

Quality & Safety - Indicator & Standard Definitions

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

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Workforce Data Report to end of August 2024**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**10**

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 report on a number of aspects of people management performance.			
Summary of Key Messages:	The key messages arising from this report are: • The attached workforce dashboard is the first report created since we temporarily withdrew reporting to allow review. • This report has greater information on the data sources and labels. • The report come with some warning signs, due to the complex nature of drawing data from multiple sources there remains some discrepancy between finance and people ledgers. (Work continues to reconcile these ledgers). • A summary narrative on the report is below. **New Starters –** This data reflects the high level of recruitment undertaken since mid-year, with the normal season variation of the August holiday season reflected. **Vacancies** – The reduction in vacancies reflects the focus on recruitment. **Turnover** – This is an expression of staff that leave GoJ employment, it is not possible at this stage to report HCS turnover. **Sickness** – This appears to be running at circa 6% which as noted in a previous paper does not indicate an immediate issue for attention. **Staff Costs** – We seem to be reducing our overtime spend in year, but it still appears higher than previous years. The increase in basic			

	pay relates to the increase in recruitment and is offset by reduction in agency spend. **Zero Hours** - relates mainly to our bank spend, for both bank only workers and full-time staff that also hold a bank contract. **Connected Performance –** This reports the recorded level of objective setting and mid-year reviews undertaken, there is both a manager compliance issue with completion of appraisal cycles, but we also believe a Connect issue due to the lack of training and development for managers in effective use of the system. **My Welcome –** This is the level of completion of GoJ induction days. This dashboard will continue to be developed to enable managers sight of their performance in people management and for Board assurance of people management issues. Further data will be added as the reports are developed though the data reporting workstream and these dashboards will be refined to include more comparative data and benchmarks as well as seeking to gain HCS specific data.
Recommendations:	The Board is asked to note the August workforce report and the ongoing work on developing reporting.

Link to JCC Domain:		**Link to BAF:**	
Safe	√	SR 1 – Quality and Safety	
Effective		SR 2 – Patient Experience	
Caring	√	SR 3 – Operational Activity (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	16 September 2024	Approved for Committee / Board presentation
People and Culture Committee	26 September 2024	

List of Appendices:
Appendix 1: Operational People Dashboard

END OF REPORT

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

August 2024

Workforce Profile

2,456.4
Actual FTE

2,604
Actual H/C

360
Starters in Last 12 Months

Turnover

186
Leavers in Last 12 Months

Turnover %

7.3% ✓
Same Period Last Year: 7.8% (-0.5%)

Leaver Category	Leavers	Turnover	Same Period Last Year
Compulsory Redundancy	3	0.1% ↑	
Retirement	20	0.8% ↓	1.5%
Involuntary	29	1.1% ↓	1.8%
Voluntary	135	5.3% ↑	4.5%
Total	**186**	**7.3%** ↓	**7.8%**

Sickness

32,268.4
Sickness Days Lost

Av. Days Sick Per Employee

12.7 !
Same Period Last Year: 11.46 (+1.3)

Main Reasons for Absence

Reason for Absence	%
Cold, Cough, Flu - Influenza	26.4%
Gastrointestinal problems incl. D&V	15.6%
Anxiety/Stress	11.7%
Headache / migraine	7.4%
Chest & respiratory problems	5.9%
Surgical Procedure	4.9%
Musculoskeletal prob excl back incl	3.8%

Staff Costs

Monthly Staff Costs

£14,653,162 !
Same Period Last Year: £12.4M
(+18.08%)

Monthly Overtime

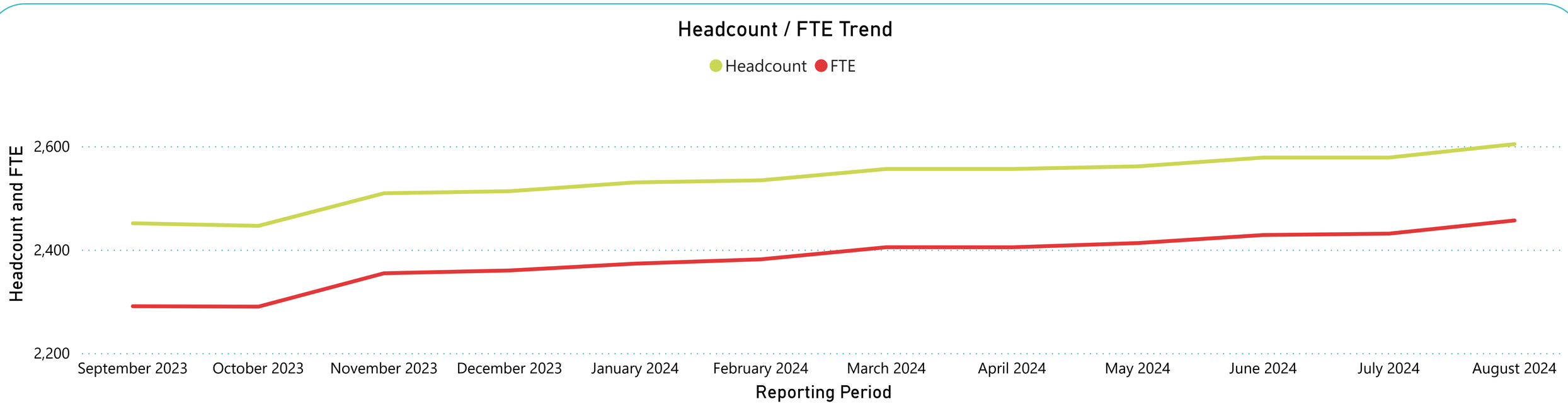
£353,899 ✓
Same Period Last Year: £365,115
(-3.07%)

Main Pay Excl. Basic Pay

Pay Code - Categorised	% of Total Pay
Shift Allowances	41.6%
Skill Related Payments	23.7%
Overtime	21.2%
Ad Hoc Payments / Supplements	8.2%
Standby Payments	3.9%

Headcount

August 2024



Department	Total	FTE
Health and Community Services	2,604	2,456.45
Total	**2,604**	**2,456.45**

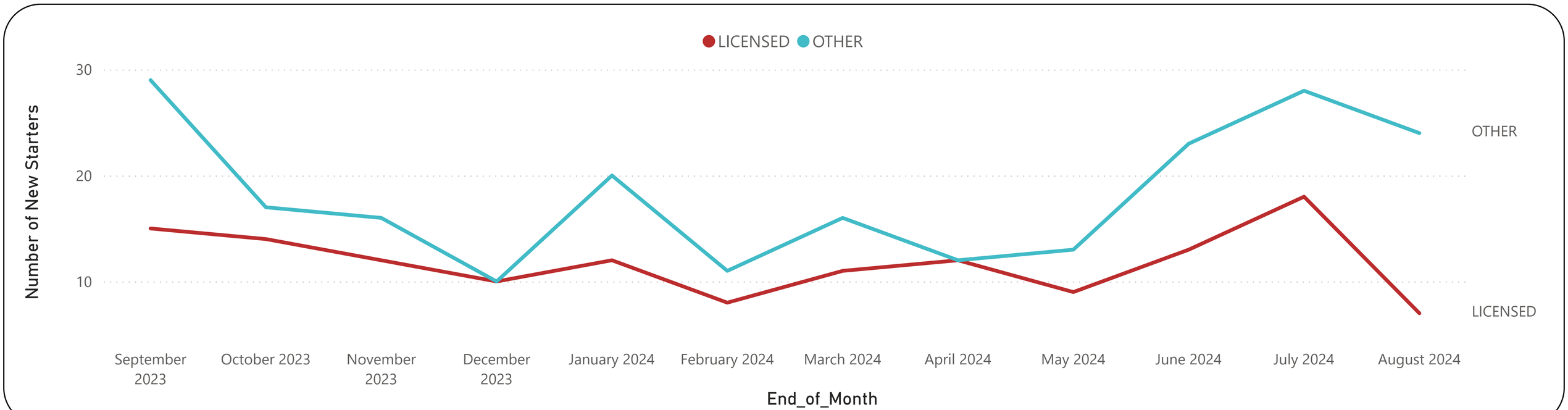
Methodology:

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

August 2024



Department	LICENSED	OTHER	**Total**
⊞ Health and Community Services	141	219	**360**
Total	**141**	**219**	**360**

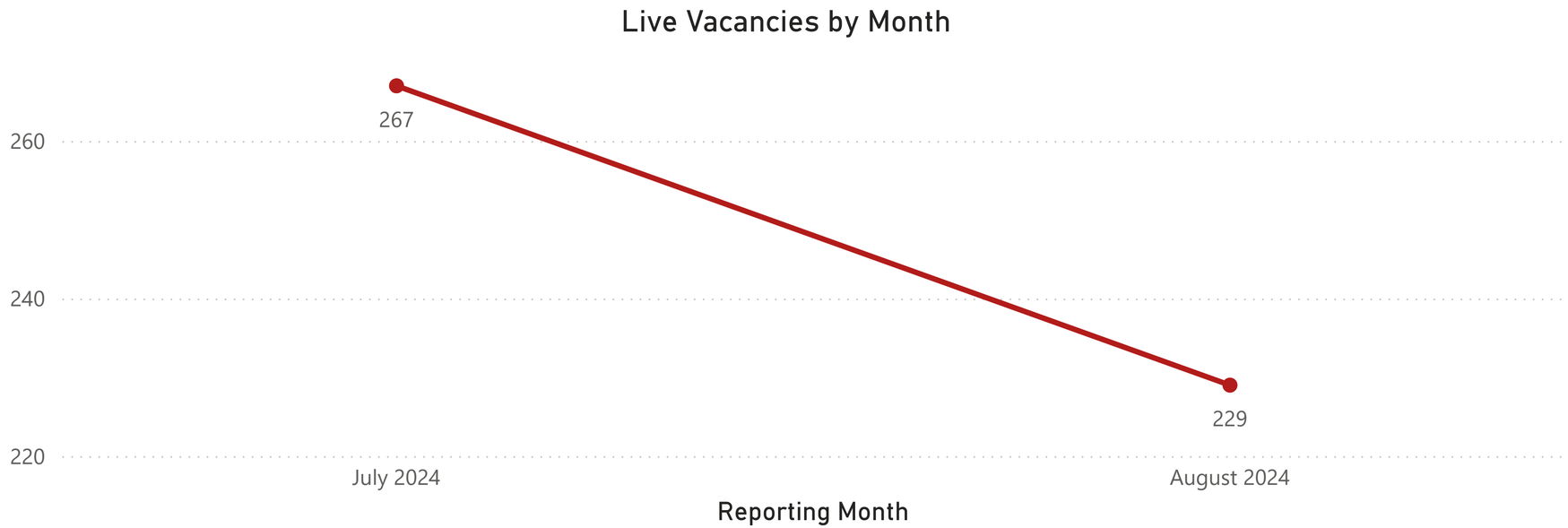
Methodology:

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.

Vacancies

August 2024



Department	New Candidates	Shortlisting	Interview	Offer and Contract	Clearances	Total
Health and Community Services	54	1	30	35	109	**229**
Total	**54**	**1**	**30**	**35**	**109**	**229**

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.

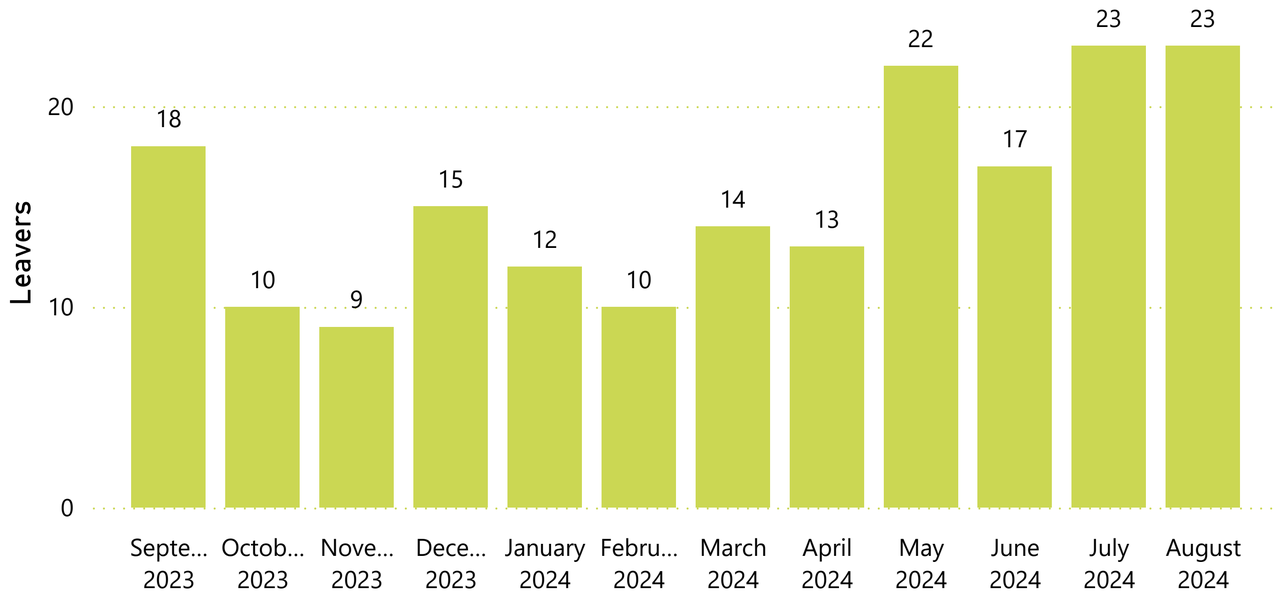
Figures are taken as a snap-shot in time; the last day of each month. Therefore, they do not include any vacancies which were hired or which closed down earlier in the month.

Figures 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.

Turnover

August 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	20
Total	**20**

Department	Compulsory Redundancy	Involuntary	Retirement	Voluntary	**Total**
⊞ Health and Community Services	3	29	20	135	**186**
Total	**3**	**29**	**20**	**135**	**186**

Leaver Category	Leavers	Turnover	Same Period Last Year
Compulsory Redundancy	3	0.1% ↑	
Retirement	20	0.8% ↓	1.5%
Involuntary	29	1.1% ↓	1.8%
Voluntary	135	5.3% ↑	4.5%
Total	**186**	**7.3%** ↓	**7.8%**

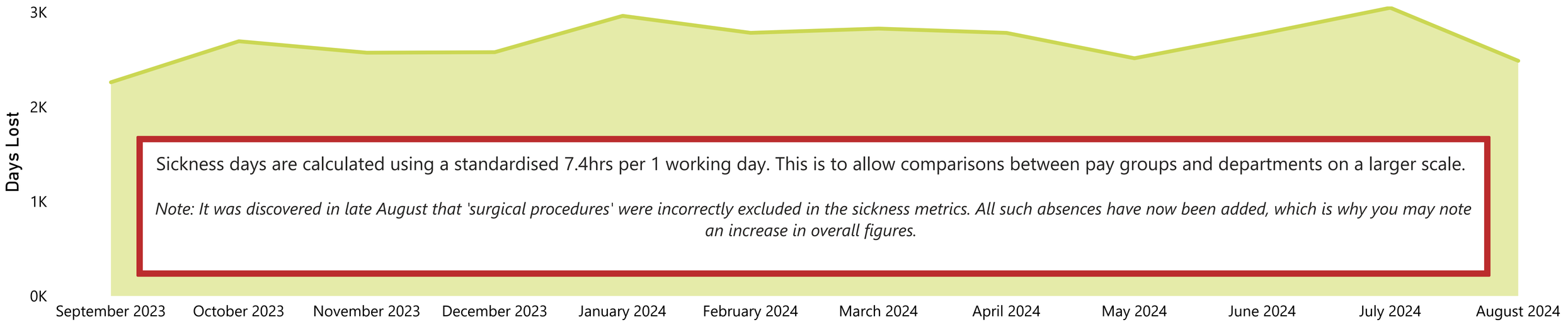
Sickness Term

All

Mental Health Related

Sickness

August 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 - Sep-23 - Aug-24

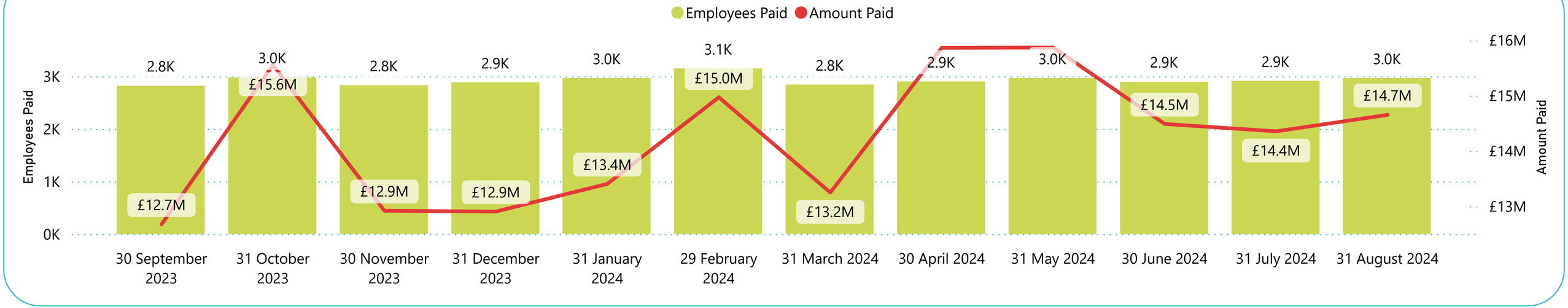
Department	Sickness Hours	Days	Instances	% Working Days Lost	Av. Days Sick Per Employee*	Av. Days Same Period Last Year
⊞ Health and Community Services	238,786.3	32,268.4	6,152	6.1%	12.7 ↑	11.46
Total	**238,786.3**	**32,268.4**	**6,152**	**6.1%**	**12.7** ↑	**11.46**

*Compared to same period last year

Absence Reason	Number of instances
Cold, Cough, Flu - Influenza	1,624
Gastrointestinal problems incl. D&V	961
Anxiety/Stress	721
Headache / migraine	453
Chest & respiratory problems	361
Surgical Procedure	299
Musculoskeletal prob excl back incl neck	234
Back Problems	233
Injury, fracture incl bruising/cuts	215
Depression/other psych	161
Genitourinary & gynaecological disorders	160
Benign and malignant tumours, cancers	142
Pregnancy related disorders	69
Eye problems	63
Cat 5 - Confirmed COVID19 With Positive	58
Total	**6,152**

Staff Costs

August 2024



Payment Type	£
	£20,701.9
Ad Hoc Payments / Supplements	£137,199.1
Basic Pay	£12,979,929.9
Benefits	£36,863.5
Business Expenses	£6,546.7
Exclusions	£10,400.0
Other Time Payments	£16,259.6
Total	**£14,653,162.1**

Basic Pay YTD

£103,061,403.7

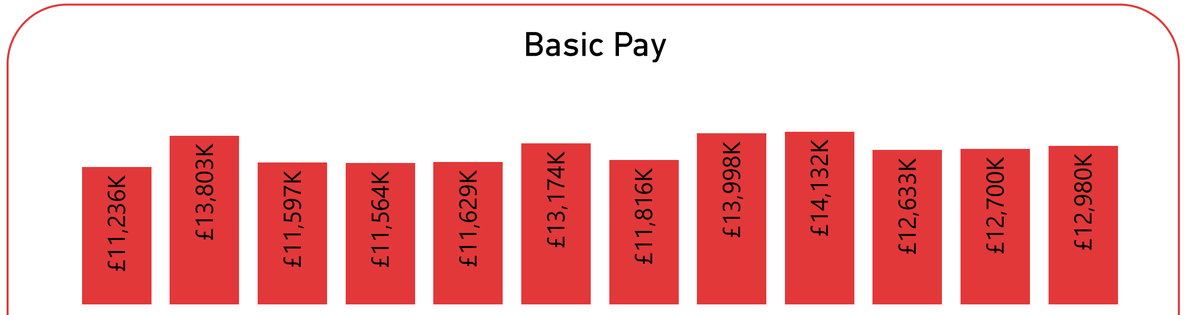
YTD Last Year: £85,516,827.1

(+20.52%)

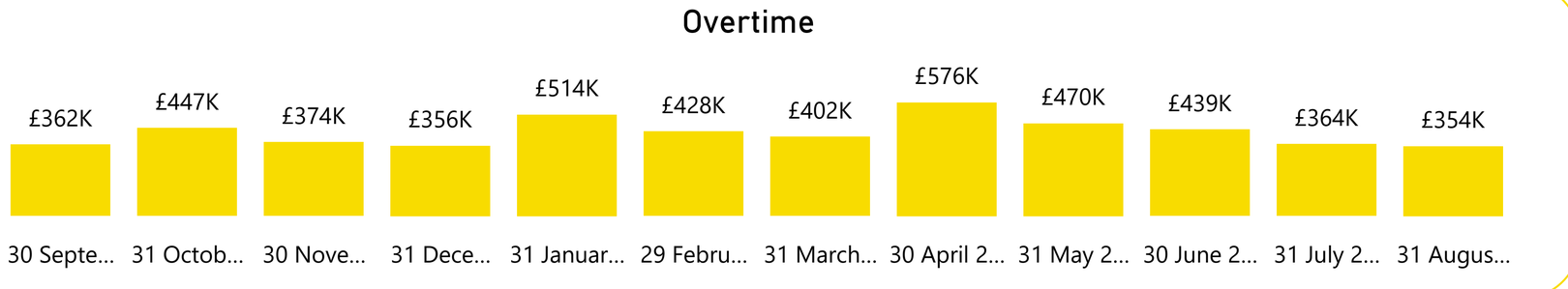
Overtime YTD

£3,548,429.5

YTD Last Year: £3,230,400.2 (+9.84%)



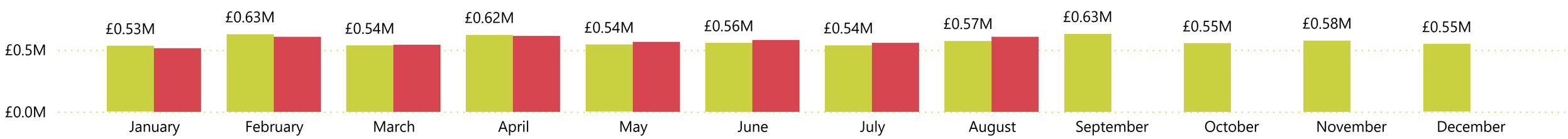
Department	£
⊟ **Health and Community Services**	**£14,653,162.1**
⊞ Chief Nurse	£848,009.7
⊞ Hospital and Community Services	£12,902,918.3
⊞ Improvement & Innovation	£169,262.3
⊞ Medical Director	£642,467.1
Total	**£14,653,162.1**



Zero Hours

August 2024

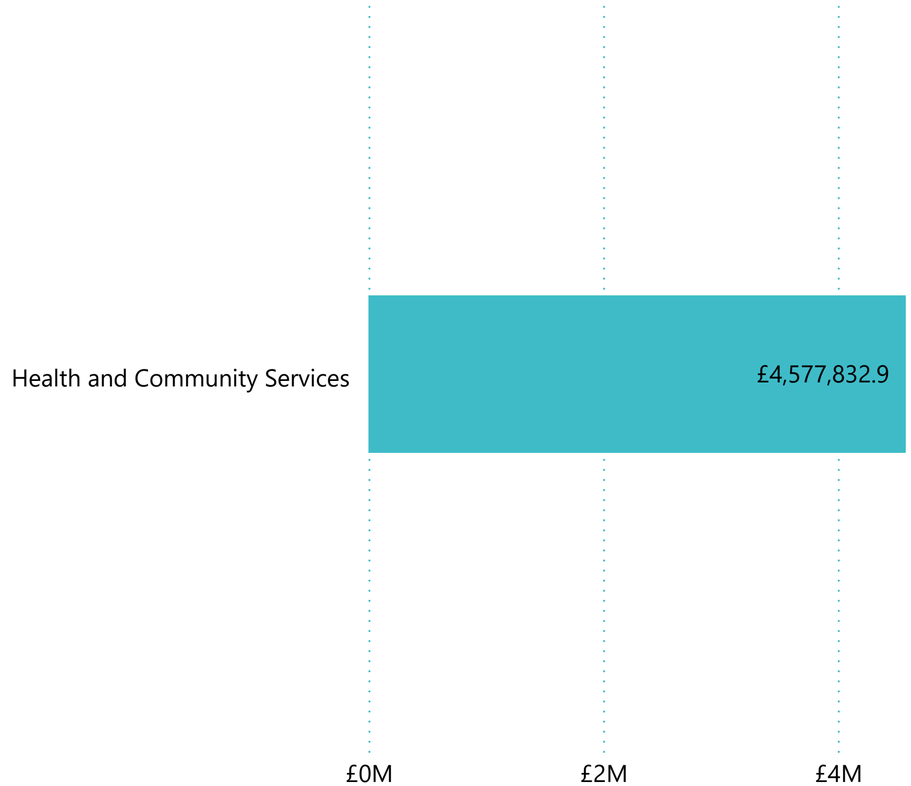
Zero Hour Spend



Department	Has a PM / FTC Role	Unique ZH Role	**Total**
⊞ Health and Community Services	1,049	725	**1,774**
Total	**1,049**	**725**	**1,774**

Department	Not Worked in Last 12 Months	Worked in Last 6 Months	Worked in Last 7 - 12 Months	**Total**
⊞ Health and Community Services	818	907	135	**1,774**
Total	**818**	**907**	**135**	**1,774**

YTD Zero Hour Spend



Connected Performance

August 2024

47.5%	19.3%	7.4%	25.8%
Objective Setting	Mid Year Self-Review	Mid Year Manager Review	Year End Self Rerview

Connect Performance

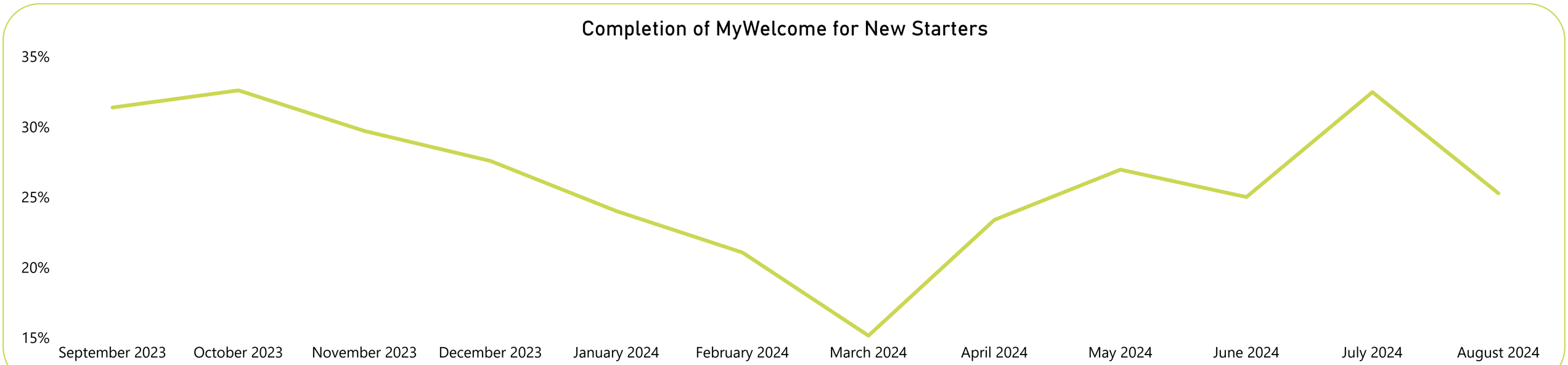
Department	Objective Setting	Mid Year Self-Review	Mid Year Manager Review	Year End Self Review	**Total**
⊞ **Health and Community Services**	**1,033**	**420**	**162**	**561**	**2,176**
Total	**1,033**	**420**	**162**	**561**	**2,176**

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.

My Welcome

August 2024



Department	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
⊞ Health and Community Services	19.4%	35.7%	26.4%	28.3%	25.1%	21.0%	15.1%	23.4%	27.0%	25.0%	32.5%	25.3%
Total	**19.4%**	**35.7%**	**26.4%**	**28.3%**	**25.1%**	**21.0%**	**15.1%**	**23.4%**	**27.0%**	**25.0%**	**32.5%**	**25.3%**

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Working Group of the HCS Advisory Board – Out of Hospital Health and Care Services**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**11**

Executive Lead:	Dr Anuschka Muller, Director of Improvement and Innovation Andy Weir, Director of Mental Health and Social Care
Report Author:	Dr Anuschka Muller, Director of Improvement and Innovation

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion ☐
	This paper provides the Board with details about the 'Working Group of the HCS Advisory Board – Out of Hospital Health and Care Services'			
Summary of Key Messages:	The key messages arising from this report are: Following conversations held between Non-Executive Directors (NEDs) and Executive Directors, it was agreed to create a working group to provide a space for discussion about out of hospital health and care services, including: • creating an understanding of current services and their funding and governance arrangements; • opportunities for integrated working; • existing mechanisms to support partnership working; • commissioned services and their performance; • Government-wide commissioning of out of hospital services. The aim of the working group is to create a better understanding for the Board of out of hospital provided services by HCS within the context of the whole Jersey health and care system identifying opportunities for enhancing their visibility at Assurance Committee and Board meetings with a focus to enhance the outcomes and experiences for those using the services.			
Recommendations:	The Board is asked to note and support the work of the working group.			

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 Advisory Board - Part B	30 May 2024	Supported and to be presented to Part A at next Board

List of Appendices:
n/a

MAIN REPORT

1. HCS directly provides, commissions and contracts health and care services across a wide range of physical and mental health and care services. The HCS Advisory Board ("the Board") currently focuses mainly on the performance, quality and safety of secondary services directly delivered by HCS.

2. Discussions over the last months between non-executive board members and executive directors with an interest in provision and commissioning of out of hospital health and care services resulted in the identification of thematic areas to explore in more detail, including:

    - creating an understanding of current services and their funding and governance arrangements;
    - opportunities for integrated working;
    - existing mechanisms of partnership working;
    - commissioned services and their performance;
    - alignment of government-wide commissioning of out of hospital services.

3. It was agreed that it would be beneficial to create a discussion space for board members on these topics with recommendations to be fed back to the Board or relevant assurance committees as appropriate.

4. The working group meets once a month.

5. The aim of the working group is to create a better understanding for the Board of out of hospital provided services by HCS within the context of the whole Jersey health and care system identifying opportunities for increasing their visibility at Assurance Committee and Board meetings with a focus to enhance the outcomes and experiences for those using the services.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Neurodevelopmental services update – Attention Deficit Hyperactivity Disorder (ADHD) and Autism**		
Date of Meeting:	**26 September 2024**	**Agenda Item:**	**12**

Executive Lead:	Andy Weir, Director of Mental Health, Social Care and Community Services
Report Author:	Andy Weir, Director of Mental Health, Social Care and Community Services

Purpose of Report:	Approval ☐	Assurance √	Information √	Discussion ☐
	This paper provides information for the Board in relation to the current performance and position of our ADHD and Autism services.			
Summary of Key Messages:	The key messages arising from this report are: • summarises the challenges, actions taken and work underway in relation to these services, providing a current position statement for both. • Service growth in these areas will require additional funding to be found from within the current baseline. Specific on-going challenges exist in the context of finding specialist professionals in this area • A specific risk related to the waiting list for ADHD assessment is included on the HCS risk register.			
Recommendations:	The Board is asked to note and discuss this 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	16 September 2024	Board Reporting

List of Appendices:
Nil

MAIN REPORT

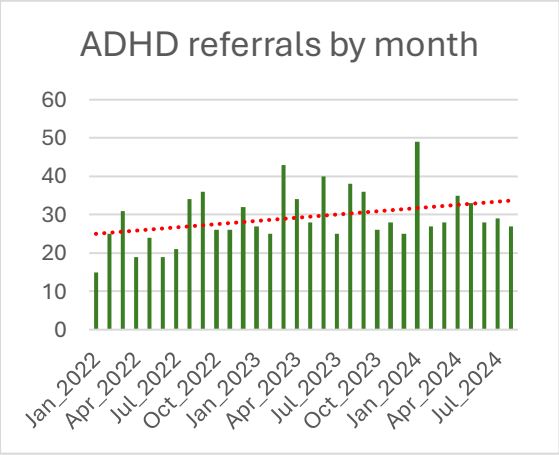
a) Attention Deficit Hyperactivity Disorder (ADHD) Service

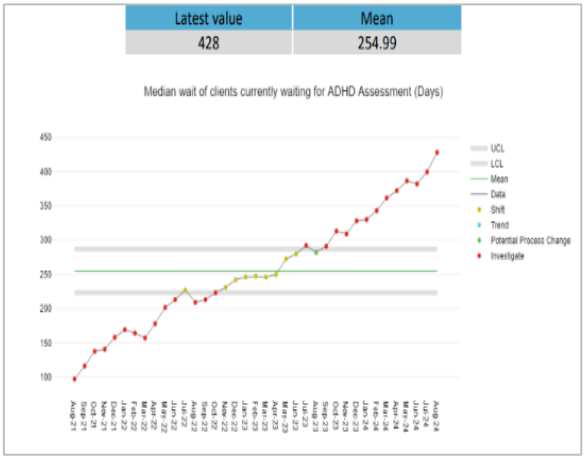
1.1 The ADHD service is an assessment and diagnostic service, which is staffed by a (part-time) Consultant Psychiatrist and a clinical fellow. In addition, in recent months we have seconded an experienced senior nurse with specific ADHD expertise for 2 days per week to support the service.

1.2 As with other jurisdictions, the ADHD service has been under immense pressure for a number of years and is unable to meet an increasing demand. This position has been made more complicated by a world-wide shortage of ADHD medication, and the local prescribing arrangements in Jersey which currently limit ADHD prescribing to specialists.

1.3 An article in the British Journal of Psychiatry (Smith et al, 2023) described UK adult ADHD services as being 'in crisis'; a most recent article in the Health Service Journal (September 2024) describes a seven year wait for ADHD assessments at a leading (and CQC rated 'outstanding') NHS mental health Trust, with the longest reported waiting time being 10 years.

1.4 Rate of referrals to the service have risen from an average of 26 per month in 2022 to 32 YTD in 2024. Due to the high level of reviews and repeat prescribing required, the service has capacity currently to see an average of 6 new referrals per month (although this figure has been impacted by sickness / unplanned absence in 2024, with capacity in some months to undertake 10 per month). We plan to increase this, as described below.





1.5 As at the end of August, the waiting list for ADHD assessment was 778 adults. This is a reduction from the reported position of 817 people in June 2024; this reduction is a result of work that has been going on to review and cleanse the waiting list. The average wait patients to access an assessment has continued to rise, as shown above, and is currently 428 days at the point of assessment.

1.6 In addition, there are circa 140 young people who are waiting for their prescribing to transfer from CAMHS to adult services. Some of these young people are at university off island and require a shared care arrangement with a GP there.

1.7 There are currently 254 patients who are prescribed for by the service. These patients need up to 12 prescriptions per year (with prescribing intervals increased as a result of medication shortages) and an annual review of their medication. In addition, 6 monthly monitoring of blood pressure, pulse and weight is required; this is generally done by the patient, their GP or at a pharmacy.

1.8 As a result of world-wide shortages of ADHD medicines, a small number of patients have not yet been able to start treatment and we have needed to increase prescribing intervals in order to manage available stock.

1.9 Shared care arrangements that exist in the UK and Europe, which allow GPs to prescribe ADHD medication supported by a specialist and reviewed annually within the specialist service, do not exist in Jersey. This would greatly alleviate the prescribing demand on the service and would vastly increase capacity for new assessments to be undertaken. Work has been done on the development of a shared care protocol with primary care, and the Pharmaceutical Benefit Advisory Committee (PBAC) have met to consider the inclusion of ADHD medication on the prescribed list for primary care / community prescribers. However, an agreed way forward is yet to be reached, and discussions are ongoing.

1.10 Without shared care arrangements (or an alternative prescribing arrangement) any newly assessed patient who requires medication will be added to the prescribing caseload; this in turn further reduces capacity to undertake new assessments.

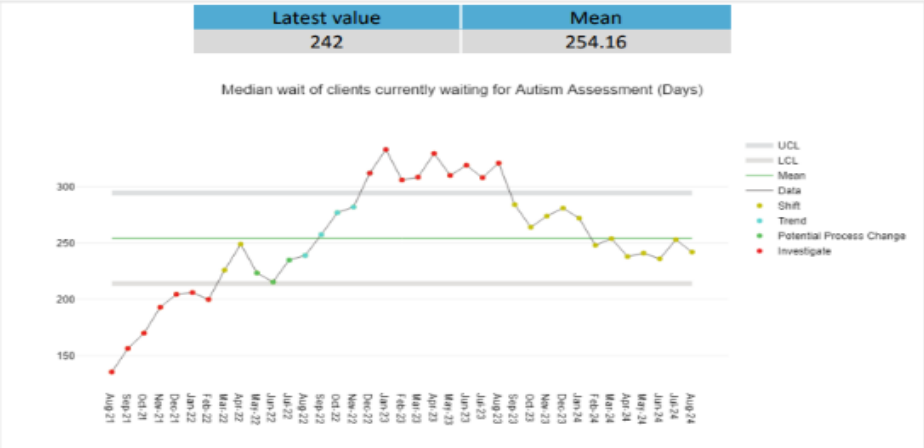
1.11 Much work has been undertaken in recent months to shorten / improve the diagnostic pathway (including the introduction of a new self-assessment questionnaire) and to review the waiting list. We are currently further reviewing the capacity of the service, including exploring the potential of joint work with a private provider, introduction of an electronic self-assessment tool, and the potential development of sessions from a GP with a special interest.

Autism Service

1.12 The adult autism service is also an assessment and diagnostic service, and is staffed by a psychologist, nurse specialist, occupational therapist and sessions of medical time.

1.13 During 2022 and early 2023, the service saw a significant rise in referrals and associated waiting times. At that stage the service was focusing significantly on post diagnostic support work and seeing very few referrals for new assessment.

1.14 Work was undertaken with the clinical team to fully review and redesign the assessment pathway, and a decision taken to focus on diagnostic assessment in light of concerns regarding increased waiting times.



1.15 As shown in the graph above, this work has been successful in significantly reducing waiting times for assessment (even despite some reduction in staff availability during this period).

1.16 Some additional pre- and post-diagnostic support has been commissioned through a partnership arrangement with Autism Jersey. This pilot work is shortly due to be reviewed.

1.17 Due to the recent resignation of the nurse team leader, we are currently reviewing the team arrangements for the service to maximise capacity and build stronger links with the ADHD service – aiming to develop a single Neurodevelopmental Disorders service that works across both areas and includes a review of pre-and post-diagnostic support offers.

1.18 This work will be further strengthened by the development of a Neuroinclusive strategy for Jersey, which is currently being developed through a joint steering group and including a range of statutory and charitable sector partners. The strategy will be finalised for Ministerial sign off at the end of the year.

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:	26th September 2024	**Agenda Item:**	**13**

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 28 August 2024. The meeting was chaired by Dame Clare Gerada. • Agenda items included the quality account, quality indicators, clinical governance, serious incidents, clinical audit, safeguarding, infection prevention and control, staff winter immunisation campaign and the pharmacy review.			
Recommendations:	**The Board is asked to note the report and the following,** • Significant reduction in **pressure trauma** acquired in care which evidences real improvement. • **Serious Incidents**: all open SIs have allocated investigators. • **CAS Alerts**: The Committee is aware of the large number of overdue alerts but received assurance that the alerts are triaged on receipt and there are no serious issues not being addressed. • **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. • **Serious Incidents**: Cross cutting themes have been identified from a review of multiple recommendations. Where appropriate, recommendations are incorporated into improvement plans which follow a 30 / 60 / 90 / 120 review to ensure change is embedded as part of business as usual. • **Absence of a paediatrically qualified Designated Doctor** • **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.

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 Account 2024 Mid-Year Report

The Committee received a paper providing progress against the priorities in the Quality Account 2024 and noted that the majority of actions are on track with some already complete. Where actions are delayed, the Committee received the reasons for this and revised timescales for completion.

Quality / Clinical Governance Framework Report

Incident Reporting: Overall incident reporting has increased which is a positive sign and levels of harm associated with this have not increased significantly. There is a significant decrease in pressure ulcers developed in care and HCS benchmarks well below the national average. Whilst an increase is noted in post-partum haemorrhage (<1500mls), this is thought to be a direct consequence of the reduction in massive obstetric haemorrhage (>1500mls). The Committee noted this improvement triangulates with progress in the wider maternity improvement programme.

Serious Incidents: All serious incidents now have allocated investigators which is a significant achievement. Regarding the completion of the investigations, HCS continues to experience delays with both internal and external investigators. However, the Committee noted that this issue is a challenge experienced by the NHS. The Executive team are not complacent in the drive to complete investigations in a timely manner.

The recent drive to complete open SI investigations led to an increase in over 100 new recommendations and work continues to establish themes. Where appropriate, recommendations are incorporated into

improvement plans which follow a 30 / 60 / 90 / 120 review to ensure change is embedded as part of business as usual.

Compliance and Assurance: The Quality and Safety Team continues to work with the Jersey Care Commission (JCC) and across HCS to prepare for inspection. This Committee will receive quarterly reports regarding this work.

Central Alert System: The policy for the management of safety alerts is not yet finalised and there is no dedicated resource to oversee this function. The addition of some temporary capacity should see the number of overdue alerts reduce. The Committee received assurance that alerts are triaged on receipt and that there are no serious issues not being addressed.

Policies: The Committee noted that approximately 50% of policies in HCS are out-of-date and targeted work has started in specific care groups. Maternity has made good progress as part of the wider improvement plan. Work was undertaken during 2023 to establish which policies required up-dating and whilst some progress was made, this slowed since the Policy Manager post was vacated.

The Committee understands this is now a regulatory issue within the Learning Disability Service as recommendations for improvement within inspection reports relate to out-of-date corporate policies.

Work is in train to improve this position, including digital solutions, and the Committee will monitor through regular reports.

Clinical Audit 2024

The Committee received year-to-date progress on the Clinical Audit Programme. Firstly, a retendering process is underway for the Dementia Audit and Jersey should be informed during September 2024 when it will be able to join. Secondly, data entry has started for the National Paediatric Diabetes Audit. Thirdly, data entry has started for the Sentinel Stroke National Audit Programme (SSNAP) although coding issues in Jersey have become apparent.

The Committee received reassurance that when HCS have received audit reports, the recommendations are being reviewed to assess their relevance to Jersey, and if relevant, assigning responsibility for implementation and monitoring – this has been a gap in the past.

Safeguarding Report Mid-Year 2024

The Committee received the mid-year report as to how HCS is discharging its safeguarding responsibilities.

Two items were noted for escalation to the Board,

1. **Absence of a paediatrically qualified Designated Doctor on the island**
2. **CAMHS Service**: There are currently 140 children held by CAMHS who should have transferred into adult ADHD services

Infection Prevention and Control

An update on the organisation's performance relating to healthcare associated infections and Infection Prevention and Control for the reporting period January to June 2024 was provided and this reflected a very positive position and HCS was commended upon this.

Staff Flu Vaccination Campaign 2024 / 2025

The Committee received a report outlining the strategy for delivering the influenza and Covid-19 vaccine campaign 2024 / 2025 targeted specifically at healthcare workers in HCS. The primary goal is to achieve high vaccination coverage among healthcare staff to ensure their safety and maintain a robust healthcare system during the flu season and booster campaign.

Approval of funding for the vaccination programme was given by the HCS Senior Leadership Team during August 2024.

The Committee will receive regular monitor reports.

Jersey General Hospital Pharmacy (External) Review

The Committee received the report and discussions focussed on accountability for the implementation and monitoring of actions. It was agreed that this Committee would receive regular reports on the pharmacy improvement programme.

Secondly, the Committee agreed it was important to communicate that the review was commissioned because of members of staff speaking up. Pharmacy staff are being engaged in a number of different ways following receipt of the report. The Freedom to Speak Up Guardian will provide feedback directly to the members of staff who spoke up.

Board Assurance Framework

The Committee reflected on the discussions and considered whether there was any material impact on the BAF risk.

The reduction in pressure trauma and unwitnessed falls was discussed and the Committee agreed that this does not affect the overall score and remains at 20. However, pressure trauma and unwitnessed falls are a key performance indicator as part of BAF monitoring.

Matters to be escalated to the HCS Advisory Board

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

- Significant reduction in **pressure trauma** acquired in care which evidences real improvement.
- **Serious Incidents**: all open SIs have allocated investigators.
- **CAS Alerts**: The Committee is aware of the large number of overdue alerts but received assurance that the alerts are triaged on receipt and there are no serious issues not being addressed.

- **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.
- **Serious Incidents**: Cross cutting themes have been identified from a review of multiple recommendations. Where appropriate, recommendations are incorporated into improvement plans which follow a 30 / 60 / 90 / 120 review to ensure change is embedded as part of business as usual.
- **Absence of a paediatrically qualified Designated Doctor**
- **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. The Committee thanked those individuals in pharmacy that had the courage to speak up.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Pharmacy Report: Update and Action Plan**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**14**

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 is to provide the Board with an update on the action plan under development in response to the recent Pharmacy Report.			
Summary of Key Messages:	The key messages arising from this report are: • The recent Pharmacy Review has resulted in 59 recommendations to support improvement within the service. • There are challenges in terms of resource to address the recommended improvements. • An action plan has been developed which is attached.			
Recommendations:	The Board is asked to note the contents of the paper.			

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	16 September 2024	Committee and Board Reporting
People and Culture Committee	25 September 2024	

List of Appendices:
Appendix1:

Main Report:

The recent review of Pharmacy highlighted areas for improvement within the pharmacy service.

These were divided into domains in the report that encompass,

- Culture
- Workforce
- Workload
- Education and training

There are 59 recommendations that have been split by the reviewers into short-, medium- and longer-term objectives.

The current proposal is that the model previously well applied to maternity, and which is now being applied to radiology is followed.

It should be noted however that Pharmacy is not like other care groups and sits under the Office of the Medical Director.

The establishment of a functional working group is challenging given low staff numbers and officers to carry the plan forward.

The action plan as developed so far is attached (Appendix 1). Action owners have been assigned but at this stage require agreement and preliminary meetings have been put in place or occurred particularly around the issue of culture.

Finance / workforce implications

The deficiencies in workforce require the use of agency staff to fill gaps.

It should be noted that the new pharmacy structure, that has been spoken of in the pharmacy review, carries no finances.

The Pharmacy Director is an interim and will leave as the end of March 2025.

The Chief Pharmacist is acting into a strategic island role.

Recent agreement on Private prescriptions spoken of in the action plan, has been the subject of recent agreement and resolution, that will improve the longer-term financial position.

Risk and issues

All the above pose a degree of risk to the success of the action plan and finances of Pharmacy.

The largest risk is ability to coordinate the program given the interim nature of senior officers and the issues described above.

Recommendation

The Board is asked to note the action plan attached.

The Board is asked to note the risks in terms of the ability to implement the plan in a timely fashion.

Work is on-going to set up a working group and identify the resources required to implement the action plan in a timely fashion.

END OF REPORT

Pharmacy Review Action Plan

As per Report

	RecID	Recommendation	Timeframe	Agreed/Partially Agreed/Not Agreed	Action(s)	Aim	Lead	Progress last period	Plans next period	Rag	Overall progress	Evidence	Comments
CULTURE	rec1	. Focus on developing an open culture of continuous improvement where staff are empowered to shape the culture of the department, and the services it provides (ongoing recommendation).	Short				KS						
CULTURE	rec2	• Introduce a local, authentic recognition approach to recognise the valuable work of individuals in the department.	Short				KS						
CULTURE	rec3	• Conduct an external positive communication/media campaign on the value of the pharmacy department and services it provides.	Short				Comms/KS						
CULTURE	rec4	• All current and future Job Descriptions should be kept in a publicly accessible space that all staff are aware of.	Short				HR/MS						
CULTURE	rec5	• Review of weekly department meeting and other communication mechanisms to improve communication of messages to the whole pharmacy department.	Short				KS						
CULTURE	rec6	• Introduce monthly coffee with the Chief Pharmacist for all new starters and any established staff as requested	Short				KS						
CULTURE	rec7	Introduce monthly Improvement Board for pharmacy department-open to all staff to be members. Representatives from across the department meet to discuss, review, implement improvement ideas.	Medium				KS/NED						
CULTURE	rec8	• Implement 'You said, we did' approach to feedback from regular Be Heard survey (or alternative feedback mechanism) to ensure staff see action on feedback.	Medium				KS						
CULTURE	rec9	Continue to embed an open culture of continuous improvement where staff are empowered to shape the culture of the department, and the services it provides (ongoing recommendation).	Longer				KS/ SLT						
WORKFORCE	rec10	Ensure additional recently approved resources (7 posts) provide operational roles to manage operational pressures.	Short				HR/MS/KS						
WORKFORCE	rec11	• Appoint appropriate dedicated support staff for pharmacy-specific staff e.g. 3 x pharmacy receptionists, 2 x pharmacy porters.	Short				HR/MS/KS						
WORKFORCE	rec12	• As a temporary/short-term support action, employ remote locum workers that can help reduce the operational burden of staff onsite. They will not be able to 'replace' an on-site member of staff but can deliver significant parts of the workload that releases on-site staff to focus on appropriate activities.	Short				WRVCP/KS						
WORKFORCE	rec13	• Implement leaving interviews for all staff with feedback provided to managers (with Human Resources).	Short				KS/SLT						
WORKFORCE	rec14	• Focus is made to increase the pipeline of future staff. This includes:	Medium										
WORKFORCE	rec15	➢ Increasing the number of student/Pre-Registration Pharmacy Technician places.	Medium				KS/MEL						
WORKFORCE	rec16	➢ Instigating Foundation Trainee Pharmacist places.	Medium				KS/MEL						
WORKFORCE	rec17	• Introduce progression/preceptorship programme for junior pharmacists into senior rotational posts (after completing post training examinations and competencies).	Medium				KS/MEL						
WORKFORCE	rec18	➢ Succession/progression planning is instigated across the department to identify who is being developed as succession for each individual role.	Medium				KS/HRBP						
WORKFORCE	rec19	➢ Introduce assistant supervisor responsible for support and development of pharmacy assistants.	Medium				KS/SLT						
WORKFORCE	rec20	• Develop the capacity planning for aseptic staff- including resources to enhance the Quality Management System.	Medium				KS/ AL						
WORKFORCE	rec21	• Target recruitment of further aseptics staff (especially pharmacists and consider further rotation of middle banding staff). Include QC/QA resource.	Medium				KS/AL						
WORKFORCE	rec22	• Introduce science manufacturing apprenticeship technician training for a pipeline of aseptic staff	Longer				KS/HRBP						
WORKFORCE	rec23	Review the space allocated to the Unit. **	Longer				ECG/NHFP						
WORKFORCE	rec24	• Develop a business case for an electronic Quality Management System (QMS).	Longer				KS/CCIO						
WORKLOAD	rec25	As above point in staffing, appoint 3 x pharmacy receptionists to help manage the telephones and other administrative/reception services to allow pharmacy assistants to undertake dispensing.	Short				KS/HRBP						
WORKLOAD	rec26	• Allow pharmacy assistants to supply stock fridge medicines without a check.	Short				KS						
WORKLOAD	rec27	• Implement a Manager of the Day (MOD) rota within the senior team to give more junior pharmacy staff a clear escalation points each day.	Short				KS						
WORKLOAD	rec28	• Stop dispensing of all private prescriptions (requires support from Medical Director/communications-see External factors).	Short				MHSS/CO						
WORKLOAD	rec29	• Stop dispensing of all outpatient prescriptions for medicines that can be purchased OTC (requires support from Medical Director/communications-see External factors)	Short				KS						
WORKLOAD	rec30	• Expand the use of discharge pre-pack medication across all areas of the hospital where possible (prioritise A and E and surgical wards plus day unit).	Short				KS						
WORKLOAD	rec31	• Ensure all prescribing clinicians have contact numbers registered with switchboard (requires support from Medical Director/communications-see External factors)	Short				KS/MDO						
WORKLOAD	rec32	• Review the need for a late duty rota in the dispensary -organisational change process required after staff investment to ensure a fair and equitable rota and staff can plan for after work activities/duties at a defined work finish time. Suggest staff are involved	Short				KS/SLT						
WORKLOAD	rec33	on an informal basis to co -produce a proposed solution.	Short				KS/SLT						
WORKLOAD	rec34	Implement an Island-wide communication campaign about bringing medicines into hospital if admitted (link with ambulance services, community pharmacies, GP surgeries, nursing homes).	Medium				KS/COMMS						
WORKLOAD	rec35	• Review operations within the dispensary- including use of staff to function as a co-ordinator to deal with patients and other hospital staff coming to the hatches or phoning and reprioritise work coming/ in the department as needs change. This role can be rotated amongst staff during a day freeing up other staff to work in teams to dispense prescriptions in a safe and timely manner without interruption.	Medium				KS/SLT						
WORKLOAD	rec36	• Review the need for bespoke adult nutrition feed bags to release capacity within the Unit.	Medium				KS/ Dieticians						
WORKLOAD	rec37	• Develop a business case for Trust porters to regularly deliver prescriptions and stock medicines to clinical areas freeing up pharmacy assistants to support services and assist in the management of medicines at ward level.	Medium				KS						
WORKLOAD	rec38	• Review the need for an appropriately funded formal weekend rota which would encompass weekend working as part of the core staff contracted hours (options of how to generate rest periods). This could also provide an opportunity to open the outpatient pharmacy service again at weekends to patients which could improve user convenience and satisfaction. Would also require a process of organisational change. Suggest staff are involved on an informal basis to co-produce a proposed solution.	Medium				HR/MS/KS						
WORKLOAD	rec39	• Review and increase the medicines available on the GP prescribing list (longer term action).	longer				KS/CLS						
WORKLOAD	rec40	• Develop Shared-care arrangements for key medications (longer term action in parallel with review of GP prescribing list).	longer				KS/PCB						

EDUCATION & TRAINING	rec41	Identify areas/medicines that junior pharmacists cannot screen (e.g. cancer drugs list) to support juniors. This will require senior staff support.	Short	KS/SLT
EDUCATION & TRAINING	rec42	• Set up screening logs process for new starters (and consider whether updates/refresher logs required).	Short	KS/SLT
EDUCATION & TRAINING	rec43	• Develop an education and training strategy for all staff groups.	Medium	PEL
EDUCATION & TRAINING	rec44	• Develop strategy for use of Independent Prescribing Pharmacist (training numbers over a period and where to deploy).	Medium	PEL
EDUCATION & TRAINING	rec45	• Introduce peer support for managers-such as buddy up mentoring from management point of view with managers across the Trust and/or provide access to coaches.	Medium	PEL
EDUCATION & TRAINING	rec46	• Review the need for any further resilience training (after evaluation of prior sessions)	Medium	PEL
EDUCATION & TRAINING	rec47	• Consultants to cease prescribing for private patients- prescriptions to be taken to community pharmacies.	Short	MHSS/CO
EDUCATION & TRAINING	rec48	• Ensure all prescribing clinicians have contact numbers registered with switchboard (requires support from Medical Director/communications-see clinical workload	Short	KS/MDO
EDUCATION & TRAINING	rec49	• Improve the visibility of waiting times for the length of the queue.	Short	KS/SLT
EDUCATION & TRAINING	rec50	Implementation of Blueteq (process of registering, and reviewing, high-cost medicines to demonstrate patients meet NICE or other locally guidance).	Longer	KS/DPL
EDUCATION & TRAINING	rec51	• In time further development/expansion of the “white list” through legislation amendments to support prescribing and dispensing of some further medicines closer to patient homes.	Longer	KS/CLS
EDUCATION & TRAINING	rec52	• Involve all staff, (to some level) in the design phases for the new hospital (ongoing).	Short	KS/NHFP
EDUCATION & TRAINING	rec53	• Train line managers in the use of relevant HR policies and make sure staff are aware of Policies and kept up to date with any changes. This is anticipated to support the informal and formal ways of working with staff and likely to reduce the level of union activity (ongoing).	Short	SLT/HRBP
EDUCATION & TRAINING	rec54	• Optimise the use of biosimilars and their timely introduction	Short	KS/SMcN
EDUCATION & TRAINING	rec55	• Development of pharmacy/medicines strategy at Trust/Island level for the next three - five years and use as an opportunity to gain staff involvement through co-production.	Medium	DoD/KS
EDUCATION & TRAINING	rec56	• Use the strategy an opportunity to agree a way of resetting the culture for the department.	Medium	DoD/KS
EDUCATION & TRAINING	rec57	• Ensure pharmacy is adequately resourced in terms of space e.g. in accordance with the relevant Health Building Note and considering likely changes such as introduction of gene therapies.	Medium	KS
EDUCATION & TRAINING	rec58	• Develop medicines governance/assurance arrangements to assist in demonstrating compliance with relevant standards/legislation.	Medium	PGL
EDUCATION & TRAINING	rec59	Complete roll out of Pyxis electronic storage to all wards in the Hospital	Longer	DPL/KS
	Total			**0**

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Getting It Right First Time (GIRFT) Report and Action Plan**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**15**

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 Board with the on-going and planned response to the recent GIRFT report in relation to Orthopaedics and Theatres.			
Summary of Key Messages:	The key messages arising from this report are: • The recent GIRFT report made 36 recommendations to improve the productivity and efficiency of the Orthopaedic Department and Theatres Department. • The recommendations will be delivered by the Surgical Care Group as part of business as usual (BAU).			
Recommendations:	The Board is asked to note the report and action plan.			

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	16 Sept 2024	Board reporting

List of Appendices:
Appendix1: Action Plan

MAIN REPORT

In April 2024, the Getting it Right First Time (GIRFT) program visited HCS as part of an invited assessment of the productivity and efficiency of Orthopaedic and Theatre services.

GIRFT is a nationally recognised program from the UK that looks to reduce unwarranted variation to improve productivity and efficiencies. It was incepted and applied initially to Orthopaedics and Theatres in the UK over 20 years ago. Since that time, it has extended into all medical and surgical specialities and is now part of a rolling program of improvement for NHS England.

The report received and published in August highlighted notable practice and commented that Jersey had the potential to become an exemplar organisation if the recommendations are implemented.

There are 36 separate recommendations. Within the UK, GIRFT reports and recommendations are seen as business-as-usual improvement work. They are owned by care groups and carried forward through the quality and safety meetings for assurance to the Board.

The Surgical Care group will own this work and prioritise the recommendations for maximum improvements in quality and improvements to service delivery. This will be fed back to the Quality, Safety and Improvement Board Committee at intervals determined by the chair, for assurance of embedding and progress. The surgical care group have obtained resource to support this work and the recommendations. The workstream has produced one report that is attached.

There was misunderstanding in the report on radiological capability with respect to prostate screening and MRI capability in Jersey. HCS has MRI capability that can determine the presence of prostate cancer. There is not in Jersey or in the UK a Prostate cancer screening process. In the UK there are early trials utilising MRI scanners with specialist MRI software, in an attempt to determine if this would aid prostate cancer screening in the future (rapid scan software). Jersey does not have scanners equipped with this specialist software.

The original GIRFT report and recommendations are attached for reference.

Finance / workforce implications

The surgical care group has resource to cover the workstream.

The actions link to improved efficiencies and productivity and will be balanced against service planning for the coming years.

Risk and issues

There are no immediate risks

Recommendation

The Board is asked to note the GIRFT report, its recommendations and the action plan produced in response.

END OF REPORT

Action Plan - GIRFT Orthopaedics and Theatres Efficiency Recommendations

Task	Workstream	GIRFT Recommendation	Action	Responsibility	Timeline	Status	Notes
1	**Governance**	Develop Task and Finish Groups to lead on the development of an action plan to implement the RNOH/GIRFT recommendations.	a) Allocate responsibilities to relevant people for relevant workstreams b) Regular updates on progress. c) Action plan and presentation of evidence of changes within six months.	SW, SC, JM, WQ; TW, SB, CA, LLM, LB, BS, RB	Complete setup by end of September 2024		6/09/24 Task & Finish Groups have been set up for Governance, Pathways, Orthopaedics, Support Services, Theatre Improvement, and Workforce Strategy.
2	**Governance**	Develop a comprehensive workforce strategy	a) Provide a unified vision across all inpatient and outpatient staffing roles. b) Include succession planning and the development of enhanced and advanced roles.	SW, SC, JM, WQ; TW, SB, CA, LLM, LB, BS, RB	Completed by March 2025		06/09/24 The Workforce Strategy Workstream has been established, focusing on staff development, succession planning, and strategic workforce needs.
3	**Governance**	Increase the number of middle-grade doctor operating lists and training opportunities:	a) Improve morale and prevent deskilling. b) Ensure competence in clinical roles.	JH, SC, ZH, SW, WQ, TW	Completed by November 2024		06/09/24: The Workforce Strategy Workstream is addressing workforce gaps and permanent appointments vs. locums.
4	**Governance**	Review the current workforce	a) Identify gaps in rotas where permanent appointments are needed instead of long-term locums. B) Make substantive posts more attractive. C) Work with HR to consider applicants from overseas.	JH, SC, WQ, TW,	Completed by December 2024		06/09/24: The Workforce Strategy Workstream aims to address this.
5	**Governance**	Review employment contracts	a) Remove limitations to allow weekend and out-of-hours working.		Completed by November 2024		06/09/24: To be reviewed as part of the Workforce Strategy meeting, focusing on weekend and out-of-hours working.
6	**Governance**	Ensure HR supports operational managers	a) Managers should focus only on service requirements, leaving recruitment and other HR tasks to HR		Completed by end of September 2024		06/09/24: This will be addressed in upcoming Workforce meetings, ensuring managers focus solely on service requirements.
7	**Governance**	Review training and development	a) Align with strategic goals. b) Ensure equitable opportunities and access to training. C) Provide opportunities to work in different units both in Jersey and off the Island.		Review progress quarterly; next review in December 2024		06/09/24: Training opportunities are being aligned with strategic goals, and off-island options are under review.
8	**Governance**	Explore strategies to address high absence rates	a) Implement effective strategies to understand and reduce absence rates.		Completed by March 2025		06/09/24: To be addressed in upcoming Workforce Strategy meetings.
9	**Governance**	Improve the management of underperforming employees	a) Explore best practice solutions.		Completed by March 2025		06/09/24: To be addressed in upcoming Workforce Strategy meetings.To be addressed in upcoming Workforce Strategy meetings.
10	**Governance**	Engage the clinical and operational workforce	a) Rapid engagement around the new hospital strategy. b) Help staff understand the impact of a single-site two-model approach on workforce, equipment, and resources. c) Model for theatres to run for 48 weeks of the year, six days a week		Ongoing		06/09/24: Workforce engagement is happening in preparation for the single-site two-model approach, particularly in theatre management
11	**Governance**	Regularly monitor the theatre dashboard	a) Share the dashboard with clinical and operational management to drive improvement.		Ongoing		06/09/24: Regular dashboard reviews are part of Theatre Scheduling and Improvement Group discussions - to be more consistently embedded.
12	**Governance**	Monitor surgeon performance	a) Use the National Joint Registry Data during consultant appraisals.		Processes established by March 2025		Ensure accurate coding and validation of hip surgery data, including correcting discrepancies between Total Hip Replacements and hemiarthroplasties. Following the meeting with BI on 06/09/24, work with them to implement a thorough data review process involving clinical leads and the IT team to prevent future errors. 09/09/24 - Progress is being made on integrating National Joint Registry (NJR) data, with Clinical Audit actively working on the development of accurate data capture and validation processes. A compliance officer visit is also part of this process to ensure that all data meets regulatory standards. However, the data is not yet at the stage where it can be used for appraisals. The focus remains on establishing reliable data flows, ensuring accuracy, and preparing systems for full integration into appraisals.
13	**Pathways**	Optimize the Maxims EPR system	a) Review the current list of procedures. b) Minimize the use of free text to support scheduling and improve reporting structures. c) Strengthen data visibility and ownership across the pathway. d) Collect outcome measures and benchmark against English averages.	IT Department with Clinical Teams	Completed by December 2024		Ensure accurate coding and validation of hip surgery data, including correcting discrepancies between Total Hip Replacements and hemiarthroplasties. Following the meeting with BI on 06/09/24, work with them to implement a thorough data review process involving clinical leads and the IT team to prevent future errors. 09/09/24 Following discussions on 06/09/24, the EPR system is being reviewed with Health Informatics for coding improvements.
14	**Pathways**	Review the Pre-Operative Assessment (POA) service	a) Identify opportunities to develop a broader MDT team approach, including geriatrics and diabetes input.	POA Lead with MDT (including geriatrics, diabetes specialists).	Completed by December 2024		
15	**Pathways**	Introduce a phone call service before surgery (TCI)	a) Ensure patients are fit and have followed POA instructions. b) Embed the "Make Every Contact Count" principle to minimize on-the-day cancellations.		Completed by January 2025		
16	**Pathways**	Establish a pool of standby patients	a) Fill gaps in theatre schedules promptly to optimize theatre capacity.	Theatre Scheduling Team.	Completed by December 2024		
17	**Pathways**	Review the 6-4-2 theatre scheduling meeting	a) Embed the GIRFT Theatre Scheduling guide. Use trend data to inform the meetings	JH, SC, WQ, TW, LB, AT, RB	First review by October 2024		
18	**Pathways**	Regularly review theatre data	a) Present data to identify unwarranted variation.	JH, SC, WQ, TW, LB, AT, RB	Ongoing		
19	**Pathways**	Improve theatre productivity and flow	a) Develop full-day operating without breaks in lists. b) Increase blended public/private all-day sessions. c) Implement Golden Patient principles. d) Review job plans, especially for anaesthetists and orthopaedic surgeons. e) Optimize workflows through the day case pathway. f) Increase day case activity to 85%. g) Allocate porters to ensure smooth patient flow.	JH, SC, WQ, TW, LB, AT, RB	Completed by March 2025		06/09/24: Full-day operating and "Golden Patient" principles are being reviewed in the Theatre Improvement Group (11/09/24). 09/09/24: HVLC pathways are being explored as part of the Orthopaedics Workstream.
20	**Pathways**	Consider moving Trauma sessions to the afternoon	a) Allow ward rounds in the morning. B) If sessions remain in the morning, plan trauma lists the previous day	SC, All Consultants, JH, WQ, RB	Confirm schedule by October 2024		A tentative agreement was reached at the Ortho Consultant meeting on 08/08/24 with Chief of Service - Surgery to move Monday PM Trauma sessions starting from 07/10/24. Action: SC to Confirm the dedicated trauma list timing with all consultants and finalize the trauma week timetable. Discussions on establishing a trauma week timetable suggest the need for clear scheduling (7:30 am trauma meetings, post-take ward rounds, trauma list at 8:30 am, and fracture clinic at 1:00 pm). This was detailed by CC, and SC AND is expected to follow up with a draft timetable by early September. Action: sc Finalize the trauma week timetable, including clear start and end times, PA allocations, and operational logistics.10/09/24: Ring-fencing orthopaedic beds and full utilization of the surgical floor are up for discussion.
21	**Orthopaedics**	Increase the use of day surgery	a) Utilize HVLC care pathways and deliver care outside traditional theatre settings where appropriate		Completed by January 2025		
22	**Orthopaedics**	Optimize elective care surgery	a) Ensure the surgical floor is fully utilized. b) Implement a ring-fenced methodology for orthopaedic beds		Completed by February 2025		
23	**Orthopaedics**	Develop a full Multi-Disciplinary Team (MDT) for orthopaedic surgery	a) Include dedicated orthopaedic physio resources and occupational health.		Completed by March 2025		06/09/24: MDT development for orthopaedic surgery to be explored, focusing on adding physio and occupational health resources.
24	**Support Services**	Establish a single area for surgical admissions	Reduce late starts and theatre turnaround times		Completed by January 2025		06/09/24: Discussions to explore reducing late starts and improve flow through a unified surgical admissions area. This will be picked up within the Surgical Pathways Optimisation Group and also Theatres Improvement Group.
25	**Support Services**	Develop Enhanced Care models	a) Increase the clinical threshold for patients on inpatient wards. b) Reduce the demand on critical care.		Completed by March 2025		06/09/24: To be addressed in the upcoming Support Services meetings. (11/09/24)

26	**Support Services**	Optimize the Sterile Services Department (CSSD)	a) Address the shortage of kit, washers, and sterilizers. b) Ensure all equipment is cleaned and sterilized by Sunday afternoon		Completed by March 2025		06/09/24: Equipment shortages and flow issues are being reviewed in the Support Services & Medical Devices and Equipment workstream. 06/09/24 Conduct a gap analysis and prioritize equipment needs by March 2025 -WQ, JT 06/09/24 Meeting held with RB, LB, WQ, LL, RM to Review trays and make decisions on replacements or alternatives - ongoing. 06/09/24: Need identified to develop the role of a Biomedical Engineering Manager. 09/09/24: Meeting scheduled 12/09/24 to discuss nest steps for completing and reviewing the asset register.
27	**Medical Devices & Equipment**	Upgrade the MRI scanner	a) Ensure the software is suitable for screening prostate cancer.		Completed by March 2025		
28	**Medical Devices & Equipment**	Centralize the purchasing function	a) Reduce expenditure on medical supplies. b) Continue price benchmarking and regular stock takes		Completed by December 2024		06/09/24: Centralization and cost reductions are being pursued through the HCS Centralised Purchasing with some involvement by the Medical Devices Workstream.
29	**Workforce**	Expand the skills of radiographers	a) Enable out-of-hours MRIs for suspected CES		Completed by March 2025		
30	**Workforce**	Increase theatre operation days	a) Ensure theatres run for 48 weeks of the year, 2.5 sessions a day, six days a week.		Initial check-in by November 2024		06/09/24: Theatre efficiency improvements are being driven by Scheduling and Improvement meetings.
31	**Workforce**	Improve the efficiency of Beauport ward	Maximize the usage of the 14 ring-fenced orthopaedic beds.		Review progress by December 2024		06/09/24:The need to focus on maximizing the use of the 14 ring-fenced orthopaedic beds will be picked in int the Surgical Pathwyas Optimisation Group
32	**Workforce**	Amend contracts to enable paid weekend working	Focus on physiotherapy and occupational therapy teams		Completed by December 2024		06/09/24: To be discussed in Workforce Strategy meetings.
33	**Workforce**	Undertake a workforce review	a) Determine the number of staff required. B) Reduce reliance on long-term locums. C) Review the management of physiotherapy referrals		Completed by March 2025		06/09/24: To be discussed in Workforce Strategy meetings.
34	**Workforce**	Address low morale in the occupational therapy team	a) Review where these teams should sit in the organizational structure		Completed by March 2025		06/09/24: To be discussed in Workforce Strategy meetings.
35	**Workforce**	Improve communication and planning between teams	a) Ensure effective use of time and resources.		First review in November 2024		Ongoing collaboration to improve cross-team planning and resource use.
36	**Workforce**	Review litigation claims annually	a) Include expert witness statements, panel firm reports, and counsel advice. c) Ensure claims are triangulated with learning themes from complaints, inquests, and serious incidents		First review by January 2025		

GETTING IT RIGHT FIRST TIME

Orthopaedics and Theatre Efficiency Review

Government of Jersey Health and Community Services

July 2024

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to identify areas of improvement in the orthopaedic service and in theatre efficiency at Jersey General Hospital to address long waiting times and ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets and to

Written by:

Professor Tim Briggs: NHS England Director of Clinical Improvement and Elective Recovery, Chair of GIRFT Programme and Orthopaedic Consultant at RNOH
Graham Lomax: National Implementation Director, GIRFT Programme
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Contents

Executive Summary

This report follows a review of orthopaedic services and theatre efficiency at Jersey General Hospital (JGH) in April 2024. All staff, both clinical and operational, were very open and honest in providing views on where they felt there were challenges and recognised that there is a real opportunity to improve services. All were enthusiastic about embracing changes in practice, if this would improve services for their local population.

We saw excellent facilities, with many examples of good practice. This confirms our view that JGH has an opportunity to become an exemplar hospital, which will improve care for all patients and encourage additional private patients to use the facilities.

We have identified opportunities for and areas of change to practice that will increase activity by maximising the use of existing resources and assets. There are procedures that should be performed in an outpatient procedure room by default, not inpatient theatres, which would bring JGH into line with GIRFT's 'Right procedure, right place' approach'.

There are opportunities to optimise pathways and increase the number of cases performed per theatre session. These include day case pathways and job planning for staff across the whole of the week to maintain activity across 5-6 days. We found that the staff are willing and excited about the challenges to use the data they have, to effectively identify variation and drive change to improve services.

In total there are 36 recommendations in Section 2 of this report, and we now need to see all of them taken forward at pace to enhance services and improve care. These changes will improve the resilience of elective surgery throughout the year, including in the winter months. JGH need to ensure elective care is delivered 48 weeks per annum. This will have a positive impact on reducing waiting times for patients in both outpatients and for those patients requiring admission for orthopaedic services. Implementing the GIRFT recommendations and guidance will increase throughput and provide capacity to repatriate services from the mainland.

Professor Tim Briggs CBE MBBS(Hons), MD(Res), MCh(Orth), FRCS, FRCS(Ed),
Director of Clinical Improvement and Elective Recovery - NHS England
Chair of The GIRFT Programme, Consultant Orthopaedic Surgeon RNOH.

1. Introduction

Getting It Right First Time (GIRFT) is a national programme in England developed by the GIRFT national team under the chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the chairmanship of Professor Tim Briggs, was commissioned by the Government of Jersey Health and Community Services (HCS) to review their current processes and procedures to improve Orthopaedics services and Theatre Utilisation at Jersey General Hospital. The intention of a critical friend review is to add an external and objective perspective, and to share good practice observed at other Trusts in the UK.

The aim of the project was to:

- Provide support to the development of the theatres dashboard;
- Review Orthopaedic surgery services; benchmark the services against recognised benchmarks in England to identify unwarranted variation and make recommendations for improvement; and
- Review the theatre data collected by Jersey HSC, observe theatres and their surrounding systems in practice and make recommendations for improvement.

The RNOH/GIRFT team undertook a two-day review (Monday 22nd April and Tuesday 23rd April 2024) of the whole elective pathway, specifically of orthopaedics, although observations of other specialties such as ophthalmology and urology were made within JGH too. As part of the review, we met with stakeholders and teams involved in all aspects of the delivery of elective activity at JGH through a combination of structured meetings and observations.

The RNOH/GIRFT review team are grateful for the input of all the staff we met during the review and the time they devoted to the process. All provided an open and honest view of the challenges, but also all felt there was a real opportunity to improve services.

We compiled and reviewed data analysis from three strands of data; two of these strands were questionnaires completed by clinical and ancillary staff relating to the provision of services, pathways and workforce. The third strand related to the orthopaedic service data. This involved combining JGH private and public patient data, Hospital Episode Statistics (HES) and other relevant registry or professional body data.

The range of orthopaedic metrics included:

- Population metrics – patient age profile;
- Key performance indicators – elective orthopaedic activity, length of stay of key procedures, one year return for another procedure analysis, one year and two year revision rates;
- Adult emergency repair of emergency fracture neck of femur activity;

- Surgeon data (number of surgeons and volume of cases including those undertaking low volumes).

This report details the methodology, findings and recommendations arising from the data analysis, deep dive engagement and on-site evidence gathering on orthopaedic and theatre services. We have made 36 recommendations in the report, which we strongly encourage the JGH Executive Team to implement via a Task and Finish group. The first of our recommendations is therefore:

Recommendation 1: JGH to develop a Task and Finish Group to lead on the development of an action plan to implement the RNOH/GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. The RNOH/GIRFT team would expect an action plan and presentation of evidence of changes over the next six months.

2. Table of Recommendations

No.	RNOH/GIRFT Recommendations
1	JGH to develop a Task and Finish Group to lead on the development of an action plan to implement the RNOH/GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. The RNOH/GIRFT team would expect an action plan and presentation of evidence of changes over the next six months.
2	JGH should seek to develop a comprehensive workforce strategy ensuring it provides a unified vision across all inpatient and outpatient staffing roles including the need for succession planning and the development of enhanced and advanced roles.
3	JGH should increase the number of middle grade doctor operating lists and available training opportunities to improve morale and prevent deskilling, ensuring this doctor cohort remain competent in their clinical roles.
4	JGH should undertake a review of the current workforce and identify gaps in rotas where there should be a permanent appointment rather than using long term locums. JGH to consider how to make substantive posts more attractive to staff and work with HR to consider applicants from oversees (particularly where an assessment of comparable training is required to assess whether applicants meet the application criteria).
5	JGH should carry out a review of employment contracts and remove any limitations to allow weekend and out of hours working.
6	HR and department managers should work together to ensure that managers only have to focus on the requirement for the service, leaving the rest to HR. This will reduce the impact on operational delivery.
7	JGH should review Training and Development across all roles to ensure they align with their strategic goals and provide equitable opportunities and access to training. Ensure staff have access to working in different units in Jersey and also off the Island.
8	JGH should explore effective strategies to understand and address the high absence rates.
9	JGH should explore best practice solutions to improve the management of underperforming employees.
10	JGH should ensure that there is rapid engagement of the clinical and operational workforce around the new hospital strategy. This is to help them understand the impacts of a single site two model approach on workforce, equipment and resources and modelling for theatres to run for 48 weeks of the year, 6 days a week.
11	JGH to further share the dashboard with clinical and operational management and monitor the data regularly to drive improvement.

12	JGH to monitor surgeon performance in consultant appraisals using the National Joint Registry Data.
13	JGH should: • Work with clinical and operational teams to optimise Maxims, review the current lists of procedures, minimise the use of free text to support scheduling and improvements to cases per session and improve reporting structures. • Understand trends using existing data. • Strengthen data visibility and ownership across the pathway. • Collect outcome measures and benchmark against English averages, identifying unwarranted variation and areas of improvement.
14	JGH should review the pre-operative assessment service to identify opportunities to develop a broader MDT team approach, including the input of geriatrics, diabetes etc.
15	JGH should introduce a phone call service to confirm TCI and ensure that patients are fit and have followed their POA instructions etc. We would recommend alongside the pre-TCI calls that opportunities to make every contact count are embedded and teams are encouraged to move from closed questions to open dialogue that can provide patients opportunities to seek clinical input where they may feel that surgery may no longer be required. This will minimise the number of on the day cancellations.
16	JGH should establish a pool of standby patients to fill gaps in theatre schedules promptly, especially when there are cancellations or unexpected openings. This will optimise theatre capacity and ensure efficient use of resources.
17	JGH should review the structure and function of the 6-4-2 theatre scheduling meeting and embed the GIRFT Theatre Scheduling guide. Use trend data to inform the meetings to provide greater insight and intelligence to drive decision-making.
18	JGH should regularly review and present theatre data to identify unwarranted variation.
19	JGH should: • Develop full day operating where appropriate without breaks in lists to maximise the operative time that is available and use a rotation model to ensure all members of the team can take a break but at staggered times. • Increase the number of blended public / private sessions all day sessions. • Implement Golden Patient principles (first on list with auto-send). • Review all job plans, especially for anaesthetists and orthopaedic surgeons, to ensure the best use of elective wards and that beds are fully utilised. • Optimise workflows to ensure efficient patient flow through the day case pathway. This includes pre-assessment, admission, surgery, and discharge. • Increase day case activity, 85% of surgery should be a day case. • Allocate porters to ensure smooth patient flow, timely equipment setup, and efficient room turnover between procedures.
20	JGH should consider moving Trauma sessions to the afternoon, thereby allowing ward rounds to occur in the morning, and better enabling efficient planning for the sessions. **FOLLOWING POST REVIEW FEEDBACK:** If JGH seek to keep the trauma theatre sessions in the AM the following should be put in place: • Agreement that the trauma list is planned the previous day (and time is provided to do this) with a clear golden pt who is not changed to allow prep / consent etc. • That either: ○ The Consultant covering the trauma list is either Job planned to start earlier so that ward rounds can be completed prior to the trauma list starting (planned start time).

	○ Second consultant (or other suitable surgeon) is able to start first case while the consultant covering trauma is completing ward rounds ○ List consultant (trauma) and post take for trauma are managed on independent rosters.
21	JGH to deliver a 'perfect week' aligning with GIRFT specialty standards: cases per theatre session.
22	JGH should undertake a rapid review of the ophthalmology pathway and should consider: • Ceasing routine use of anaesthetists in LA cataract lists; upskill the MDT to deliver blocks where they are needed. • Moving to topical anaesthesia as a default for all suitable cases. • Reviewing ophthalmologists job plans to ensure that operating sessions are protected from pressures. • Reviewing the pre-theatre time to ensure sufficient time is available to review and consent patients; this may be on the day or the day prior to the planned list. • Optimising the pathway to increase the number of cataracts per theatre list: GIRFT specialty standards: cases per theatre session.
23	CSSD should work with JGH to develop an improvement plan focussed on improving flow and kit by: • Reviewing the data in relation to delays and cancellations to inform the potential case for extended opening hours for the facility. • Increasing the number of deliveries to six times a day and introduce 'blue light priority' to drivers at the delivery point. • Addressing the shortage of kit; trauma trays, washers and steriliser. • Ensuring the equipment is cleared each day and by Sunday afternoon ALL equipment has been cleaned and sterilised ready for the next week. • Exploring effective strategies to improve staff morale, address the high absence rates and solutions to better manage of underperforming employees.
24	JGH should establish a single area for surgical admissions to reduce late starts and theatre turnaround times (ideally with close proximity to the theatres).
25	JGH should develop the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff thereby reducing the demands on critical care. (https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-care)
26	JGH should embed the GIRFT Orthopaedic Outpatient Guidance to promote greater adoption of virtual reviews, reduce DNA's and drive Patient Initiated Follow Up (PIFU) whilst ensuring that there are robust mechanisms in place for such patients to gain timely access back into secondary care. JGH should consider adopting GIRFT Outpatient Guidance across other specialties Outpatients - Getting It Right First Time - GIRFT.
27	JGH should validate waiting lists and ensure that patients on waiting lists are communicated with regularly.
28	JGH should increase the use of day surgery, HVLC care pathways and, where appropriate, delivery of care outside of a traditional theatre setting (Right Procedure, Right Place).
29	JGH should: • Adopt a "ring fenced" methodology. • Ensure a maxim of day surgery by default. • Ensure top decile length of stay. • Ensure consultant job planning throughout the week including on Mondays and Fridays to deliver the maximum utilisation of ring-fenced beds.

30	JGH should increase the number of days that theatres are running to ensure that theatres are running for 48 weeks of the year, for 2.5 sessions a day on 6 days a week.
31	Beauport ward to be used more efficiently to maximise capacity, which is currently 14 ring-fenced orthopaedic beds. Whilst we fully support a ring fenced ward, the ward usage must be maximised further. Once the ward has been fully maximized, JGH may want to review the number of beds.
32	JGH should: • Identify those on government contracts and amend the contracts to enable paid working 7 days per week for the physio and occupational therapy teams. Currently weekend working is voluntary and relies on a good-will basis and a day off during the week is given in lieu to compensate. • Undertake a review of the current workforce and identify gaps in rotas where there should be a permanent post to reduce reliance on long term locums. • Review the management of referrals to physiotherapy; proper triage and better communication can help prevent unnecessary referrals. • Work with the occupational therapy team to address the low morale and review where these teams should sit in the organisational structure. • Carry out an annual audit of the PROMS data to identify unwarranted variation and areas for improvement.
33	JGH should establish a full Multi-Disciplinary Team (MDT) for orthopaedic surgery which should include use of the dedicated orthopaedic physio resource through the full patient pathway. The MDT should also include Occupational Health resources at the appropriate time. All revisions must be discussed in the MDT.
34	JGH should: • Undertake a workforce review to determine the number of staff required to provide an efficient service. Further work needs to be done to reduce long term locums and to make substantive posts more attractive to staff; • Consider expanding the skills of their radiographers to allow out-of-hours MRIs for patients presenting with suspected CES. This should be completed within 3-6months. Once a MRI for suspected CES has been performed it can be sent digitally to Southampton for their opinion. • Improve communication and planning between teams to ensure effective use of time and resource; • Undertake a review of current equipment and upgrade where necessary. We were told that the equipment is old and the software on MRI scanner requires updating as currently it is not possible to screen for prostate cancer.
35	JGH should: • Work with the corporate procurement team to centralise the purchasing function and reduce the expenditure on medical supplies. • Continue price benchmarking exercise, comparing data against that of NHS Supply Chain and England Trusts. • Carry out regular stock takes of inventory, including regular checking for expiration dates on implant fixtures.
36	JGH should undertake an annual review of litigation claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. The meetings should be led by senior clinicians and attended by clinical staff and junior doctors (e.g. clinical governance or multidisciplinary meetings), with support from trust legal teams. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed.

3. Jersey HCS Organisational Structure

The organisational structure of Health & Community Services (HCS) within Jersey is characterised by Care Groups, each led by a Chief of Service supported by a Lead Nurse and General Managers. Lead Nurses and General Manager's report to the Chief of Service, who in turn reports to the Managing Director. The Clinical and Professional Care Groups, some of which operate in partnership with external entities, are organised into the following key Care Groups:

- **Mental Health Services**
- **Adult Social Care**
- **Medical Services**
- **Surgical Services**
- **Primary, Preventative and Immediate Care** *with Adult Therapies and Community Dental*
- **Women's, Children's and Family Services**

The Surgical Services Care Group (SSCG) oversees a bed capacity of 74 surgical inpatient beds within JGH, including 7 intensive care beds. Additionally, the Day Surgery Unit (DSU) consists of 28 beds for patients undergoing surgical day case procedures. Daily operational bed counts are subject to fluctuations owing to various operational factors. SSCG employs a Surgical Flow Coordinator who works to create capacity across surgical wards for both emergency and elective patients, collaborating closely with operational teams, clinical site staff, ward staff, ICU and theatres. The hospital is equipped with 6 main operating theatres of which 3 are laminar flow, with an additional two theatres dedicated to day surgery units alongside a minor ops suite. For endoscopic procedures, the hospital has two endoscopy theatres, situated within the Aubin ward.

4. Private Patient Services in Jersey HCS

Private Patient Services in HCS generated £12.2 million in 2023 and caters to both patients with private medical insurance and those who self-fund their healthcare.

Approximately 30% of the population, over 30,000 individuals, have private healthcare insurance. SSGC's private work generates income to support service delivery costs, helps to reduce waiting times and consequently helps to increase public capacity. The availability of private practice is considered crucial to attracting consultants and practitioners to work in Jersey.

Private patient services encompass inpatient, day case and outpatient treatment and provide access to intensive care, pathology, radiology, physiotherapy, endoscopy, audiology and clinical investigations within JGH. Sorel ward is a private patient's ward specifically designed for private patients with 14 beds. However, it is also used in emergencies for infection control management purposes in line with operational procedures and hospital escalation policies.

5. General Findings and Recommendations

This section includes findings and recommendation that are relevant to both the orthopaedics and theatre review.

5.1 Workforce

The Island has challenges due to the size of JGH which results in different models for delivery of care compared to those that we may see and make recommendations on when reviewing services within a provider in England. This is primarily seen where teams must be able to cover a wider range of specialities or sub specialisations than we would see in providers in

England who, due to specialisation of services will have teams who support smaller areas of practice. The teams we spoke to have worked hard to overcome these challenges with some excellent recruitment of staff within theatres to address challenges in this area.

The theatre team are all multi-skilled across the theatre practitioner roles (Scrub, Anaesthetics and Recovery) and are trained to work across all elective and non-elective specialities, including on call. This provides a high degree of resilience within theatres; however, delivering this type of workforce requires far more training time for new starters than would be usual in hospitals where the theatre workforce is split into distinct specialities. They still require agency staff within theatres but this is viewed as necessary in order to provide the needed capacity to fully develop the new team. The theatre team are also looking to develop Surgical First Assistants within theatres, to provide additional resilience and support to the surgical medical teams where middle grades or fellows may not be available to support a list. These roles will ensure that theatre productivity and efficiency is increased or maintained where these lists may typically have been just consultant only previously.

We observed some excellent examples of role development and innovative approaches to workforce development. However, we observed some inconsistency between departments, rather than there being a clearly defined organisational workforce strategy. This included development of non-medical (nursing and AHP) practitioners and nurse consultants. However, as these had been developed at speciality level, we felt there was more opportunity to standardise practice and ensure that enhanced and advanced nursing and AHP roles were fully utilised to the top of their licence. This would provide significant opportunity for on-island career progression, would support specialities where medical input was scarce and support the development of minor surgical services which could be nursing or AHP led (such as the use of surgical care practitioners). It would also provide additional capacity by removing lower complexity surgery from medical workloads so that their skill set could be targeted at more complex activity.

Given the challenges on the Island in terms of workforce resilience and the potential for 'single points of failure', a clear focus on a more strategic approach to workforce development would support the services in the short, medium and long term.

Recommendation 2: JGH should seek to develop a comprehensive workforce strategy ensuring it provides a unified vision across all inpatient and outpatient staffing roles including the need for succession planning and the development of enhanced and advanced roles.

The orthopaedic workforce for JGH is detailed in **Figure 1.**

Figure 1 Orthopaedic Workforce JGH

	Total no. persons	Total persons doing out of hours on-calls	Total WTE employed
Consultant	3 (2)	3	3 (2)
SAS/career staff grade	1 Associate Specialist 4 Middle Grade	5	5
Nursing/PA Band 8	1	-	1
Nursing/PA Band 7	2 (specialist nurses)	-	2
Nursing/PA Band 6	1 ward manager		
Nursing/PA Band 5	2.8 deputy		2.8

We were told that the middle grade doctor surgical lists had been reduced or reallocated and given to consultants who would perform the surgical tasks more quickly. This has had a negative impact on staff morale and has deskilled middle grade doctors and increased the risk of them leaving Jersey for other opportunities. We felt that if this happened, recruitment to these vacant posts would be difficult.

Recommendation 3: JGH should increase the number of middle grade doctor operating lists and available training opportunities to improve morale and prevent deskilling, ensuring this doctor cohort remain competent in their clinical roles.

We were also told that there is a relatively high use of locums, agency staff and interims. Given the high cost of these and a need for a more permanent workforce to ensure continuity, the board need to develop a strategy to ensure on-going recruitment.

Recommendation 4: JGH should undertake a review of the current workforce and identify gaps in rotas where there should be a permanent appointment rather than using long term locums. JGH to consider how to make substantive posts more attractive to staff and work with HR to consider applicants from oversees (particularly where an assessment of comparable training is required to assess whether applicants meet the application criteria).

We heard that some of the pay and grading arrangements in place are not supporting the workforce models required. For example, we heard that physiotherapists and occupational therapists are on civil service contracts which limits the ability to support on-call rotas, especially at weekends, which are required for these roles. Currently, appropriate weekend cover relies on a good-will, voluntary basis. This is neither sustainable nor cost effective.

Recommendation 5: JGH should carry out a review of employment contracts and remove any limitations to allow weekend and out of hours working.

We were told that more could be done by HR to support recruitment and that recent changes in the recruitment system mean that departmental managers now have to spend much more time on the recruitment process themselves which impacts on their other work.

Recommendation 6: HR and department managers should work together to ensure that managers only have to focus on the requirement for the service, leaving the rest to HR. This will reduce the impact on operational delivery.

Expanding staff's knowledge and experience by working in different units can be incredibly beneficial. This provides opportunities to broaden skill sets and learn different pathways and specialties across different environments.

We were told about inconsistencies in the training and development offered to staff and that this has an impact on morale.

Recommendation 7: JGH should review Training and Development across all roles to ensure they align with their strategic goals and provide equitable opportunities and access to training. Ensure staff have access to working in different units in Jersey and also off the Island.

For some of the areas we met, we were told that absence rates were quite high.

Recommendation 8: JGH should explore effective strategies to understand and address the high absence rates.

In the areas we covered we were told that performance management of underperforming staff could be improved. It was felt that in some areas there was a reluctance to tackle these issues.

Recommendation 9: JGH should explore best practice solutions to improve the management of underperforming employees.

5.2 New Hospital Strategy

There was significant variation in the extent to which colleagues were engaged or even aware about the plans for the new hospital development. We heard about the strategy for either a single or two site option, with an acute and ambulatory model. We understand that the need for rapid engagement with the clinical and operational teams was fully recognised; clearly this will be critical in terms of planning and delivering a successful transition. It was positive to hear that as part of the plans there was an understanding for the need to increase the number of Minor Operative Procedure rooms (MOPs). We observed a number of cases being undertaken in main theatres that could safely be moved into these environments to release core capacity. We highlighted that MOPs would require investment in equipment and staff to ensure the full realisation of the benefits.

Recommendation 10: JGH should ensure that there is rapid engagement of the clinical and operational workforce around the new hospital strategy. This is to help them understand the impacts of a single site two model approach on workforce, equipment and resources and modelling for theatres to run for 48 weeks of the year, 6 days a week.

5.3 Data and Digital

RNOH/GIRFT identified unwarranted variation across several metrics detailed in the GIRFT orthopaedic data pack. The detail around this variation and the recommended improvements can be found in the Orthopaedics Action Plan in **Annex A.**

JGH have developed a theatre dashboard that allows consultants and managers to review clinical activity and performance outcomes. RNOH/GIRFT Chief Data Analyst, Ed Bramley-Harker met virtually with the Jersey data team to provide insights and advice about improving the theatre dashboard. He found that the dashboard uses a comprehensive cohort of key metrics that identifies activity and measures outcomes. On the visit, we saw less evidence of operational and clinical teams using the data to inform planning and review actual versus planned utilisation. We encourage the data team to keep engaging with clinical and operational teams and to explore how data can be made more easily accessible and used consistently to inform planning and review of throughput.

Recommendation 11: JGH to further share the dashboard with clinical and operational management and monitor the data regularly to drive improvement.

JGH are due to start recording orthopaedic data on the National Joint Registry (NJR). RNOH/GIRFT supports this and encourages JGH to analyse the reports on performance outcomes in joint replacement surgery. All surgical consultants should show all their practice data at their annual appraisal, including their JGH patient and private practice data. In addition, all consultants should sit down with their colleagues who carry out joint replacements and share their data to learn from each other.

Recommendation 12: JGH to monitor surgeon performance in consultant appraisals using the National Joint Registry Data.

JGH has recently adopted Maxims as the electronic patient record (EPR) solution for the Island. Throughout the visit, the challenges with this system were highlighted by all staff groups, either through a feeling of lack of training on the system to be able to use it correctly,

or where there was a perception that Maxims did not support effective working and flows across all stages of the pathway. We heard of issues with the use of intended procedures not directly relating to the surgery that was intended by the surgeon, due to the way in which the theatre reports were collated. This made it more challenging to ensure lists were well booked and the checks on kit etc. were made. There is clearly some optimisation work that needs to be supported to ensure that the system is working for clinical and operational teams. We would strongly encourage a review of the current list of procedures to ensure that these are relevant and agreed with the surgical teams to minimise the use of free text. This will also mean that procedure time data will become more valuable to support scheduling and improvements to cases per session by being more understandable and accurate for clinical staff on what procedure is intended.

The staff we spoke to highlighted the challenges with Maxims and e-listing for clinicians which they felt was taking significantly longer than with the previous systems. There also appeared to be a lag when new procedure codes were required, and as highlighted earlier we would suggest that this is an area of focus.

Recommendation 13: JGH should:

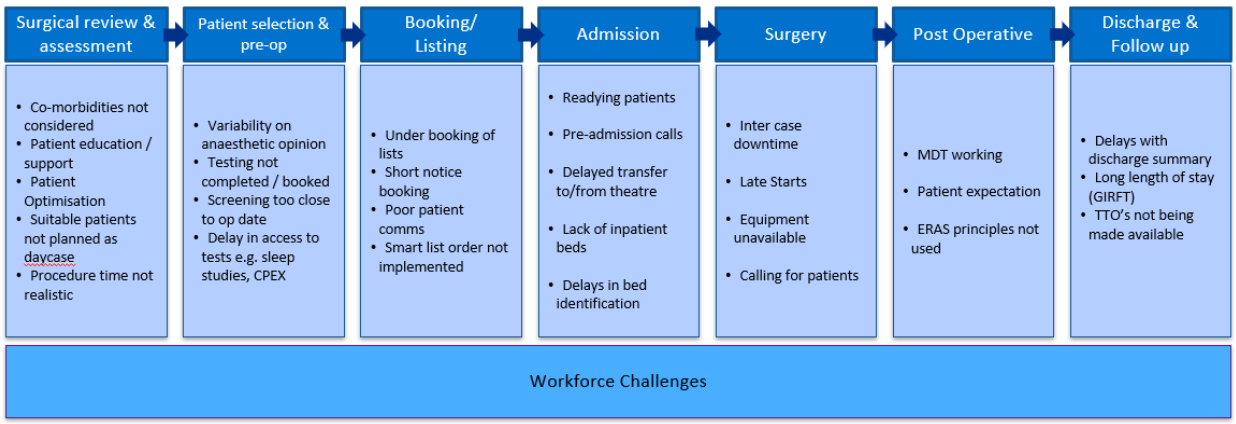
- **Work with clinical and operational teams to optimise Maxims, review the current lists of procedures, minimise the use of free text to support scheduling and improvements to cases per session and improve reporting structures.**
- **Understand trends using existing data.**
- **Strengthen data visibility and ownership across the pathway.**
- **Collect outcome measures and benchmark against English averages, identifying unwarranted variation and areas of improvement.**

6. GIRFT Theatre Pathway Review Findings and Recommendations

This section lays out the findings and recommendations arising from the review of Theatre productivity by the RNOH/GIRFT Theatre Review team.

Theatre productivity is influenced at all stages of the theatre pathway which is represented below in Figure 2.

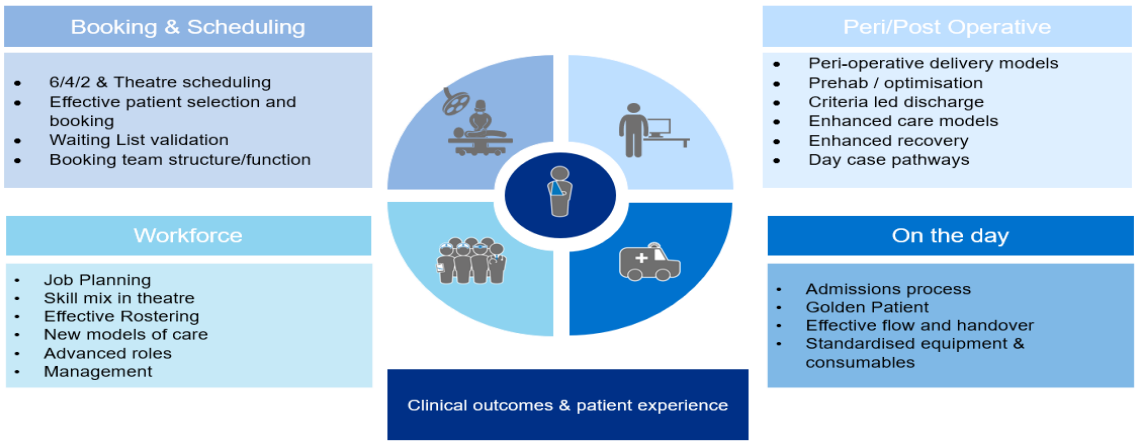
Figure 2: Theatre Productivity Pathway



6.1 Area of Focus

The team focussed its review on the areas shown in Figure 3.

Figure 3 Areas of focus of the theatre efficiency review:



6.2 Selecting and preparing patients

6.2.1 Pre-operative Assessment

The pre-operative assessment (POA) service is located on a separate site by the Airport. The unit is primarily nurse led and three sessions of consultant time has recently been added to the service (not formally funded). The team appeared to be well engaged in delivering the service in line with the five core standards for early screening and risk assessment. POA pull patients directly from the waiting list and triage patients to either face to face or telephone assessments alongside identifying those patients where a formal POA is not required e.g. Local Anaesthetic (LA) cases, etc. There was an acknowledgement that there remained some work to be done in ensuring non cancer patients are only provided with a “To Come In” (TCI) once passed fit, though considerable progress has already been made, for which the team should be commended. The outcomes of POA and optimisation are entered into Maxims to support prioritisation. There is currently no formal geriatric support to POA, which would further enhance development of the service and ensure that optimisation opportunities are expanded to drive further improvements in length of stay and day surgery rates.

Recommendation 14: JGH should review the pre-operative assessment service to identify opportunities to develop a broader MDT team approach, including the input of geriatrics, diabetes etc.

6.2.2 Theatre Booking

There are five booking clerks responsible for the booking of public patients within the organization. Private booking is done separately. The team aims to book theatre lists out to four weeks, with urgent cases aiming for a TCI within four weeks of listing, ‘soons’ in 3-5 months and then chronologically for routines. The booking clerks have regular meetings with their consultants to discuss and plan lists, which appears to work well. The team were concerned about the move to limit public inpatient admission to 4 males and 4 females per day and there was a meeting planned for later in the week to discuss how this would be managed.

There is a text reminder service in place that sends texts at 1 week prior to TCI and 3 days prior, but this is one way rather than two way, and we understood that this is not fully deployed. Due to the levels of on the day cancellations where “procedure is not required” or “patient did not attend” we would recommend that a phone call service is established. This would be to confirm TCI and that patients are fit and have followed their POA instructions to help minimise these on the day cancellations. The high levels of DNA also indicate that patients do not feel that there is an opportunity to go back to their clinical team when their symptoms may have changed or when they do not feel that surgery is the correct option.

Recommendation 15: JGH should introduce a phone call service to confirm TCI and ensure that patients are fit and have followed their POA instructions etc. We would recommend alongside the pre-TCI calls that opportunities to make every contact count are embedded and teams are encouraged to move from closed questions to open dialogue that can provide patients opportunities to seek clinical input where they may feel that surgery may no longer be required. This will minimise the number of on the day cancellations.

As Jersey HSC are making good progress with moving to patients being passed fit prior to a TCI being offered, we recommend that consideration is given to developing lists of patients who are willing to take short notice cancellation appointments or implementing standby patients (in effect overbooking theatre lists). Also, JGH could make an offer for patients that if they are not operated on, they are guaranteed a date in the following 4-6 weeks. An outline of these processes can be found in the GIRFT Theatre Booking Guide.

Recommendation 16: JGH should establish a pool of standby patients to fill gaps in theatre schedules promptly, especially when there are cancellations or unexpected openings. This will optimise theatre capacity and ensure efficient use of resources.

6.2.3 Theatre Scheduling

During our visit we were able to observe a cut down version of the 6-4-2 meeting, which was chaired by the anaesthetic lead and had representatives from booking, specialities and theatres. The meeting reviewed upcoming lists and list allocation with some limited look back of previous performance, supported by in house reporting. There was an acknowledgement that lists were, in some cases, planned light but that this was difficult to challenge effectively due to the issues with procedure codes and use of free text.

Whilst we were not able to observe a full meeting, we would recommend that the structure and function of this group is reviewed, in line with the GIRFT Theatre Scheduling guide, and ensure that trend data is more easily accessible to identify trends in performance to identify opportunities for continuous improvement.

Recommendation 17: JGH should review the structure and function of the 6-4-2 theatre scheduling meeting and embed the GIRFT Theatre Scheduling guide. Use trend data to inform the meetings to provide greater insight and intelligence to drive decision-making.

6.2.4 Theatre Data

There was variation with regard to whether Surgeons included anaesthetic time or not in their predicted procedure time. Clearly this variation makes the total predicted utilisation figure inconsistent. In the absence of specific personalised data developed over time, we would recommend adopting a standard of ‘x’ minutes, with all those involved agreeing what the standard number of minutes should be.

From what we observed in the 6-4-2, and from our discussions with various members of the teams, there is a lack of longitudinal trend data to inform the meetings in terms of genuine improvement trends as opposed to simple comparisons with the previous week. We think there is sufficient data to suggest there is a significant opportunity to analyse it and present it in a way that would provide greater insight and intelligence to drive decision-making.

Recommendation 18: JGH should regularly review and present theatre data to identify unwarranted variation.

Clearly, engagement from surgical specialties in the Theatre Utilisation Group is critical, and must be at an appropriately senior level to ensure that rapid decision making, and follow up actions are taken, including direct discussion with individuals when required. As recommended above, the provision of more insightful data trends and correlation should support this engagement.

6.2.5 Theatre Productivity and Flow

6.2.5.1 Theatre session planning

Due to the mixed public and private nature of Jersey's health economy, consultant theatre sessions are currently split between public and private. During the visit we were told that there is a drive to moving these to blended sessions where both public and private patients will be treated on the same lists. This would support more effective use of clinical time. However, teams will need to be mindful of managing capacity between the two streams to ensure neither is disadvantaged. Sessions are 3.5 hours as standard, with some all-day operating; however, where this occurs, the list breaks for lunch, which can lead to reduced productivity across the full day. Consideration should be given, as part of the move to blended sessions, to developing full day operating where appropriate. This will maximise the operative time that is available and this move should also explore ensuring lists do not routinely break for lunch through staggering breaks for staff groups. Where anaesthetic capacity is a constraint to delivering this, the team can consider scheduling a local anaesthetic case during the session to release the anaesthetic team for their break.

We were told that the anaesthetists and surgeons start work at different times, resulting in a delay to theatre start times. There are also delays in transitioning patients from the ward to the operating theatres.

Recommendation 19: JGH should:

- **Develop full day operating where appropriate without breaks in lists to maximise the operative time that is available and use a rotation model to ensure all members of the team can take a break but at staggered times.**
- **Increase the number of blended public / private sessions all day sessions.**
- **Implement Golden Patient principles (first on list with auto-send).**
- **Review all job plans, especially for anaesthetists and orthopaedic surgeons, to ensure the best use of elective wards and that beds are fully utilised.**
- **Optimise workflows to ensure efficient patient flow through the day case pathway. This includes pre-assessment, admission, surgery, and discharge.**
- **Increase day case activity, 85% of surgery should be a day case.**
- **Allocate porters to ensure smooth patient flow, timely equipment setup, and efficient room turnover between procedures.**

6.2.5.2 Trauma Theatre

Currently trauma is scheduled each morning, with an additional afternoon session on Fridays. There are significant challenges with efficiency of these lists, particular in relation to start times.

Recommendation 20: JGH should consider moving Trauma sessions to the afternoon, thereby allowing ward rounds to occur in the morning, and better enabling efficient planning for the sessions.

FOLLOWING POST REVIEW FEEDBACK:

If JGH seek to keep the trauma theatre sessions in the AM the following should be put in place:

- **Agreement that the trauma list is planned the previous day (and time is provided to do this) with a clear golden patient who is not changed to allow prep / consent etc.**
- **That either:**
  - **The Consultant covering the trauma list is either Job planned to start earlier so that ward rounds can be completed prior to the trauma list starting (planned start time).**
  - **Second consultant (or other suitable surgeon) is able to start first case while the consultant covering trauma is completing ward rounds**
  - **List consultant (trauma) and post take for trauma are managed on independent rosters.**

6.2.5.3 Cases per session

We observed several lists that were delivering far fewer cases per session than we would expect (other areas such as orthopaedics and urology were already delivering good cases per session). Whilst we understand that there were several factors that were impacting this, ensuring we make best use of our operative sessions is critical if we are minimise waiting lists. As staffing recruitment is now almost complete, as is the associated training of the team, we recommend that the theatres team, working with specialty teams start to plan for events in theatres. For example a 'perfect week', where all teams work in collaboration to deliver to the GIRFT recommended cases per session or where, if these do not exist, they look at productivity differentials in weekend lists as an opportunity to make productivity gains through sessions.

Recommendation 21: JGH to deliver a 'perfect week' aligning with GIRFT specialty standards: cases per theatre session.

6.3 Cataract Surgery

We were informed that Jersey HSC has allocated approx. £100,000 for a 12month project to drive down the ophthalmology waiting list. This will be done by transferring 500 patients requiring cataract surgery to Southampton for their treatment.

GIRFT and the Royal College of Ophthalmologists recommend a minimum of 8 cataracts per 4 hour theatre session on a training list (10 on a non-training list). This includes all but the very highest complexity procedures. We would recommend a rapid initiative with the whole ophthalmology team to understand what would need to be in place to achieve these standards. We also noted that all lists include the provision of a consultant anaesthetist. This is contrary to standard practice in the vast majority of NHS units, and the GIRFT pathway recommends topical anaesthesia. Where there are requirements for GA cases, these would normally be cohorted into specific lists. There was a clear view expressed from a senior anaesthetist that this wouldn't be possible; however, we would recommend that analysis be undertaken to explore the possibility.

In the interim, there did however appear to be an opportunity to increase cases by ensuring adequate pre-theatre time is allocated for the review of patients. This would enable a reduction in theatre time that could increase cases per session. The theatre and anaesthetic team felt this would be a positive initial step. There is also an opportunity to look at job plans for the

ophthalmologists to ensure that operating sessions are protected from pressures such as being on call, which the management team reported as being one of the barriers highlighted by the ophthalmology team.

Recommendation 22: JGH should undertake a rapid review of the ophthalmology pathway and should consider:

- **Ceasing routine use of anaesthetists in LA cataract lists; upskill the MDT to deliver blocks where they are needed.**
- **Moving to topical anaesthesia as a default for all suitable cases.**
- **Reviewing ophthalmologists job plans to ensure that operating sessions are protected from pressures.**
- **Reviewing the pre-theatre time to ensure sufficient time is available to review and consent patients; this may be on the day or the day prior to the planned list.**
- **Optimising the pathway to increase the number of cataracts per theatre list: GIRFT specialty standards: cases per theatre session.**

6.4 Sterile Services

The Central Sterile Services Department (CSSD) is located offsite approximately 1.5 miles away from the hospital. We were told that this creates a problem with tray turnaround which then has an impact on the time it takes to process trays that have bodily fluids dried on them.

The department is open 16.5 hours a day, Monday to Friday 6:00am – 10:30pm; Saturday from 7:00am to 4:00pm and Sunday 7:00am to 12:00pm. There are 5 deliveries each day and we were told that there are delays with delivering and collecting equipment as the drivers often have to wait in a queue at the hospital delivery point. This results in delays of up to 45 minutes.

The service is operated by 14 production staff. The team turnaround an average of 1000 IMS trays, 800 supplementary devices, 180 washer cycles and 45 steriliser cycles per month. Some of the devices are loaned from the mainland. There are currently 5 washers and 3 sterilisers. We were told that CSSD requires two additional washers and one additional steriliser to provide an efficient service. They say space for extra equipment is at a premium; however, it is essential that this space is identified at both the hospital and CSSD site. There is only one trauma tray, therefore this tray takes priority over the elective timetable.

We were told that the team has good retention rates and delivers an in-depth training programme. However, we were also told that that there are some workforce challenges within the department; staff are on manual worker contracts, there is long term sickness within the department and 9 of the 14 members of the team are being performance managed due to high absence rates. As written in the workforce section of this report, RNOH/GIRFT recommend that JGH should explore best practice solutions to improve the management of underperforming employees and address high rates of absence. A workforce review is being carried out and has identified that the service would require an uplift of 3 WTE's to deliver a sustainable, effective service.

We were informed that there are pressures with kit because two lower limb consultants operate on the same day. When reviewing the job plans, this will need to be considered.
We were also informed that there is a plan to increase private work at the weekends especially Saturday. It is essential that the CSSD workforce are valued as they are critical to its success. Furthermore, some of the "profit" from private practice at the weekend should be utilised to pay for extra hours for CSSD staff to work on Saturdays and Sundays. This would ensure that

all equipment from the week is processed and sterilised so that on the Monday morning everyone starts with a clean sheet.

Recommendation 23: CSSD should work with JGH to develop an improvement plan focussed on improving flow and kit by:

- **Reviewing the data in relation to delays and cancellations to inform the potential case for extended opening hours for the facility.**
- **Increasing the number of deliveries to six times a day and introduce 'blue light priority' to drivers at the delivery point.**
- **Addressing the shortage of kit; trauma trays, washers and steriliser.**
- **Ensuring the equipment is cleared each day and by Sunday afternoon ALL equipment has been cleaned and sterilised ready for the next week.**
- **Exploring effective strategies to improve staff morale, address the high absence rates and solutions to better manage of underperforming employees.**

7. Surgical Wards and Environment Findings and Recommendations

7.1 Surgical Admissions Lounge (SAL)

There are clear advantages to having a single area for surgical admissions to reduce late starts and theatre turnaround times, and typically we would recommend this where it's possible, ideally in close proximity to the theatres. We were told that it had been trialled but wasn't considered to be necessary. A data driven root cause analysis in relation to cancellations and delays should be used to drive this consideration and whether the introduction of this area could reduce cancellations. We heard about frequent delays at multiple admission locations. However, there are other ways to mitigate these issues through process and communication. For example, there is an excellent forward wait area in main theatres that does not appear to be routinely used. Using this more systematically, encouraging surgeons to ask for the next patient to be sent for when they are approaching the end of their current procedure, would be a simple step to take.

Recommendation 24: JGH should establish a single area for surgical admissions to reduce late starts and theatre turnaround times (ideally with close proximity to the theatres).

7.2 Enhanced Care

GIRFT recommend the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff. This reduces the demand for Critical Care beds, which are a scarce resource. We heard about various cohorts of patients currently being treated in CCU for whom this would be relevant (e.g. non-invasive ventilation patients). We referred to the example of Enhanced Care in Cornwall, which is a model we would suggest JGH considers.

Recommendation 25: JGH should develop the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff thereby reducing the demands on critical care. (https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-care)

8. Orthopaedics Review Findings and Recommendations

This section lays out the findings and recommendations arising from the review of orthopaedic services.

8.1 Outpatients

Orthopaedic outpatient flows occur in two ways. Patients can be seen in the private setting by consultants and then referred in for public treatment or patients can be referred to the hospital outpatient department. Orthopaedic outpatient services are delivered in the Gwyneth Huelin Wing. Orthopaedic outpatient clinics are carried out by consultants and middle-grade doctors. Approximately 10 patients are seen in each 4-hour session, 7 of the appointments being for new patients and 3 for follow up appointments.

Improving this element of the service, by reducing the number of follow up appointments where appropriate, thereby freeing up capacity for new patients, would reduce pressure on the constrained outpatients. GIRFT have produced guidance to standardise clinical prioritisation, thereby optimising outpatient capacity and resources in outpatients to improve patient pathways and experience. We were told that appointments were lost due to DNA's.

Recommendation 26: JGH should embed the GIRFT Orthopaedic Outpatient Guidance **to promote greater adoption of virtual reviews, reduce DNA's and drive Patient Initiated Follow Up (PIFU) whilst ensuring that there are robust mechanisms in place for such patients to gain timely access back into secondary care. JGH should consider adopting GIRFT Outpatient Guidance across other specialties** Outpatients - Getting It Right First Time - GIRFT.

Recommendation 27: JGH should validate waiting lists and ensure that patients on waiting lists are communicated with regularly.

8.2 Day Surgery

The Day Surgery Unit (DSU) current opening times are between 6:00am -8:00pm. To maximise the use of the unit, JGH should extend the opening hours to 10:00pm, allowing operating up to 6:00pm. The DSU is an excellent facility with many examples of good practice. The procedure room had a high specification, and there were various procedures in main theatres that could be safely undertaken in the procedure room, whilst there were procedures taking place in the procedure room that could be performed in a standard outpatient room. Moving operations down the gradient of care is a core aim within GIRFT's Right Procedure Right Place programme, as it makes better use of estates, releasing core capacity for other patients.

Recommendation 28: JGH should increase the use of day surgery, HVLC care pathways and, where appropriate, delivery of care outside of a traditional theatre setting (Right Procedure, Right Place).

8.3 Elective Care Surgery

Currently the surgical floor is being utilised for non-elective flow with elective admissions being made across the private patient and elective ward. During the visit we were informed of the plans to re-establish the surgical floor as the main admissions area for public inpatient admissions (excluding orthopaedics) with an initial cap of 4 male and 4 female beds planned to be ring fenced. Consideration needs to be given to the theatre schedule and case types being planned throughout the week to ensure that this does not result in a bottle neck where patients with long lengths of stay are front loaded into the week, which will result in potential for beds to become a constraint later in the week.

Recommendation 29: JGH should:

- **Adopt a "ring fenced" methodology.**
- **Ensure a maxim of day surgery by default.**
- **Ensure top decile length of stay.**
- **Ensure consultant job planning throughout the week including on Mondays and Fridays to deliver the maximum utilisation of ring-fenced beds.**

Beauport Ward is an orthopaedic and trauma unit with 14 ring fenced beds. We were told that orthopaedic elective surgery does not take place every day and at the time of our visit (Monday), we only observed two patients on the ward.

Recommendation 30: JGH should increase the number of days that theatres are running to ensure that theatres are running for 48 weeks of the year, for 2.5 sessions a day on 6 days a week.

Recommendation 31: Beauport ward to be used more efficiently to maximise capacity, which is currently 14 ring-fenced orthopaedic beds. Whilst we fully support a ring fenced ward, the ward usage must be maximised further. Once the ward has been fully maximized, JGH may want to review the number of beds.

8.4 Therapies and Radiology

The outpatient physiotherapy workforce is detailed in **Figure 4.**

Figure 4 Outpatient physiotherapy workforce

	Total no. persons	Total WTE employed
Grade 11	4	3.3
Grade 10	9	5
Grade 9	1	1
Grade 6	1	1

The aquatic therapy workforce is detailed in Figure 5.

Figure 5 Aquatic therapy workforce

	Total no. persons	Total WTE employed
Grade 11	1	0.5
Grade 10	vacancy	0.5
Grade 8	1	0.8

Patients from secondary care, primary care, rheumatology, lymphedema and pain clinic (just Aquatic therapy) are seen in the above services. It is not a standalone service for the trauma and orthopaedic department.

The physiotherapy team comprises of 10.3 WTE's, of which 3 are locums who have been employed for a number of years. The service operates 08:30am-5:30pm on Monday to Friday and 9:00am-5:00pm on a weekend. Weekend cover is predicated on staff volunteering, on a good will basis.

The occupational therapy team comprises 3 Occupational Therapists and 1 Rehab Support Worker. We were told that some of the occupational therapy service's main challenges are due to inappropriate referrals from primary care and an increase in activity due to the recent

rheumatology review. The morale within the team was extremely low. We were told that the team sits under a different service area and tends to work as a silo.

The therapy teams are regularly collecting EQ-5D index patient reported outcome measures (PROMS) data; however, the data is not currently being submitted to a national registry and therefore the team are unable to benchmark their outcomes against other providers. There are plans in place for JGH to join the NJR, which will enable the team to measure their clinical outcomes.

Recommendation 32: JGH should:

- **Identify those on government contracts and amend the contracts to enable paid working 7 days per week for the physio and occupational therapy teams. Currently weekend working is voluntary and relies on a good-will basis and a day off during the week is given in lieu to compensate.**
- **Undertake a review of the current workforce and identify gaps in rotas where there should be a permanent post to reduce reliance on long term locums.**
- **Review the management of referrals to physiotherapy; proper triage and better communication can help prevent unnecessary referrals.**
- **Work with the occupational therapy team to address the low morale and review where these teams should sit in the organisational structure.**
- **Carry out an annual audit of the PROMS data to identify unwarranted variation and areas for improvement.**

Recommendation 33: JGH should establish a full Multi-Disciplinary Team (MDT) for orthopaedic surgery which should include use of the dedicated orthopaedic physio resource through the full patient pathway. The MDT should also include Occupational Health resources at the appropriate time. All revisions must be discussed in the MDT.

The radiology service is available between 08:30am-5:30pm on Monday to Friday. The team provides urgent and emergency examinations outside these hours, and some MRI and ultrasound examinations in the evenings and at weekends. The on call out-of-hours service relies on staff volunteering to cover the service. We were told that there are recruitment challenges within the service and work has been carried out to recruit from overseas. Approximately 65% of the team are employed under a locum contract.

Cauda Equina Syndrome (CES) is a spinal surgical emergency which can lead to lower limb paralysis and loss of bowel, bladder and sexual function if not assessed and treated urgently. The GIRFT report showed that more than 20% of litigation claims for spinal surgery in England relate to CES. When acute CES is suspected, timely diagnosis is crucial, and there should be access to a 24/7 MRI imaging service in these cases. Once a MRI for suspected CES has been performed, it can be sent digitally to Southampton for their opinion.

We were told that there is a substantial amount of time spent waiting to see patients from other departments. Improving communication between the teams and better planning and preparation will reduce this waiting time and enhance the service.

We heard that the scanning equipment is old and the software on the MRI scanner requires updating as it is currently not possible to screen for prostate cancer.

Recommendation 34: JGH should:

- **Undertake a workforce review to determine the number of staff required to provide an efficient service. Further work needs to be done to reduce long term locums and to make substantive posts more attractive to staff;**

- **Consider expanding the skills of their radiographers to allow out-of-hours MRIs for patients presenting with suspected CES. This should be completed within 3-6months. Once a MRI for suspected CES has been performed it can be sent digitally to Southampton for their opinion.**
- **Improve communication and planning between teams to ensure effective use of time and resource;**
- **Undertake a review of current equipment and upgrade where necessary. We were told that the equipment is old and the software on MRI scanner requires updating as currently it is not possible to screen for prostate cancer.**

9. Procurement

The purchasing of medical equipment and supplies is devolved across various teams with a reliance on a self-serve function via JGH requisitioners for non-managed stock and a team of buyers within Five Oaks who manage the managed inventory stock (clinical and non-clinical) purchasing function. The Directorate is also supported by limited procurement expertise resource provided by the current Treasury and Exchequer Commercial Services function to undertake complex and high-risk procurement activity.

The annual budget for non-pay expenditure for HCS medical equipment and supplies is £8.6m. (The budget and respective spend does not include the purchase of HCS capital replacement equipment which is funded separately via the HCS Capital Equipment programme budget).

A strategy paper is in development that aims to improve the service and reduce expenditure by centralising the purchasing function to build resilience including investment in the development of existing HCS buyers and requisitioners who possess the knowledge and experience. Current activity is also focused around maximising the opportunities to purchase via platforms such as NHS Supply Chain. We fully support this initiative.

Recommendation 35: JGH should:

- **Work with the corporate procurement team to centralise the purchasing function and reduce the expenditure on medical supplies.**
- **Continue price benchmarking exercise, comparing data against that of NHS Supply Chain and England Trusts.**
- **Carry out regular stock takes of inventory, including regular checking for expiration dates on implant fixtures.**

10. Litigation Claims

Figure 6 shows the number of orthopaedic litigation claims and the costs associated with the claims for publicly funded patients.

Figure 6

Year	Number of orthopaedic claims	Cost of Orthopaedic Claims
2021	8	£180,000
2022	11	£400,000
2023	5	£20,000

*This is not a complete reflection of orthopaedic claims as this data does not include private patient claims.

Recommendation 36: JGH should undertake an annual review of litigation claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. The meetings should be led by senior clinicians and attended by clinical staff and junior doctors (e.g. clinical governance or multidisciplinary meetings), with

support from trust legal teams. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed.

Annex A - Orthopaedic Action Plan

Metric	Meeting Outputs	Actions / Recommendations
Fixation method for elective hip replacements (%) – Patients 70+ years	High usage of uncemented hip fixations being used in patients over 65+ years.	At least 80% of patients over 70 years of age should be receiving a fully cemented or hybrid hip replacement. This is compliant with the standardised Hip replacement in HVLC endorsed by the BOA.
Elective joint procedure for adults (cases)	Primary hip replacement – 160 Revisional hip replacement – 14 Primary knee replacement – 77 Revisional knee replacement – 6 Primary shoulder replacement – 8 Revisional shoulder replacement – 0 Ankle procedures are referred to Southampton.	Annual peer review of the NJR data to be carried out at subspecialty level with all consultants present and documenting of this should be integral to the continuation of Consultant Practicing Privileges. All revisions and primary, elbow and ankle replacement cases to be discussed in appropriate MDTs prior to surgical intervention.
Elective joint replacement length of stay (days)	Primary hip replacement – 3.2 Revisional hip replacement – 6.6 Primary knee replacement – 3.1 Revisional knee replacement – 3.7 Primary shoulder replacement – 5.5	Review shoulder replacement length of stay data, this could be coding issue. Consider whether hip and knee replacement day case surgery could be more broadly used for some patient groups.
Primary hip - return in one year	High primary hip return to theatre rates approx. 5-6%.	Undertake review of all orthopaedic readmission surgery data to identify themes, understand outcomes and establish an improvement strategy. This to be audited on an annual basis,
Primary hip - 1-year revision rate	Slightly high 1-year primary hip revision rates.	Undertake review of primary hip revision surgery data to identify themes, understand outcomes and establish an improvement strategy.
Primary hip - 2-year revision rate	Good 2-year primary hip revision rates.	
Primary knee - length of stay (days)	Good length of stay for primary knee procedures, better than the England average.	

Primary knee - return in one year	Good primary knee return to theatre rates, better than the England average.	
Primary knee - 1-year revision rate	Good primary knee 1-year revision rates, in line with the England average.	
Primary knee - 2-year revision rate	Good primary knee 2-year revision rates, in line with the England average.	
Primary knee - arthroscopy in previous year	Good primary knee - arthroscopy in previous year rates.	
Primary shoulder - length of stay (in days)	Outlier in terms of high primary shoulder length of stay rates.	Undertake review of primary shoulder length of stay data. There is a small volume of primary shoulder activity recorded, it may skew the data if one patient has a longer length of stay.
Primary shoulder - return in one year	Outlier in terms of high primary shoulder return to theatre in 1-year rates (approx. 17%).	Undertake review of primary shoulder return to theatre rates to identify themes, understand outcomes and establish an improvement strategy.
Average length of stay (days) for repair of emergency fracture neck of femur for years 74 and under	Excellent length of stay rates for repair of emergency fracture neck of femur for years 74 and under, 10 days. England average is 17days.	
Average length of stay (days) for repair of emergency fracture neck of femur for years 75 and older	High length of stays rates for repair of emergency fracture neck of femur for years 75 and older. We were told that there are delays with discharging the trauma patients because the community package of care is not available.	Undertake a review of length of stays rates for repair of emergency fracture neck of femur for years 75 and older to identify themes, understand outcomes and establish an improvement strategy. By implementing the RNOH/GIRFT recommendation of extending therapy services to 7-days and mobilising the patient faster will support in reducing the length of stay for these patients.
Number of orthopaedic procedures carried out by each surgeon	The data identified a variance in procedure volumes and several surgeons doing 5 procedures or less per annum within the totality of their practice.	Undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering less than 10 hip and knee revisions

	We were told that the middle grade doctor lists were reduced and lists were given to specialist grade doctors that would perform the surgery quicker. This has had a negative impact on staff morale and deskilling middle grade doctors. The national guidelines for totality of practice in certain procedures recommend the following: • Unicompartmental Knee Replacement: no less than 12 procedures a year per consultant (referenced by the NJR as best practice). • Ankle replacements: a minimum of 10 a year (BOFAS).	over three years should no longer be performing this surgery. Operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications and cost.

Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	**Board Assurance Framework**		
Date of Meeting:	26 September 2024	**Agenda Item:**	**16**

Executive Lead:	Chris Bown, Chief Officer HCS
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 August 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**: remains at 12 (although likely to increase) - **Finance**: remains at 25 The People and Culture Committee and Finance and Performance Committee deferred from August to 25 September, therefore any changes to the relevant sections of the BAF will be reflected in subsequent reports.			
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	August / September 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 28 August 2024. The Committee reflected on the discussions and considered whether there was any material impact on the BAF risk.

The reduction in pressure trauma and unwitnessed falls was discussed and the Committee agreed that this does not affect the overall score and remains at 20. However, pressure trauma and unwitnessed falls are a key performance indicator as part of BAF monitoring. Agreement that the level of risk remains 20

Patient Experience: The Quality, Safety and Improvement Committee met on the 28 August 2024. Th level of risk remains 8.

Operational Performance: The Finance and Performance Committee will be meeting on 25 September. The current level of risk remains at 20.

Workforce and Culture: The People and Culture Committee met on 26 June 2024. will be meeting on 25 September. The current level of risk remains at 20.

Finance: The Finance and Performance Committee will be meeting on 25 September. The current level of risk remains at 20.

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 May 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 October 2024.

END OF REPORT

Health and Community Services

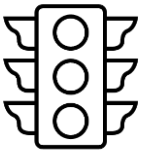
Board Assurance Framework

2024

The content of this report was last reviewed as follows:

Quality, Safety and Improvement Committee	August 2024
People and Culture Committee	June 2024
Finance and Performance Committee	June 2024
Executive Team	June 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**	**16**	↔
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					Finance
Likely 4				People and Culture	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**	28 August 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		
Number of Serious Incidents completed in timeframe	0%	21% to-date		
Number of patients who have had a VTE risk assessment completed within 24 hours of admission	14.5%	12.7%		
Number of medication errors resulting in harm / per 1000 bed days	0.90	1.14		
Number of organisational never events	1	0		
Number of cat 3/4 pressure injury & deep tissue injury acquired in care / 1000 bed days	1.03	3.72		

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**	28 August 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		
Number of Complaints received	68	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**	26 June 2024
Risk ID SR 3	**Risk** Our patients do not receive timely access to the care they need due to delays in treatment.	**JCC Domain**	Awaited	**JCC Outcomes**	Awaited

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

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

Relevant Key Performance Indicators

	Q1	Q2	Q3	Q4
Patients waiting for 1st outpatient appointment > 52 weeks	662	747		
Patient on elective waiting list > 52 weeks	297	264		
Cancer diagnosis				

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

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

					Mental Health and Adult Social Care	
Strategic Objective			We will lead and support a high performing workforce. We will create a well-led and great place to work.		**Overall Assurance Level**	Medium
Monitoring Committee			People and Culture	**Board / Executive Lead**	Director of Workforce, Director of Culture, Engagement and Wellbeing	**Date last reviewed**	26 June 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	**16 (4 x 4)**
Tolerable risk	4
Direction of travel	N/A

Relevant Key Performance Indicators

	Q1	Q2	Q3	Q4
Staff offered TRiM assessment/wellbeing check within 72 hours of incident.	36 wc 12 TRiM	33 wc 9 TRiM		
Staff offered wellbeing support.	152	118		
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. Towards the end of QTR3 succession planning processes to be reviewed for HCS.	Director of Workforce	Oct/Dec 2024
Some staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised	Development of Freedom to Speak Champions to support the work of the FTSUG	Chief Nurse/Director of Workforce	April - July 2024
Absence of an Education Strategy and organisation wide plan detailing education and development needs to upskill existing and future workforce.	Development of an overarching (multidisciplinary) Education Strategy. 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
Limited resource to deliver culture intervention/organisational development	Review resource required for targeted service areas	Director Culture, Engagement & Wellbeing	May- June 2024
Inadequate ICT infrastructure, hardware, and software to access on-line learning.	Executive Leadership to review the level of GOJ supply of ICT infrastructure, Hardware and software to enable staff to access e-leaning v the TNA (Training Needs Analysis) agreed	Director of Digital Health and Informatics (when in post)	June 2024

	with HCS Directors and their managers for e-learning		
Continued staff exposure to violence and aggression by service-users	Review of Violence and Aggression in the workplace policy 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
Absence of a People and Culture Dashboard with relevant KPIs to measure the impact of the Cultural Change Programme.	Development of the People and Culture Dashboard is underway and will be presented to Board June 2024	Director Culture, Engagement & Wellbeing / Director of Workforce	June 2024
An immature restorative and just learning culture	Review of safety huddles post incident. Lessons learned are collected on Datix incident reporting. Further work is required to ensure lessons learned are implemented into practice with a restorative approach.	Director Culture, Engagement & Wellbeing	October to December 2024
Recruitment redesign process	New Workforce Attraction/ Recruitment and Retention Packages being developed in March/April for approval by HCS Executive and the States Employment Board	FRP Change Team	May 2024
GOJ Internship Programme / Patchy take up of internship by HCS managers linked to process.	Undertake regular soundings with HCS Managers throughout the course of the year in advance of the time when Internship opportunities are promoted by GOJ	Director of Workforce	April to Dec 2024
	Dedicated recruitment campaigns for specific services / Developing dedicated nurse cohort recruitment campaigns in QTR 2 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	April – May 2024

Strategic Objective			We will ensure effective financial management through budget planning, monitoring/reporting and delivery of HCS services within agreed financial limits.			**Overall Assurance Level**	Medium
Monitoring Committee			Operations, Performance and Finance Committee	**Board / Executive Lead**	Finance Lead	**Date last reviewed**	26 June 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%		
FRP Delivery	£1.853m	£3.557m		

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

Health and Community Services

Health and Community Services Advisory Board Declarations of Interests: September 2024

HCS is committed to openness and transparency in our work and decision making. As part of this commitment, we maintain and publish this register. The register draws together Declarations of Interests made by members of the Board.

Also, at the start of each board meeting, we ask members of the Board to declare any interests on items on the agenda.

Name	Role	Detail of Interest
Vacant	Chair	N/A
Carolyn Downs CB	Non-Executive Director	Senior Advisor – Newton Europe Consultancy Non-Executive Director – Imperial College Hospital and Westminster Hospital (North East London Collaboration) Non-Executive Member – London Policing Board, Mayor's Office for Policing and Crime
Clare Gerada DBE	Non-Executive Director	Patron – Doctors in Distress Co-Chair – NHS Assembly Non-Executive Director – Cygnet Health (Chair Quality Committee) Lead for NHS Primary Care Gambling Service Senior Partner, Hurley Clinic Co-Founder and Shareholder – eConsult
Anthony Hunter CBE	Non-Executive Director	Chair – Persona Care and Support Limited (Bury) Trustee – St Christopher's Hospice, Sydenham (South East London) Trustee – FND Action (Kent)
Julie Garbutt	Non-Executive Director	Chief Executive – MHA Jersey (Provider of Residential Care for the Elderly) Non-Executive Director / Board Trustee – Citizens Advice Jersey
Christopher Bown	Chief Officer HCS	Nil
Mr Patrick Armstrong MBE	Medical Director	Private Practice – Armstrong Orthopaedic Practice
Jessie Marshall	Chief Nurse	Family Member – Employed within health and Community Services
Andy Weir	Director of Mental Health Services and Adult Social Care	Family Member - Employed within Health and Community Services
Claire Thompson	Chief Operation Officer – Acute Services	Family Member - Works for Venner International who have provided medical consumables to HCS
Dr Anuschka Muller	Director of Improvement and Innovation	Nil
Ian Tegerdine	Director Of Workforce	Registered as a contingent worker with DAC Beachcroft's 'People Pool'. DAC Beachcroft are a UK based law firm which provides services to the GoJ People Team
Obi Hasan	Interim Lead of Finance Business Partnering HCS	Member of the Osteopathic Foundation UK