



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



## AGENDA

**MEETING:** Part A - Health and Community Services Advisory Board  
**DATE:** Wednesday 1<sup>st</sup> November 2023  
**TIME:** 9:00am – 12:00pm  
**VENUE:** Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

	Description	Owner	Time
<b>OPENING ITEMS</b>			
1	Welcome and Apologies	Chair	9:00am
2	Declarations of Interest	Chair	
3	Minutes of the Last Meeting	Chair	
4	Matters Arising and Action Tracker	Chair	
5	Chair's Introductions	Chair	
6	Chief Officer's Report	Chief Officer	
<b>QUALITY AND PERFORMANCE</b>			
7	Quality and Performance Report (Month 9) <ul style="list-style-type: none"> <li>To include a focus on elective theatre utilisation, % triaged within target (majors), % patients waiting over 90 days for 1<sup>st</sup> out-patient (community), new to follow up ratio</li> </ul>	Director of Clinical Service, Director of Mental Health Services and Adult Social Care, Medical Director and Chief Nurse	9:45am
8	Finance Report (Month 9)	Finance Lead – HCS Change Team	10:30am
9	Workforce Report (Month 9) <ul style="list-style-type: none"> <li>To include an analysis of exit interview data</li> </ul>	Associate Director of People	10:40am
10	Serious Incidents Position Statement	Medical Director	10:50am
11	Complaints Position Statement	Chief Nurse	11:00am
12	Waiting List Report <p>To include,</p> <ul style="list-style-type: none"> <li>The progress of the spend of the money allocated to recover the waiting lists (to include reasons for delays).</li> </ul>	Director of Clinical Services	11:10am
13	Job Planning	Medical Director	11:20am
14	Acute Medicine <p>To include,</p> <ul style="list-style-type: none"> <li>a summary of the action plan.</li> <li>a list of the recommendations that HCS intends to enact with timescales</li> </ul>	Director of Clinical Services	11:30am
15	Maternity Improvement Plan (MIP) Workstreams	Medical Director	11:40am



	To include, - Specific progress against targets and cultural issues		
16	Infection Prevention and Control (IPAC)  To include, - Flu / Covid vaccination uptake rates	Chief Nurse and Medical Director	11:50am
<b>GOVERNANCE</b>			
17	Safeguarding Report (Verbal)	Director of Mental Health Services and Adult Social Care	12:00pm
18	Board Timetable 2024	Board Secretary	12:10pm
<b>QUESTIONS FROM THE PUBLIC (Related to Agenda Items only)</b>			
19	<b>Questions</b>		12:15pm
	<b>MEETING CLOSE</b>  Date of next meeting: 6 <sup>th</sup> December 2023		12:30pm



<b>Date:</b> 4 October 2023	<b>Time:</b> 9:30 – 2:30pm	<b>Venue:</b> Main Hall, Dumaresq St, St Helier, Jersey JE2 3RL
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<b>Board Members:</b>		
Professor Hugo Mascie-Taylor - <b>CHAIR</b>	Fixed-Term Chair of the Board	<b>HMT</b>
Christopher Bown	Chief Officer HCS	<b>CB</b>
Carolyn Downs	Non-Executive Director	<b>CD</b>
Anthony Hunter	Non-Executive Director	<b>AH</b>
Patrick Armstrong	Medical Director	<b>PA</b>
Jessie Marshall	Chief Nurse	<b>JM</b>
Claire Thompson	Director of Clinical Services	<b>CT</b>
Andy Weir	Director of Mental Health Services and Adult Social Care	<b>AW</b>
Anuschka Muller	Director of Improvement and Innovation	<b>AM</b>
Cheryl Power	Director of Culture, Engagement and Wellbeing	<b>CP</b>
Steve Graham	Associate Director of People HCS	<b>SG</b>
<b>In Attendance:</b>		
Obi Hasan	Finance Lead – HCS Change Team	<b>OH</b>
Simon MacKenzie	Medical Lead – HCS Change Team	<b>SMK</b>
Cathy Stone	Nursing and Midwifery Lead – HCS Change Team	<b>CS</b>
Beverley Edgar	Workforce Lead – HCS Change Team	<b>BE</b>
Emma O'Connor	Board Secretary	<b>EOC</b>
Bob Scullen	Business Support Officer (Items 1 – 13 only)	<b>BS</b>
Sophie Bird	Head of Communications HCS	<b>SB</b>
David Hopkins	(Interim) Chief of Service Women, Children and Family Care (Item 18 only)	<b>DH</b>
Jonathan Carter	Head of Estates (Item 29 only)	<b>JC</b>

<b>1</b>	<b>Welcome and Apologies</b>	<b>Action</b>
	<p>HMT welcomed all to the meeting, including members of the public and the newly recruited Non-Executive Directors (NEDs). This first meeting with independent members is an important day as the overall purpose is to improve healthcare (as much as possible) for islanders and visitors to the Island.</p> <p>HMT acknowledged the hard work of the Minister for Health and Social Services (MHSS), Deputy Karen Wilson, in establishing this Board. It has been her consistent support and energy which has driven this forward. Unfortunately, the MHSS is unable to attend in person today primarily due to a sitting of the States Chamber but also an episode of illness.</p> <p>The Board will be made up of a Chair, five NEDs and five Executive Directors, all with voting rights. CB is in the process of determining which five Executive Directors these should be, and the proposition will be discussed the Chair and the MHSS.</p> <p>Board meetings will be guided by openness and transparency so that members of the public understand what has been achieved, what cannot be achieved and the future plans for the healthcare services that they fund. All issues will be discussed in a meeting in public unless there is a good reason not to, i.e., legal process, commercial sensitivity or identification of an individual. The meeting will be recorded and minuted, both of which will be available to the public. It was acknowledged that this is a learning process for all. The HCS Change Team have been invited to today's meeting as the papers are a collective contribution.</p> <p>HMT advised that due to the large number of agenda items, all papers would be taken as read and asked Executive Directors to draw the Board's attention to important issues with a focus on outcomes and compliance, rather than a description of process.</p>	

Apologies received from:	
Dr Clare Gerada      Non-Executive Director	CG

<b>2</b>	<b>Meeting in Public - Conduct</b>	<b>Action</b>
<p>Paper taken as read. Noted that primarily, a meeting in public provides an opportunity for members of the public to ask questions (written and verbal).</p> <p>EOC suggested that the written questions should be submitted no later than two working days before the meeting, rather than three, to allow individuals sufficient time to read the papers. The was agreed by the Board.</p>		

<b>3</b>	<b>Declarations of Interest</b>	<b>Action</b>
No declarations.		

4	Minutes of the Previous Meeting	Action
The minutes of the previous meeting held on 10 <sup>th</sup> July 2023 were agreed.		
The minutes of the previous meeting held on 23 <sup>rd</sup> August 2023 were agreed.		

<b>5</b>	<b>Matters Arising and Action Tracker</b>	<b>Action</b>
<p><b>ACTION 49:</b> CB advised this is progressing well – the Project Management Office (PMO) is starting to form. Whilst not all posts are recruited to, CB confident that this will take place. Agreed <b>CLOSE</b>.</p> <p><b>ACTION 47:</b> It was noted that the extraordinary Board meeting on 23<sup>rd</sup> August 2023 was convened to address this (minutes approved in item 4 of this agenda). <b>Agreed CLOSE</b>.</p> <p><b>ACTION 37:</b> HMT has discussed benchmarking with the MHSS, and the view is to find appropriate benchmarks (likely from the UK but, if necessary, elsewhere) and use these to measure HCS against this standard. CT drew the Board's attention to the Maternity paper (item 18 on the agenda) with a proposed suite of metric for Maternity which are in line with UK benchmarks for Maternity Services. CS also advised the Board that HCS is progressing a professional relationship with an integrated care board (ICB) in the UK which receives the majority of HCS patients and benchmarking aligns. CT advised that HCS is confident it has the ability to collect this data and benchmarked information will be available at the Board next month (November meeting). It was agreed that due to the high profile of Maternity Services, the Board will review the Maternity data monthly. Agree <b>CLOSE</b>.</p> <p><b>ACTION 31:</b> OH explained that the lack of budgetary information available to budget holders has been tracked over the last six months. Following the implementation of the new system, access rights were changed. The HCS finance team have been told that work to resolve this has been delayed with a revised timeframe of Quarter 1 (Q1) 2024. The HCS Finance Business Partners have limited access, it is the wider access across HCS that will take time. CB noted this was not a satisfactory position. To mitigate the risk associated with this lack of access, the finance business partners download the information and produce reports for budget holders. However, this is an inefficient (manual) process. OH provided assurance that there is a process in place to hold budget holders to account for management of their budgets including weekly meetings with the care groups and the care group performance reviews. The Board asked to be provided with an update at the meeting in December Remain <b>OPEN</b>.</p> <p><b>ACTION 25:</b> EOC explained that meetings are taking place with the Government of Jersey (GOJ) Internal Audit (IA) to ensure that the terms of reference for the HCS Audit Committee align with the IA function. Following this, the HCS Risk Management Committee Terms of Reference will be reviewed to ensure there is no duplication. Agree <b>CLOSE</b>.</p> <p><b>ACTION 23:</b> SG advised that once the Statutory and Mandatory training Matrix is approved (item 27 on the agenda), this can be shared with the Group Director People and corporate Services</p>		

6 Chair's Introductions	Action
<p>HMT invited both CD and AH to introduce themselves as newly appointed Non-Executive Directors (NEDs).</p> <p>CD informed the Board that she is a recently retired local authority Chief Executive Officer. Previous appointments include,</p> <ul style="list-style-type: none"> <li>• Chief Executive Officer (CEO) of the London Borough of Brent.</li> <li>• CEO of the Local Government Association which is the National Body for all Councils in England and Wales.</li> <li>• Deputy Permanent Secretary at the Ministry of Justice.</li> <li>• CEO of Shropshire County Council</li> </ul> <p>Current posts include,</p> <ul style="list-style-type: none"> <li>• A NED for the largest four acute NHS Trusts in the UK which work as a collaborative in Northwest London and hosted by Imperial College NHS Trust.</li> <li>• A member of the London Policing Board appointed by the Mayor of London to monitor the improvement of the Metropolitan Police.</li> </ul> <p>Anthony Hunter (Tony) informed the Board that he is a Social Worker by background, working in Health and Social Care for the totality of his career in a range of different roles across private, public and charity sectors. Previous posts include,</p> <ul style="list-style-type: none"> <li>• Chief Executive Officer of the Social Care Institute for Excellence, an improvement agency for Social Care and Health, working closely with the Department of Health and Social Care and the Department for Education.</li> <li>• Chair of two Children's Trusts in areas where the responsibility for Children's Social Services had been taken away from the Council for persistent failures.</li> <li>• Director of Social Services in two Councils</li> <li>• Chief Executive in a third Council</li> <li>• President of the Association of Directors of Social Services in England</li> </ul> <p>Current posts include,</p> <ul style="list-style-type: none"> <li>• Chair of the Berry Metropolitan Borough Council Adult Function</li> <li>• NED for a Hospice in Southeast London</li> <li>• NED for a Charity for Functional Neurological Disorder Action UK</li> </ul> <p>Noting CG's absence (see apologies), HMT informed the Board that CG is a General Practitioner and currently the President for the Royal College of General Practitioners (GPs) UK. Previous posts include a plethora of roles across the National Health Service (NHS) at National level.</p> <p>HMT informed the Board that he was a Consultant Physician in Leeds, moving into various management roles including,</p> <ul style="list-style-type: none"> <li>• Medical Director in Leeds (was the largest Trust in the UK at the time).</li> <li>• Interim Chief Executive Officer</li> <li>• Variety of roles in provisioning and commissioning at local, regional and National level. This includes Trust Special Administrator at Mid-Staffordshire.</li> <li>• Clinical governance reviews including Australia, Middle East and most recently, Jersey.</li> </ul> <p>One of the recommendations of the Jersey report is the establishment of this independent Board. HMT's fixed-term contract ends end-November meaning that he will act as Chair at one further meeting. The process to recruit his successor is underway.</p>	

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7	Chief Officer's Report	Action
	<p>CB took the paper as read and advised the Board that the purpose of the report is to summarise the key issues that HCS faces. These issues are covered by fuller reports as part of today's agenda and aim to reflect the three pillars of the HCS turnaround work:</p> <ol style="list-style-type: none"> <li>1. Strengthening of clinical governance and clinical services,</li> <li>2. Financial improvement and financial recovery,</li> <li>3. Cultural change.</li> </ol> <p>The aim of these is to improve health services for the people of Jersey.</p> <p>Both CD and AH thanked CB for the report, noting the issues will be covered more fully later in the agenda. In addition, AH noted it was very useful to understand the issues that matter to CB as the Chief Officer and direct the Boards attention.</p>	

8	Quality and Performance Report Month 8	Action
	<p>HMT suggested that the Board's approach to this report should be those metrics that are continuously red and request a clear plan of action to resolve.</p> <p><b>1. New to follow up ratio (outpatients)</b></p> <p>HMT asked if the standard ratio of 2 is an appropriate benchmark (compared to other health jurisdictions) to which there was agreement. Noting that HCS has never reached this target, HMT asked what is being done about this and when does HCS expect to reach 2. CT advised this is a complex issue attributable to specific specialities (urology and dermatology as examples), the detail of which is presented and discussed at the care groups performance reviews to assure the Executive Directors regarding utilisation of clinical capacity. However, this data is affected by patient pathways in Jersey which require patients to be on a waiting list for annual surveillance (as they cannot be followed up in primary care as would be in the UK). All speciality outliers of this metric are considered as part of the clinical productivity work in support of the financial recovery programme, providing an opportunity to review other health jurisdictions practice.</p> <p>CB asked CT how much of the PTL is impacted by keeping patients on a hospital pathway, rather than discharging to Primary Care as would be common in other health jurisdictions. Secondly, are there specific speciality outliers that can be targeted, the impact of which would see the ratio reduce. In the absence of specific detail, CT is confident that the inability to follow up in Primary care significantly impacts the PTL.</p> <p>HMT suggested that HCS must be clear that there are very good reasons for not meeting targets i.e., HCS should benchmark against other health jurisdictions and if unable to do so, then it must be explained to the Board why not. Following this, if HCS continues to use 2 as the standard benchmark, what is the trajectory to achieve this?</p> <p>CD in support of this approach and adds that it is difficult to ascertain from the report what is improving (difficult to understand any long-term change) and what are the actions being taken. Of all the red metrics, what are the most important issues and what is being done about these? CD suggested that if there is a specific focus on these areas, hopefully an improvement would be noted over the following months which is more motivating for staff to see their efforts making a positive impact.</p> <p>In addition, CD noted her concerns about the quality of the performance data and asked how confident HCS is (as the report seems to imply the opposite).</p> <p>AH said it would also be useful to understand what variance was anticipated and what was the learning, to inform practice in future years.</p> <p>Areas of focus,</p>	

## 1. Elective Theatre Utilisation

## 2. % triaged within target – majors.

CT advised the Board that this data is not correct (as detailed in the exception report) and has received assurance from the care group management team that all patients are being triaged within the defined standard. HMT asked to see the corrected figure in future reports. CT advised there are ongoing discussions with the Clinical lead in the Emergency Department (ED) and the HCS Informatics team as to whether this data can be split according to the different triage categories of majors patients.

## 3. % patients waiting over 90 days for 1<sup>st</sup> OP appointment – community

Although the data is red for acute services, CD noted that community services are much further away from target than acute services. What is the cause of this?

CT advised the Board that the improvement seen in the outpatient community PTL has been achieved through the commission of Community Dental Services for Children (Social Recovery Scheme following Covid). Capacity within the HCS Dental Department is not sufficient to see all children in Jersey. In addition, dental was particularly affected by the impact of infection control measures through Covid. The detail of this work can be found in the paper under item 19 (Waiting List Report). The development of an Oral Strategy for Jersey will be key to understanding what services HCS will need to provide for children which is not currently part of business as usual (BAU) capacity.

CD also remarked that diagnostics is significantly deteriorating. Noting SMKs comment that not all diagnostic functions are captured in this data (excludes radiology), CD asked if this makes the position better or worse. The current wait for routine MRI scan is 44 weeks and CB reported there is a plan to reduce this to 6 weeks by Christmas 2023. Whilst accepting there are areas of challenge and improvement, CT assured the Board that the rise in the diagnostics waiting list is not real and this is a reporting issue following the implementation of Maxims (electronic patient record).

## 4. Rate of emergency readmission within 30 days of a previous inpatient discharge.

CT advised that the deep dive of this metric has been provided at a previous Board (2022). Broadly, HCS benchmarks well. Noting that HCS benchmarks well, CD asked if the target is correct? SMK noted that although HCS was within the benchmark for England, case-mix change is not understood in the absence of coding data.

**ACTION: Copy of the readmission deep-dive to be sent to the NEDs.**

SMK advised the Board that if changes are made to the data, a supplementary paper should be submitted to the Board explaining what has been changed and why, to provide confidence that the Board understands what is being measured. HMT advised that this information is equally important to the management of HCS because if an organisation does not understand or have confidence in its data, how can it be managed.

AH advised the Board that himself and AW have already discussed the key performance indicators (KPIs) to be expected from a well working social care system as the current suite of metrics is under-developed.

**ACTION: AW will lead the work to further develop the suite of metrics for social care, supported by Andy Weir, Director of Mental health services and Adult Social Care. The proposal to be presented at a future Board meeting (date to be advised by AW).**

**ACTION: Executive Directors to review the current suite indicators, standards set and quality of data to provide assurance that the data is meaningful and directs activity (date to be advised by CB).**



**ACTION:** Executive Directors to provide a focus in the next meeting (November 2023) on the areas highlighted above:

- elective theatre utilisations,
- % triaged within target – majors
- % patients waiting over 90 days for 1st OP appointment – community
- New to follow up ratio.

**ACTION:** To determine who is accountable at Executive level for the exception reports detailed at the back of the Quality and Performance Report (December 2023).

CB / SMK gave a brief verbally summary of the work being undertaken with the Informatics Team to ensure that the content and format is appropriate, including the addition of statistical process control (SPC) to better explain any variation. HMT asked that any variation in format of the report is detailed in a paper for the Board to approve.

9	Finance Report Month 8	Action
	<p>OH explained at end Month 8,</p> <ul style="list-style-type: none"> <li>• Overspend of £18.9 million (rising by 2.8 million in-month)</li> <li>• Year-end forecast remains £29 million overspend. Three main drivers of the overspend are pay, non-pay and income.</li> <li>• The true position of the underlying problem is £35 million, which includes non- recurrent funding of £6 million pounds that has been drawn away.</li> <li>• Agency pay is very high to recruitment challenges. There are 205 agency staff against 516 vacancies.</li> <li>• Pay represents an overall £5 million overspend. However, this masks the underlying reality of the pressures which are mitigated by underspends in other areas. Key pressures are in the key clinical services: Medicine, Surgery, Women and Children, Mental Health placements, Social Care packages.</li> <li>• £13 million pound year-to-date overspend on non-pay, increasing to £22 million by year-end. The area of non-pay is made up of a number of large contracts including Mental Health and Tertiary Care.</li> <li>• Opening budget pressures of £13 million pounds. Part of the financial recovery work has looked to discover why this budget was not available to services already being provided.</li> <li>• Income under-achievement of £2.7 million: this has been impacted by theatre underutilisation and reduced bad capacity.</li> </ul> <p>OH highlighted that the finances of the organisation are a consequence of the actions taken to deliver care. The better and more efficient that care be delivered, the better the quality of care delivered which will also directly improve the financial position. This is what the financial recovery programme is based on – a set of core values which looks at the actions that can be taken to improve the quality of care and deliver better value for money. Recruitment of substantive staff is key.</p> <p>The Financial Recovery Plan that has been developed will address the deficit for HCS sustainably over the next three years. An external consultancy firm was used whilst HCS built its own capacity to continue to deliver the FRP over the next three years (those factors within the control of HCS). Of the total deficit, £25 million is within the control of HCS through improvement in process, activity and recruitment. However, £10 million is outside the control of HCS and requires permanent funding – this has been accepted and agreed by Treasury. Key to the delivery of the £25 million over the next three years is culture change, accountability and ownership, and leadership. However, HCS must deliver £3 million in-year savings.</p> <p>CD asked what progress has been made against the £3 million in-year saving target. In addition, noting the low number of reserves, CD also asked if the States of Jersey has larger reserves which can be called upon if a catastrophic event were to occur. Also, has the 2.93 million reserve been frozen in case the three million in-year target is not achieved?</p>	

<p>OH responded that the reserves have been frozen to mitigate the risk of an unforeseen event compromising the £3 million savings.</p> <p>Regarding assurance that there are sufficient reserves that HCS can request in extreme circumstances, CB and AM explained that the Government of Jersey and Council of Ministers (CoM) would determine how central reserves could be used. There was general agreement that a sufficient reserve for HCS would be 10% of its annual budget, £28.6 million.</p> <p>AH noted it is important to remain open and transparent about what would happen if the financial targets were not achieved and how this could impact upon quality of care. OH provided assurance that before any financial recovery scheme is implemented, a quality impact assessment is carried out with clinician engagement. However, it is key to note that there are financial limits to what services HCS can deliver.</p>	
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10	Workforce Report Month 8	Action
	<p>SG took the paper as read and highlighted some key points for the Board.</p> <ul style="list-style-type: none"> <li>There has been a significant increase in the funded establishment over the last 6 months due to Government Plan work and the development of new services. Whilst the number of staff in post has also increased, the differential between the increase in funded establishment and staff in post has led to a higher vacancy.</li> <li>Recruitment is a focus for work and activity with additional capacity to support the recruitment process, redesign of the process and targeted recruitment activity and campaigns. There has been successful recruitment following the redesigned campaigns to attract candidates.</li> <li>The increase in turnover rate can be accounted for by the Junior Doctors rotation in August. The voluntary turnover rate (resignations) is stable at approx. 4%. There is no evidence that there is a larger turnover of staff. However, as there are small teams in Jersey, if an individual leaves, this can have a big impact upon the team.</li> <li>The sickness absence rate has remained constant over the last quarter with the main reason for sickness as coughs / colds.</li> <li>A new system was introduced at beginning of 2023 to record staff appraisal. HCS has and continues to experience system and access issues, leading to a low reported rate of appraisal completion. As of this week, 19% staff have their objectives agreed, with 9% completed the mid-year review. The GOJ HR team are providing a lot of support to HCS to overcome these issues.</li> </ul> <p>HMT invited JM to give an overview of nurse recruitment.</p> <ul style="list-style-type: none"> <li>In process of producing a micro-site for nursing colleagues which includes midwifery, mental health, general and speciality nursing. The focus of the microsite is what Jersey can offer in terms of career development, training and education. The site should be live at the beginning of November 2023.</li> <li>In the interim, HCS has been working with agencies to find substantive staff in those hard to recruit areas. There has been progress in some areas.</li> <li>The additional capacity (mentioned above) is supporting the recruitment process to be carried out in a timely manner.</li> </ul> <p>HMT invited BE to comment. BE noted that the development of the microsite is a breakthrough. It is also recognised that the UK market is the richest market for staff. Due to the vacancy rate in the UK, this is now a very competitive market. As HCS is not OSCE ready, the overseas market cannot be pursued (due to the amount of money this would cost).</p> <p>CB noted that the shortage of staff (both substantive and agency) in some areas, impacts upon waiting times, for example, in Mental Health Services – psychological practitioners. AW echoed the importance of highlighting development opportunities for staff, particularly in the redesign of services and roles.</p>	

<p>AH would like to understand the different recruitment strategies considering ethnic origin, age, disability, gender etc. and what HCS is learning about effective recruitment and retention strategies in Jersey.</p> <p><b>ACTION: AH to email HMT above list and HMT will pass this onto Board members to be answered. SG to respond at next Board meeting (November 2023).</b></p> <p>CS advised the Board that Jersey has signed a contract with a facility in the UK for the continuation of training and education of Registered Nurses. The UK are exploring the role of the Nursing Associate, and this is an opportunity that can be exploited in Jersey to develop staff (for which there is an appetite).</p> <p>CD noted that recruitment difficulties are a theme that run through most of the reports and suggested it would be helpful for the Board to receive a report in November / December which looks at the longer terms approach to recruitment across the whole service. This may also support recruitment across wider Government.</p> <p><b>ACTION: The Board to receive a report detailing the longer-term approach to recruitment across HCS (December 2023).</b></p> <p>SMK advised the Board that recruitment of Doctors is also experiencing significant challenges which may lead to decisions about service continuity. However, it is important to appoint the right candidates, and, in some circumstances, it is appropriate not to appoint.</p> <p>Following a discussion regarding the data for those who have left HCS, SG advised that he intends to bring the analysis of exit interview data to a future Board meeting.</p> <p><b>ACTION: SG to bring a paper detailing the analysis of exit interview data to the next Board meeting (November 2023).</b></p> <p>Noting the lack of flexible working as a reason for leaving, AH commented that it is important to set expectations initially and how the function of the microsite will be key to this.</p>	
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11	Serious Incident (SI) Position Statement	Action
	<p>PA took the paper as read. It was acknowledged that HCS is not in a position it would like to be as regards to timeliness of investigations and assurance regarding lessons learned.</p> <p>Changes have been made including the governance around SIs. There are challenges in identifying investigators (both internal and external). The challenges to identifying internal investigators include job planning process and time away from clinical activities. For assurance, safety huddles are convened following an incident to identify any immediate learning.</p> <p>The Quality and Safety team have undertaken a piece of work to collate all the learning from incidents. Assurance regarding the learning will be a feature of the care group governance meetings which will be starting soon.</p> <p>To overcome the challenge of identifying investigators, the SLT will be asked to consider a proposal to appoint individuals to investigate all incidents, with support of specialist clinicians when needed. General discussion followed regarding professional responsibilities to learning and the potential appointment of investigators does not remove this responsibility. General agreement that investigating an SI is a valuable Continuing Professional Development (CPD) opportunity.</p> <p>CD noted this report raised a number of serious concerns particularly in relation to those SIs where an investigator has not yet been appointed. Of these, how many relate to serious incidents of harm and if necessary, should an external investigator be appointed for a timely investigation and learning. Drawing on previous experience, CD noted that she has never seen that SI investigation is not part of individuals jobs i.e., these are usually allocated and turned round quickly to understand the learning. PA clarified that HCS has commissioned external</p>	

<p>investigators for those SIs where there has been a significant delay in sourcing internal investigators.</p> <p>Regarding the inclusion of SI investigation in job planning, CD stated this should be done as a matter of urgency. In addition, themes, service areas and outcomes should feature in future reports. PA responded that the main themes are lack of recognition of a deteriorating patient and lack of escalation once deterioration has been identified. There is a particular focus now on Massive Obstetric Haemorrhage (MOH). Job planning will be addressed later in the agenda.</p> <p>CB noted SIs are an area of concern for the HCS Senior Leadership Team and a monthly report is received. CB also drew the Boards attention to the cultural issues within HCS as staff are reluctant to undertake SI investigations due to the size of the organisation. General discussion highlighting that SIs are about learning and preventing future harm, not apportioning blame. A discussion followed regarding a culture of attributable justice rather than restorative justice and how this has contributed to reluctance of individuals to investigate.</p> <p><b>ACTION: Future SI papers to include the themes that arise for SIs, the changes that need to be as made as a result of these themes, who is responsible for enacting the change (at Executive Director level), and how do we know that the change has occurred (December 2023).</b></p> <p>It was agreed that SI investigation is a crucial process that improves the quality and safety of care for patients.</p>	
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12	Complaints Position Statement	Action
	<p>Paper taken as read. Key points include,</p> <ul style="list-style-type: none"> <li>• This is the first report since the change in structure within the Patient Experience Team.</li> <li>• Trend analysis has been limited by system issues, but this is expected to be resolved and therefore included in future reports.</li> <li>• Early closure and resolution were a focus during August with support from the Patient Advisory Liaison Service (PALS).</li> <li>• At the time of writing the report, there were 80 open complaints. This has reduced to 51 at end of Sept (unvalidated data).</li> <li>• Key themes of complaints included appointment letters and do not attempt cardiopulmonary resuscitation (DNACPR). Targeted learning has been identified for action.</li> <li>• There are six legacy complaints which cannot be closed for reasons including, legal services review and external investigation.</li> <li>• Compliments have been received through the My Experience Survey. This will be changed soon to the Friends and Family Test which is expected to produce more useful data.</li> <li>• In discussion with the Picker Institute regarding the planned launch of the survey in November 2023. This will cover inpatients, urgent and emergency care, maternity and community mental health. JM proposed bringing back the outcomes of this to the Board in 2024.</li> </ul> <p><b>ACTION: The outcomes of the Picker Survey to be presented to the Board (JM to advise on a date).</b></p> <p>AH noted an emerging theme of organisational learning from the papers received this morning and highlighted it is encouraging to see HCS emphasise this. In addition, how well does HCS understand patient experience and what is being done to improve this when standards are not met.</p>	

13	Waiting List Report	Action
	<p>Paper taken as read. Although not directly addressed in the paper, CT emphasised that the impact of waiting for care upon individuals and their families is part of the workstream to improve access to care and treatment.</p>	

<p>The implementation of the new Electronic Patient Record (EPR) in May 2023 has affected the waiting list position (PTL) for inpatients, outpatients and diagnostics. Firstly, CB commented on the importance of resolving the system issues to understand the true PTL position. Secondly, CB noted that it is important for patients to understand how long they will have to wait, rather than the total number of patients on a waiting list. Funding (5 million) has been provided by the GOJ to insource / outsource additional capacity to recover the waiting lists and procurement of these services is following the GOJ process. Once the backlog is recovered, the challenge for HCS will be to maintain the waiting times which will require a review of medical / surgical pathways and theatre utilisation. The increased waiting times are a symptom of many issues.</p> <p><b>ACTION: The board to receive a report at the next meeting detailing the progress of spend of the £5 million, to include reasons for any delays (November 2023).</b></p> <p>Noting the individuals deemed 'urgent' who have been waiting &gt; 90 days, CD asked what assessment of harm is undertaken as a result of the wait, does the cost of treatment then rise as a direct consequence of this wait and is there any data regarding the conversion of those on a PTL seeking treatment as an emergency.</p> <p>CT responded that harm reviews (physical / psychological) were a key feature for HCS coming out of the Covid pandemic. Any incidents of harm followed the organisational policy for patient safety incidents. However, there is no data to understand how many patients on the PTL convert to emergency admissions.</p> <p>PA commented that the harm review that is in place could be strengthened.</p> <p><b>ACTION: HMT asked for there to be a focus on six of the areas where patients experience long waits and detail the constraints, how these are managed and the timeline for resolution (December 2023).</b></p> <p>It was agreed that the current position is unacceptable, and the Board needs to understand what is being done to address this through six areas which could include MRI, endoscopy, ophthalmology, dermatology and lower limb.</p>	
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14	General Surgical Acute Rota	Action
	<p>PA provided a verbal summary following concerns raised at the last meeting regarding the sustainability and safety of the general surgical on-call rota (at Consultant level). PA advised the Board this is an example of the challenges of a small health jurisdiction, such as Jersey, in providing emergency and urgent on-call services.</p> <p>PA provided the background of the rota and changes that have been previously made following concerns raised by the Consultants and increasing sub-specialisation. Work has continued within the surgical department to develop the on-call rota.</p> <p>The current challenge is sustainability of the on-call rota and whether there are enough senior Doctors (Consultants) to cover, whilst exposing them to the number of patient required to maintain skills in this area.</p> <p>One possible solution is to commission a Royal College of Surgeons review and to understand how the service is delivered in similar jurisdictions. HMT advised it was important for the Board to be assured and supported PA's suggestion for an external review to understand if HCS is doing the best it can and if not, what should / could we do.</p> <p><b>ACTION: PA to report on progress in commissioning external reviews (November 2023)</b></p>	

15	Job Planning	Action
	<p>Paper taken as read. The process for job planning has been more difficult than anticipated due to a number of factors including the lack of requirement for job planning previously and less emphasis on what HCS needs from individuals and rather more emphasis on how individuals wish to work.</p>	



<p>The previous deadlines for completion of the process have not been met (July and September 2023). However, in areas with Doctors that have recently come from the UK where job planning is BAU, the process has been much quicker, for example the Emergency Department.</p> <p>There has been an improvement since the paper was written with just over 50% with an in-date job plan with an anticipated increase to 90% over the next few months. However, as this process is not embedded, there is an expectation of more appeals than normally would be expected. Appeals are addressed through a consistency panel.</p> <p>CB observed that this is another area where culture is key, and individuals must be held to account for the care provided. Some of the conversations taking place reflect the conversations that were held in the UK when job planning was first introduced circa 30 years ago.</p> <p>However, job planning is key for both HCS and the public of Jersey to be clear about the services delivered. The use of taxpayer's funds needs to be clear, particularly in relation to the use of Supporting Professional Activity (SPA) time. Job planning is a contractual requirement of all Doctors.</p> <p>Referring to potential financial gains / losses mentioned in the paper, PA explained this is due to historical timetabling where individuals are found to be working hours that are not considered safe: the reduction of hours would have a consequential loss in income.</p> <p>HMT stressed the advantages of job planning for both HCS (probity, planning clinical activity, provision of safer services) and individual Doctors (openness and protection against unfair criticism). From a financial perspective, OH very supportive of the process as job planning delivers many productivity benefits. Considering the current recruitment issues, HCS needs to maximise current capacity which can be done through job planning.</p> <p>The Board agreed that job planning is a matter of urgency for HCS.</p> <p><b>ACTION: PA to provide an update paper at the next meeting (November 2023).</b></p>	
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16	National Institute for Health and Clinical Excellence (NICE) / Royal College Guidelines	Action
	<p>PA advised that the HCS SLT agreed to adopt NICE guidance as the default position for clinical guidelines. This does not mean that NICE was not being used, rather this is now a clear statement that sets expectations.</p> <p>Currently, HCS is not able to provide assurance to the Board regarding compliance. However, a piece of work to address this is planned for early next year. A process has been developed for any new guidance that is issued to ensure that it is incorporated into HCS practice.</p> <p>CB emphasised the decision to adopt NICE (and other available evidence-based practice) is about improving safety of services and ensuring that clinicians are protected. Recognising that there may be legitimate circumstances where HCS cannot follow NICE (or other evidence-based practice), HMT stressed this must be discussed in an open and transparent way at the Board so that the people of Jersey know that they are getting what they should get as dictated by the scientific evidence and if not, it should be clear as to why there are not. For clarification, deviation from evidence based best practice is not a matter for individual arbitrary decision-making. Organisations across most industries manage patient safety through standardisation and systemisation i.e., not allowing random individualistic behaviour. SMK clarified that a process to manage this has been developed.</p> <p>In addition, NICE was adopted as HCS clinicians are registered with General Medical Council (GMC) and are members of the Royal Colleges in the UK.</p> <p>In response to HMT's question about the purpose of the Policy and Procedure Ratifying Group (PPRG), PA clarified that it is not about redebating any evidence-based practice, rather to understand what the policy is and that if it effects more than one care group, this has been</p>	

<p>considered. Dr Hopkins reflected on the current process as a robust process with the required level of flexibility to adopt evidence-based practice.</p> <p>As a point of clarity, CS highlighted that the term clinician is not limited to Doctors, but also includes nurses, midwives, social care partners and allied health professionals (AHPs).</p> <p><b>ACTION: PA to provide a verbal update on progress so far at the next meeting (November 2023).</b></p>	
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17	Acute Medicine	Action
	<p>Paper taken as read. CT advised the Board that the Royal College of Physician reports have not been appended as they are being reviewed by Information Governance (to ensure that there is no patient identifiable data released). Pending this review, the reports will be appended to the minutes.</p> <p>The report describes areas of concern and the approach to improving these. To replicate the model being used in Maternity improvement (see item 18), a two-weekly medical improvement group will be established. Oversight is also provided monthly at the HCS Change Programme Board.</p> <p>The support and expertise of an external colleague has been commissioned following the RCP report with areas of focus to include improving Same Day Emergency Care (SDEC), the Acute Admission Unit (AAU) / Enhanced Care Area (ECA) and bed modelling. Access to beds is critical to the quality of care delivered to patients and impacts upon the elective programme and financial recovery.</p> <p>AH asked if there is a detailed plan in relation to this. CT confirmed there is an action plan, a summary of which can be provided at the next Board. In addition, where the report refers to additional funding, given that HCS is already in financial recovery AH asked how the Board should respond to this. CT responded that savings have been identified by substantiating already open beds which are staffed by locum / agency staff. Other work will feature in the financial recovery plan.</p> <p>CD noted the absence of social care considerations in the paper and asked whether the proposed business plan will consider potential capital investment in the community as a longer-term solution. CT responded that the Winter Plan is taking this approach. In addition, AW explained that a piece of work has commenced that is jointly led by social care, acute services and intermediate care to understand all delays i.e., what is the cause of the delay and what can be done to minimise this. The team meets weekly and initial analysis show delays due to flow – step down beds and availability of care packages for people.</p> <p>SMK gave an overview of the current bed position and advised that the average length of stay has increased by two days from 2019 to 2022, partly due to delays in transfers but also internal inefficiencies. However, there are advantages to both HCS and patients to increase the medical bed base, but this will come at a cost, potentially to the detriment of other services.</p> <p>In response to HMTs question, it was confirmed that substantive Medical Consultants are not carrying out daily ward rounds of patients.</p> <p><b>ACTION: HMT asked for future report to summary of action plan and detail which recommendations HCS intends to enact (in list form), with a timescale (November 2023).</b></p> <p>In support of these discussions, OH advised this work is critical from both a quality of care and financial point of view. However, the challenge is not what needs to be done, rather it is the culture.</p>	

18	Maternity Improvement Plan (MIP) Workstreams	Action
	DH was introduced to the Board as a Consultant Diabetologist and the Chief of Service of Women, Children and Family Care.	

<p>Paper taken as read which highlights the significant concerns regarding maternity care as considered by HCS and external reviews that have been commissioned in the past. The aim is to improve outcomes and the care delivered to patients and their families.</p> <p>All the recommendations from the variety of reports have been consolidated into one comprehensive action plan to facilitate a systematic approach to addressing these.</p> <p>Led by the Executive leadership team, the Maternity Improvement Group (MIG) meets weekly with the Clinical leaders from the care group to review the recommendations and associated actions and escalate any issues. Of the 131 recommendations, 52 have been achieved to-date.</p> <p>Appendix B demonstrated to the Board how the programme has good clinical engagement and support. A collective response from the department is key to achieving the improvement and sustainability. The recommendations in relation to the culture and relationships will be longer term.</p> <p>As discussed earlier in the meeting (item 5), Appendix C shows the maternity dashboard, which details metrics to demonstrate safety of care. In response to CDs question, CT stated that the dashboard will be available from next month.</p> <p>JM advised the Board that a substantive Director of Midwifery has been appointed and will in post on 11<sup>th</sup> December. There is currently an interim Head of Midwifery.</p> <p>Noting the documented disproportionality in outcomes for women and their babies depending upon ethnic origins and affluence, the link to antenatal services and community services is exceedingly important. CD suggested that visibility of this link would be valuable in the dashboard i.e., number of women who do not attend antenatal appointments who then experience a still birth.</p> <p>HMT asked how culture and interpersonal relationships are being improved in the Maternity department. CP advised the following,</p> <ul style="list-style-type: none"> <li>• Five listening events with professional groups that sit within maternity have been carried out which has generated a number of themes. These themes have been used to develop further initiatives to address the cultural issues raised. Themes include, <ul style="list-style-type: none"> <li>○ Professional knowledge and skills not being respected.</li> <li>○ Engagement between professional groups.</li> </ul> </li> <li>• Further initiatives include specific mediation to build psychological safety.</li> <li>• A Civility Saves Lives approach to help people to understand that uncivil behaviours can have a negative impact on patient safety.</li> <li>• Multi-professional training.</li> <li>• Recruitment and retention of staff</li> </ul> <p>DH advised that the culture change is recognised as a significant element of the improvement work.</p> <p><b>ACTION: The Board to receive a monthly report with specific progress against the targets that have been set, including any general comments about culture issues.</b></p>	
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19	Infection Prevention and Control (IPAC) Audit Improvement Work	Action
	<p>Paper taken as read. Key highlights,</p> <ul style="list-style-type: none"> <li>• No outbreaks of healthcare associated infections (HCAIs) or C. Difficile (C. Diff) during August 2023.</li> <li>• Overall compliance with hand hygiene is 93.2% across all staff groups (against a target of &gt;90%).</li> </ul>	



<p>CB advised it would be useful to see the staff uptake rate of vaccinations in this report and asked if there is any historic data. JM confirmed that HCS reports yearly on the flu / COVID vaccination uptake rates, and it was agreed that this can be included in future reports.</p> <p>HMT asked JM if there is an issue with compliance in Jersey. JM confirmed not and added that there are IPAC Champions on the wards, supported by the IPAC team. When monthly audit results yield a low compliance rate, the audits are carried out daily until required level of compliance is achieved.</p> <p><b>ACTION: Flu / Covid vaccination uptake rates to be included in the report at the next meeting (November 2023).</b></p>	
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20	Appraisal and Revalidation for Doctors – Position Statement	Action
	<p>From the outset, HMT advised that whilst appraisal and revalidation are processes of the regulator, this does not remove the responsibility from HCS (as the employer) for patient safety. HCS is responsible for ensuring that the people it manages are behaving appropriately and have required level of competence to remain safe.</p> <p>PA took the paper as read. Key highlights,</p> <ul style="list-style-type: none"> <li>• A difference between appraisal in Jersey and appraisal in the UK is the lack of useful information and data that feeds into the appraisal system, for example individual clinician wound infection rate, Datix data showing which incidents clinicians have been involved in.</li> <li>• The high-level responsible officer (RO) from the South of England recently visited to Jersey and provided advice and suggestions including having Deputy Responsible Officers (DROs) and a broader team to oversee the appraisal process.</li> </ul> <p>HMT stated HCS has a responsibility to provide relevant data to support the appraisal process.</p> <p><b>ACTION: The Board to receive an update in January 2024.</b></p>	

21	Cultural Change Programme	Action
	<p>Paper taken as read and it was noted that culture issues are a common theme through most of the papers on today's agenda. Key points,</p> <ul style="list-style-type: none"> <li>• A positive cultural workplace enables better patient outcomes.</li> <li>• A GOJ wide BeHeard survey has recently taken place with a 28.5% HCS response rate. When compared to the 2020 survey results, growth can be seen across all eight factors of engagement.</li> <li>• Cultural needs are beginning to be understood following a series of listening events.</li> <li>• Key actions plans are being developed as discussed for Maternity (item 18).</li> </ul> <p>AH noted there is a lot of work taking place in this area and reminded Board members that culture is about thinking how our own individual behaviours impact upon others and the workplace.</p> <p>CD suggested it is a priority for the Board to see the improvement plan for culture in the next couple of months including what success looks like and differences that have been made.</p> <p>Over the last six months, CB stated that he has noted an increase in the number of staff speaking up, whether through the Freedom to Speak Up Guardian or himself. However, the Board agreed that culture change is a long-term programme, potentially 4-5 years.</p> <p><b>ACTION: The Board to receive the improvement plan for culture in December 2023 including what success looks like and the differences that have been made.</b></p>	

22	Management of Incidents of Racial Abuse	Action
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<p>Paper taken as read. Following the cultural report received at the (shadow) board meeting, a report was requested detailing the action taken in response to 29 reported incidents of racial abuse.</p> <p>Datix was used to retrieve the data and action taken was measured against the Unacceptable Behaviour Policy. Whilst there no reported incidents of racial abuse between staff members, CB advised the Board that it should not be assumed that it is not taking place: CB has received verbal descriptions where BAME colleagues have experienced racial abuse from colleagues.</p> <p>There was evidence to show that actions taken were either appropriate or partially appropriate (both immediate and follow up). However, the recording of 'no harm' related to physical harm rather than the consideration of psychological harm. There was also limited evidence to show that staff were offered a debrief or support as a follow up when exposed to racial abuse. Some evidence shows that staff declined to report incidents of racial abuse to the Police.</p> <p>AW advised this is a particular issues in acute inpatient Mental Health Services as evidenced through the 66% reported incidents in this area. AW explained whilst unacceptable, it is a complex issue because some of the guidance does not apply when detaining individuals against their will because they are acutely mentally unwell, for example you cannot ask them to leave the premises. Whilst there may be no initial harm (physical or psychological), AW is concerned about 'weathering' where staff are subjected to racial abuse daily with a consequential effect upon staff morale and HCS's ability to recruit and retain staff.</p> <p>One individual has been successfully prosecuted for repeated racial abuse towards staff. Mental Health Services are working jointly with the Police to produce a Prosecution Policy which provides clear guidance when an individual is unwell but is breaking the law as to what to do. In addition, across both acute services and mental health services, the Police will be called to assist in an event but then staff decline to give any statement – this restricts the Police's ability to respond. Training will be a key part in the development of this policy.</p> <p>AH noted that this links with respect for each other and the wider culture work that is needed.</p> <p>SG advised the Board that at the point of recruitment, ethnicity is not asked. Consequently, there is currently no definitive data regarding the diversity of the workforce. However, as GOJ staff move to the new system (Employee Central), staff will be encouraged to update demographic information which will include ethnicity. This data will facilitate a greater understanding of the population affected by these issues. In addition, BAME was renamed as REACH as ethnic minority in Jersey is different as to what is seen in the UK. BE also highlighted that Jersey does not have the Equality Delivery System (EDS2) Framework.</p> <p><b>ACTION: AW to indicate when the Prosecution Policy will be available.</b></p>	
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23	<b>Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor</b>	<b>Action</b>
	<p>AM advised the Board that this monthly report details the progress against each of the 61 recommendations in the Review of HCS Clinical Governance Arrangement within Secondary Care (2022).</p> <p>Many of the recommendations are being addressed through the work detailed in the reports on today's agenda, including the establishment of this Board.</p> <ul style="list-style-type: none"> <li>• As of August 2023, seven recommendations have been marked as complete.</li> <li>• 11 are close to completion.</li> <li>• 41 recommendations are in progress.</li> <li>• Two have not started (due to dependencies).</li> </ul> <p>A similar approach is being taken to this as in the MIP and any evidence to support closure of a recommendation is reviewed closely.</p>	

<p>The detail regarding impact and outcomes of the recommendations are covered across a variety of agenda items.</p> <p>In response to HMT's question, AM advised that the recommendations are not embedded in BAU, rather the action plans, monitoring of progress, reporting and tracking are embedded. This will continue to be monitored through the Change Programme Board and Committees. AM suggested that if the Board would like to review any specific recommendations, this is presented as a separate paper, rather than in the overview document as presented today.</p> <p>CD responded it would be helpful to have a forward plan for fewer but more detailed reports which would facilitate deeper discussions i.e., understanding what is really important / urgent and as a Board, what difference can be made so that the people of Jersey experience this.</p> <p><b>ACTION: Quarterly report Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor to be presented to the Board.</b></p>	
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24	<b>Mental Health and Capacity Legislation – Report from the Multi-Agency Assurance Group</b>	<b>Action</b>
	<p>AW advised that at the beginning of 2022, there was no mechanism for monitoring how the Mental Health law and Capacity Law is applied: the multiagency oversight group was established in response to this. Key points,</p> <ul style="list-style-type: none"> <li>• Currently developing proposals with SPPP for changes in legislation as gaps have been identified. In addition, there are nuances that require redrafting.</li> <li>• Documentation is being reviewed.</li> <li>• Strengthening the information that is given to patients, so they are able to understand their rights when they are detained.</li> <li>• The review process for those detained in the community on long-term leave has been strengthened.</li> <li>• Implemented a process for the authorisation of designated professionals (those that have statutory roles) to ensure that these individuals are appropriately qualified, experienced and authorised.</li> <li>• In the last 21 months, there have been two instances of unlawful detention. On both occasions this was due to the incorrect completion of documentation, and this was quickly corrected. Both individuals and their legal representative were notified of this.</li> <li>• Quality of documentation is highlighted as a theme and whilst this does not result in unlawful detention, it can be improved - there is quality improvement work in relation to this.</li> <li>• Working jointly with the Police around the use of Article 36 (Police ability to detain an individual as they believe there is mental illness and to hold them whilst an assessment is undertaken). There were 163 uses of this during 2021, and following partnership work, this has reduced to 112 during 2022 and to-date 49 uses. This does not mean that individuals are not being seen when in crisis, rather they are being assessed by MH services rather than the Police. The Police also report a 32% year-to-date reduction in amount of Police time associated with Mental Health cases.</li> <li>• When Orchard House moves to Clinique Pinel, there will be a dedicated Article 36 suite. Currently, the Emergency Department is used.</li> <li>• A Rapid Tranquilisation Policy has just been signed off and use of this will be monitored.</li> <li>• The provision of training in Capacity and Self-determination has resulted in a significant increase in applications for a capacity assessment. There is currently a high number of individuals waiting for this assessment. Each application is reviewed and risk assessed. In addition, there is an improvement plan to reduce these waiting times.</li> </ul> <p><b>ACTION: It was agreed that this report is presented to Board on a 6 monthly basis (March 2024).</b></p>	

25	<b>Management of Policy Documents and Procedural Guidelines</b>	<b>Action</b>
	Paper taken as read. Key points,	

<ul style="list-style-type: none"> <li>• This is an area where oversight has not been good, but an understanding of the current position has improved following the appointment of a Policy Manager as part of the Quality and Safety team.</li> <li>• Work to address this includes further appointments to compliance roles and the implementation of a policy management system. However, it is unlikely that either of these will be in place until Q1 2024.</li> <li>• There is a process for the oversight and governance of new policies developed. However, significant work is required to bring current policies up to date.</li> </ul> <p>When addressing the issue of ratification, SMK explained that when developing policies, many individuals do not recognise the consequences for the wider organisation and there needs to be a process to identify these. However, the current PPRG mechanism could be improved. For clarity, the function of the PPRG is not to ratify already agreed evidence-based guidelines.</p> <p>A general concern was expressed that the paper does not provide a sense of how big a problem this is. CS advised the Board that the Care Quality Commission (CQC) was used as a framework to determine what they would expect as a suite of policies for an organisation of the size of HCS. There is a level of confidence that HCS does have many of these.</p> <p>In response to HMTs question about the level of confidence in being able to resolve this, PA explained he is confident that HCS is beginning to sort this out but asked the Board to acknowledge that this will take time. The gaps in HCS policy are not fully understood. Policy management is a feature of the newly established monthly quality governance reviews.</p> <p><b>ACTION: A position statement to be presented in January 2024 regarding the suite of corporate policies that help to provide assurance that HCS is safe, well-led and effective.</b></p>	
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26	Overdue Risks	Action
	PA explained this paper was produced in response to an issue highlighted in a previous (shadow) board meeting regarding a high number of overdue risks. This paper demonstrated the number of overdue risks has significantly reduced.	

27	Statutory and Mandatory Training Needs Analysis	Action
	<p>AW explained that this work has been led by himself and JM, with a significant contribution from Tim Hill, Practice Development Sister HCS.</p> <p>There is no clearly identified set of mandatory training requirements for HCS staff. This paper describes how this will be achieved and sets out in detail the mandatory training HCS is intending to prescribe from 2024 onwards. AW emphasised that much of this training is being carried out already, however this provides a framework.</p> <p>CD commented on the absence of Equality, Diversity and Inclusion training and AW explained that this is covered in the GOJ mandatory training. Where HCS does not cover elements of training, these will continue to be delivered by GOJ.</p> <p>AW asked the Board to note that this is the first step and there will be training in specific clinical areas that will be required to be completed.</p> <p>On behalf of the Change Team, CS advised the Board that the importance of this policy cannot be underestimated and commended AW / JM for this work.</p> <p>The Board endorsed the Policy and an update to be provided in January 2024.</p> <p><b>ACTION: An update to be provided to the Board in January 2024.</b></p>	

28	Consultant Appointments	Action
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<p>CB explained that due to the level of salary for Consultants, the States Employment Board (SEB) is required to approve all Consultant posts. With the introduction of the Advisory Board, it is now proposed that the request to recruit to medical consultant roles will be approved in the following order:</p> <ol style="list-style-type: none"> <li>1. By the leadership team of the appropriate Care Group</li> <li>2. By the Senior Leadership Team of HCS</li> <li>3. By the Advisory Board (following this signed by the Chief officer for HCS, Group Director PCS and the Minister for Health and Social Services).</li> <li>4. By SEB</li> </ol> <p>HMT confirmed that the purpose of the Board is to determine whether the funding is available, is it safe etc. before it goes to SEB.</p> <p>AH asked if HCS was satisfied with the recruitment element and SG confirmed that HCS follows best practice in the UK with Royal College attendance.</p> <p>In response to CD's question, CB responded that this process is required for all posts, not just new posts. Following this CD sought to clarify that this process has to be followed for posts in the current establishment that are required for operational delivery.</p> <p>The Board approved the proposal that all proposed Consultant appointments should come to the Board prior to SEB with immediate effect.</p>	
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29	Estates Report	Action
	<p>The paper which describes the current HCS estate was taken as read. The importance of having a decant ward is described to allow service continuity whilst carrying out ward refurbishments.</p> <p>HMT asked JC to provide an update regarding Reinforced Autoclaved Aerated Concrete (RAAC). JC advised that an independent structural engineer has visited the Estates and three locations containing RAAC have been confirmed. Further investigation is required but there is no current concern regarding the need to decant these areas or stop services within these areas. The mitigation and management plans will follow the report.</p> <p>The capital funding provided for the backlog maintenance programme is a rolling annual sum to support the BAU and capital management of the estate is now a key element of day-to-day business.</p> <p>CD thanked JC for the report and advised it contains a compelling case for new facilities.</p> <p><b>ACTION: It was agreed that NEDs would receive a separate briefing (workshop) on the Estates, including visits to all the sites.</b></p>	

	Questions from the Public	Action
	<p>No pre-submitted questions.</p> <p>HMT asked the members of the public if they had any questions that arise from the agenda.</p> <p><b>Member A</b></p> <p>Q1. Waiting times</p> <p>A1. Waiting times have been addressed through the agenda item 13. CB confirmed that the aim of HCS is to reduce waiting times which is very much dependent on having the right workforce and physical capacity to carry out the work. The £5million pound allocation will help to address the waiting times.</p>	

<p>Q2. Has the Board considered the introduction of a whole-Island private health insurance programme. In addition, has a Pan-Island collaboration which could include France been considered?</p> <p>A2. HMT responded that the HCS Board is not responsible for how the Island funds healthcare. France has not been considered due to the language barrier and the Professional Regulators are based in the UK, not France. Work is continuing with Guernsey.</p> <p>Q3. Noting the financial overspend, will costs escalate as Jersey moves towards the proposed multi-site facilities.</p> <p>A3. The Board have not had the opportunity to discuss these issues and understandably been consulted. There will be a future Board workshop on this issue. In principle, duplication of sites has a risk of increasing costs and making safety a more difficult issue.</p> <p>Q4. What will the HCS Board be advising HCS and the Minister for Health and Social Services in methods not only to counteract the current spending but the measures to be put in place to contain future overspends.</p> <p>A4. Healthcare and social care costs will increase, and a political decision will be required in the future as to how this is funded. Health inflation runs across the world at approx. 8% / year which is well above normal inflation.</p> <p>A also commented on the costs of Managers increasing from 12 in 2012, to 131 managers in 2023 (describing these figures as accurate). CB advised the latter figure is incorrect as concluded by a recent review. A paper has been sent to the SEB and agreed by the SEB which shows that the number of managers in HCS is 1.7% of the total workforce, equating to approx. 20-30 frontline managers and 70 speciality managers. CB advised that HCS is undermanaged, especially when compared to similar healthcare organisations.</p> <p><b>Member B</b></p> <p>Q1. Does the Board feel it could recommend that the Care Quality Commission (CQC) is given legal status to undertake an inspection?</p> <p>HMT responded that his understanding was that the JCC were working closely with the CQC and that the methodologies might be similar. However, Jersey has chosen to establish its own independent commission and HCS looked forward to working constructively with it. Further discussions on the issue took place.</p>	
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<b>MEETING CLOSE</b>	<b>Action</b>
<b>Date of next meeting: Wednesday 1<sup>st</sup> November 2023</b>	



	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	75	04-Oct-23	29	Estates Report	It was agreed that NEDs would receive a separate briefing (workshop) on the Estates, including visits to all the sites.	Chris Bown	Dec-23	A series of Board workshops has been scheduled and a briefing on the HCS Estate (to include site visits) will feature as one of these.  Agenda item 18 at meeting on 1st November 2023.			OPEN - Todays agenda
5	74	04-Oct-23	27	Statutory and Mandatory Training Needs Analysis	An update to be provided to the Board in January 2024	A. Weir / J. Marshall	Jan-24				OPEN - Future Agenda
6	73	04-Oct-23	25	Management of Policy Documents and Procedural Guidelines	A position statement to be presented in January 2024 regarding the suite of corporate policies that help to provide assurance that HCS is safe, well-led and effective.	C. Bown	Jan-24				OPEN - Future Agenda
7	72	04-Oct-23	24	Mental Health and Capacity Legislation – Report from the Multi-Agency Assurance Group	It was agreed that this report is presented to Board on a 6 monthly basis (March 2024).	A. Weir	Mar-24				OPEN - Future Agenda
8	71	04-Oct-23	23	Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor	Quarterly report Update on the 61 recommendations from the Review of Governance Arrangements within Secondary Care (2022) by Professor Hugo Mascie-Taylor to be presented to the Board.	A. Muller	Jan-24				OPEN - Future Agenda
9	70	04-Oct-23	22	Management of Incidents of Racial Abuse	AW to indicate when the Prosecution Policy will be available	A. Weir	Nov-23				OPEN - For Discussion
10	69	04-Oct-23	21	Cultural Change Programme	The Board to receive the improvement plan for culture in December 2023 including what success looks like and the differences that have been made.	C. Bown / C. Power	Dec-23				OPEN - Future Agenda
11	68	04-Oct-23	20	Appraisal and Revalidation for Doctors – Position Statement	The Board to receive an update in January 2024.	P. Armstrong	Jan-24				OPEN - Future Agenda
12	67	04-Oct-23	19	Infection Prevention and Control (IPAC) Audit Improvement Work	Flu / Covid vaccination uptake rates to be included in the report at the next meeting (November 2023).	P. Armstrong / J. Marshall	Nov-23	Agenda item 16 at meeting on 1st November			OPEN - Todays agenda
13	66	04-Oct-23	18	Maternity Improvement Plan (MIP) Workstreams	The Board to receive a monthly report with specific progress against the targets that have been set, including any general comments about culture issues.	P. Armstrong	Nov-23	Agenda item 15 at meeting on 1st November			OPEN - Todays agenda
14	65	04-Oct-23	17	Acute Medicine	HMT asked for future report to summary of action plan and detail which recommendations HCS intends to enact (in list form), with a timescale (November 2023).	C. Thomspen	Nov-23	Agenda item 14 at meeting on 1st November			OPEN - Todays agenda
15	64	04-Oct-23	16	National Institute for Health and Clinical Excellence (NICE) / Royal College Guidelines	PA to provide a verbal update on progress so far at the next meeting (November 2023) - to also confirm there has been broad dissemination thorough line management structure.	P. Armstrong	Nov-23				OPEN - For Discussion
16	63	04-Oct-23	15	Job Planning	PA to provide an update paper at the next meeting (November 2023).	P. Armstrong	Nov-23	Agenda item 13 at meeting on 1st November			OPEN - Todays agenda
17	62	04-Oct-23	14	General Surgical Acute Rota	PA to report on progress in commissioning external reviews (November 2023)	P. Armstrong	Nov-23				OPEN - For Discussion
18	61	04-Oct-23	13	Waiting List Report	HMT asked for there to be a focus on six of the areas where patients experience long waits and detail the constraints, how these are managed and the timeline for resolution (December 2023).	C. Thomspen	Dec-23				OPEN - Future Agenda
19	60	04-Oct-23	13	Waiting List Report	The board to receive a report at the next meeting detailing the progress of spend of the £5 million, to include reasons for any delays (November 2023).	C. Thomspen	Nov-23				OPEN - Todays agenda
20	59	04-Oct-23	12	Complaints Position Statement	The outcomes of the Picker Survey to be presented to the Board (JM to advise on a date).	J. Marshall	Nov-23				OPEN - For Discussion
21	58	04-Oct-23	11	Serious Incident (SI) Position Statement	Future SI papers to include the themes that arise for SIs, the changes that need to be as made as a result of these themes, who is responsible for enacting the change (at Executive Director level), and how do we know that the change has occurred (December 2023).	P. Armstrong	Nov-23	Agenda item 10 at meeting on 1st November			OPEN - Todays agenda
22	57	04-Oct-23	0	Workforce Report Month 8	SG to bring a paper detailing the analysis of exit interview data to the next Board meeting (November 2023).	C. Bown / S. Graham	Nov-23	Agenda item 9 at meeting on 1st November			OPEN - Todays agenda
23	56	04-Oct-23	10	Workforce Report Month 8	The Board to receive a report detailing the longer-term approach to recruitment across HCS (December 2023).	C. Bown / S. Graham	Dec-23				OPEN - Future Agenda
24	55	04-Oct-23	10	Workforce Report Month 8	AH to email HMT above list and HMT will pass this onto Board members to be answered. SG to respond at next Board meeting (November 2023).	C. Bown / S. Graham	Nov-23				OPEN - For Discussion

	A	B	C	D	E	F	G	H	I	J	K
25	54	04-Oct-23	8	Quality and Performance Report Month 8	To determine who is accountable at Executive level for the exception reports detailed at the back of the Quality and Performance Report (December 2023).	C. Bown	Dec-23				OPEN - Future Agenda
26	53	04-Oct-23	8	Quality and Performance Report Month 8	Executive Directors to provide a focus in the next meeting (November 2023) on the areas highlighted above: -Blective theatre utilisations, -% triaged within target – majors -% patients waiting over 90 days for 1st OP appointment – community -New to follow up ratio.	C. Thompson	Nov-23	Agenda item 7 and 12 at meeting on 1st November			OPEN - Todays agenda
27	52	04-Oct-23	8	Quality and Performance Report Month 8	Executive Directors to review the current suite indicators, standards set and quality of data to provide assurance that the data is meaningful and directs activity (date to be advised by CB).	C. Bown	Nov-23				OPEN - For Discussion
28	51	04-Oct-23	8	Quality and Performance Report Month 8	AW will lead the work to further develop the suite of metrics for social care, supported by Andy Weir, Director of Mental health services and Adult Social Care. The proposal to be presented at a future Board meeting (date to be advised by AW).	A. Weir	Nov-23				OPEN - For Discussion
29	50	04-Oct-23	8	Quality and Performance Report Month 8	Copy of the readmission deep-dive to be sent to the NEDs	C. Thompson	Nov-23				OPEN - For Discussion
30	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	December 2023 <del>04/10/2023</del>	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 performance reviews. The Board asked to be provided with an update at the meeting in December Remain OPEN.			OPEN - Future Agenda
31	17	31-May-23	9	Activity, Finance and Workforce	AW to report on the Safeguarding audit results November 2023.	A. Weir	Nov-23	Update 10 July 2023 Not due until November 2023 meeting. Remain OPEN.			OPEN - Todays agenda
32	8	31-May-23	6	Chief Officer (HCS) Report	Transition Dircetor to be invited to the next meeting of the Board to provide an update on the New Healthcare Facilities and feedback received following the feasibility study.	E. O'Connor	Nov / Dec 2023	Agenda item outstanding.  Update 10 July 2023 Postponed until Sept meeting due to leave. Remain OPEN.  Update 14 June 2023 Invite sent to MW.			OPEN - For Discussion
33	6	31-May-23	6	Chief Officer (HCS) Report	AW to present the review of the EPR in Mental Health Services and Adult Social care at the next meeting of the Board.	A. Weir	Nov / Dec 2023	Agenda item outstanding. The Mental Health and Adult Social Care EPR is to be included in an overall report reagrding the EPR.  Update 10 July 2023 Deferred until the next meeting as the Programme Board for the EPR has only recently held it's first meeting. Remain OPEN.			OPEN - For Discussion
34	2	31-May-23	5	Chair's Introduction	Each responsible ED to review the relevant assurance committee terms of reference with the support of the Change Team in preparation for the next meeting of the Board.	All Executive Directors	01 Nov 2023 <del>04/07/2023</del>	The Assurance committees to be discussed at the Board wrokshop planned for 5th December.  The Assurance Committee structure will be discussed and agreed once the Board is fully recruited to.  Update 10 July 2023 Noted that the approval route for terms of reference (ToR) for assurance committees is addressed in the Board ToR and there is also a requirement to establish a Risk and Audit Committee.			OPEN - For Discussion
35	1	31-May-23	5	Chair's Introduction	The Chief Officer / Executive Director to determine the dates of the next board and timeline to facilitate production of papers.	C. Brown & all Executive Directors	Nov 2023 <del>04/07/2023</del>	Agenda item 18 at meeting on 1st November 2023.  Following a meeting with the Head of Informatics, (Interim) Head of Finance Business Partnering HCS, the Associate Director of Peole HCS and Chair of the Board reagrding the availability of data, the Board Secratry will provide a paper at the meeting on 1st November 2023.  Update 10 July 2023 Ongoing. However, as per previous discussion at Item1, the meetings will be held over a whole day. Remain OPEN.			OPEN - Todays agenda





## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	1 November 2023		
<b>Title of paper:</b>	Chief Officer Report		
<b>Report author (&amp; title):</b>	Chris Bown, Chief Officer	<b>Accountable Executive:</b>	Chris Bown, Chief Officer

### 1. Purpose

What is the purpose of this report?  What is being asked of the HCS Advisory Board?	The Chief Officer report provides a summary of key activities for HCS and an overview of HCS' performance since the last Board meeting and summarises key issues as presented in more detailed board papers.  The Board is asked to note the report.	Information	x
		Decision	
		Assurance	
		Update	x

### 2. Introduction

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

### 3. Key Issues

#### Delayed Transfers of Care

Services both acute and mental health have been under significant pressures with high numbers of Medically Fit for Discharge impacting on hospital flow. Staff are to be thanked for their considerable efforts in managing under such challenging circumstances. Solutions to improve the situation continue including opportunities for increasing non acute capacity available in the private sector.

#### Financial Recovery Plan

The Financial Recovery Plan (FRP) has been completed and published last month, concluding the planning phase, and has now entered the delivery phase. This quality-led FRP sets out how HCS plans to tackle the underlying deficit of £35m through a comprehensive financial recovery program and return the system to a financially sustainable position.

The headline financials of the FRP are:

- HCS's financial position has deteriorated from £1.5m surplus in FY19, to a forecast of £29m deficit in FY23, and the underlying position is currently £35m.
- Some of the key drivers of this deterioration in the financial position are inflation, higher spend on agency staff, increases in non-clinical staff compared to the front line, non-delivery of efficiency targets, activity pressures and business case pressures, and provision of unfunded services.
- To address the challenge, HCS plans to deliver £25m savings (£3m in FY23, £12m in FY24, and £10.6m in FY25).
- This is a significant target and equates to 3.6% recurrent savings year-on-year in real terms.
- The structural deficit (unfunded services) is £15m.
- The Financial Recovery Plan, by delivering £25m savings, will address £5m of the structural deficit.
- The remaining balance of £10m requires additional funding or decision on continuity of services.

### M9 Progress Update

The FRP schemes identified as at M9 are £26m with a risk-adjusted value of £17m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m.

The immediate priority is to deliver the in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23. Work has been progressing at pace with the Care Groups and Directorate given individual targets to accelerate the FRP savings identified in-year to deliver the £3m target supported by the newly established Programme Management and Delivery Team (PMDT).

## **Clinical Governance**

### Care Group Governance reviews (CGGR)

During the last month Governance has been strengthened by the formation of a monthly core meeting with each of the Care Groups. These Care Group Governance meetings will be phased in, and in October have taken place for Surgery, Medicine and Woman's and Children's (WaC) care groups.

These meetings allow each of the care groups to provide assurance on their progress against key metrics, for example Serious Incidents as well as allowing review of Risks, Complaints and areas specific to the relevant care group. As much as possible they follow a standardised approach but are tailored to the individual needs of the Care Groups.

These will continue monthly and become more refined to avoid overlap with other core meetings such as the performance reviews to avoid duplication of work for the care groups.

### Getting It Right First Time

Discussion has occurred with the team of the UK national programme Getting It Right First Time (GIRFT). HCS has also commissioned a review of Theatres and Orthopaedic Surgery. This is a nationally recognised programme that has been in place for over 15 years and is headed by Professor Tim Briggs.

Professor Briggs and his team will visit in January 2024 and conduct a two-day review of services and feedback to all parties on their findings. It is anticipated that this will be the first of other service reviews and if successful, see adoption of the GIRFT principles which are recognised as a strong adjunct to the delivery good governance and reducing unwarranted variation in clinical practice.

### National Audit Programmes

A discussion in principle with clinical leads reached a consensus that HCS should enter and maintain upload to as many UK National audit programmes as possible. It was agreed that this is a matter of good governance. It was recognised that the nuances of a small island population may mean we are unable to enter all audits due to requisite numbers but where possible we should.

### Quality and Safety Team

Following passage through the States Employment Board (SEB), the Quality and Safety team has further substantiated its workforce. The previous interim position of the Serious Incident Lead and Quality lead have been filled.

Interviews for the Head of Quality and Safety are set for the middle of November.

### **Electronic Patient Record (EPR) Implementation**

The Electronic Patient Record (EPR) release one and two were delivered in late May 2023. This included Maxims in replacement of TrakCare across HCS, GluIT EPR in the Jersey Neonatal Unit (JNU), data migration and relevant deployment of new devices and tools. We are currently meeting with the different HCS teams and departments to optimise the system and process workflows.

The current key focus of the programme is now mobilisation of release three which includes clinical noting, integrated care pathways (ICPs), electronic observations, ITU EPR Hospital at Night and electronic referrals. Descriptions of these tools / applications are detailed in Appendix A.

### **Maternity Improvement Plan**

During October, further progress has been made:

- Completion of rotas.
- Commencement of the gynecology service within Day Surgery Unit.
- Workforce strategy development has been progressed by engaging Birthrate Plus. They will review the Midwifery workforce requirements, starting at the end of October 23.
- 17 recommendations have been approved by WACs senior leadership team as complete.

For further detail on the Maternity Improvement Plan, please see the separate Board report.

### **Acute Medicine Improvement Plan**

The Medicine Improvement Plan now includes four external documents, these are detailed below:

- Invited Service Review June 2014
- Initial Royal College of Physicians (RCP) Letter 2022
- Invited Service Review Nov 2022
- Visit Dr Rob Haigh Sept 2023

In addition to extending the scope of the medicine improvement plan, the Care Group SLT now meets fortnightly with the Executive and Change Team to increase momentum, provide challenge and support with escalation. The first of a series of meetings took place on Monday 16th October 2023. A weekly meeting is also in place within the care group.

Recommendations from the initial findings letter are now complete with supporting evidence. These are detailed below.

- The review team identified concerns about the nurse staffing ratio of the enhanced care unit (ECU) as being sub optimal for a higher-level care area and should refer to the enhanced care guidance on service development in the hospital setting (May 2020).
- A potential patient safety issue was highlighted with the mixed economy of inpatient drug prescribing, paper in the emergency department (ED) and intensive therapy unit, electronic prescribing and medicines administration (EPMA) on AAU and base wards such that nurses cross covering staffing gaps in other areas e.g. ITU nurses were not able to utilize the EPMA system and thus not administer medications in a timely manner. There is an immediate need to ensure that ED and ITU are updated to the EPMA system and/ or ensure that the relevant ED/ ITU nurses can access the EMPA system so that medications can be administered to patients on the AAU without delay.

Progress has been made across all 21 recommendations and significant progress has been made within 10 recommendations. Noteworthy progress can be seen in areas of AAU / same day emergency care (SDEC) structure, workforce planning, rotas, prescribing, clinical drift, multi-disciplinary teams (MDTs), training programmes for clinical fellows and job planning.

Areas of development which are linked to the improvement plan include a board paper to SLT to create substantive consultation positions, standard operating procedure (SOP) for SDEC and the development of same day emergency care. The recruitment of a Clinical Governance Lead will also support the medicine improvement plan wider care group.

For further details, please see the separate Acute Medicine Improvement Plan Board paper.

## **New Healthcare Facilities (NHF) Programme**

As part of the ongoing development of the business cases, work is underway to establish the revenue costs associated with delivering care across this multi-site approach.

The focus continues to be design and development of the acute facility at Overdale and all aspects associated with it. The overarching functional brief has been divided into site specific briefs which are more digestible, and the next steps are to share these more widely across HCS.

The demolition contractors are on site at Overdale and all buildings except for the Westmount building have been decommissioned. The team are reviewing suitable alternative locations to temporarily relocate Samares Ward, to allow the site to be fully vacated ahead of the new build.

Work has commenced to develop an Estates Strategy and a Digital Strategy, both of which will underpin care delivery over all future sites.

## **Cultural Change Programme**

Work continues to develop the culture change programme with particular focus on providing an environment for staff to speak up and address incidents of bullying and discrimination.

The Government of Jersey's 'Be Heard' Survey identified a number of areas for HCS improvement including opportunities for learning and growth within roles, raising awareness of the values and behaviours of the organisation and understanding how internal politics get in the way of finding solutions.

We continue to see staff feeling able to raise concerns through listening events and the Freedom to Speak Up pathways. Intensive cultural interventions such as Civility Saves Lives are being developed for service areas requiring targeted support such as maternity.

### a. Waiting Lists

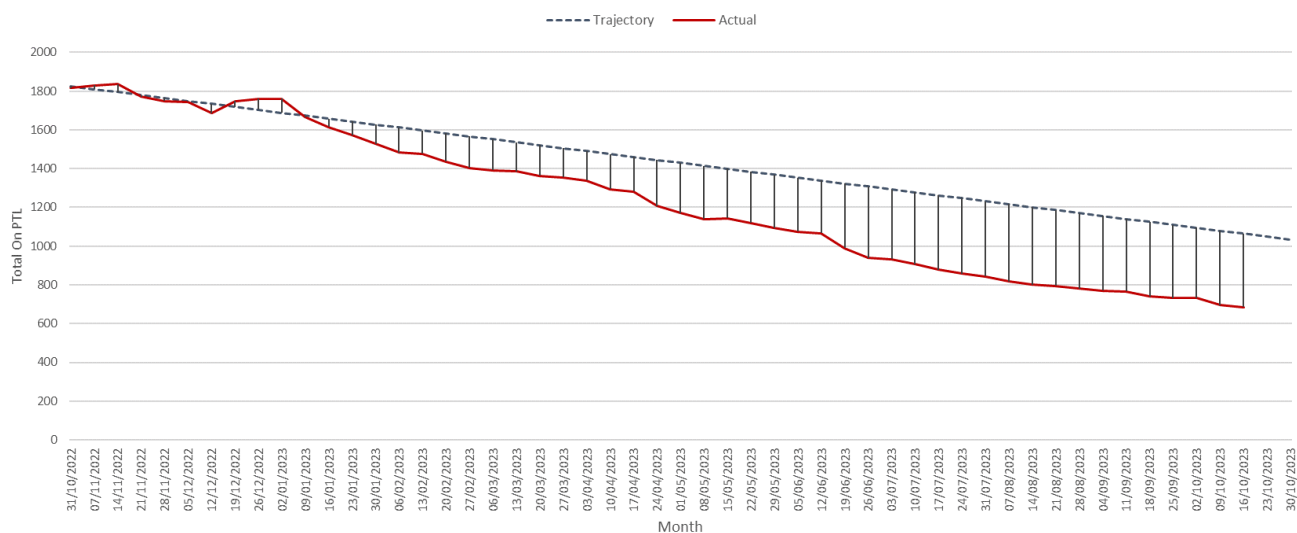
The outpatient Patient Tracking List (PTL) is stabilising following significant growth since the new Electronic Patient Record went live. Dermatology represents the greatest clinical risk with plans to utilise a variety of options from outsourcing or insourcing from providers in the UK alongside additional temporary workforce at HCS and the use of other healthcare professionals in Jersey e.g., GPs with enhanced skills. Further options include medical photography clinics which are being explored and then procured if clinically appropriate.

Waits in Ophthalmology continue to grow, with routine waits for a first outpatient appointment at 21 months. Successful recruitment to medical vacancies allows for a ring-fenced routine cataract clinic each week to commence in November 2023 in line with the new medical starters second week in post (post induction).

The Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a limited time period aiming to reduce the backlog of patients in Ophthalmology. The outsourced service will provide additional clinical capacity and allow patients to be seen and treated by an alternative provider at their facilities for either the full patient pathway or elements of it as required. This premarket engagement stage is not a call for competition and the information being gathered is to assist HCS to better understand the services available within the marketplace and the detail needed to confirm the market and commercial approach.

The remaining patients waiting > 1 year are in community dental which continues to deliver the commissioned recovery programme ahead of trajectory. (see Figure 1 below). The waiting list volume has now recovered to the pre-pandemic level.

**Figure 1:** Community Dental Actual Waiting List Volume Vs Trajectory.



The elective waiting list has increased since the implementation of the EPR as active and suspend lists are reported as a combined position which was not the case with the previous system. Theatre utilisation is not as poor as previously reported in the QPR (49%) following interrogation of the theatre's dashboard in the past two weeks. Capped utilisation is currently 70% for October 2023 whilst the uncapped position is at 78%. The difference is primarily due to planned operations being added to emergency lists in error.

The weekly 6-4-2 meeting has been overhauled to be a data led exercise which interrogates the next two weeks of bookings with the wider theatres team to ensure maximum 'touch time' where clinically safe and appropriate to do so.

The diagnostic PTL is currently being validated as reported to the Board in October 2023. This has seen an immediate decrease in the volume on the PTL from > 2716 patients to 1413. Xyla Elective Care commenced clinical activity on the 7<sup>th</sup> October 2023 with 88 procedures completed in the first two weekends. The endoscopy PTL has decreased by 77 patients in this period with another 6 weekends planned until the end of 2023.

A specific waiting list initiative, to improve access for patients waiting for MRI scans, has been in planning in September and commenced on the 9<sup>th</sup> October following the recruitment and on boarding of staff. This has reduced the events (scans) waiting to be completed from 1,111 to 744 at the stage of writing this report. This means that patients were waiting 52 weeks for a scan which has improved to a wait of 31 weeks. This initiative is scheduled to complete pre-Christmas and is on trajectory for reducing waits for public patients to a wait for a routine scan to 6 weeks, soon 4 and urgent 2.

For further information please see the separate Waiting List Board report.

## **b. Workforce**

A priority focus has continued to be on the recruitment of substantive employees with agency and locum usage remaining too high. This is a key aspect of the FRP with significant savings to be achieved as well as improved service quality. This work will be covered in detail in the Board's workforce report but in summary the vacancy rate has dropped by 2% at the end of September compared with the end of August and is now 16%, this equates to 458 wte vacancies out of a funded establishment of 2863 wte.

The HCS HR team has been offering leavers face to face exit interviews since March 2023. During that time the uptake of the offer of face-to-face requests has been variable, but of those staff who have spoken with the HR team the common themes for leaving are cost of living in Jersey, lack of communication and dissatisfaction with management. The review has also identified issues with the process and further work will be undertaken to ensure staff are given enough time to contact the HR team before they leave HCS.

For more information, please see the separate Workforce Board report.

## **4. Performance Summary**

### **Quality**

September has seen a decrease in complaints received from 44 to 28, with care being referenced having received the most complaints. Further analysis of complaints classified as care has been undertaken; it includes administration / disposal of medication, coordination of medical treatment and delay in diagnosis. Pharmacy saw a rise in complaints particularly around opening times and length of wait, they are now reviewing the current model in line with the feedback. Lessons learned from completed investigations were analysed and shared across care groups. Work is ongoing to reduce the number of open complaints, improve response times and move toward local resolution.

There has been an increase in the numbers of pressure damage acquired in care from 1.32 in August to 2.95 per 1000 bed days in September, this equates to 22 instances of pressure damage. Changes in the pressure ulcer reporting requirements have been added to the Datix system which will enable a more detailed analysis and development of improvement plans. The Inside and Outside Challenge which is a joint initiative with the tissue viability and nutrition teams has been launched which provides extra resource to ward staff with regards to pressure ulcer prevention and management.

As part of the food and nutrition improvement programme following a serious incident investigation, a series of clinical audits have been undertaken. Early indications from the October audit demonstrate an overall improvement of 10% in compliance with MUST (Malnutrition Universal Scoring Tool), with some areas scoring in excess of 90%.

Falls have shown a decrease in numbers this month from 68 (3 guided to floor / assisted by staff) to 54, (2 guided to floor / assisted by staff) however there has been an increase in the level of harm to patients; 1 resulting in moderate harm and 1 resulting in severe harm.

In general, bacteraemia rates are lower than the average in England except hospital MSSA rates which are comparable with England as is, C.difficile. Earlier GP appointments and use of antibiotics are likely to contribute to this picture. Root cause analysis of the alert organisms suggest a number of responses that may prevent some cases. However high occupancy rates are not easily remediable, and, in some cases, no evidently preventable cause is found. Hand hygiene compliance is above 90% and environmental hygiene is in the 80-90% (amber) range because of building works.

## **Performance: Acute Hospital Services**

September saw a 4% decrease in the number of Emergency Department attendances and although a slight increase in the proportional number of non-elective admissions, it was noted the conversion rate within the Emergency Department remains within the KPI at 15%. Longer stays within the Emergency Department have been noted with 72 patients remaining in the Department over 10 hours, this is a 148% increase from September 2022, some of these delays are attributable to trolley waits for admissions and which have been longer due to the increased in delayed discharge patients which had an average of 57.8 during September.

11% of hospital discharges were achieved before midday and to improve this indicator the Golden Patient Initiative has been commenced whereby inpatient areas are proactively identifying next day discharges to be discharged before 10am. In addition, the relaunch of the Red to Green initiative has been planned for October 2023 which will enable the identification of delays and enable the Operations Centre to reduce blockages within the system.

Winter Planning continues to be undertaken with care group schemes being identified. These schemes specifically target inpatient flow or admission prevention to maximise efficiency of the hospital over the winter period. This includes reviewing winter arrangements for testing of COVID-19, Influenza and RSV to ensure appropriate and timely management of non-elective admissions and to reduce the risk of outbreaks and nosocomial transmission.

Delayed discharges continue to be high. Prior to Covid the number of delayed discharges averaged between 10 and 15. Over the previous 4 years the number of delayed discharges has increased year on year. The current trend of delayed discharges waivers between 38 to 47 daily. These reductions were identified through operating efficiencies however, external factors such as EU Exit, COVID-19 has impacted on the care sector.

## Mental Health and Social Care

Mental health services continue to receive a high number of referrals. However, in line with the aspiration of the new community model, the service has seen 93% of crisis referrals within 4 hours and 80% of all referrals within 10 days. This does not yet achieve the aim of 85%, although review of all referrals not seen within 10 days highlights that service user choice is a key factor within this. Face to face follow up on discharge from hospital is consistently improved within working age adult services, but the target of 80% is not yet being achieved in the older adult service – this is being worked upon. A Quality Improvement programme across inpatient mental health services is now underway.

Waiting times for the dementia assessment service and psychological therapies continue to present a significant challenge, as a result of both increased demand and reduced clinical capacity (which is being addressed through recruitment and some redeployment of resources). The mental health leadership team are currently developing improvement trajectories in these areas.

The multi-agency Mental Health System Partnership Board recently commissioned the development of a Co-production Framework, led by the Jersey Recovery College and jointly developed in partnership with a range of service users, carers and staff from across the sector. The framework is now complete and has been launched this month. Alongside the successful completion of Peer Support training by a group of people with lived experience from across agencies, this is a significant step towards increased engagement, involvement and service development within our mental health system.

Adult Social Care continue to have a particular focus on developing the discharge service and supporting flow through the hospital. Unfortunately, this has continued to impact on their KPI relating to the review of support plans within 6 weeks (achieving 60% in September against a target of 80%) - the service are currently looking at how to address this. Linked to this, placement and domiciliary care costs remain a significant financial pressure for the service.

## Finance

The Year-to-date (YTD) actual vs budget overspend to September M9 is £23.1m vs budget rising by £4.2m in-month. The FY23 year-end forecast remains at a deficit of £29.0m.

HCS Categorisation	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	16,127	17,710	142,258	150,623	(8,364)	194,206	205,434	(11,228)	(3.3%)	(5.8%)
Non Pay	7,733	12,558	74,588	88,778	(14,189)	97,205	115,125	(17,920)	(25.0%)	(18.4%)
Income	(2,146)	(4,301)	(18,897)	(18,347)	(550)	(26,207)	(26,355)	148	(2.9%)	0.6%
<b>Grand Total</b>	<b>21,714</b>	<b>25,966</b>	<b>197,950</b>	<b>221,053</b>	<b>(23,103)</b>	<b>265,205</b>	<b>294,205</b>	<b>(29,000)</b>	<b>(11.7%)</b>	<b>(10.9%)</b>

Key drivers of the overspend are:

- **Staff Costs** - £8.4m YTD overspend which includes £3.5m of opening budget pressure re agency/locum costs, a further £20.6m agency/locum overspend (201 FTE), and £2.9m of overtime costs, which are substantially mitigated by underspends of £18.6m in substantive staffing due to vacant posts (471 FTE) across other Care Groups/Directorates. The FY23 year-end forecast overspend is £11.2m which includes an element of the Opening Pressure of £4.7m, a £17.8m underspend on substantive staffing due to vacancies.

These cost pressures are mainly driven by factors identified in developing the Financial Recovery Programme (FRP) such as recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services, Surgical Services, and Women & Children & Family Care.



- **Non-Pay** - £14.2m is adverse to budget which includes £6.1m part-year effect of the opening pressure with the remaining £8.1m overspend driven by scarce capacity and activity pressures in Mental Health on off-Island placements and drugs £2.6m, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Tertiary Care £0.8m due to increased activity, Surgical Services £0.9m, Chief Nurse re Accommodation Service £1.2m due to expansion of staff accommodation costs exceeding rental income (see accommodation income below), and Non-Clinical Support Services £0.8m, of which the majority relates to increased patient travel costs and Estates compliance works. The FY23 year-end forecast is £17.9m overspend of which £9.2m relates to the opening budget pressure, with the remaining £8.5m spread across Care Groups including Mental Health, Surgical Services, Chief Nurse, Social Care, Tertiary Care, Non-Clinical Support Services, Medical Services, and Estates.
- **Income** shows an under-achievement of £0.6m due to Surgical Services underperformance by £2.1m against private patient income targets, and £0.3m underperformance in Social Care. These are partially mitigated by overachievements in Chief Nurse £0.5m from additional staff accommodation capacity, and Mental Health £0.4m in relation to Long Term Care Benefit. However, the FY23 year-end forecast is an over-achievement of £0.1m due to over-performance in Chief Nurse £0.8m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Medical Services £0.3m, and Women & Children & Family Care £0.2m to offset the under-performance in Surgery private patient income of £3.0m due to a lack of surgical beds capacity from medical outliers and escalation beds.

The reserves position which is made-up of growth, Covid and capital reserves has further reduced to £1.78m (M8 £2.93m). £3.1m of reserves have been used to offset additional cost pressures in the last 2 months to maintain the forecast year end deficit position at £29m. The remaining reserves have been frozen to ring-fence in partial mitigation against the in-year deficit position.

### Financial risks and issues

The risks to the year-end forecast remain as follows:

- Delays in recruitment to substantive posts to replace agency staff.
- Further substantive recruitment fill without replacing agency.
- Agency/Locums rates pressures due to stricter application of Jersey tax rules.
- Tertiary Care contracts commissioning relating to activity volumes through the Southampton contract.
- Significant price and activity variations experienced throughout this year in mental health and social care packages.

The Board is asked to note the FY23 forecast deficit of £29m and the requirement to deliver £3m in savings to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury. This means delivering key cost reduction and income improvement schemes including:

- Reduction in agency spend by recruiting substantive staff.
- Increasing income from surgical private patients and laundry income.
- Mitigating the forecast risks from delays in recruitment to substantive posts to replace agency staff, further substantive recruitment fill without replacing agency, agency / locum rate pressures, tertiary care contracts commissioning relating to activity volumes, and the significant price and activity variations in mental health and social care packages.

## **Risk**

Ownership and overdue performance metrics remain green. The Overdue risk position for all HCS risks was 67 (26%) out of 262 live risks. There were zero HCS Principle (BAF) overdue risks and 7 out of 8 had assurance data. The Risk Assurance metric was introduced at the end of Q1 2023 and continues a path to green (currently 190 (73%) out of 262 have assurance data), currently amber.

During the month of September, six quarterly risk summits were completed with 35 risk actions generated.

The Quality and Safety team have worked closely with the HCS informatics team to produce improved risk dashboards and a dynamic risk heatmap data presentation platform (known as PowerBi) which integrates back to Datix to facilitate and encourage timely updates.

## **Workforce**

Due to an increase in funded establishment from Government Plan business case funded roles coming online from January 2023, the funded establishment has increased by 232 WTE since the beginning of 2023. This has had a corresponding impact on the overall vacancy number which has increased, as has the vacancy rate and the agency numbers. However, at the end of September, HCS is reporting 458 WTE vacancies (down from 527 WTE at the end of August) and a vacancy rate of 16% down from 18% at the end of August. This equates to 40 new nurses, 31 new doctors and 21 new Health Care Assistants.

The dedicated focus on the recruitment to substantive roles appears to be proving successful and HCS continues to adopt several approaches to increase the attraction element of HCS as an employer utilising several approaches. The microsite for all nurses' roles will go live in November and specialist recruiters have been engaged to assist with identifying candidates for hard to fill roles.

The total turnover rate has dropped slightly this month from 7.3% to 7% with a similar drop in the voluntary turnover rate (i.e., resignations) to 4.3%; this is equivalent to 104 staff resigning over the previous 12 months. In that period HCS has over 300 new starters, which is a mix of people new to HCS and people within HCS taking up alternative roles.

The sickness absence rate has remained constant at 5.5%, with the main reason for absence continuing to be coughs, cold and flu over the last month.

The September data for the objective setting shows positive movement in the approval of objectives and the mid-year reviews with an increase from 9.9% to 21.5% of the workforce having their objectives approved and from 6.8% to 10.6% having had their mid-year review. However, this is still low and will remain an area of focus for Executive team.

## **5. Highlights of Staff achievements**

We continue to build a culture of listening and action through a range of staff engagement events including a breakfast with the Chief Officer to recognise and celebrate the achievements of key HCS staff such as an Informatics Analyst presenting their MSc research at an international conference in Japan and winning best presentation of all candidates. The Chief Officer Teams listening events continue. Other key staff engagement events include:

- Enid Quenault Health and Wellbeing Centre opened – colleagues involved in official opening ceremony.
- Staff engaged in the McMillian Coffee Morning in various departments - Corbiere Ward raised £430.
- The Cardiology Team took part in the Jersey Marathon - Ravenscroft Relay Race and raised over £1,800 for Jersey Heart Support group.

- Help2Quit team took part in the Seafit Event which helps local fishermen to improve their health and wellbeing.
- Ronan Mulhern, Consultant Nurse at HCS won Pride of Jersey: Mental Health Champion of the Year Award.
- Third year nursing students and fourth and fifth year medical students came together for a day of multi-professional activities and learning.
- The Education Team held their first HCS students in healthcare conference.
- Jersey Resus Service has been working with two schools to educate children on how to restart a heart.
- Medical Ward Sisters – Jocelyn O'Connell is a finalist (1 of 3) in the Angel of Year category (Pride Awards)

## **6. Recommendation**

The Board is asked to note the report.

## **7. Appendices**

### **A. Electronic Patient Record (EPR) Implementation**

The current key focus of the EPR programme is now mobilisation of release three which includes clinical noting, ICPs, electronic observations, ITU EPR Hospital at Night and electronic referrals. Descriptions of these tools/applications are:

#### **Pyxis Integration**

Medication cabinets integration with EPMA and EPR. Allows for the medication to be administered to the patient for that date/time to be displayed in the cabinet screen. Ensures the right medication is given to the right patient at the right time. Process efficiency.

#### **eReferrals**

Electronic referrals between GP practices and HCS: provides an easy way for patients to choose their first hospital or clinic appointment with a specialist. Bookings can be made online, using the telephone, or directly in the GP surgery at the time of referral.

#### **Clinical Notes / Integrated Care Pathways**

Clinical electronic documentation: move from paper clinical notes / forms to electronic, structured clinical noting and enablement of Integrated Care Pathways, Care Planning and Care Bundles. Part of Maxims Mobile Platform.

#### **eOBS (Electronic Observations)**

Electronic observations: ability to record the observations electronically with automatic NEWS calculation and escalation. This enables a nurse to remain with the patient should their observations deteriorate, as alerts can be sent automatically to the responding teams who can then come and review the patient. It also allows the consultants when away from the wards to keep track of their patients and have a 'bird's eye' view of the ward from afar. Part of Maxims Mobile Platform.

#### **Hospital At Night**

Hospital At Night is a multidisciplinary team-based approach to providing safe and effective patient centred care to our patients overnight. It allows clinicians to allocate tasks and monitor deteriorating patients, out of hours. Part of Maxims Mobile Platform.

#### **ITU**

ITU EPR: Suitable for ICU and HDU environments for both ventilated and non-ventilated patients, the system allows the full management of the patient records via a single view.

## Porters Management Solution

Allows for porter request and porter activity scheduling and linking with patient movements.

## Nuance – Dragon Mobile

Voice-to-Text: Dragon lets you dictate and edit documents/EPR clinical notes by voice on your Desktop, iOS or Android mobile device quickly and accurately, so you can stay productive anywhere you go. It will replace G2 in the future as well. Already deployed to ED and a few OP clinics.

## Milktrac

Closed loop for breast milk administration tracking - closes the loop on breast milk collection and donation, ensuring the right milk gets to the right baby. MilkTrac enables the whole process to be monitored and controlled, from breast milk collection to feeding, including management of volumes, fractions, and shelf life.

## Endobase integration

Integration with Omni and EPR in Endoscopy.

	Aug 23	SEPT 23	OCT - 23	NOV - 23	DEC - 23	JAN - 24	FEB - 24	MARCH - 24
<b>IMS Modules</b>								
Order Comms 2.01	Build	Build	UAT/Training/Pilot	Pilot / Go - LIVE				
eReferrals	Discovery	Delay in JCHI	Build	Build	Build	Config	UAT	LIVE
Clinical Noting	Initiation	Planning	Planning	Build	Build	Build	UAT	Live
Clinical Pathways	Initiation	Planning	Plan Approval	Implementation	Implementation	Implementation	Implementation	Implementation
eObservations	Infrastructure	Build	UAT/Training	Pilot	Go-Live	Rollout		
Hospital @ Night	Infrastructure		UAT/Training	Go-Live	Other Location			
Porter Tracking	Discovery	Discovery	Scope	Config	Go-Live			
<b>RTT (Ref to Treatment)</b>	Define	Define	Strategy Review					
<b>CMM</b>								
EMPA version upgrade			Install / UAT	UAT	UAT/Go-Live Prep	V8.2 LIVE		
Pharmatrac	Release 4							
GlueIT	Build	Build	UAT	Training/ ITU Go-Live				
Infusion Pumps	Build	Build	Interface Dev/Testing	Config / Training	Config/ Training	UAT	Go-Live	
Ventilators	Dev / Testing	Training/UAT	Go-Live					
Dialysis	Interface design	Dev / Testing	Dev / Testing		UAT	UAT	Go-Live	
CD Manager			Install/Training/Config	UAT	Go-Live	Roll-out	Roll-out	
<b>Clinical Coding -</b>								
EasyAudit	Initiation	Planning						
Coding Analyst	Initiation	Planning						
<b>Nuance</b>								
Nuance - Speech to text	Roll-out	Roll-out	Roll-out	Roll-out				
<b>Integrations</b>								
Pyxis – Med Dispensers	Integration/Config	Med Config	ADT & Med UAT	Ward Training	Go-Live Prep	Go-Live on V.82		
Auditbase -Audiology	Initiation	Planning	Config	Live				
Philips PACS – to IMS	Discovery	Development	Testing	UAT	Go-Live			
Release Optimisation		On going	On going	On going	On going	On going	On going	On going

**END OF REPORT**



Health and  
Community Services

# Quality and Performance Report September 2023

Government of Jersey

## *INTRODUCTION*

The Operations, Performance & Finance Committee obtains assurance that high standards of care are provided by Health and Community Services (HCS) and in particular, that adequate and appropriate governance structures are in place.

## *PURPOSE*

The Quality and Performance Report (QPR) is the reporting tool providing assurance and evidence to the committee 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 organisation's objectives. Where performance is below standards, the committee will ensure that robust recovery plans are developed and implemented.

## *BACKGROUND*

The Operations, Performance & Finance Committee has been established by the Health and Community Services Board and is authorised to investigate any activity within its terms of reference.

## *SPONSORS:*

Interim Chief Nurse - Jessie Marshall

Medical Director - Patrick Armstrong

Director Clinical Services - Claire Thompson

Director Mental Health & Adult Social Care - Andy Weir

## *DATA*

HCS Informatics

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## EXECUTIVE SUMMARY

The Quality & Performance Report is designed to provide assurance in relation to Health and Community Services' performance. Indicators are chosen that are considered important and robust to enable monitoring against the organisation's objectives.

### General & Acute Performance

The Outpatient Patient Tracking List (PTL) is stabilising following significant growth since the new Electronic Patient Record went live. Dermatology represents the most challenged specialty with plans to utilise a variety of options from outsourcing or insourcing from providers in the UK alongside additional temporary workforce at HCS and the use of other healthcare professionals in Jersey e.g., GPs with enhanced skills. Further options include medical photography clinics which are being explored and then procured if clinically appropriate.

Waits in Ophthalmology continue to grow, with routine waits for a first outpatient appointment at 21 months. Successful recruitment to medical vacancies allows for a ring-fenced routine cataract clinic each week to commence in November 2023 in line with the new starters second week in post (post induction).

The Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a limited time period aiming to reduce the backlog of patients in Ophthalmology.

The remaining patients waiting more than 1 year are in community dental which continues to deliver the commissioned recovery programme ahead of trajectory. The waiting list volume has now recovered to the pre-pandemic level.

The diagnostic PTL is currently being validated as reported to the Board in September 2023. This has seen an immediate decrease in the volume on the PTL from > 2716 patients to 1413. Xyla Elective Care commenced clinical activity on the 07th of October 2023 with 88 procedures completed in the first two weekends. The endoscopy PTL has decreased by 77 patients in this period with another 6 weekends planned until the end of 2023.

A specific waiting list initiative, to improve access for patients waiting for MRI scans, has been in planning in September and commenced on the 9<sup>th</sup> October which is delivering in line with projection.

September saw a 4% decrease in the number of Emergency Department attendances and although a slight increase in the proportional number of non-elective admissions, it was noted the conversion rate within the Emergency Department remains within the KPI at 15%. Longer stays within the Emergency Department have been noted with 72 patients remaining in the Department over 10 hours, this is a 148% increase from September 2022, some of these delays are attributable to trolley waits for admissions and which have been longer due to the increase in delayed discharge patients which had an average of 57.8 during September.

11% of hospital discharges were achieved before midday and to improve this indicator the Golden Patient Initiative has been commenced, whereby inpatient areas are proactively identifying next day discharges to be discharged before 10am. In addition, the relaunch of the Red to Green initiative has been planned for October 2023 which will enable the identification of delays and enable the Operations Centre to reduce blockages within the system.

Winter Planning continues to be undertaken with care group schemes being identified, the schemes specifically target inpatient flow or admission prevention to maximise efficiency of the hospital over the winter period. This includes reviewing winter arrangements for testing of COVID-19, Influenza and RSV to ensure appropriate and timely management of non-elective admissions and to reduce the risk of outbreaks and nosocomial transmission.

Delayed discharges continue to be high, prior to Covid the number of delayed discharges averaged between 10 and 15. Over the previous 4 years the number of delayed discharges has increased year on year. The current trend of delayed discharges varies between 38 to 47 daily. These reductions were identified through operating efficiencies however external factors such as EU Exit and COVID-19 has impacted on the care sector.



## **Mental Health and Adult Social Care**

Access remains significantly improved as a result of the new community model, with 93% of all crisis referrals being seen within 4 hours and 80% of all routine referrals being seen within 10 days. Whilst this is below the 85% target, review of all cases who were not seen within the timeframe indicates that service user choice is a reason for many of these. Waiting times for the memory assessment service and psychological therapies remain a concern. This is being addressed in part through recruitment and the temporary redeployment of some resources. However, the service are also currently exploring other potential solutions, through the development of an improvement trajectory.

Social care continue to significantly focus on developing the discharge service and maintaining flow through the hospital. This has impacted consistently on the target to review all support plans within 6 weeks (60% achieved in month); the service have current plans to address this.

## **Quality and Safety**

September has seen a decrease in complaints received from 44 to 28. Temporary additional support has been put into the patient experience team to investigate complaints that are outside of the required timescale which has resulted in 57 complaints being closed in the month of September. Work is ongoing to reduce the number of open complaints and improve response times. Pharmacy has seen a rise in complaints particularly around opening times and length of wait, they are now reviewing the current model in line with the feedback. Lessons learned from completed investigations were analysed and shared across care groups. Work is ongoing to reduce the number of open complaints, improve response times and move toward local resolution.

There has been an increase in the number of pressure damage acquired in care from 1.32 in August to 2.95 per 1000 bed days in September. The tissue viability team continue to provide regular training and education to staff, patients and relatives. There has been an increase in the number of pressure relieving devices provided to the wards in the past month to support the management of pressure area care.

Falls have shown a decrease in numbers this month from 68 (3 guided to floor / assisted by staff) to 54, (2 guided to floor / assisted by staff), the level of harm to patients; 1 resulting in moderate harm and 1 resulting in severe harm. There is no one ward or clinical area experiencing recurrent falls. The rate of falls in hospital will be impacted by the number of delayed transfer of care patients.

## DEMAND








These measures monitor demand and activity in Health & Community Services. The information is used to provide contextual information when planning services and interpreting the Quality and Performance indicators in the following sections of the report.

Measure	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Referrals	3440	3586	4104	3332	3837	3622	4812	3731	3797	4512	4204	4100	4173		36788	2%	21%
General and Acute Outpatient Referrals - Under 18	301	302	365	411	348	432	414	308	305	439	384	321	400		3351	25%	33%
Additions to Inpatient Waiting List	434	535	581	451	455	495	571	468	430	297	303	264	490		3773	86%	13%
Referrals to Mental Health Crisis Team	ND	ND	52	91	87	83	90	91	93	113	104	102	93		856	-9%	NA
Referrals to Mental Health Assessment Team	ND	ND	139	201	237	215	272	187	229	249	234	319	221		2163	-31%	NA
Referrals to Memory Service	33	21	33	30	57	43	56	43	29	27	27	39	5		326	-87%	-85%
Referrals to Jersey Talking Therapies	98	112	113	74	104	98	134	109	94	105	90	110	120		964	9%	22%

## ACTIVITY

Measure	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	On Month	YoY
General and Acute Outpatient Attendances	17344	19057	21502	16596	19916	19315	21533	16712	17425	16875	15572	16046	16695		160089	4%	-4%
Elective Admissions	221	240	230	163	213	233	335	315	265	166	155	132	138		1952	5%	-38%
Elective Day Cases	592	685	700	532	629	615	701	428	583	549	513	545	529		5092	-3%	-11%
Elective Regular Day Admissions	919	908	923	903	952	884	1064	932	1087	1072	1029	1046	1002		9068	-4%	9%
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	292	274	277	268	316	240	245	180	162	160	150	147	144		1744	-2%	-51%
Emergency Department Attendances	3515	3479	3394	3325	3270	2982	3501	3345	3547	3762	3671	3713	3569		31360	-4%	2%
Emergency Admissions	529	583	588	571	579	502	571	555	627	591	553	544	542		5064	0%	2%
Admissions to Adult Mental Health unit (Orchard House)	16	14	11	8	16	13	15	10	9	12	15	14	14		118	0%	-13%
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	5	3	11	7	5	4	4	5	6	6	11	5	10		56	100%	100%
Maternity Deliveries	71	63	70	63	77	60	68	59	69	54	81	71	65		604	-8%	-8%

## WAITING LISTS

Measure	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	On Month	YoY
Outpatient 1st Appointment Waiting List	9815	9394	9049	9245	9036	8571	9044	9296	9814	10917	12668	13077	13398		13398	2%	37%
Outpatient 1st Appointment Waiting List - Acute	7652	7265	7069	7247	7232	6807	7413	7860	8399	9875	11388	11793	12099		12099	3%	58%
Outpatient 1st Appointment Waiting List - Community	2163	2129	1980	1998	1804	1764	1631	1436	1415	1042	1280	1284	1299		1299	1%	-40%
Diagnostics Waiting List	1055	1022	1027	992	955	908	1030	1025	1027	971	2400	2489	2548		2548	2%	142%
Elective Waiting List	2230	2157	2186	2293	2409	2424	2385	2434	2375	2699	2730	2651	2724		2724	3%	22%
Elective Waiting List - Under 18	110	100	84	87	90	106	101	91	93	100	86	71	79		79	11%	-28%
Jersey Talking Therapies Assessment Waiting List	133	143	150	145	138	117	159	167	147	133	97	68	124		124	82%	-7%




## QUALITY AND PERFORMANCE SCORECARD

The Quality and Performance Scorecard summarises HCS performance on the key indicators, chosen because they are considered important and robust to enable monitoring against the organisation's objectives. Standards are set based on appropriate benchmarks, e.g. with other jurisdictions, or past performance in Jersey. Where performance is below standards, exception reports are provided. For some indicators, a standard is not considered applicable.

















CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
GENERAL AND ACUTE WAITING LISTS																	
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	47.2%	46.2%	44.0%	43.5%	42.3%	42.1%	38.1%	38.1%	40.5%	40.2%	41.8%	42.5%	45.8%		45.8%	<35%
	% patients waiting over 90 days for 1st OP appointment - Acute	37.6%	35.2%	33.0%	34.2%	34.5%	35.6%	30.6%	32.2%	35.0%	35.8%	39.4%	40.8%	44.9%		44.9%	<35%
	% patients waiting over 90 days for 1st OP appointment - Community	81.0%	83.6%	83.1%	77.2%	73.7%	67.3%	71.9%	70.0%	73.4%	81.7%	63.0%	58.3%	54.0%		54.0%	<35%
Diagnostics	% patients waiting over 90 days for diagnostics	48.6%	48.1%	49.8%	53.6%	55.4%	58.8%	49.6%	49.2%	50.6%	69.8%	70.8%	70.2%	69.2%		69.2%	<35%
Inpatients	% patients waiting over 90 days for elective admissions	57.4%	53.3%	49.6%	50.0%	54.5%	57.8%	56.1%	55.1%	55.7%	58.1%	56.4%	58.1%	59.0%		59.0%	<35%
PLANNED (ELECTIVE) CARE																	
Outpatients	New to follow-up ratio	2.7	2.6	2.7	2.8	2.8	2.8	2.9	2.8	2.9	2.9	2.9	2.7	2.6		2.8	2.0
	Outpatient Did Not Attend (DNA) Rate	8.2%	7.6%	8.2%	7.8%	7.5%	6.8%	6.9%	7.0%	7.3%	11.7%	12.6%	12.3%	12.9%		9.3%	<8%
Elective Inpatients	Acute elective Length of Stay (LOS)	1.9	2.5	2.6	2.3	1.8	1.7	2.1	2.3	2.2	2.5	3.1	3.6	2.8		2.4	<3
	% of all elective admissions that were day cases	81%	79%	76%	81%	80%	79%	78%	75%	76%	76%	75%	79%	75%		77.0%	>80%
Theatres	% of all elective admissions that were private	29%	25%	25%	30%	30%	24%	29%	28%	30%	31%	27%	24%	28%		27.9%	>32% and <34%
	Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)	74.0%	77.9%	75.0%	69.1%	74.0%	73.1%	73.6%	78.4%	72.9%	63.4%	64.3%	63.4%	64.2%		68.7%	>85%
	Turnaround time as % of total session time	14.0%	13.1%	14.9%	14.7%	18.3%	19.0%	16.9%	14.7%	14.3%	10.4%	12.1%	10.7%	12.8%		14.1%	<15%

CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE																	
Emergency Department (ED)	Median Time from Arrival to Triage	11	9	10	10	11	11	10	12	14	26	17	16	17		15	<11
	% Triage within Target - Minor	51%	59%	53%	51%	51%	52%	54%	49%	43%	26%	43%	46%	44%		45%	>=90%
	% Triage within Target - Major	64%	67%	63%	61%	60%	60%	64%	58%	56%	31%	42%	44%	46%		51%	>=90%
	Median Time from Arrival to commencing Treatment	44	43	39	40	38	41	38	44	41	60	40	37	33		41	<75
	% Commenced Treatment within Target - Minor	84%	83%	86%	84%	83%	86%	85%	82%	84%	78%	89%	89%	94%		86%	>=70%
	% Commenced Treatment within Target - Major	65%	63%	61%	61%	62%	64%	66%	63%	66%	53%	71%	70%	73%		65%	>=70%
	Median Total Stay in ED (mins)	142	153	148	160	158	148	149	160	156	173	149	146	146		154	<189
	Total patients in ED > 10 hours	29	12	27	69	45	19	55	39	54	58	36	76	72		454	<1
	ED conversion rate	15%	16%	17%	17%	17%	16%	16%	16%	16%	15%	14%	14%	15%		15.3%	<20%
Emergency Inpatients	Non-elective acute Length of Stay (LOS)	7.3	6.0	6.1	7.4	7.1	7.0	7.1	6.6	6.5	6.1	6.8	7.3	8.8		7.0	<10
	% Emergency admissions with 0 Length of Stay (Same day discharge)	9%	11%	8%	7%	7%	9%	8%	8%	11%	14%	12%	15%	13%		11%	<17%
	Acute bed occupancy at midnight (Elective & Non-Elective)	96%	95%	97%	94%	97%	90%	95%	95%	89%	87%	89%	87%	92%		91%	<85%
	% of Inpatients discharged between 8am and noon	13%	10%	11%	11%	13%	11%	12%	11%	13%	13%	11%	13%	11%		12%	>=15%
	Average daily number of patients Medically Fit For Discharge (MFFD)	32.4	26.2	24.0	31.1	23.2	23.9	31.1	24.2	23.2	ND	ND	ND	57.8		30.5	<30
	Total Bed Days Medically Fit For Discharge	972	811	721	932	718	669	932	702	579	ND	ND	ND	1733		5333	<910
	Total Bed Days Delayed Transfer Of Care (DTC)	582	578	466	622	442	511	628	467	412	ND	ND	ND	ND		2460	NA
	Rate of Emergency readmission within 30 days of a previous inpatient discharge	10%	12%	11%	10%	10%	10%	9%	10%	13%	11%	8%	12%	10%		10%	<10%

CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
MENTAL HEALTH																	
Jersey Talking Therapies (JTT)	% of clients waiting for assessment who have waited over 90 days	0.0%	0.7%	1.3%	0.0%	2.2%	1.7%	0.0%	2.4%	4.1%	3.0%	3.1%	2.9%	3.2%		2%	<5%
	% of clients who started treatment in period who waited over 18 weeks	59%	59%	64%	28%	61%	38%	47%	20%	38%	35%	59%	33%	46%		44%	<5%
	JTT Average waiting time to treatment (Days)	156	196	170	102	165	130	141	96	134	154	162	126	137		138	<=177
	% of eligible cases that have completed treatment and were moved to recovery	50%	56%	42%	62%	67%	44%	59%	64%	54%	91%	67%	43%	32%		56%	>50%
	% of eligible cases that have shown reliable improvement	75%	92%	71%	85%	78%	76%	71%	68%	77%	91%	81%	57%	77%		76%	>75%
Community Mental Health Services	Memory Service - Average Time to assessment (Days)	168	180	153	152	126	137	110	126	159	177	182	188	214		158	<138
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	ND	ND	70.0%	77.1%	84.4%	93.0%	85.2%	87.3%	86.7%	98%	84%	85%	93%		89%	>85%
	% of referrals to Mental Health Assessment Team assessed in period within 10 working days	ND	ND	96.8%	88.4%	83.9%	76.9%	80.7%	89.6%	86.0%	83%	77%	83%	80%		82%	>85%
	% of Adult Acute discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	ND	57%	64%	100%	67%	56%	100%	92%	89%	84%	94%	87%		85%	>80%
	% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days	ND	ND	60%	50%	67%	0%	100%	80%	83%	100%	0%	100%	75%		78%	>80%
	Community Mental Health Team did not attend (DNA) rate	6.9%	7.4%	4.8%	6.6%	6.0%	5.3%	6.0%	7.1%	6.4%	7.0%	5.8%	7.0%	6.3%		6%	<10%
	Adult Acute Admissions per 100,000 population - Rolling 12 month	253	241	234	224	229	226	233	229	221	219	220	209	206		206	<255
Inpatient Mental Health	Adult acute admissions under the Mental Health Law as a % of all admissions	50%	64%	36%	50%	25%	31%	47%	40%	11%	50%	47%	43%	64%		41%	<37%
	Adult acute bed occupancy at midnight (including leave)	100%	92%	93%	91%	95%	88%	94%	99%	93%	89%	84%	86%	86%		90%	<88%
	Older Adult Admissions per 100,000 population - Rolling 12 month	373	357	376	380	369	379	363	342	362	361	384	353	372		372	<475
	Older adult acute bed occupancy (including leave)	100%	98%	91%	98%	99%	99%	99%	96%	89%	86%	93%	88%	85%		93%	<85%
	Average daily number of patients Medically Fit For Discharge (MFFD) on Mental Health inpatient wards	20	19	16	14	15	14	13	13	15	ND	ND	ND	11		13.40	<13

CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
SOCIAL CARE																	
Learning Disability	Percentage of clients with a Physical Health check in the past year	62%	65%	65%	63%	66%	66%	65%	68%	68%	71%	73%	74%	74%		69%	>80%
Adult Social Care Team (ASCT)	Percentage of Assessments completed and authorised within 3 weeks (ASCT)	94%	95%	90%	91%	70%	83%	80%	73%	53%	86%	85%	84%	86%		78%	>=80%
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	50%	35%	62%	56%	39%	68%	73%	49%	47%	55%	64%	64%	60%		58%	>=80%

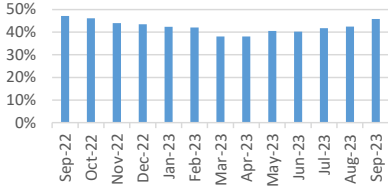
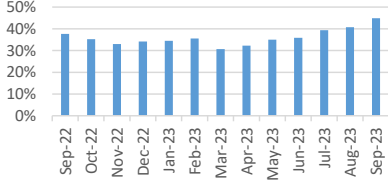
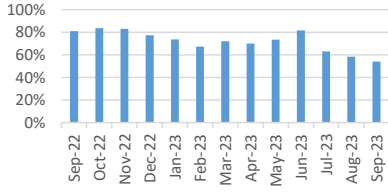


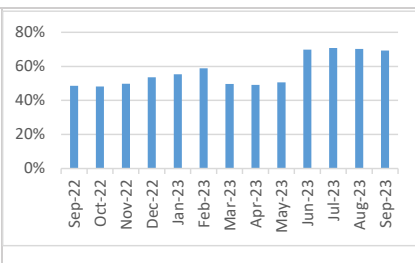
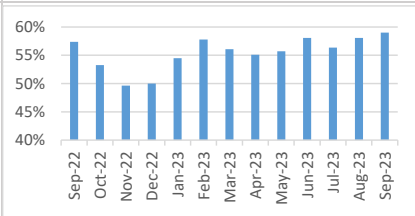
CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
WOMEN'S AND CHILDREN'S SERVICES																	
Children	Was Not Brought Rate	11.2%	10.5%	11.6%	10.9%	9.5%	8.1%	8.5%	10.6%	10.9%	19.9%	19.8%	20.3%	19.2%		14.2%	<=10%
	Average length of stay on Robin Ward	1.07	1.62	2.21	1.85	1.35	1.56	2.93	1.73	2.74	1.50	1.38	1.39	1.44		1.8	<=1.65
	% deliveries home birth (Planned & Unscheduled)	7.0%	4.8%	14.3%	3.2%	7.8%	5.0%	11.8%	8.5%	4.3%	7.4%	2.5%	5.6%	3.1%		6.1%	NA
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	37.1%	38.7%	44.3%	28.3%	44.0%	50.0%	46.3%	33.9%	24.2%	39.6%	35.2%	32.4%	34.4%		37.7%	NA
	% Instrumental deliveries	12.7%	12.7%	4.3%	9.5%	9.1%	16.7%	7.4%	15.3%	11.6%	11.1%	7.4%	16.9%	6.2%		11.1%	NA
	% Emergency caesarean section births	17.1%	17.7%	15.7%	25.0%	25.3%	16.7%	16.4%	20.3%	27.3%	9.4%	31.0%	22.5%	15.6%		21.0%	NA
	% Elective caesarean section births	18.6%	24.2%	28.6%	26.7%	29.3%	16.7%	22.4%	23.7%	27.3%	26.4%	23.9%	22.5%	21.9%		23.9%	NA
Maternity	% of women that have an induced labour	31.0%	25.4%	20.0%	38.1%	14.3%	26.7%	20.6%	23.7%	34.8%	22.2%	19.8%	28.2%	27.7%		24.0%	=27.57%
	Number of stillbirths	0	1	0	0	0	0	0	0	0	0	0	0	0		0	
	Rate of Vaginal Birth After Caesarean (VBAC)	0.0%	0.0%	0.0%	25.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		3.7%	>15%
	% primary postpartum haemorrhage >= 1500ml	7.0%	6.3%	2.9%	4.8%	5.2%	3.3%	4.4%	5.1%	14.5%	3.7%	4.9%	2.8%	4.6%		5.5%	<=6.75%
	% 3rd & 4th degree tears – normal birth	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.9%		0.8%	<2.5%
	% of births less than 37 weeks	4.2%	7.9%	10.0%	12.7%	13.0%	10.0%	13.2%	3.4%	10.1%	0.0%	8.6%	2.8%	3.1%		7.5%	<=6.85%
	% births requiring Jersey Neonatal Unit admission	8.5%	11.1%	8.6%	11.1%	13.0%	10.0%	17.6%	5.1%	9.0%	3.8%	18.2%	11.3%	4.7%		10.7%	<=5.05%
	% of babies that have APGAR score below 7 at 5 mins	0.0%	0.0%	5.7%	1.7%	0.0%	0.0%	1.5%	1.7%	3.0%	0.0%	4.2%	1.4%	1.6%		1.5%	<=1.3%
	Average length of stay on maternity ward	2.30	2.15	2.44	2.20	1.86	2.07	2.21	2.15	2.33	1.43	1.74	1.45	1.58		1.84	<=2.28

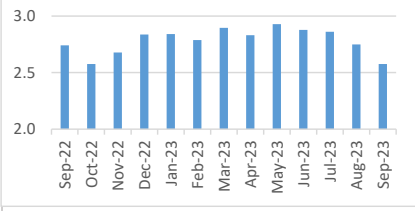
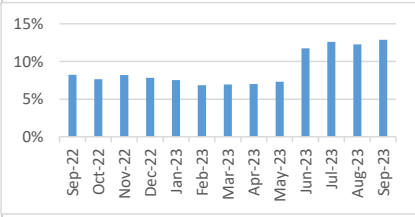
CATEGORY	INDICATOR		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
QUALITY AND SAFETY																		
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
	MSSA Bacteraemia	Hosp	0	0	1	1	0	0	1	1	1	0	0	0	0		3	
	E-Coli Bacteraemia	Hosp	0	0	1	0	0	0	0	1	1	0	1	0	1		4	
	Klebsiella Bacteraemia	Hosp	0	1	0	0	0	1	1	0	0	0	0	0	0		2	
	Pseudomonas Bacteraemia	Hosp	0	0	0	1	0	0	0	0	1	1	0	0	0		2	
	C-Diff Cases	Hosp	1	2	0	0	1	2	1	1	2	1	1	0	1		10	1
Safety Events	Number of falls resulting in harm (low/moderate/severe) per 1,000 bed days		1.2	1.2	2.8	2.8	2.3	2.4	2.9	2.8	4.1	3.9	2.8	4.6	2.6		3	NA
	Number of falls per 1,000 bed days		4.3	4.5	5.5	7.6	5.9	6.0	6.2	5.6	6.9	8.0	7.1	9.4	5.9		7	<6
	Number of medication errors across HCS resulting in harm per 1000 bed days		0.0	0.2	1.5	0.8	1.2	0.9	1.0	0.5	0.7	0.7	0.5	1.3	1.0		0.9	<0.40
VTE	Number of serious incidents		2	1	2	1	0	2	3	4	2	9	5	4	2		31	NA
	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		ND	ND	ND	ND	ND	ND	ND	ND	ND	11%	11%	31%	16%		17%	>95%
	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		3.40	3.00	2.66	1.62	2.33	2.44	1.46	1.82	1.55	2.74	1.62	1.32	2.95		2.02	<2.87
Pressure Ulcers	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days		2.89	2.00	1.50	1.30	1.71	1.69	1.13	1.66	0.86	2.23	1.30	1.16	2.46		1.6	<1.96
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		0.34	0.67	1.00	0.32	0.62	0.75	0.32	0.17	0.52	0.17	0.00	0.00	0.16		0.30	<0.60
Feedback	Number of comments received		27	18	29	25	15	8	17	12	27	25	35	22	35		196	NA
	Number of compliments received		50	69	53	96	76	95	60	70	57	62	83	49	180		732	NA
	Number of complaints received		34	47	53	29	55	43	34	35	24	43	36	42	27		339	NA
	% of all complaints closed in the period which were responded to within the target		ND	ND	54%	21%	31%	14%	23%	37%	21%	6%	18%	19%	20%		20.0%	>40%

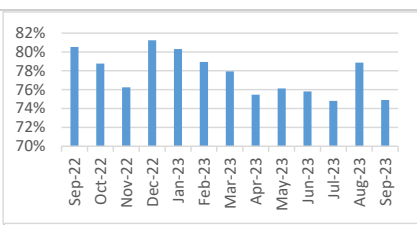
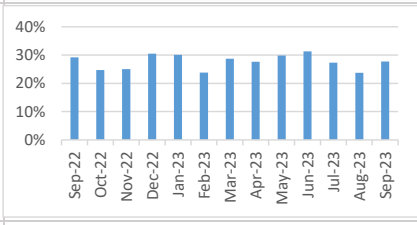
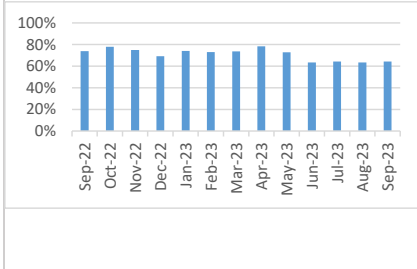
## EXCEPTION REPORTS

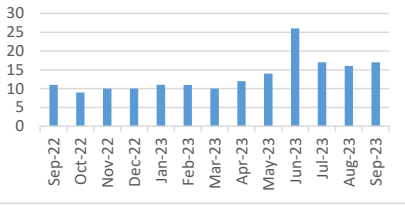
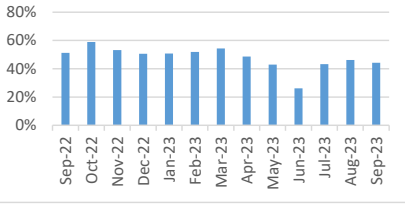
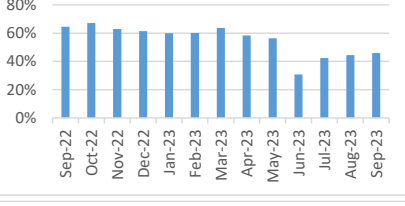
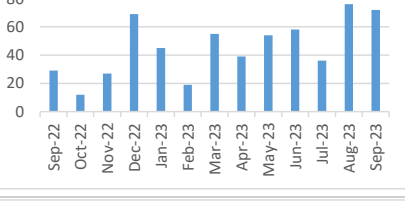
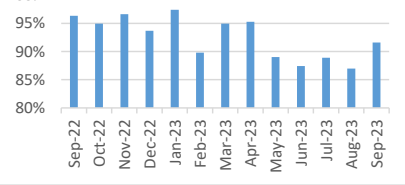
## GENERAL AND ACUTE WAITING LISTS

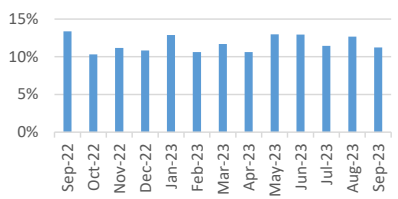
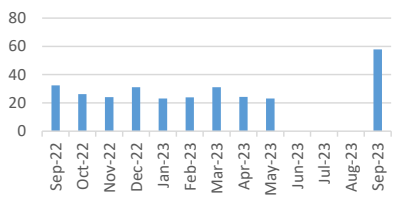

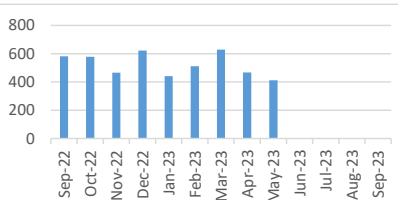
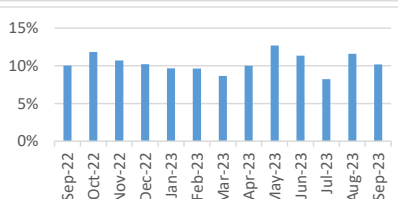
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
% patients waiting over 90 days for 1st outpatient appointment		This indicator is made up of two component parts (Acute and Community) which have their own commentary and action plans.	>35%
% patients waiting over 90 days for 1st OP appointment - Acute		<p>Ophthalmology, Clinical Genetics and Trauma and Orthopaedics remain the greatest outlier in the relation to patients waiting &gt; 90 days.</p> <p><b>Ophthalmology:</b> The last medical vacancy has been successfully recruited to with a start date for November. This capacity will ensure ringfenced routine cataract clinics are established for the longest waiting patients. In addition to this the Government of Jersey on behalf of Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model that could meet the specific requirements of Jersey patients. The specific clinical outsourcing service will provide additional capacity for a time limited period aiming to reduce the backlog of patients in Ophthalmology.</p> <p><b>Clinical Genetics:</b> Proposals for a service re-design have been submitted facilitated by the purchase of clinical genetics specific software.</p> <p><b>Trauma and Orthopaedics:</b> Waiting List Initiative clinics are commencing on the 06th October on Friday afternoons until the end of the year to ensure the outliers in relation to this metric are seen. The surgical waiting list manager is supporting to ensure chronological booking for the patient tracking lists.</p> <p><b>Paediatrics</b> continues to recover with the PTL reducing from &gt;400 patients to 267. The longest waiting patient without an appointment is now at 38 days.</p> <p><b>Dermatology</b> continues to be a challenge to recruit to. Alternative solutions are being sought to reduce the number of patients waiting with a particular emphasis on the urgent acuity.</p>	>35%
% patients waiting over 90 days for 1st OP appointment - Community		<p>At month end the commissioned dental scheme has reduced the total waiting volume from 1826 patients to 731 (-1095 or -60%). The remaining long waiters to be seen have either not engaged in the scheme or did not attend appointments in the scheme. These cases are being transferred back to the HCS Dental Departments care for appointments.</p> <p>An additional 200 patients were transferred into the scheme in August, HCS continues to receive the outcomes for this cohort as appointments are attended in the community practices. The scheme runs until the end of 2023. Discussions are on going with relevant Ministers in regards to the opportunity to continue the scheme into 2024 to reduce the risk on this list growing again post reduction.</p> <p>Staffing within the physiotherapy department is improving and waiting times are improving in line with this, although on boarding of new services has slowed down expected recovery.</p>	>35%
			Head of Access
			Head of Access
			Head of Access

<p>% patients waiting over 90 days for diagnostics</p>		<p>The diagnostic waiting list is being validated in October as post implementation of the new EPR the diagnostic PTL included a number of patients on surveillance pathway. It is expected that the October figure will return to approximately 45%.</p> <p>Endoscopy remains the greatest outlier in relation to this metric. Xyla Elective Care have been appointed as a quality assured provider delivering time limited additional capacity to the endoscopy unit. The mobilisation period commenced in August with the first activity on track to commence on the weekend 07th-08th October. With the impact of the WLI in endoscopy it is expected that this metric to be reaching standard by March 2024 but would be dependant on rates of referrals.</p>	<p>&gt;35%</p>
<p>% patients waiting over 90 days for elective admissions</p>		<p>HCS remains challenged across a number of specialties including Trauma and Orthopaedics, General Surgery, Ophthalmology, ENT and Gynaecology in relation to the % of patients waiting &gt; 90 days.</p> <p>HCS is funded to complete additional ad-hoc activity through a variety of initiatives across all specialties. Extra sessions have taken place in Urology, General Surgery and Ophthalmology as a part of waiting list initiative. This metric would be supported to improve post the opening of additional beds in Plemont end of November into December but would be dependent on staffing and any impact of seasonal admissions as we move into the winter months and increase/decrease in MFFD in JGH.</p>	<p>&gt;35%</p>
			<p>Head of Access</p>
			<p>Head of Access</p>

PLANNED (ELECTIVE) CARE			
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
<p>New to follow-up ratio</p>		<p>Detailed discussions took place at the Care Group Performance meetings this month in relation to achieving this standard. The surgical care group are taking action to focus on specific specialties pain management (2.66) although a reduction from 3.2 is noted from August, ENT &amp; Urology although it is understood that appropriate higher follow up ratio is expected for glaucoma &amp; some elements of ENT. General Surgery has reduced from 1.5 to 1.08 same period and T&amp;O has reduced 6% 2.02 - 1.9. All clinical leads have been requested to consider PIFU guidance and this work will be quantified and monitored within FRP workstream. A trajectory for improvement will be forth coming next month as an outcome of this.</p>	<p>&gt; 2.0</p>
<p>Outpatient Did Not Attend (DNA) Rate</p>		<p>Since the introduction of Maxims, reminder text messages are no longer being sent to all patients for their appointments as it is now an opt in function. This is further compounded by receipt of several letters cases where appointments are changed. The opt in function is in the process of being reversed and we should see an improvement going forward once this is done (go live set 5pm 24/10/23)</p> <p>Work continues within therapies, community dental and screening – significant resource has been allocated to call patients before their appointment to ensure attendance. Most effected, Pain (17.23%), Ophthalmology (15.2%), Urology (15.02%), General Surgery (13.63%), T&amp;O (12.03%), ENT (11.82%). Breast has reduced DNA rates in month so opportunities for learning is being explored.</p>	<p>&gt;8%</p>
			<p>Care Group General Managers</p>
			<p>Care Group General Managers</p>

<p>% of all elective admissions that were day cases</p>		<p>We continue to monitor cases that can be converted to day cases to assist with our elective bed management however more proactive benchmarking needs to be undertaken as part of clinical effectiveness agenda but current focus is on POLCV and then will be expanded. Further work needs to take into account the re provision of Sorel ward for private activity, increasing elective work generally as part of WLI, as will be impacted by increasing denominator.</p>	<p><b>&lt;80%</b></p> <p>Surgical Services Care Group General Manager</p>
<p>% of all elective admissions that were private</p>		<p>Delivery of 27% of private patient elective activity compared to 23% in previous period. This is subjected to the limitations of separate listing, and the listing of private patients is subject to the requirement of the individual clinicians. Work is on going as part of the private patient committee to consider list utilisation &amp; impact of opening of Plemont will drive increased bed base for private activity with associated benefits in income and patient choice.</p>	<p><b>&lt;32% or &gt;34%</b></p> <p>Surgical Services Care Group General Manager</p>
<p>Elective Theatre List Utilisation (Main Theatres and Day Surgery, Excluding Minor Operations)</p>		<p>Please Note: the adjusted position compared to the August QPR. The data quality for this figure has been interrogated by the Head of Access and reporting is now in line with Model Hospital Methodology. The 6-4-2 meeting continues to check and challenge the next 2/52 planned operating lists utilising historic data in relation to operating length. Data quality continues to be an issue, particularly with the adjustment to the new EPR and missing time stamps in theatre. The Head of Access and Lead Nurse are 'cashing' up each day to ensure all lists are representative of the work completed and that the October figure is a true representation of capped theatre utilisation. With data quality addressed, key actions taking place to add to under utilised planned lists and start of the day activity will be monitored in FRP work stream. The metric is expected to improve to 70-75% in November.</p>	<p><b>&lt;85%</b></p> <p>Surgical Services Care Group General Manager</p>

UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE			
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
Median Time from Arrival to Triage		Triage is an ongoing issue due to training and staffing, we have now recruited a Practice Development Nurse who will be addressing the improvements. ED nursing staff template has not been changed despite the Staffing Review done last year which recommended a 50% increase in Grade 4s and same for HCAs.	>10
	Medical Services Care Group General Manager		
% Triage within Target - Minor		Triage is an ongoing issue due to training and staffing, we have now recruited a Practice Development Nurse who will be addressing the improvements. ED nursing staff template has not been changed despite the Staffing Review last year which recommended a 50% increase in Grade 4s and same for HCAs. Sustained improvement will be difficult without staffing increase but will be considered as part of the unfunded pressures. The new lead nurse is focusing on the quality of care in this area to provide assurance and actions to mitigate any risk but is not current feature of complaints or incident reporting.	90%
	Medical Services Care Group General Manager		
% Triage within Target - Major		Majors patients are seen on arrival or within 10 minutes as part of SOP however nurses completing triage also start with IV cannula and blood tests as well as doing any urgent clinical interventions that are necessary, thus entering clinical triage data on MAXIMS retrospectively. An audit of the SOP is going to be conducted to build assurance. An Ambo triage area to mitigate any impact of winter pressures is under consideration and would likely improve data capture for P2's & P3s. Therefore the data has not been recorded correctly, to mitigate this we are looking at developing a more accurate quality indicators to reflect current patient care in the department at a granular level.	90%
	Medical Services Care Group General Manager		
Total patients in ED > 10 hours		This data contains data quality issues as not all notes are recorded in real time. Some patient data will be accurate and are due to awaiting an inpatient bed or to discharge from ED, however this is compounded by the high number of delayed discharge patients. Discharge workstreams are looking to address the high number of delayed discharges to resolve the data quality issue we are looking at flow in the hospital as well as ensuring appropriate staffing (nursing and medical) to allow contemporaneous discharges on MAXIMS.	>0
	Medical Services Care Group General Manager		
Acute bed occupancy at midnight (Elective & Non-Elective)		The metric has been reviewed in keeping with KH03 metric standards which removed ICU, paediatric in patients activity to allow benchmarking going forward and also historic in standard achievement did not sense check with daily operational pressures & observations.	>85%
	Medical Services Care Group General Manager		

<p>% of Inpatients discharged between 8am and noon</p>		<p>Implementation of the Red2Green initiative in October will support identification of delays and enable teams to troubleshoot how patient flow can be improved. As part of winter planning the golden patient initiative will be restarted and monitored through the operations meetings.</p>	<p><b>15%</b></p> <p>Medical Services Care Group General Manager</p>
<p>Average daily number of patients Medically Fit For Discharge (MFFD)</p>		<p>The average numbers of medically fit patients significantly increased in September thus increasing hospital occupancy and patients awaiting over 10 hours for a bed. A ministerial paper has been produced highlighting concerns with the available capacity across community sector and the subsequent impact on the General Hospital. A discharge taskforce has been established to implement improvements on internal aspects relating to medically fit for discharge patients.</p>	<p><b>&gt;30</b></p> <p>Care Group General Managers</p>
<p>Total Bed Days Medically Fit For Discharge</p>		<p>The total bed days for medically fit patients significantly increased in September thus increasing hospital occupancy and patients awaiting over 10 hours for a bed. A ministerial paper has been produced highlighting concerns with the available capacity across community sector and the subsequent impact on the General Hospital. A discharge taskforce has been established to implement improvements on internal aspects relating to medically fit for discharge patients</p>	<p><b>&gt;910</b></p> <p>Care Group General Managers</p>
<p>Total Bed Days Delayed Transfer Of Care (DTOC)</p>		<p>Snapshot only data available from new Patient Administration System currently. Informatics have been working with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. When this was first implemented in early August it worked for MFFD patients but failed for DTOC patients. This has been subsequently resolved, however we are unable to calculate a full month until October.</p>	<p><b>NA</b></p> <p>Care Group General Managers</p>
<p>Rate of Emergency readmission within 30 days of a previous inpatient discharge</p>		<p>At present the re-admission review process has been suspended however due to the increase this is under review. The medicine care group has added to their governance meeting for September this as a priority for discussion. Recent deep dive work has shown however we benchmark good against the UK.</p>	<p><b>&gt;10%</b></p> <p>Medical Services Care Group General Manager</p>



MENTAL HEALTH																															
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER																												
% of clients who started treatment in period who waited over 18 weeks	<table><thead><tr><th>Month</th><th>Percentage</th></tr></thead><tbody><tr><td>Sep-22</td><td>55%</td></tr><tr><td>Oct-22</td><td>55%</td></tr><tr><td>Nov-22</td><td>65%</td></tr><tr><td>Dec-22</td><td>25%</td></tr><tr><td>Jan-23</td><td>55%</td></tr><tr><td>Feb-23</td><td>35%</td></tr><tr><td>Mar-23</td><td>45%</td></tr><tr><td>Apr-23</td><td>20%</td></tr><tr><td>May-23</td><td>35%</td></tr><tr><td>Jun-23</td><td>35%</td></tr><tr><td>Jul-23</td><td>55%</td></tr><tr><td>Aug-23</td><td>35%</td></tr><tr><td>Sep-23</td><td>45%</td></tr></tbody></table>	Month	Percentage	Sep-22	55%	Oct-22	55%	Nov-22	65%	Dec-22	25%	Jan-23	55%	Feb-23	35%	Mar-23	45%	Apr-23	20%	May-23	35%	Jun-23	35%	Jul-23	55%	Aug-23	35%	Sep-23	45%	<p>Jersey Talking Therapies received 120 referrals in September, which was an increase from the previous month in which 110 referrals were received in August.</p> <p>The average waiting time for treatment is 137 days.</p> <p>Our waiting times from assessment to treatment remain above our KPI.</p> <p>We have a new Senior Psychological Therapist starting in post, which will have a positive impact on waiting times for treatment and we are recruiting a new step 2 Psychological wellbeing practitioner, and two Psychological practitioners to work at step 3.</p>	<div>&gt;5%</div> <div>Lead Allied Health Professional Mental Health</div>
Month	Percentage																														
Sep-22	55%																														
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% of eligible cases that have completed treatment and were moved to recovery	<table><thead><tr><th>Month</th><th>Percentage</th></tr></thead><tbody><tr><td>Sep-22</td><td>50%</td></tr><tr><td>Oct-22</td><td>55%</td></tr><tr><td>Nov-22</td><td>45%</td></tr><tr><td>Dec-22</td><td>60%</td></tr><tr><td>Jan-23</td><td>65%</td></tr><tr><td>Feb-23</td><td>45%</td></tr><tr><td>Mar-23</td><td>55%</td></tr><tr><td>Apr-23</td><td>60%</td></tr><tr><td>May-23</td><td>50%</td></tr><tr><td>Jun-23</td><td>90%</td></tr><tr><td>Jul-23</td><td>65%</td></tr><tr><td>Aug-23</td><td>45%</td></tr><tr><td>Sep-23</td><td>35%</td></tr></tbody></table>	Month	Percentage	Sep-22	50%	Oct-22	55%	Nov-22	45%	Dec-22	60%	Jan-23	65%	Feb-23	45%	Mar-23	55%	Apr-23	60%	May-23	50%	Jun-23	90%	Jul-23	65%	Aug-23	45%	Sep-23	35%	<p>This indicator requires clients to show recovery on both GAD (Anxiety) and PHQ (Depression) measures. The outcome measure for this month shows that the clients who have completed their intervention with JTT have shown improvements that have tended to be in either GAD or PHQ but not both.</p>	<div>&lt;50%</div> <div>Lead Allied Health Professional Mental Health</div>
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Memory Service - Average Time to assessment (Days)	<table><thead><tr><th>Month</th><th>Average Time (Days)</th></tr></thead><tbody><tr><td>Sep-22</td><td>160</td></tr><tr><td>Oct-22</td><td>175</td></tr><tr><td>Nov-22</td><td>150</td></tr><tr><td>Dec-22</td><td>150</td></tr><tr><td>Jan-23</td><td>125</td></tr><tr><td>Feb-23</td><td>135</td></tr><tr><td>Mar-23</td><td>110</td></tr><tr><td>Apr-23</td><td>125</td></tr><tr><td>May-23</td><td>155</td></tr><tr><td>Jun-23</td><td>170</td></tr><tr><td>Jul-23</td><td>180</td></tr><tr><td>Aug-23</td><td>190</td></tr><tr><td>Sep-23</td><td>210</td></tr></tbody></table>	Month	Average Time (Days)	Sep-22	160	Oct-22	175	Nov-22	150	Dec-22	150	Jan-23	125	Feb-23	135	Mar-23	110	Apr-23	125	May-23	155	Jun-23	170	Jul-23	180	Aug-23	190	Sep-23	210	<p>Greatly reduced team over this period due to sickness and maternity leave and reduced availability of medical staff. Meeting arranged to develop improvement trajectory with team.</p>	<div>&gt;138</div> <div>Lead Nurse - Mental Health</div>
Month	Average Time (Days)																														
Sep-22	160																														
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% of referrals to Mental Health Assessment Team assessed in period within 10 working days	<table><thead><tr><th>Month</th><th>Percentage</th></tr></thead><tbody><tr><td>Sep-22</td><td>100%</td></tr><tr><td>Oct-22</td><td>95%</td></tr><tr><td>Nov-22</td><td>95%</td></tr><tr><td>Dec-22</td><td>85%</td></tr><tr><td>Jan-23</td><td>80%</td></tr><tr><td>Feb-23</td><td>75%</td></tr><tr><td>Mar-23</td><td>75%</td></tr><tr><td>Apr-23</td><td>85%</td></tr><tr><td>May-23</td><td>80%</td></tr><tr><td>Jun-23</td><td>80%</td></tr><tr><td>Jul-23</td><td>75%</td></tr><tr><td>Aug-23</td><td>75%</td></tr><tr><td>Sep-23</td><td>75%</td></tr></tbody></table>	Month	Percentage	Sep-22	100%	Oct-22	95%	Nov-22	95%	Dec-22	85%	Jan-23	80%	Feb-23	75%	Mar-23	75%	Apr-23	85%	May-23	80%	Jun-23	80%	Jul-23	75%	Aug-23	75%	Sep-23	75%	<p>The service continues to review all referrals that are not seen within the 10 day target in orer to understand the reasons for this and address where possible. Service user choice remains a key component.</p>	<div>&lt;85%</div> <div>Mental Health Care Group Manager</div>
Month	Percentage																														
Sep-22	100%																														
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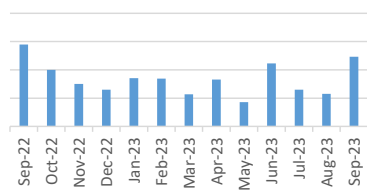
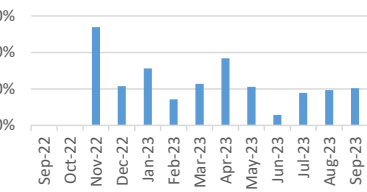
<p>% of Older Adult discharges with a face to face contact from an appropriate Mental Health professional within 3 days</p>		<p>The 75% achievement represents 3 of 4 people who were seen within the 3 day target on discharge. The circumstances of the 1 person that was not seen are being reviewed.</p>	<p>&lt;80%</p> <p>Mental Health Inpatient Lead Nurse</p>
<p>Adult acute admissions under the Mental Health Law as a % of all admissions</p>		<p>This indicator reflects the complexities of the admissions that cannot be cared for by home treatment and require MHL admission</p>	<p>&gt;37%</p> <p>Mental Health Inpatient Lead Nurse</p>

SOCIAL CARE			
INDICATOR	13-MONTH GRAPH	COMMENTARY & ACTION PLAN	TRIGGER & OWNER
<p>Percentage of clients with a Physical Health check in the past year</p>		<p>Percentage of clients with a physical health check in the past year is currently 74%. This was previously progressing towards the target of 80% over the last few months. Challenges relate to a lack of specific clinic space to carry out the health appointments (currently being reviewed for its own space to hold a clinic) and DNAs relating to service users who do not wish to have a health check.</p>	<p>&gt;=80%</p> <p>Social Care Care Group General Manager</p>
<p>Percentage of new Support Plans reviewed within 6 weeks (ASCT)</p>		<p>Review metric had improved but regressed when the hospital discharge service were unable to complete any initial reviews in August/September. This task was brought back under the Adult Social Care team in late September. Service continues to monitor and has plans in place to bolster the HDS and move hospital reviews to that centre of care (currently subject to staff consultation).</p>	<p>&gt;=80%</p> <p>Social Care Care Group General Manager</p>

## WOMEN'S AND CHILDREN'S SERVICES

Was Not Brought Rate		<p>Appointment reminder text messages are not being sent to patients as it has become an opt-in function. The care group expect an improvement once the system has been upgraded.</p> <p>Actions currently in place are telephone calls by clinical teams at time of appointments if a DNA has occurred and a follow-up letter/appointment sent as required. Clinic outcomes are monitored weekly to cross-check any missed outcomes.</p>	<p><b>&gt;9.8%</b></p> <p>General Manager Womens, Childrens &amp; Family Care Group</p>
% of women that have an induced labour		<p>Induction of labour is required where condition of the mother or foetus would deteriorate should the pregnancy continue. Also maternal request for the same is also one of the issues to consider when reviewing the IOL rate. Nationally the IOL rate is approx 30% with range nationally being 17.5% to 40% (2022)</p>	<p><b>&gt;25%</b></p> <p>Lead Midwife</p>
Rate of Vaginal Birth After Caesarean (VBAC)		<p>No requests this month for VBAC</p>	<p><b>&lt; 25%</b></p> <p>Lead Midwife</p>
% 3rd & 4th degree tears – normal birth		<p>Each case is reported on Datix and once identified repaired by experienced Obstetrician and then followed up at 6 weeks post-natal</p>	<p><b>&gt;2.5%</b></p> <p>Lead Midwife</p>
% of babies that have APGAR score below 7 at 5 mins		<p>Small number of deliveries, this number equates to two babies who are reviewed by a consultant.</p>	<p><b>&gt;0.6%</b></p> <p>Lead Midwife</p>

QUALITY AND SAFETY			
<b>E-Coli Bacteraemia - Hosp</b>		RCA being completed. No learning outcomes identified currently	<div>0</div> <div>Director of Infection Prevention and Control</div>
<b>Number of medication errors across HCS resulting in harm per 1000 bed days</b>		These have improved in month although have not fallen back to previous levels. The implementation of electronic prescribing has allowed more accurate determination of errors. It has also allowed redress with focussed training and mediation where required.	<div>&gt; 0.40</div> <div>Medical Director</div>
<b>% of adult inpatients who have had a VTE risk assessment within 24 hours of admission</b>		This was previously a mandated review in TrakCare which was driving higher levels of performance before MAXIMS was implemented in MAY. This is not feasible as a mandatory field in MAXIMS however a repeated pop up feature is being implemented which will continually flag until VTE assessment is complete. This should go live in October. Snap shot audits is showing performance averaging 65% with outliers identified for action. Additional work needs to occur to develop options paper for ITU as the Critical Care module is implemented for EPR/link to MAXIMS.	<div>&gt;97%</div> <div>Medical Director</div>
<b>Number of pressure ulcers acquired as an inpatient per 1,000 bed days</b>		There has been an increase in the number of pressure damage acquired in care from 1.32 in August to 2.95 per 1000 bed days in September. This equates to 22 instances of pressure damage of which 19 were category 2 there were 2 x unstageable and 1 x category 3. The category 3 pressure damage was reviewed by tissue viability team has been recategorized as category 2. There were instances where patients have been informed of the risks of pressure damage but have declined pressure relieving devices. The tissue viability team continue to provide regular training and education to staff, patients and relatives. There has been an increase in the number of pressure relieving devices onto the wards in the past month to support the management of pressure area care.	<div>&gt; 2.87</div> <div>Interim Chief Nurse</div>

Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days	 <table><thead><tr><th>Month</th><th>Number of Cat 2 pressure ulcers</th></tr></thead><tbody><tr><td>Sep-22</td><td>2.8</td></tr><tr><td>Oct-22</td><td>2.0</td></tr><tr><td>Nov-22</td><td>1.5</td></tr><tr><td>Dec-22</td><td>1.2</td></tr><tr><td>Jan-23</td><td>1.8</td></tr><tr><td>Feb-23</td><td>1.8</td></tr><tr><td>Mar-23</td><td>1.2</td></tr><tr><td>Apr-23</td><td>1.8</td></tr><tr><td>May-23</td><td>1.0</td></tr><tr><td>Jun-23</td><td>2.2</td></tr><tr><td>Jul-23</td><td>1.5</td></tr><tr><td>Aug-23</td><td>1.2</td></tr><tr><td>Sep-23</td><td>2.46</td></tr></tbody></table>	Month	Number of Cat 2 pressure ulcers	Sep-22	2.8	Oct-22	2.0	Nov-22	1.5	Dec-22	1.2	Jan-23	1.8	Feb-23	1.8	Mar-23	1.2	Apr-23	1.8	May-23	1.0	Jun-23	2.2	Jul-23	1.5	Aug-23	1.2	Sep-23	2.46	Further analysis of the data shows an increase in category 2 pressure damage from 1.16 in August to 2.46 per 1000 bed days in September. Further analysis of the data does not show that there is any one ward with a high incidence of pressure damage. All wards have been provided with additional mattress pumps and pressure relieving cushions to support delivery of patient care.	> 1.96
Month	Number of Cat 2 pressure ulcers																														
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% of all complaints closed in the period which were responded to within the target	 <table><thead><tr><th>Month</th><th>% of all complaints closed</th></tr></thead><tbody><tr><td>Sep-22</td><td>20%</td></tr><tr><td>Oct-22</td><td>20%</td></tr><tr><td>Nov-22</td><td>55%</td></tr><tr><td>Dec-22</td><td>20%</td></tr><tr><td>Jan-23</td><td>30%</td></tr><tr><td>Feb-23</td><td>15%</td></tr><tr><td>Mar-23</td><td>20%</td></tr><tr><td>Apr-23</td><td>35%</td></tr><tr><td>May-23</td><td>20%</td></tr><tr><td>Jun-23</td><td>5%</td></tr><tr><td>Jul-23</td><td>15%</td></tr><tr><td>Aug-23</td><td>15%</td></tr><tr><td>Sep-23</td><td>20%</td></tr></tbody></table>	Month	% of all complaints closed	Sep-22	20%	Oct-22	20%	Nov-22	55%	Dec-22	20%	Jan-23	30%	Feb-23	15%	Mar-23	20%	Apr-23	35%	May-23	20%	Jun-23	5%	Jul-23	15%	Aug-23	15%	Sep-23	20%	September has seen a decrease in complaints received from 44 to 28, with care being referenced having received the most complaints (14). Further analysis of complaints classified as care has been undertaken; it includes administration / disposal of medication, coordination of medical treatment and delay in diagnosis. Pharmacy has seen a rise in complaints particularly around opening times and length of wait, they are now reviewing the current model in line with the feedback. Lessons learned from completed investigations were analysed and shared across care groups. Temporary additional support has been put into the patient experience team to investigate complaints that are outside of the required timescale which has resulted in 57 complaints being closed in the month of September. Work is ongoing to reduce the number of open complaints and improve response times.	<40%
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Sep-22	20%																														
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Jun-23	5%																														
Jul-23	15%																														
Aug-23	15%																														
Sep-23	20%																														
			Head of Patient Experience																												

## CHANGES AND TECHNICAL NOTES

As part of our commitment to enhancing the quality of our services, we have developed performance indicators to track our progress and provide greater transparency into our operations. These indicators enable us to better monitor our performance towards achieving our objectives and make informed decisions about the future of our services.

However, please note these indicators may be subject to change in future versions of this report as we strive to refine our approach and respond to the changing needs of the community. We remain dedicated to providing accurate and insightful performance data and therefore use the most accurate data available at the time of publication.

The Hospital Patient Administration System was replaced at the end of May. There are significant differences between the two systems, the business processes and the data that are available to the Informatics Team. As far as possible we have attempted to ensure consistency and integrity in the indicators - and have noted where changes in the system have caused changes in the indicators.

General and Acute Outpatient Attendances - in month 6 report, the methodology has been updated following the implementation of the new system which identified some previous over-counting. The back series has therefore been revised to ensure full comparability with the recent data points.

Elective Regular Day Admissions - these are recorded differently in the new patient administration system. A different methodology is therefore in use to count these from month 6 onwards, meaning the pre/post system changeover are not wholly comparable.

For indicators related to Medically Fit for Discharge and Delayed Transfers of Care (DTOC), only snapshot data are currently available directly from new Patient Administration System. Informatics continue to work with the supplier to identify a fix. In the meantime we have introduced a workaround method to store the snapshots to be able to calculate these indicators. As this was implemented in early August, the first full month able to be calculated was September (month 9). Unfortunately the fix did not fully work for DTOC indicator, so this will be reported from October (month 10).

Community Mental Health Services indicators in relation to follow up within 3 days of discharge have been reviewed. This has resulted in a name change on the indicator to better reflect the service provided. These are now labelled:

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

Theatre Utilisation Rate has now been fully reviewed following the implementation of Maxims and the indicator updated to reflect the improved data availability. In addition the standard has been revised based on NHS GIRFT Benchmarks.

Acute Bed Occupancy has been reviewed to ensure it aligns with the NHS definition used for the standard KH03 return.

## APPENDIX - DATA SOURCES

DEMAND		
INDICATOR	SOURCE	DEFINITION
General and Acute Outpatient Referrals	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of General and Acute Outpatient referrals accepted by HCS clinicians in the period. This specifically excludes Mental Health specialties
General and Acute Outpatient Referrals - Under 18	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of General and Acute Outpatient referrals accepted by HCS clinicians in the period for patients under 18 years of age (at time of referral). This specifically excludes Mental Health specialties
Referrals to Mental Health Crisis Team	Community services electronic client record system	Number of referrals into the Crisis Team Centre of Care in the reporting period
Referrals to Mental Health Assessment Team	Community services electronic client record system	Number of referrals into the Assessment Team Centre of Care in the reporting period
Referrals to Memory Service	Community services electronic client record system	Number of referrals into the Memory Assessment Service Centre of Care in the reporting period
Referrals to Jersey Talking Therapies	JTT & PATS electronic client record system	Number of referrals received by Jersey Talking Therapies in the reporting period
Additions to Inpatient Waiting List	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of new additions to the inpatient waiting list for all care groups

ACTIVITY		
INDICATOR	SOURCE	DEFINITION
General and Acute Outpatient Attendances	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Number of General & Acute public outpatient appointments attended in the period
Elective Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of General & Acute public elective inpatient admissions in the period
Elective Day Cases	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of General & Acute Elective Day Case admissions in the period
Elective Regular Day Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of JGH/Overdale Elective Regular Day Admissions in the period. A regular day admission is a planned series of admissions for broadly similar ongoing treatment, for example, chemotherapy or renal dialysis.
Ward Attenders and Ambulatory Emergency Care (AEC) non-elective day admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), TrakCare Emergency Department Report (ED5A), Maxims Admissions & Discharge Report (IP13DM) & Maxims Emergency Department Report (ED1DM))	Number of Ward Attenders and non-elective AEC admissions in the period. Ward attenders includes visitors to a ward who received covid swabbing in the Emergency Department. E.g. Maternity birth partners
Emergency Department Attendances	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Number of attendances to Emergency Department in period



Emergency Admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Number of emergency inpatient admissions to General & Acute Hospital in the period
Admissions to Adult Mental Health unit (Orchard House)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions & Discharges Report (IP013DM))	Number of admissions to Orchard House
Admissions to Older Adult Mental Health units (Beech/Cedar wards)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Number of Older Adult inpatient admissions in the period
Maternity Deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Number of on-Island maternity deliveries in the period. Note that the birth of twins/triplets would count as one delivery

WAITING LISTS - ACTIVITY		
INDICATOR	SOURCE	DEFINITION
Outpatient 1st Appointment Waiting List	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients on the Outpatient first appointment waiting list at period end
Outpatient 1st Appointment Waiting List - Acute	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Acute Outpatient appointment at period end
Outpatient 1st Appointment Waiting List - Community	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Community Outpatient appointment at period end
Elective Waiting List	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of patients on the Inpatient elective waiting list at period end
Elective Waiting List - Under 18	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Number of patients under 18 years of age on the elective inpatient waiting list at period end
Diagnostics Waiting List	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Number of patients waiting for a first Diagnostic appointment at period end
Jersey Talking Therapies Assessment Waiting List	JTT & PATS electronic client record system	Number of JTT clients which match the services eligibility criteria waiting for their first assessment at the end of reporting period

GENERAL AND ACUTE WAITING LISTS						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Outpatients	% patients waiting over 90 days for 1st outpatient appointment	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the outpatient waiting list who have been waiting over 90 days at period end. Numerator: Number of patients on the outpatient waiting list who have been waiting over 90 days at period end. Denominator: Number of patients on the outpatient waiting list at period end.
	% patients waiting over 90 days for 1st OP appointment - Acute	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Acute Outpatient waiting list who have been waiting more than 90 days since referral for their first appointment at period end
	% patients waiting over 90 days for 1st OP appointment - Community	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Community Outpatient waiting list who have been waiting more than 90 days since referral for their first appointment at period end
Inpatients	% patients waiting over 90 days for diagnostics	Hospital Electronic Patient Record (TrakCare Outpatient Waiting List Report (WLS6B) & Maxims Outpatient Waiting List Report (OP2DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the Diagnostic waiting list who have been waiting more than 90 days since referral at period end
Diagnostics	% patients waiting over 90 days for elective admissions	Hospital Electronic Patient Record (TrakCare Inpatient Listings Report (WLT11A) & Maxims Inpatient Listings Report (IP9DM))	Head of Access	<35%	Standard set locally. Waiting times are measured differently elsewhere so no comparable benchmarks	Percentage of patients on the elective inpatient waiting list who have been waiting over 90 days at period end. Numerator: Number of patients on the elective inpatient waiting list who have been waiting over 90 days at period end. Denominator: Number of patients on the elective inpatient waiting list at period end.

PLANNED (ELECTIVE) CARE						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Outpatients	New to follow-up ratio	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Care Group General Managers	2.0	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	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP1DM))	Care Group General Managers	<8%	Standard set locally	Percentage of public General & Acute outpatient appointments where the patient did not attend and no notice was given. Numerator: Number of General & Acute public outpatient appointments where the patient did not attend. Denominator: the number of attended and unattended appointments
Elective Inpatients	Acute elective Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Surgical Services Care Group General Manager	<3	Standard set locally	Average (mean) Length of Stay (LOS) in days of all elective inpatients discharged in the period from a Jersey 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 rehabilitation patients were treated on Plemont Ward and therefore the data is not comparable for this period.
	% of all elective admissions that were day cases	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Surgical Services Care Group General Manager	>80%	Standard set locally	Percentage of elective admissions for surgery that are managed as day cases (with same day discharge). Numerator: Number of elective surgical day case admissions both public and private. Denominator: Total surgical elective admissions
	% of all elective admissions that were private	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B) & Maxims Theatres Report (TH1DM))	Surgical Services Care Group General Manager	>32% and <34%	Based on clinical job plans	Number of private elective admissions divided by the total number of elective admissions

Theatres	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))	Surgical Services Care Group General Manager	>85%	NHS Benchmarking- Getting It Right First Time 2024/25 Target	Sum of touch time divided by the sum of theatre session duration (as a percentage). This is reported for all operations (Public and Private) to take account of mixed lists.
	Turnaround time as % of total session time	Hospital Electronic Patient Record (TrakCare Operations Report (OPT7B), TrakCare Theatres Report (OPT11A), Maxims Theatres Report (TH001DM) & Maxims Session Booking Report (TH002DM))	Surgical Services Care Group General Manager	<15%	Standard set locally	Numerator: Sum of the time duration between successive patients within a single theatre session Denominator: Total theatre session duration. This is reported for all operation lists containing multiple operations (Public and Private) to take account of mixed lists.

UNPLANNED (NON-ELECTIVE / EMERGENCY) CARE						
INDICATOR		SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Emergency Department (ED)	Median Time from Arrival to Triage	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<11	NHS England published data for Nov 2022 England Average. <a href="https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider">https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider</a>	Median of minutes between ED arrival time and triage time
	% Triage within Target - Minor	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=90%	Generated based on historic performance	Percentage of P4, P5 patients triaged within 15 mins
	% Triage within Target - Major	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=90%	Generated based on historic performance	Percentage of P1, P2,P3 patients triaged within 15 mins
	Median Time from Arrival to commencing Treatment	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<75	NHS England published data for Nov 2022 England Average. <a href="https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider">https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider</a>	Median of minutes between ED arrival time and time patient was seen
	% Commenced Treatment within Target - Minor	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=70%	Generated based on historic performance	Percentage of patients seen within targets: P4 120 mins, P5 240 mins
	% Commenced Treatment within Target - Major	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	>=70%	Generated based on historic performance	Percentage of patients seen within targets: P1 1 min, P2 15 mins, P3 60 mins
	Median Total Stay in ED (mins)	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<189	NHS England published data for Nov 2022 England Average. <a href="https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider">https://digital.nhs.uk/data-and-information/publications/statistical/provisional-accident-and-emergency-quality-indicators-for-england/november-2022-by-provider</a>	Median of minutes between ED arrival and discharge from ED
	Total patients in ED > 10 hours	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<1	Standard set locally - zero tolerance to ensure all long stays in ED are investigated	Number of ED attendances in the period where total stay in department is greater than 10 hours
	ED conversion rate	Hospital Electronic Patient Record (TrakCare Emergency Department Report (ED5A) & Maxims Emergency Department Report (ED1DM))	Medical Services Care Group General Manager	<20%	Generated based on historic performance	Percentage of ED attendances that resulted in an inpatient admission. Numerator: Total ED attendances that resulted in an inpatient admission. Denominator: Total ED attendances.

Emergency Inpatients	Non-elective acute Length of Stay (LOS)	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	<10	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 rehabilitation patients were treated on Piemont Ward and therefore the data is not comparable for this period.
	% Emergency admissions with 0 Length of Stay (Same day discharge)	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	<17%	Generated based on historic performance	Percentage of emergency (non-elective) inpatient admissions that were discharged the same day. Numerator: Total ED attendances that were discharged the same day. Denominator: Total ED attendances.
	Acute bed occupancy at midnight (Elective & Non-Elective)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Medical Services Care Group General Manager	<85%	Generated based on historic performance	Percentage of beds occupied at the midnight census, JGH and Overdale. Numerator: Number of beds occupied by a patient at midnight in the period. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	% of Inpatients discharged between 8am and noon	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Admissions and Discharge Report (IP13DM))	Medical Services Care Group General Manager	>=15%	Generated based on historic performance	% of inpatients discharged from General & Acute wards between 8am and Noon. Excluding private patients, self discharges and deceased patients. Numerator: Patients discharged between 8am and 12 noon in period. Denominator: Total patients discharged in period
	Average daily number of patients Medically Fit For Discharge (MFFD)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	<30	Generated based on historic performance	Average (mean) number of inpatients marked as Medically Fit each day at 8am, JGH/Overdale only
	Total Bed Days Medically Fit For Discharge	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	<910	Generated based on historic performance	Sum of bed days in period of patients marked as Medically Fit
	Total Bed Days Delayed Transfer Of Care (DTCOC)	Hospital Electronic Patient Record (TrakCare Current Inpatients Report (ATD49) & Maxims Current Inpatients Report (IP20DM))	Care Group General Managers	NA	Not Applicable	Sum of bed days in period of patients marked as Delayed Transfer Of Care (DTCOC)
	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 Admissions and Discharge Report (IP013DM))	Medical Services Care Group General Manager	<10%	Generated based on historic performance	The rate of emergency readmission. This being the number of eligible emergency admissions to Jersey General Hospital occurring within 30 days (0-29 days inclusive) of the last, previous eligible discharge from hospital as a percentage of all eligible discharges from JGH and Overdale. Exclusions apply see detailed definition at:  <a href="https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20102040%20v3.3.pdf">https://files.digital.nhs.uk/69/A27D29/Indicator%20Specification%20-%20Compendium%20Readmissions%20%28Main%29%20-%20102040%20v3.3.pdf</a>

MENTAL HEALTH						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Jersey Talking Therapies	% of clients waiting for assessment who have waited over 90 days	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	<5%	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
	% of clients who started treatment in period who waited over 18 weeks	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	<5%	Improving Access to Psychological Therapies (IAPT) Standard	Percentage of JTT clients waiting 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	Lead Allied Health Professional Mental Health	<=177	Generated based on historic percentiles	Average (mean) days waiting from JTT referral to the first attended treatment session
	% of eligible cases that have completed treatment and were moved to recovery	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	>50%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that completed treatment and were moved to recovery (defined as a clinical case at the start of their treatment and are no longer defined as a clinical case at the end of their treatment), divided by the total number of JTT referrals which match the services eligibility criteria
	% of eligible cases that have shown reliable improvement	JTT & PATS electronic client record system	Lead Allied Health Professional Mental Health	>75%	Improving Access to Psychological Therapies (IAPT) Standard	Number of JTT referrals which match the services eligibility criteria that showed reliable improvement (there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition), divided by the total number of JTT referrals which match the services eligibility criteria
Community Mental Health	Memory Service - Average Time to assessment (Days)	Community services electronic client record system	Lead Nurse - Mental Health	<138	Generated based on historic percentiles	Average (mean) days waiting from the date of referral to the assessment date for all those who have been referred and assessed under the Memory Assessment Service centre of care
	% of referrals to Mental Health Crisis Team assessed in period within 4 hours	Community services electronic client record system	Mental Health Care Group Manager	>85%	Agreed locally by Care Group Senior Leadership Team	Number of Crisis Team referrals assessed 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	Mental Health Care Group Manager	>85%	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
	% 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 (ATDSL), Maxims Discharges Report (IP013DM), Maxims Admissions Report (IP013DM) & Community services electronic client record) system	Mental Health Inpatient Lead Nurse	>80%	National standard evidenced from Royal College of Psychiatrists	Number of patients discharged from 'Orchard House' 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 'Orchard House'

	% 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	Mental Health Inpatient Lead Nurse	>80%	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
	Community Mental Health Team did not attend (DNA) rate	Community services electronic client record system	Lead Nurse - Mental Health	<10%	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
Inpatient Mental Health	Adult Acute Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), Maxims Admissions Report (IP013DM))	Mental Health Inpatient Lead Nurse	<255	NHS Benchmarking Network 2021/22 upper quartile. For green (<240) this reflects an improvement on GOJ 2021 performance.	Number of admissions to 'Orchard House' in the past 12 months from the reporting month for every 100,000 population
	Adult acute admissions under the Mental Health Law as a % of all admissions	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L), Maxims Admissions Report (IP013DM) & Mental Health Articles Report)	Mental Health Inpatient Lead Nurse	<37%	Jersey has a much lower rate than NHS Benchmarking Network. Standard is based on local historic benchmarking	Number of 'Orchard House' admissions under a formal Mental Health article, divided by total number of admissions to 'Orchard House'
	Adult acute bed occupancy at midnight (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Mental Health Inpatient Lead Nurse	<88%	Generated based on historic performance	Percentage of beds occupied at the midnight census, Orchard House. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	Older Adult Admissions per 100,000 population - Rolling 12 month	Hospital Electronic Patient Record (TrakCare Admissions Report (ATD5L) & Maxims Admissions Report (IP013DM))	Mental Health Inpatient Lead Nurse	<475	Jersey is an extreme outlier in the NHS Benchmarking Network. Standard set based on improving 2021 performance toward the NHS Benchmarking Network mean	Number of admissions to 'Older Adults' units, in the past 12 months from reporting month, for every 100,000 population
	Older adult acute bed occupancy (including leave)	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM))	Mental Health Inpatient Lead Nurse	<85%		Percentage of beds occupied at the midnight census, Beech and Cedar Wards. Numerator: Number of beds occupied by a patient at midnight in the period, including patients on leave. Denominator: Number of beds either occupied or marked as available for a patient at the midnight census
	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))	Mental Health Inpatient Lead Nurse	<13	Generated based on historic percentiles	Average (mean) number of Mental Health inpatients marked as Medically Fit each day at 8am

SOCIAL CARE						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Learning Disability  Adult Social Care Team (ASCT)	Percentage of clients with a Physical Health check in the past year	Community services electronic client record system	Social Care Care Group General Manager	>80%	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	Social Care Care Group General Manager	>=80%	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
	Percentage of new Support Plans reviewed within 6 weeks (ASCT)	Community services electronic client record system	Social Care Care Group General Manager	>=80%	Generated based on historic performance	Percentage of Support Plan Reviews in the ASCT Centre of Care (only counting those that follow a FACE Support Plan) that were opened within 6 weeks of closing a FACE Support Plan in the ASCT Centre of Care

WOMENS AND CHILDRENS SERVICES						
	INDICATOR	SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Children	Was Not Brought Rate	Hospital Electronic Patient Record (TrakCare Outpatients Report (BKG1A) & Maxims Outpatients Report (OP13DM))	General Manager Womens, Childrens & Family Care Group	<=10%	Standard set locally based on average (mean) of previous two years' data	Percentage of JGH/Overdale public outpatient appointments where the patient did not attend (was not brought). Numerator: Number of JGH/Overdale public outpatient appointments where the patient did not attend. Denominator: Number of all attended and unattended appointments. Under 18 year old patients only. All specialties included.
	Average length of stay on Robin Ward	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Lead Nurse for Children	<=1.65	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay in days of all patients discharged in the period from Robin Ward, including leave days
	% deliveries home birth (Planned & Unscheduled)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Percentage of deliveries home births (Planned & Unscheduled) out of the total number of deliveries in the period. Numerator: Number of deliveries recorded as being at "Home" (regardless of whether they were 'planned' or 'unplanned') in the period. Denominator: number of deliveries in the period.
	% Spontaneous vaginal births (including home births and breech vaginal deliveries)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of spontaneous vaginal births including home births and breech vaginal deliveries divided by total number of deliveries
	% Instrumental deliveries	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Instrumental deliveries divided by total number of deliveries
	% Emergency caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Emergency Caesarean sections, divided by total number of deliveries
	% Elective caesarean section births	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	NA	Not Applicable	Number of Elective Caesarean sections, divided by total number of deliveries

Maternity	% of women that have an induced labour	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=27.57%	Standard set locally based on average (mean) of previous two years' data	Percentage of women that have an induced labour in the period. Numerator: Number of women that had an induced labour. Denominator: number of deliveries.
	Number of stillbirths	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife		Stanadard set locally based on historic performance	Number of stillbirths (A death occurring before or during birth once a pregnancy has reached 24 weeks gestation)
	Rate of Vaginal Birth After Caesarean (VBAC)	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	>15%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, standard set to match the NHS National value of 15%.	Number of Vaginal Births after Caesarean (VBAC) divided by the total number of Births after Caesarean
	% primary postpartum haemorrhage >= 1500ml	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=6.75%	NHS National Value is 3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that resulted in a blood loss of over 1500ml out of the total number of deliveries in the period. Numerator: Number of deliveries that resulted in a blood loss of over 1500ml. Denominator: number of deliveries
	% 3rd & 4th degree tears – normal birth	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<2.5%	As the Jersey numbers that drive this indicator are so low and have such a skewed distribution across the last two years, we have set the standard to match the NHS National value of 2.5%.	Number of women who had a vaginal birth (not instrumental) and sustained a 3rd or 4th degree perineal tear as percentage of all normal births
	% of births less than 37 weeks	Hospital Electronic Patient Record (TrakCare Maternity Report (MAT23A) & Maxims Maternity Report (MT005))	Lead Midwife	<=6.85%	NHS National Value is 6.3%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Number of live babies who were born before 37 weeks (less than or equal to 36 weeks + 6 days gestation) divided by total number of live births
	% births requiring Jersey Neonatal Unit admission	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P), TrakCare Movements Report (ATD5PA), TrakCare Deliveries Report (MAT23A), Maxims Discharges Report (IP013DM), Maxims Movements Report (IP001DM) & Maxims Deliveries Report (MT005) )	Lead Midwife	<=5.05%	Standard set locally based on average (mean) of previous two years' data	Number of births requiring admission to the Jersey Neonatal Unit, divided by total number of births
	% 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))	Lead Midwife	<=1.3%	NHS National Value is 1.2%. However, as the Jersey numbers that drive this indicator are so low, the standard has been set locally based on average (mean) of previous two years' data	Percentage of deliveries that have APGAR score (a measure of the physical condition of a newborn baby) below 7 at 5 minutes after birth
	Average length of stay on maternity ward	Hospital Electronic Patient Record (TrakCare Discharges Report (ATD9P) & Maxims Discharges Report (IP013DM))	Lead Midwife	<=2.28	Standard set locally based on average (mean) of previous two years' data	Average (mean) length of stay for all patients discharged in the period from the Maternity Ward



QUALITY AND SAFETY							
INDICATOR			SOURCE	OWNER	STANDARD THRESHOLD		DEFINITION
Infection Control	MRSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control		Standard based on historic performance	Number of Methicillin Resistant Staphylococcus Aureus (MRSA) cases in hospital in the period, reported by the IPAC team
	MSSA Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control		Standard based on historic performance	Number of Methicillin-Susceptible Staphylococcus Aureus (MSSA) cases in the hospital in the period, reported by the IPAC team
	E-Coli Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control		Standard based on historic performance	Number of E. Coli bacteraemia cases in the hospital in the period, reported by the IPAC team
	Klebsiella Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control		Standard based on historic performance	Number of Klebsiella bacteraemia cases in the hospital in the period, reported by the IPAC team
	Pseudomonas Bacteraemia - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control		Standard based on historic performance	Number of Pseudomonas bacteraemia cases in the hospital in the period, reported by the IPAC team
	C-Diff Cases - Hosp	Hosp	Infection Prevention and Control Team Submission	Director of Infection Prevention and Control	1	Standard based on historic performance (2020)	Number of Clostridium Difficile (C-Diff) cases in hospital in the period, reported by the IPAC team
Safety Events	Number of falls resulting in harm (low/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	Interim Chief Nurse	NA	No Standard Set	Number of inpatient falls with harm recorded where approval status is not "Rejected" per 1000 occupied bed days
	Number of falls per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Interim Chief Nurse	<6	Standard based on historic performance	Rate of recorded inpatient falls per 1000 bed days. Numerator: Number of inpatient falls recorded in the period where the approval status is not "Rejected". Denominator: Number of occupied bed days in the period in General Hospital, Overdale and Acute Mental Health wards
	Number of medication errors across HCS resulting in harm per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Medical Director	<0.40	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.
	Number of serious incidents		HCS Incident Reporting System (Datix)	Interim Chief Nurse	NA	Standard removed 2022-09-28 per Q&R Committee instruction	Number of safety events recorded in Datix in the period where the event is marked as a 'Serious Incident'
	% of adult inpatients who have had a VTE risk assessment within 24 hours of admission		Hospital Electronic Patient Record (Maxims Report IP026DM)	Medical Director	>95%	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.
VTE							

Pressure Ulcers	Number of pressure ulcers acquired as an inpatient per 1,000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Interim Chief Nurse	<2.87	Standard set locally based on improvement compared to historic performance	Number of inpatient pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 2 pressure ulcers acquired as an inpatient per 1,000 bed days	Hosp	Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Interim Chief Nurse	<1.96	Standard set locally based on improvement compared to historic performance	Number of inpatient Cat 2 pressure ulcers where approval status is not "Rejected" per 1000 occupied bed days
	Number of Cat 3-4 pressure ulcers / deep tissue injuries acquired as inpatient per 1000 bed days		Hospital Electronic Patient Record (TrakCare Ward Utilisation Report (ATD3Z) & Maxims Ward Utilisation Report (IP007DM)) & Datix Safety Events Report	Interim Chief Nurse	<0.60	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
Feedback	Number of complaints received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of formal complaints received in the period where the approval status is not "Rejected"
	Number of compliments received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of compliments received in the period where the approval status is not "rejected"
	Number of comments received		HCS Feedback Management System (Datix)	Head of Patient Experience	NA	Not Applicable	Number of comments received in the period where approval status is not "Rejected"
	% of all complaints closed in the period which were responded to within the target		HCS Feedback Management System (Datix)	Head of Patient Experience	>40%	Response time standards are those in GoJ Feedback Policy which does not set achievement targets, so target set locally	Percentage of all complaints closed in the period responded to within the target time as set by GoJ Feedback Policy. Numerator: Number of all closed complaints in the period, responded to within the target. Denominator: Number of complaints closed in the period.



## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services (HCS) Advisory Board		
<b>Date of meeting:</b>	1 November 2023		
<b>Title of paper:</b>	Finance Report		
<b>Report author (and title):</b>	Obi Hasan, Finance Lead Change Team, Interim Head of Finance Business Partnering HCS	<b>Accountable Executive:</b>	Chris Bown, Chief Officer HCS

### 1. Purpose

<p>What is the purpose of this report?</p> <p>What is being asked of the HCS Advisory Board?</p>	<p>To provide an update on the Month 9 (M9) Financial position and year-end forecast</p> <p>To discuss current financial position and year-end forecast noting the risks and mitigations.</p>	Information	x
		Decision	
		Assurance	x
		Update	x

### 2. Executive Summary

The Year-to-date (YTD) actual vs budget overspend to September M9 is £23.1m vs budget rising by £4.2m in-month. The FY23 year-end forecast remains at a deficit of £29.0m.

Key drivers of the overspend are:

- Staff Costs** - £8.4m YTD overspend which includes £3.5m of opening budget pressure re agency/locum costs, a further £20.6m agency/locum overspend (201 FTE), and £2.9m of overtime costs, which are substantially mitigated by underspends of £18.6m in substantive staffing due to vacant posts (471 FTE) across other Care Groups/Directorates. The FY23 year-end forecast overspend is £11.2m which includes an element of the Opening Pressure of £4.7m, a £17.8m underspend on substantive staffing due to vacancies.

These cost pressures are mainly driven by factors identified in developing the Financial Recovery Programme (FRP) such as recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services, Surgical Services, and Women & Children & Family Care.

- Non-Pay** - £14.2m is adverse to budget which includes £6.1m part-year effect of the opening pressure with the remaining £8.1m overspend driven by scarce capacity and activity pressures in Mental Health on off-Island placements and drugs £2.6m, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Tertiary Care £0.8m due to increased activity, Surgical Services £0.9m, Chief Nurse re Accommodation Service £1.2m due to due to expansion of staff accommodation costs exceeding rental income (see accommodation income below), and Non-Clinical Support Services

£0.8m, of which the majority relates to increased patient travel costs and Estates compliance works. The FY23 year-end forecast is £17.9m overspend of which £9.2m relates to the opening budget pressure, with the remaining £8.5m spread across Care Groups including Mental Health, Surgical Services, Chief Nurse, Social Care, Tertiary Care, Non-Clinical Support Services, Medical Services, and Estates.

- **Income** shows and under-achievement of £0.6m due to Surgical Services underperformance by £2.1m against private patient income targets, and £0.3m underperformance in Social Care. These are partially mitigated by overachievements in Chief Nurse £0.5m from additional staff accommodation capacity, and Mental Health £0.4m in relation to Long Term Care Benefit. However, the FY23 year-end forecast is an over-achievement of £0.1m due to over-performance in Chief Nurse £0.8m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Medical Services £0.3m, and Women & Children & Family Care £0.2m to offset the under-performance in Surgery private patient income of £3.0m due to a lack of surgical beds capacity from medical outliers and escalation beds.

The reserves position which is made-up of growth, Covid and capital reserves has further reduced to £1.78m (M8 £2.93m). £3.1m of reserves have been used to offset additional cost pressures in the last 2 months to maintain the forecast year end deficit position at £29m. The remaining reserves have been frozen to ring-fence in partial mitigation against the in-year deficit position.

## **Risk and issues**

The risks to the year-end forecast remain as follows:

- Delays in recruitment to substantive posts to replace agency staff.
- Further substantive recruitment fill without replacing agency.
- Agency/Locums rates pressures due to stricter application of Jersey tax rules.
- Tertiary Care contracts commissioning relating to activity volumes through the Southampton contract.
- Significant price and activity variations experienced throughout this year in mental health and social care packages.

The Board is asked to note the FY23 forecast deficit of £29m and the requirement to deliver £3m in savings to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury. This means delivering key cost reduction and income improvement schemes including:

- Reduction in agency spend by recruiting substantive staff.
- Increasing income from surgical private patients and laundry income.
- Mitigating the forecast risks from delays in recruitment to substantive posts to replace agency staff, further substantive recruitment fill without replacing agency, agency / locum rate pressures, tertiary care contracts commissioning relating to activity volumes, and the significant price and activity variations in mental health and social care packages.

## **3. Main Report**

The Year-to-date actual vs budget overspend has increased by £4.2m in M9 to £23.1m. The FY23 year-end forecast remains at a deficit of £29m.

	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)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	16,127	17,710	142,258	150,623	(8,364)	194,206	205,434	(11,228)	(3.3%)	(5.8%)
Non Pay	7,733	12,558	74,588	88,778	(14,189)	97,205	115,125	(17,920)	(25.0%)	(18.4%)
Income	(2,146)	(4,301)	(18,897)	(18,347)	(550)	(26,207)	(26,355)	148	(2.9%)	0.6%
Grand Total	21,714	25,966	197,950	221,053	(23,103)	265,205	294,205	(29,000)	(11.7%)	(10.9%)

The key drivers are:

Year-to-date (YTD) position £23.1m deficit:

- **Staff Costs £8.4m overspend** which includes £3.5m of opening budget pressure re agency/locum costs, a further £20.6m agency/locum overspend (201 FTE), and £2.9m of overtime costs, which are substantially mitigated by underspends of £18.6m in substantive staffing due to vacant posts (471 FTE) across other Care Groups/Directorates. These cost pressures are mainly driven by factors which have been clearly identified in developing the Financial Recovery Programme (FRP) such as recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services £7.6m, Surgical Services £2.7m, and Women & Children & Family Care £1.3m.
- **Non-Pay £14.2m overspend** which includes £6.1m part-year effect of the opening pressure with the remaining £8.1m overspend driven by scarce capacity and activity pressures in Mental Health on off-Island placements and drugs £2.6m, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Tertiary Care £0.8m due to increased activity, Surgical Services £0.9m, Chief Nurse re Accommodation Service £1.2m due to due to expansion of staff accommodation costs exceeding rental income (see accommodation income below), and Non-Clinical Support Services £0.8m, of which the majority relates to increased patient travel costs and Estates compliance works.
- **Income under-achievement £0.6m** due to Surgical Services underperformance by £2.1m against private patient income targets, £0.3m underperformance in Social Care (forecast to achieve full year target). These are partially mitigated by overachievements in Chief Nurse £0.5m from additional staff accommodation capacity, and Mental Health £0.4m in relation to Long Term Care Benefit.

FY23 year-end forecast £29m deficit:

- **Staff Costs are forecast to overspend by £11.2m** which includes an element of the Opening Pressure of £4.7m, a £17.8m underspend on substantive staffing due to vacancies (471 FTE), and a £24.3m overspend on agency locums (201 FTE). The month-on-month movement is a forecast increase of £1.5m, driven by an agency expenditure forecast increase of £1.1m, and a £0.4m substantive staffing forecast increase.
- **Substantive Pay underspend £17.8m** is made up of underspends from vacancies in Mental Health £5.7m, Surgical Services £3.3m, Women & Children & Family Care £2.0m, Primary Care & Prevention £1.8m, Medical Director £1.8m, Chief Nurse £1.2m, Non-Clinical Support Services £0.7m, Estates & Hard FM £0.5m, Social Care £0.3m, and Improvement & Innovation £0.3m. These are partially offset by a forecast overspend in Medical Services of £2.6m.
- **Agency overspend £24.3m** is driven by the same factors as YTD in Medical Services £7.3m, Surgical Services £6.3m, Mental Health £4.3m, Women & Children's Services £3.4m, Primary Care £1.3m, Medical Director and Chief Nurse both £0.4m, and Jersey Care Model £0.3m.
- **Non-Pay overspend £17.9m** £9.2m relates to the opening budget pressure, with the remaining £8.5m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.7m, Chief

Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non Clinical Support Services £1.0m, Medical Services £0.9m, and Estates £0.5m.

- **Income over-achievement £0.1m** this is made up of an under-performance in Surgery private patient income of £3.0m mainly due to a lack of surgical beds capacity from medical outliers and escalation beds. This is offset by over-performance in Chief Nurse £0.8m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Medical Services £0.3m, and Women & Children £0.2m.

## Financial Position By Care Group/Directorate:

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
<b>Care Groups &amp; Directorates</b>										
Chief Nurse	515	1,286	4,954	4,775	179	6,604	6,499	105	3.6%	1.6%
Director General's Office	(24)	(1,322)	(354)	6,491	(6,845)	(1,649)	6,710	(8,359)	(1,935.0%)	(507.0%)
Estates & Hard Facilities	747	682	8,427	8,318	109	10,669	10,658	11	1.3%	0.1%
Improvement & Innovation	1,146	2,744	13,809	12,967	842	18,183	18,202	(19)	6.1%	(0.1%)
Intermediate Care	177	129	1,554	1,387	167	2,058	1,949	109	10.8%	5.3%
Jersey Care Model	433	587	3,895	4,270	(375)	5,193	4,793	401	(9.6%)	7.7%
Medical Director	841	900	6,848	6,025	822	9,168	7,913	1,255	12.0%	13.7%
Medical Services	4,515	5,931	40,714	48,483	(7,769)	55,186	65,704	(10,518)	(19.1%)	(19.1%)
Mental Health	2,735	3,084	24,011	25,578	(1,567)	32,840	33,901	(1,061)	(6.5%)	(3.2%)
Non-Clinical Support Ser	1,885	2,387	16,961	17,075	(114)	22,614	22,769	(155)	(0.7%)	(0.7%)
Primary Care & Preventio	870	896	7,790	7,337	453	9,982	9,486	496	5.8%	5.0%
Social Care	1,755	1,857	15,790	16,982	(1,192)	21,061	22,100	(1,039)	(7.6%)	(4.9%)
Surgical Services	3,475	4,269	30,385	36,166	(5,781)	41,789	49,529	(7,740)	(19.0%)	(18.5%)
Tertiary Care	1,067	791	9,599	10,441	(842)	12,799	14,072	(1,273)	(8.8%)	(9.9%)
Women Children & Family	1,577	1,745	13,567	14,757	(1,190)	18,708	19,920	(1,213)	(8.8%)	(6.5%)
<b>Grand Total</b>	<b>21,714</b>	<b>25,966</b>	<b>197,950</b>	<b>221,053</b>	<b>(23,103)</b>	<b>265,205</b>	<b>294,205</b>	<b>(29,000)</b>	<b>(11.7%)</b>	<b>(10.9%)</b>

## Reserves Position

The reserves position which is made-up of growth, Covid and capital reserves has further reduced to £1.78m (M8 £2.93m). £3.1m of reserves have been used to offset additional cost pressures in the last 2 months to maintain the forecast year end deficit position at £29m. The remaining reserves have been frozen to ring-fence in partial mitigation against the in-year deficit position.

£3.1m of reserves have been used to offset additional cost pressures in the last 2 months to maintain the forecast year end deficit position at £29m, leaving a balance of £7.9m as at M9. The year-end forecast after accounting for further forecast expenditure of £6.1m to year-end, depletes our reserves position to £1.78m.

## Forecast Risks

There are further risks to the year-end forecast which may materialise through the remainder of this year which are as follows:

- Tertiary Care contracts commissioning relating to activity volumes through the Southampton contract which shows an YTD over-performance. The current forecast assumption is based on Tertiary Care contracts to come within budget for the remainder of the year.
- Further extension of agency/locums and substantive recruitment fill without replacing agency.
- £3.1m of the reserves position has been used to mitigate cost pressures with risk to further depletion to manage cost pressures.

## Adjustment to correctly apportion the 'Opening Budget Pressure' of £13.9m

Previously, the 'Opening Budget Pressure' for FY23 of £13.9m is shown entirely as a Non-Pay cost pressure. However, more detailed analysis of the 2023 budget setting workings has highlighted that this pressure should have been apportioned as Pay £4.7m (34%) and Non-Pay £9.2m (66%). This has been adjusted in the Executive Summary and will be corrected in the detail supporting tables going forward.

## Movement in Agency vs Substantive Costs

- The below table shows Vacancy has decreased by 45, mainly due to reductions in Mental Health and Non-Clinical Support Services. Vacancies covered by agency have dropped by 49, although overall agency numbers have only dropped by 4. There has been an increase in forecast agency costs of £1.0m, mainly due to extension of bookings. The increase of £1.0m is mainly seen in Medical Services £0.5m, Women & Children, Mental Health, and Primary Care & Prevention £0.2m, and Chief Nurse £0.1m, offset by a reduction in Surgical Services £0.2m.

	July	August	September		July	August	September		July	August	September		July	August	September	
Care Group	Vacancy	Vacancy	Vacancy	Difference	Vacancy covered by Agency	Vacancy covered by Agency	Vacancy covered by Agency	Difference	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Difference	Agency Forecast	Agency Forecast	Agency Forecast	Difference
	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	Amount (£)	Amount (£)	Amount (£)	Amount (£)
Chief Nurse	16	16	21	-5	1	2	3	-1	15	14	18	-4	199,457	251,257	362,105	-110,848
Director General's Office - HCS	1	12	25	-13	1	0	0	0	0	12	25	-13	1,070,819	1,097,085	1,104,735	-7,651
Estates & Hard Facilities Management	8	9	7	2	0	0	0	0	8	9	7	2				0
Improvement & Innovation	9	8	8	0	0	0	0	0	9	8	8	0				0
Intermediate Care	0	5	1	3	0	2	1	1	0	3	0	3	0	179,588	179,588	0
Jersey Care Model	0	0	2	-2	0	0	0	0	0	0	2	-2	0	295,256	295,256	0
Medical Director	23	27	27	0	4	4	5	-1	19	23	22	1	420,268	420,268	420,268	0
Medical Services	81	76	76	0	57	59	39	20	24	17	37	-19	6,858,417	7,034,424	7,542,248	-507,824
Mental Health	119	125	100	25	39	40	33	7	80	85	67	17	4,126,912	4,158,331	4,369,401	-211,070
Non-Clinical Support Services	40	37	27	10	0	1	0	1	40	36	27	9	0	0	0	0
Primary Care & Prevention	35	36	28	8	18	18	10	8	17	18	18	0	1,184,530	1,150,570	1,300,974	-150,404
Social Care	29	32	36	-4	3	3	2	1	26	29	34	-5	116,742	209,716	209,716	0
Surgical Services	86	86	69	17	55	52	44	8	31	34	25	9	6,765,982	6,920,097	6,720,415	199,682
Women Children & Family Care	46	48	45	3	16	24	18	6	30	24	27	-3	2,443,919	3,375,328	3,553,325	-177,996
Grand Total	493	516	471	45	194	205	155	49	299	311	316	-5	23,187,046	25,091,920	26,058,031	-966,111

## 4. Financial Recovery Plan (FRP)

The Financial Recovery Plan (FRP) has been completed and published last month, concluding the planning phase, and has now entered the delivery phase. This quality-led Financial Recovery Plan sets out how HCS plans to tackle the underlying deficit of £35m through a comprehensive financial recovery program and return the system to a financially sustainable position.

The headline financials of the FRP are:

- HCS's financial position has deteriorated from £1.5m surplus in FY19, to a forecast of £29m deficit in FY23, and the underlying position is currently £35m.
- Some of the key drivers of this deterioration in the financial position are inflation, higher spend on agency staff, increases in non-clinical staff compared to the front line, non-delivery of efficiency targets, activity pressures and business case pressures, and provision of unfunded services.
- To address the challenge, HCS plans to deliver £25m savings (£3m in FY23, £12m in FY24, and £10.6m in FY25).
- This is a significant target and equates to 3.6% recurrent savings Y.O.Y in real terms.
- The structural deficit (unfunded services) is £15m.
- The Financial Recovery Plan, by delivering £25m savings, will address £5m of the structural deficit.
- The remaining balance of £10m requires additional funding or decision on continuity of services.

## M9 Progress Update

The FRP schemes identified as at M9 are £26m with a risk-adjusted value of £17m which are phased to be delivered over FY23 £3m, FY24 £12m and FY25 £10m. See table below.



GoJ FRP Project Plans Development Summary												
<i>All checks okay</i>												
Item	Workstreams	Projects	Total Saving Identified FY1	Remaining Gap	Investment Required	Net Annualised Amount	FY23 Identified Savings	FY24 Identified Savings	FY25 Identified Savings	Total Risk Adj Amount	In Year Risk Adj Amount	RAG Status
	<b>Clinical Productivity</b>	Patient Flow and Discharge/LOS	1,000	-	-	1,000	-	500	500	1,000	-	●
		Theatres Efficiency	3,084	-	-	3,084	-	2,449	636	3,084	-	●
	<b>Workforce</b>	Clinical - Medical	2,736	-	-	2,736	223	1,668	723	2,049	223	●
		Clinical - Nursing	3,949	-	-	3,949	-	2,276	1,674	2,567	-	●
		Clinical - AHPs	1,944	-	-	1,944	-	1,329	615	1,264	-	●
		Non-Clinical Directorate	1,840	-	-	1,840	-	920	920	1,196	-	●
		Workforce Savings	1,190	-	-	1,190	30	160	-	374	20	●
		Service Development	-	-	163	-163	-	-	-	-	-	●
	<b>Non-Pay and Procurement</b>	Medicines Management	1,363	-	-	1,363	156	65	-	418	119	●
		Procurement	3,085	-	70	3,015	585	2,163	266	2,278	585	●
		Other Non-Pay	257	-	-	257	-	257	-	156	-	●
		Non-Pay Controls (NPCP)	293	-	-	293	113	180	-	280	108	●
		Theatres Efficiency	20	-	-	20	-	-	-	5	-	●
	<b>Income</b>	Other Income Opportunities	2,351	-	100	2,251	404	2,087	-	1,528	263	●
		Private Patients	1,940	-	-	1,940	184	371	-	457	120	●
		Service Development	200	-	-	200	50	-	-	50	13	●
		Mental Health and Social Care	600	-	-	600	-	-	-	150	-	●
	<b>Other Care group scheme</b>	Patient Flow and Discharge/LOS	111	-	46	64	-	-	-	72	-	●
		Clinical - Medical	200	-	-	200	-	200	-	130	-	●
	<b>IT &amp; Digital Health</b>	EPR	-	-	-	-	-	-	-	-	-	●
<b>TOTAL EFFICIENCY SAVINGS</b>			<b>26,161</b>	<b>8,839</b>	<b>379</b>	<b>25,782</b>	<b>1,745</b>	<b>14,624</b>	<b>5,333</b>	<b>17,057</b>	<b>1,449</b>	
<b>Target</b>			<b>35,000</b>				<b>3,000</b>	<b>16,000</b>	<b>16,000</b>			
<b>Variance</b>			<b>(8,839)</b>				<b>(1,255)</b>	<b>(1,376)</b>	<b>(10,667)</b>			

The immediate priority is to deliver the in-year savings target of £3m by the year end requiring a challenging run-rate reduction of £1m per month over 3m Oct-Dec-23. Work has been progressing at pace with the Care Groups and Directorate given individual targets to accelerate the FRP savings identified in-year to deliver the £3m target supported by the newly established Programme Management and Delivery Team (PMDT).

## 5. Recommendation

The Board is asked to note the FY23 forecast deficit of £29m, the FRP plan delivery and the requirement to deliver £3m in savings to achieve a £26m deficit position in line with the FRP Plan as agreed with Treasury. This means delivering key cost reduction and income improvement schemes including:

- Reduction in agency spend by recruiting substantive staff.
- Increasing income from surgical private patients and laundry income.
- Mitigating the forecast risks from delays in recruitment to substantive posts to replace agency staff, further substantive recruitment fill without replacing agency, agency / locum rate pressures, tertiary care contracts commissioning relating to activity volumes, and the significant price and activity variations in mental health and social care packages.

## END OF REPORT





Treasury and  
Exchequer

# **HCS Finance Report 30<sup>th</sup> September 2023**

# Executive Summary – Month 9

The Year-to-date actual vs budget overspend has increased by £4.2m in M9 to £23.1m. The FY23 year-end forecast remains at a deficit of £29m.



	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)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	16,127	17,710	142,258	150,623	(8,364)	194,206	205,434	(11,228)	(3.3%)	(5.8%)
Non Pay	7,733	12,558	74,588	88,778	(14,189)	97,205	115,125	(17,920)	(25.0%)	(18.4%)
Income	(2,146)	(4,301)	(18,897)	(18,347)	(550)	(26,207)	(26,355)	148	(2.9%)	0.6%
<b>Grand Total</b>	<b>21,714</b>	<b>25,966</b>	<b>197,950</b>	<b>221,053</b>	<b>(23,103)</b>	<b>265,205</b>	<b>294,205</b>	<b>(29,000)</b>	<b>(11.7%)</b>	<b>(10.9%)</b>

The key drivers are:

Year-to-date (YTD) position £23.1m deficit:

- **Staff Costs £8.4m overspend** which includes £3.5m of opening budget pressure re agency/locum costs, a further £20.6m agency/locum overspend (201 FTE) , and £2.9m of overtime costs, which are substantially mitigated by underspends of £18.6m in substantive staffing due to vacant posts (471 FTE) across other Care Groups/Directorates. These cost pressures are mainly driven by factors which have been clearly identified in developing the Financial Recovery Programme (FRP) such as recruitment issues, dependency on temporary staffing, expansion/escalation beds, and loss in productivity since 2019. The main Care Groups/Directorates accounting for this overspend are Medical Services £7.6m, Surgical Services £2.7m, and Women & Children & Family Care £1.3m.
- **Non-Pay £14.2m overspend** which includes £6.1m part-year effect of the opening pressure with the remaining £8.1m overspend driven by scarce capacity and activity pressures in Mental Health on off-Island placements and drugs £2.6m, and Social Care on domiciliary care packages £1.0m. Other cost pressures are in Tertiary Care £0.8m due to increased activity, Surgical Services £0.9m, Chief Nurse re Accommodation Service £1.2m due to due to expansion of staff accommodation costs exceeding rental income (see accommodation income below), and Non-Clinical Support Services £0.8m, of which the majority relates to increased patient travel costs and Estates compliance works.
- **Income under-achievement £0.6m** due to Surgical Services underperformance by £2.1m against private patient income targets, £0.3m underperformance in Social Care (forecast to achieve full year target). These are partially mitigated by overachievements in Chief Nurse £0.5m from additional staff accommodation capacity, and Mental Health £0.4m in relation to Long Term Care Benefit.

FY23 year-end forecast £29m deficit:

- **Staff Costs are forecast to overspend by £11.2m** which includes an element of the Opening Pressure of £4.7m, a £17.8m underspend on substantive staffing due to vacancies (471 FTE), and a £24.3m overspend on agency locums (201 FTE). The month-on-month movement is a forecast increase of £1.5m, driven by an agency expenditure forecast increase of £1.1m, and a £0.4m substantive staffing forecast increase.
- **Substantive Pay underspend £17.8m** is made up of underspends from vacancies in Mental Health £5.7m, Surgical Services £3.3m, Women & Children & Family Care £2.0m, Primary Care & Prevention £1.8m, Medical Director £1.8m, Chief Nurse £1.2m, Non-Clinical Support Services £0.7m, Estates & Hard FM £0.5m, Social Care £0.3m, and Improvement & Innovation £0.3m. These are partially offset by a forecast overspend in Medical Services of £2.6m.
- **Agency overspend £24.3m** is driven by the same factors as YTD in Medical Services £7.3m, Surgical Services £6.3m, Mental Health £4.3m, Women & Children's Services £3.4m, Primary Care £1.3m, Medical Director and Chief Nurse both £0.4m, and Jersey Care Model £0.3m.

# Executive Summary – Month 9 (cont.)



**Non Pay overspend £17.9m** £9.2m relates to the opening budget pressure, with the remaining £8.5m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.7m, Chief Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non Clinical Support Services £1.0m, Medical Services £0.9m, and Estates £0.5m.

**Income over-achievement £0.1m** this is made up of an under-performance in Surgery private patient income of £3.0m mainly due to a lack of surgical beds capacity from medical outliers and escalation beds. This is offset by over-performance in Chief Nurse £0.8m, Mental Health £0.7m, Intermediate Care £0.5m, Social Care £0.4m, Medical Services £0.3m, and Women & Children & Family Care £0.2m.

## Financial Position By Care Group/Directorate:

	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	515	1,286	4,954	4,775	179	6,604	6,499	105	3.6%	1.6%
Director General's Office	(24)	(1,322)	(354)	6,491	(6,845)	(1,649)	6,710	(8,359)	(1,935.0%)	(507.0%)
Estates & Hard Facilitie	747	682	8,427	8,318	109	10,669	10,658	11	1.3%	0.1%
Improvement & Innovation	1,146	2,744	13,809	12,967	842	18,183	18,202	(19)	6.1%	(0.1%)
Intermediate Care	177	129	1,554	1,387	167	2,058	1,949	109	10.8%	5.3%
Jersey Care Model	433	587	3,895	4,270	(375)	5,193	4,793	401	(9.6%)	7.7%
Medical Director	841	900	6,848	6,025	822	9,168	7,913	1,255	12.0%	13.7%
Medical Services	4,515	5,931	40,714	48,483	(7,769)	55,186	65,704	(10,518)	(19.1%)	(19.1%)
Mental Health	2,735	3,084	24,011	25,578	(1,567)	32,840	33,901	(1,061)	(6.5%)	(3.2%)
Non-Clinical Support Ser	1,885	2,387	16,961	17,075	(114)	22,614	22,769	(155)	(0.7%)	(0.7%)
Primary Care & Preventio	870	896	7,790	7,337	453	9,982	9,486	496	5.8%	5.0%
Social Care	1,755	1,857	15,790	16,982	(1,192)	21,061	22,100	(1,039)	(7.6%)	(4.9%)
Surgical Services	3,475	4,269	30,385	36,166	(5,781)	41,789	49,529	(7,740)	(19.0%)	(18.5%)
Tertiary Care	1,067	791	9,599	10,441	(842)	12,799	14,072	(1,273)	(8.8%)	(9.9%)
Women Children & Family	1,577	1,745	13,567	14,757	(1,190)	18,708	19,920	(1,213)	(8.8%)	(6.5%)
<b>Grand Total</b>	<b>21,714</b>	<b>25,966</b>	<b>197,950</b>	<b>221,053</b>	<b>(23,103)</b>	<b>265,205</b>	<b>294,205</b>	<b>(29,000)</b>	<b>(11.7%)</b>	<b>(10.9%)</b>

\*Note: For detailed break-down see Appendices - slides 10-15 for Pay Position, slides 16-17 for Non-Pay Position, and slides 18-19 for Income Position.

# Executive Summary – Month 9 (cont.)



Reserves have been frozen to ring-fence this money to partially mitigate the HCS in-year deficit position.

£3.1m of reserves have been used to offset additional cost pressures in the last 2 months to maintain the forecast year end deficit position at £29m, leaving a balance of £7.9m as at M9. The year-end forecast after accounting for further forecast expenditure of £6.1m to year-end, depletes our reserves position to £1.78m made-up as follows:

- Growth Reserves £0.54m
- Covid Reserves £1.24m
- Capital Reserves £ nil

## Forecast Risks

- There are further risks to the year-end forecast which may materialise through the remainder of this year which are as follows:
- Tertiary Care contracts commissioning relating to activity volumes through the Southampton contract which shows an YTD over-performance. The current forecast assumption is based on Tertiary Care contracts to come within budget for the remainder of the year.
- Further extension of agency/locums and substantive recruitment fill without replacing agency.
- £3.1m of the reserves position has been used to mitigate cost pressures with risk to further depletion to manage cost pressures.

## Adjustment to correctly apportion the 'Opening Budget Pressure' of £13.9m

Previously, the 'Opening Budget Pressure' for FY23 of £13.9m is shown entirely as a Non-Pay cost pressure. However, more detailed analysis of the 2023 budget setting workings has highlighted that this pressure should have been apportioned as Pay £4.7m (34%) and Non-Pay £9.2m (66%). This has been adjusted in the Executive Summary and will be corrected in the detail supporting tables going forward.

# Run Rate Analysis

Year-to-date run rate shows £2.6m overspend per month, with projected overspend for remaining periods at just under £2.0m



Monthly Finance Position	Jan (£ million)	Feb (£ million)	Mar (£ million)	April (£ million)	May (£ million)	June (£ million)	July (£ million)	August (£ million)	September (£ million)	Oct-Dec (£ million)	Full Year 2023 (£ million)	Explanation																																								
Reported Variance			(5.40)	(6.80)	(12.50)	(14.46)	(16.14)	(18.88)	(23.10)			<div>Monthly Finance Position - Movement Summary</div> <table><tr><th>Month</th><th>Reported Variance</th><th>Monthly Variance Movement</th><th>Average Monthly Run-Rate</th></tr><tr><td>Jan</td><td>0.00</td><td>0.00</td><td>0.00</td></tr><tr><td>Feb</td><td>1.80</td><td>1.80</td><td>1.80</td></tr><tr><td>Mar</td><td>5.40</td><td>1.80</td><td>1.80</td></tr><tr><td>April</td><td>6.80</td><td>1.40</td><td>1.70</td></tr><tr><td>May</td><td>12.50</td><td>5.70</td><td>2.50</td></tr><tr><td>June</td><td>14.46</td><td>1.96</td><td>2.41</td></tr><tr><td>July</td><td>16.14</td><td>1.68</td><td>2.31</td></tr><tr><td>August</td><td>18.88</td><td>2.74</td><td>2.36</td></tr><tr><td>September</td><td>23.10</td><td>4.22</td><td>2.57</td></tr></table>	Month	Reported Variance	Monthly Variance Movement	Average Monthly Run-Rate	Jan	0.00	0.00	0.00	Feb	1.80	1.80	1.80	Mar	5.40	1.80	1.80	April	6.80	1.40	1.70	May	12.50	5.70	2.50	June	14.46	1.96	2.41	July	16.14	1.68	2.31	August	18.88	2.74	2.36	September	23.10	4.22	2.57
Month	Reported Variance	Monthly Variance Movement	Average Monthly Run-Rate																																																	
Jan	0.00	0.00	0.00																																																	
Feb	1.80	1.80	1.80																																																	
Mar	5.40	1.80	1.80																																																	
April	6.80	1.40	1.70																																																	
May	12.50	5.70	2.50																																																	
June	14.46	1.96	2.41																																																	
July	16.14	1.68	2.31																																																	
August	18.88	2.74	2.36																																																	
September	23.10	4.22	2.57																																																	
Monthly Variance Movement	(1.80)	(1.80)	(1.80)	(1.40)	(5.70)	(1.96)	(1.68)	(2.74)	(4.22)																																											
Average Monthly Run-Rate	(1.80)	(1.80)	(1.80)	(1.70)	(2.50)	(2.41)	(2.31)	(2.36)	(2.57)																																											
Adjustments:																																																				
Drugs interface not posted month 4				(1.40)	1.40																																															
Surgical Services private patient income- reviewed income expectations	(0.14)	(0.14)	(0.14)	(0.14)	0.56																																															
Non Clinical Support Services- postage and patient travel expenditure processing delays	(0.14)	(0.14)	(0.14)	(0.14)	0.56																																															
Tertiary Care- variability in payment profile	(0.10)	(0.10)	(0.10)	(0.10)	0.40																																															
Social Care- catch-up on domiciliary care packages expenditure and Les Amis	(0.10)	(0.10)	(0.10)	(0.10)	0.40																																															
Accounts receivable error							(0.70)	0.70																																												
Stamp Duty accounting error								1.30	(1.30)																																											
Adjusted Variance	(2.28)	(2.28)	(2.28)	(3.28)	(2.38)	(1.96)	(2.38)	(0.74)	(5.52)																																											
Year to Date Cumulative Variance	(2.28)	(4.56)	(6.84)	(10.12)	(12.50)	(14.46)	(16.84)	(17.58)	(23.10)	(5.90)	(29.00)																																									
Underlying run-rate	(2.28)	(2.28)	(2.28)	(2.53)	(2.50)	(2.41)	(2.41)	(2.20)	(2.89)	(1.97)	(2.42)																																									

# Substantive vs Agency



- The below table shows Vacancy has decreased by 45, mainly due to reductions in Mental Health and Non-Clinical Support Services. Vacancies covered by agency have dropped by 49, although overall agency numbers have only dropped by 4. There has been an increase in forecast agency costs of £1.0m, mainly due to extension of bookings. The increase of £1.0m is mainly seen in Medical Services £0.5m, Women & Children, Mental Health, and Primary Care & Prevention £0.2m, and Chief Nurse £0.1m, offset by a reduction in Surgical Services £0.2m.

Care Group	July	August	September	Difference	July	August	September	Difference	July	August	September	Difference	July	August	September	Difference
	Vacancy	Vacancy	Vacancy		Vacancy covered by Agency	Vacancy covered by Agency	Vacancy covered by Agency		Vacancy NOT covered by Agency	Vacancy NOT covered by Agency	Vacancy NOT covered by Agency		Agency Forecast	Agency Forecast	Agency Forecast	
	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE	Amount (£)	Amount (£)	Amount (£)	Amount (£)
Chief Nurse	16	16	21	-5	1	2	3	-1	15	14	18	-4	199,457	251,257	362,105	-110,848
Director General's Office - HCS	1	12	25	-13	1	0	0	0	0	12	25	-13	1,070,819	1,097,085	1,104,735	-7,651
Estates & Hard Facilities Management	8	9	7	2	0	0	0	0	8	9	7	2		0		0
Improvement & Innovation	9	8	8	0	0	0	0	0	9	8	8	0		0		0
Intermediate Care	0	5	1	3	0	2	1	1	0	3	0	3	0	179,588	179,588	0
Jersey Care Model	0	0	2	-2	0	0	0	0	0	0	2	-2	0	295,256	295,256	0
Medical Director	23	27	27	0	4	4	5	-1	19	23	22	1	420,268	420,268	420,268	0
Medical Services	81	76	76	0	57	59	39	20	24	17	37	-19	6,858,417	7,034,424	7,542,248	-507,824
Mental Health	119	125	100	25	39	40	33	7	80	85	67	17	4,126,912	4,158,331	4,369,401	-211,070
Non-Clinical Support Services	40	37	27	10	0	1	0	1	40	36	27	9	0	0	0	0
Primary Care & Prevention	35	36	28	8	18	18	10	8	17	18	18	0	1,184,530	1,150,570	1,300,974	-150,404
Social Care	29	32	36	-4	3	3	2	1	26	29	34	-5	116,742	209,716	209,716	0
Surgical Services	86	86	69	17	55	52	44	8	31	34	25	9	6,765,982	6,920,097	6,720,415	199,682
Women Children & Family Care	46	48	45	3	16	24	18	6	30	24	27	-3	2,443,919	3,375,328	3,553,325	-177,996
Grand Total	493	516	471	45	194	205	155	49	299	311	316	-5	23,187,046	25,091,920	26,058,031	-966,111

# Summary and Conclusion - Month 9



- The Year-to-date overspend has increased by £4.2m in M9 to £23.1m and the FY23 year-end forecast shows a deficit of £29.0m.
- The monthly headline run-rate of overspend shows an increase at month 9 to £2.9m. However, the run-rate is forecast to reduce to £2.0m for the remaining 3 months of the year, mainly through the planned application of reserves underspends to the position over these periods.
- There are further risks to the year-end forecast which may materialise through the remainder of this year relating to Tertiary Care contracts increased activity volumes and additional substantive recruitment with delayed agency displacement incurring additional double-running costs.
- £3.1m of the reserves position has been used to mitigate cost pressures leaving a forecast £1.78m by year-end with risk to further depletion to manage cost pressures.

# Appendices



# Summary Position by Care Groups/Directorates – Month 9



Care Groups & Directorates	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	515	1,286	4,954	4,775	179	6,604	6,499	105	3.6%	1.6%
Director General's Office	(24)	(1,322)	(354)	6,491	(6,845)	(1,649)	6,710	(8,359)	(1,935.0%)	(507.0%)
Estates & Hard Facilitie	747	682	8,427	8,318	109	10,669	10,658	11	1.3%	0.1%
Improvement & Innovation	1,146	2,744	13,809	12,967	842	18,183	18,202	(19)	6.1%	(0.1%)
Intermediate Care	177	129	1,554	1,387	167	2,058	1,949	109	10.8%	5.3%
Jersey Care Model	433	587	3,895	4,270	(375)	5,193	4,793	401	(9.6%)	7.7%
Medical Director	841	900	6,848	6,025	822	9,168	7,913	1,255	12.0%	13.7%
Medical Services	4,515	5,931	40,714	48,483	(7,769)	55,186	65,704	(10,518)	(19.1%)	(19.1%)
Mental Health	2,735	3,084	24,011	25,578	(1,567)	32,840	33,901	(1,061)	(6.5%)	(3.2%)
Non-Clinical Support Ser	1,885	2,387	16,961	17,075	(114)	22,614	22,769	(155)	(0.7%)	(0.7%)
Primary Care & Preventio	870	896	7,790	7,337	453	9,982	9,486	496	5.8%	5.0%
Social Care	1,755	1,857	15,790	16,982	(1,192)	21,061	22,100	(1,039)	(7.6%)	(4.9%)
Surgical Services	3,475	4,269	30,385	36,166	(5,781)	41,789	49,529	(7,740)	(19.0%)	(18.5%)
Tertiary Care	1,067	791	9,599	10,441	(842)	12,799	14,072	(1,273)	(8.8%)	(9.9%)
Women Children & Family	1,577	1,745	13,567	14,757	(1,190)	18,708	19,920	(1,213)	(8.8%)	(6.5%)
<b>Grand Total</b>	<b>21,714</b>	<b>25,966</b>	<b>197,950</b>	<b>221,053</b>	<b>(23,103)</b>	<b>265,205</b>	<b>294,205</b>	<b>(29,000)</b>	<b>(11.7%)</b>	<b>(10.9%)</b>

**Year-to-date overspend £23.1m (11.7%, adverse movement of £4.2m from August), made up of:**

- **£4.8m overspend on Staff Costs- £18.6m underspend on Substantive staffing offset by £20.6m Agency plus £2.9m Overtime** - The position includes significant overspends in Medical Services £7.6m, Surgical Services £2.7m, and Women & Children & Family Care £1.3m, where agency usage and other temporary workforce has been used to cover vacant roles and staff absences. Offset by vacancy underspends across other areas.
- **£17.7m overspend on Non Pay-** £9.6m part-year effect of the opening pressure. The remaining £8.1m overspend includes Mental Health on off-Island placements and drugs £2.6m, Chief Nurse in relation to the Accommodation Service £1.2m, Social Care on domiciliary care packages £1.0m, Surgical Services £0.9m, Tertiary Care £0.8m, and Non-Clinical Support Services £0.8m, of which the majority relates to Patient Travel and Estates Compliance works.
- **£0.6m underachievement of Income-** Surgical Services has underperformed by £2.1m against private patient income targets, and there is a £0.3m underperformance in Social Care (although forecast to achieve target full year). There are overachievements in Chief Nurse £0.5m due to expansion of staff accommodation services, and Mental Health £0.4m in relation to Long Term Care Benefit.

**Full-year forecast overspend £29.0m (10.9%, no movement from August), made up of:**

- **£6.5m overspend on Staff Costs** this relates to a £17.8m underspend on substantive staffing due to vacancies, offset with £24.3m on agency staffing. Significant forecast overspends in Medical Services £9.9m, Surgical Services £3.0m, and Women & Children £1.4m.
- **£22.6m overspend on Non Pay-** £13.9m relates to the opening budget pressure, with the remaining £8.5m spread across Care Groups, with Mental Health £3.2m, Surgical Services £1.7m, Chief Nurse £1.6m, Social Care £1.5m, Tertiary Care £1.3m, Non Clinical Support Services £1.0m, Medical Services £0.9m, and Estates £0.5m.
- **£0.1m overachievement of Income** - a Surgical Services private patient income under-recovery of £3.0m, offset by an over-recovery of Long Term Care Benefit income and Accommodation income in Chief Nurse.

# Pay Position – Month 9



	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Substantive	16,053	13,981	144,110	125,484	18,626	197,016	179,167	17,849	12.9%	9.1%
Agency	74	3,383	1,689	22,265	(20,576)	1,910	26,179	(24,268)	(1,218.3%)	(1,270.5%)
Overtime	0	338	0	2,863	(2,863)	0	80	(80)		
Recharges	0	7	0	11	(11)	0	9	(9)		
<b>Grand Total</b>	<b>16,127</b>	<b>17,710</b>	<b>145,798</b>	<b>150,623</b>	<b>(4,824)</b>	<b>198,926</b>	<b>205,434</b>	<b>(6,508)</b>	<b>(3.3%)</b>	<b>(3.3%)</b>

## Assumptions and methodology:

### Year-to-date:

- GoJ staffing figures are as per payroll processed January to September
- Agency medical outstanding costs of £1.2m have been accrued into position based on Holt Doctors booking data
- Other agency staffing expenditure assumed complete as should be processed via purchase order and receipted in a timely manner

### Forecast:

- Overtime costs assume to be extrapolated full year, but included in Substantive forecast number
- Zero hours costs assumed to continue at current rates for the rest of the year in high usage areas
- Agency medical forecasts based on the value of current bookings, obtained from supplier Holt Doctors
- Other agency staffing assumed to be in place for up to 12 months in 2023, based on agency staff currently in place and information provided by Care Groups and Directorates.

# Pay Position – Month 9



Care Groups & Directorates	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	476	366	4,135	3,253	882	5,670	4,840	830	21.3%	14.6%
Director General's Office	552	(425)	5,547	3,380	2,167	7,132	4,976	2,156	39.1%	30.2%
Estates & Hard Facilitie	380	365	3,422	2,992	430	4,563	4,043	520	12.6%	11.4%
Improvement & Innovation	166	69	1,494	1,048	445	1,998	1,726	272	29.8%	13.6%
Intermediate Care	270	282	2,298	2,286	12	3,182	3,455	(273)	0.5%	(8.6%)
Jersey Care Model	(309)	197	1,840	2,226	(386)	2,453	2,247	206	(21.0%)	8.4%
Medical Director	817	748	6,628	5,352	1,277	8,875	7,537	1,338	19.3%	15.1%
Medical Services	3,272	4,598	28,518	36,081	(7,563)	39,261	49,130	(9,870)	(26.5%)	(25.1%)
Mental Health	2,200	2,422	19,155	18,521	634	26,400	25,046	1,354	3.3%	5.1%
Non-Clinical Support Ser	1,568	1,506	14,114	13,472	642	18,819	18,073	746	4.6%	4.0%
Primary Care & Preventio	780	679	6,975	6,404	570	9,349	8,805	544	8.2%	5.8%
Social Care	957	987	8,312	8,219	93	11,488	11,422	67	1.1%	0.6%
Surgical Services	3,547	4,276	30,947	33,690	(2,743)	42,567	45,564	(2,997)	(8.9%)	(7.0%)
Women Children & Family	1,449	1,638	12,413	13,698	(1,285)	17,169	18,571	(1,402)	(10.4%)	(8.2%)
<b>Grand Total</b>	<b>16,127</b>	<b>17,710</b>	<b>145,798</b>	<b>150,623</b>	<b>(4,824)</b>	<b>198,926</b>	<b>205,434</b>	<b>(6,508)</b>	<b>(3.3%)</b>	<b>(3.3%)</b>

## Year-to-date overspend £4.8m, made up of:

- **Substantive pay underspend of £18.6m** in respect of vacant posts totalling 471 FTE, mainly within Mental Health £5.0m, Surgical Services £3.5m, Medical Director £1.6m, Women & Children & Family Care £1.5m, Non-Clinical Support Services £1.4m, Primary Care & Prevention £1.3m, Chief Nurse £0.9m, Estates & Hard FM £0.7m, Improvement & Innovation £0.5m, Social Care £0.3m, and Intermediate Care £0.2m. There is an overspend of £0.5m on Medical Services, and £0.1m on Jersey Care Model.
- **Overtime spend of £2.9m**, with major spends in Non-Clinical Support Services £0.7million, Medical Services £0.6m, Surgical Services £0.4m, Mental Health £0.4m, Estates & Hard FM and Women & Children's Services both £0.2m each, and Intermediate Care £0.1m.
- **Agency staffing overspend £20.6m**, with Medical Services £6.4m, Surgical Services £5.8m, Mental Health £4.0m, Women & Children's Services £2.6m, Primary Care £0.7m, Medical Director and Jersey Care Model both £0.3m, Social Care £0.2m, DG's Office and Non Clinical Support £0.1m each.

## Full year forecast overspend £6.5m, made up of:

- **Substantive pay underspend of £17.8m (includes forecast of Zero Hours and Overtime)** in respect of vacant posts mainly within Mental Health £5.7m, Surgical Services £3.3m, Women & Children & Family Care £2.0m, Medical Director £1.8m, Primary Care & Prevention £1.8m, Chief Nurse £1.2m, Non-Clinical Support Services £0.7m, Estates & Hard FM £0.5m, Social Care £0.3m, and Improvement & Innovation £0.3m. These are offset by a forecast overspend in Medical Services of £2.6m.
- **Agency staffing overspend £24.3m**, with Medical Services £7.3m, Surgical Services £6.3m, Mental Health £4.3m, Women & Children's Services £3.4m, Primary Care £1.3m, Medical Director and Chief Nurse both £0.4m, and Jersey Care Model £0.3m.

# Temporary Workforce- Agency Month 9



Care Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year Total	% of Forecast Full Year
Row Labels	Sum of Jan Actuals	Sum of Feb Actuals	Sum of March Actuals	Sum of April Actuals	Sum of May Actuals	Sum of June Actuals	Sum of July Actuals	Sum of Aug Actuals	Sum of September Forecast	Sum of October Forecast	Sum of November Forecast	Sum of December Forecast	Sum of Full Year Forecast	
Chief Nurse	0	1,048	8,790	744	0	0	9,461	23,905	79,539	79,539	79,539	79,539	362,105	1%
Director General's Offic	1,113,417	429,925	-515,023	5,816	72,382	-27,048	32,656	17,266	-6,164	-6,164	-6,164	-6,164	1,104,735	4%
Improvement & Innovation	0	0	0	0	0	0	0	1,368	-342	-342	-342	-342	0	0%
Intermediate Care	23,089	0	0	2,325	0	0	1,608	7,258	36,327	36,327	36,327	36,327	179,588	1%
Jersey Care Model	-68,800	96,678	68,100	57,793	32,928	13,200	77,900	-26,871	11,082	11,082	11,082	11,082	295,256	1%
Medical Director	17,907	11,384	20,468	100,285	29,047	-6,375	65,700	32,597	37,314	37,314	37,314	37,314	420,268	2%
Medical Services	304,414	551,688	884,310	682,538	468,879	1,018,558	843,501	796,419	497,985	497,985	497,985	497,985	7,542,248	29%
Mental Health	15,022	158,571	719,298	575,756	372,060	607,444	518,080	399,173	250,999	250,999	250,999	250,999	4,369,401	17%
Non-Clinical Support Ser	16,842	13,531	24,033	20,783	12,335	6,581	2,982	665	-24,438	-24,438	-24,438	-24,438	0	0%
Primary Care & Preventio	869	34,567	74,243	46,470	164,939	121,643	82,169	98,836	169,309	169,309	169,309	169,309	1,300,974	5%
Social Care	-10,115	3,704	28,983	18,904	16,873	6,471	63,009	20,389	15,374	15,374	15,374	15,374	209,716	1%
Surgical Services	186,591	501,583	836,359	1,041,492	540,667	642,331	741,913	568,556	415,231	415,231	415,231	415,231	6,720,415	26%
Women Children & Family	191,104	178,453	450,538	288,632	274,062	337,942	335,571	265,884	307,785	307,785	307,785	307,785	3,553,325	14%
<b>Grand Total</b>	<b>1,790,340</b>	<b>1,981,132</b>	<b>2,600,099</b>	<b>2,841,538</b>	<b>1,984,172</b>	<b>2,720,748</b>	<b>2,774,551</b>	<b>2,205,445</b>	<b>1,790,001</b>	<b>1,790,001</b>	<b>1,790,001</b>	<b>1,790,001</b>	<b>26,058,031</b>	<b>100%</b>

## Forecast Assumptions:

- Agency medical forecasts based on the value of current bookings, obtained from supplier Holt Doctors, reviewed with Care Groups, some forecasts extended based on advice from Care Group
- Other agency staffing assumed to be in place for a maximum of 12 months in 2023, based on agency staff currently in place, as substantive replacements assumed to be recruited in Q4 where WEARs are in place

# Temporary Workforce- Overtime & Zero Hour Month 9



		Actuals									Forecast					
Care Group	Pay Type	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Full Year Total	% of Forecast Full Year Tot	YTD
Chief Nurse	Overtime	1,132	784	7	0	1,651	144	77	72	156	447	447	447	5,363		4,022
Chief Nurse	Zero Hours	5,115	6,504	19,492	15,734	21,061	9,382	14,317	2,611	17,112	12,370	12,370	12,370	148,438		111,329
Chief Nurse Total		6,247	7,288	19,499	15,734	22,712	9,526	14,394	2,683	17,268	12,817	12,817	12,817	153,801	0.99%	115,351
Director General's Office - HCS	Overtime	2,358	1,242	872	74	1,814	262	0	0	198	758	758	758	9,094		6,820
Director General's Office - HCS	Zero Hours	15,619	17,282	14,236	12,255	11,429	11,662	13,409	14,358	15,021	13,919	13,919	13,919	167,026		125,270
Director General's Office - HCS Total		17,977	18,524	15,108	12,329	13,243	11,924	13,409	14,358	15,218	14,677	14,677	14,677	176,120	1.13%	132,090
Improvement & Innovation	Overtime	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Improvement & Innovation	Zero Hours	0	0	0	0	0	94	0	0	0	10	10	10	126		94
Improvement & Innovation Total		0	0	0	0	0	94	0	0	0	10	10	10	126	0.00%	94
Estates & Hard Facilitie	Overtime	35,531	27,355	37,742	30,884	33,304	32,816	28,601	34,427	34,607	32,807	32,807	32,807	393,689		295,267
Estates & Hard Facilitie	Zero Hours	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Estates & Hard Facilities Management Total		35,531	27,355	37,742	30,884	33,304	32,816	28,601	34,427	34,607	32,807	32,807	32,807	393,689	2.54%	295,267
Jersey Care Model	Overtime	0	0	0	0	0	0	147	0	0	16	16	16	196		147
Jersey Care Model	Zero Hours	0	0	0	0	0	0	0	0	571	63	63	63	762		571
Jersey Care Model Total		0	0	0	0	0	0	147	0	571	80	80	80	958	0.01%	718
Medical Director	Overtime	8,668	4,808	3,373	10,976	8,896	8,721	7,571	7,606	8,336	7,662	7,662	7,662	91,941		68,956
Medical Director	Zero Hours	5,458	7,015	7,107	11,134	9,652	11,744	11,538	11,491	16,077	10,135	10,135	10,135	121,620		91,215
Medical Director Total		14,126	11,823	10,480	22,111	18,547	20,464	19,109	19,097	24,413	17,797	17,797	17,797	213,562	1.38%	160,171
Medical Services	Overtime	101,023	90,327	95,241	107,241	72,819	82,517	69,479	80,606	69,279	85,393	85,393	85,393	1,024,710		768,533
Medical Services	Zero Hours	275,311	344,264	301,188	320,335	346,984	401,676	366,189	439,976	472,348	363,141	363,141	363,141	4,357,695		3,268,272
Medical Services Total		376,334	434,590	396,429	427,576	419,804	484,193	435,668	520,583	541,627	448,534	448,534	448,534	5,382,406	34.67%	4,036,804
Mental Health	Overtime	65,645	60,153	37,659	60,713	45,227	37,328	50,988	36,502	37,839	48,006	48,006	48,006	576,072		432,054
Mental Health	Zero Hours	51,345	110,924	85,477	98,063	73,151	109,275	93,651	120,566	67,979	90,048	90,048	90,048	1,080,573		810,430
Mental Health Total		116,990	171,077	123,136	158,775	118,378	146,603	144,639	157,067	105,818	138,054	138,054	138,054	1,656,645	10.67%	1,242,484
Non-Clinical Support Ser	Overtime	164,398	69,669	68,121	79,364	124,887	144,077	81,403	85,077	101,881	102,097	102,097	102,097	1,225,167		918,875
Non-Clinical Support Ser	Zero Hours	87,552	87,753	79,469	88,405	74,210	84,769	80,082	79,760	79,260	82,362	82,362	82,362	988,344		741,258
Non-Clinical Support Services Total		251,951	157,422	147,590	167,768	199,096	228,846	161,484	164,837	181,141	184,459	184,459	184,459	2,213,512	14.26%	1,660,134
Primary Care & Preventio	Overtime	12,454	5,838	14,340	8,724	4,750	10,079	7,617	4,121	7,182	8,345	8,345	8,345	100,141		75,106
Primary Care & Preventio	Zero Hours	33,980	46,002	18,804	38,174	21,184	20,209	20,188	26,567	18,910	27,113	27,113	27,113	325,359		244,019
Primary Care & Prevention Total		46,434	51,840	33,145	46,899	25,933	30,288	27,806	30,689	26,092	35,458	35,458	35,458	425,500	2.74%	319,125
Social Care	Overtime	5,587	5,635	3,986	8,924	4,988	6,974	7,100	3,810	7,911	6,102	6,102	6,102	73,222		54,916
Social Care	Zero Hours	38,345	49,299	44,330	59,896	44,839	44,619	46,709	46,666	46,147	46,761	46,761	46,761	561,134		420,850
Social Care Total		43,932	54,934	48,317	68,820	49,828	51,593	53,809	50,476	54,058	52,863	52,863	52,863	634,355	4.09%	475,767
Surgical Services	Overtime	68,886	65,924	49,812	57,109	57,037	52,480	54,200	69,399	49,878	58,303	58,303	58,303	699,633		524,724
Surgical Services	Zero Hours	184,793	243,777	173,498	123,192	213,822	201,975	211,442	307,456	206,920	207,431	207,431	207,431	2,489,168		1,866,876
Surgical Services Total		253,679	309,701	223,310	180,301	270,859	254,455	265,642	376,855	256,798	265,733	265,733	265,733	3,188,800	20.54%	2,391,600
Women Children & Family	Overtime	36,116	20,359	14,839	18,896	24,463	25,418	20,612	21,251	19,285	22,360	22,360	22,360	268,321		201,241
Women Children & Family	Zero Hours	18,470	40,077	28,513	29,960	21,105	35,524	21,576	17,073	29,206	26,834	26,834	26,834	322,006		241,505
Women Children & Family Care Total		54,586	60,437	43,353	48,856	45,568	60,941	42,189	38,324	48,491	49,194	49,194	49,194	590,327	3.80%	442,745
Intermediate Care	Overtime	8,885	19,017	20,694	14,263	13,533	19,701	18,202	15,302	17,026	16,292	16,292	16,292	195,499		146,624
Intermediate Care	Zero Hours	33,933	22,391	18,765	29,693	24,969	22,843	0	49,426	24,543	25,174	24,858	25,016	301,610		226,562
Intermediate Care Total		42,818	41,407	39,459	43,956	38,502	42,544	18,202	64,728	41,569	41,465	41,150	41,307	497,109	3.20%	373,186
Overall Total		1,260,605	1,346,398	1,137,567	1,224,009	1,255,775	1,374,288	1,225,097	1,474,124	1,347,672	1,293,948	1,293,633	1,293,791	15,526,908	100.0%	11,645,536

## Assumptions:

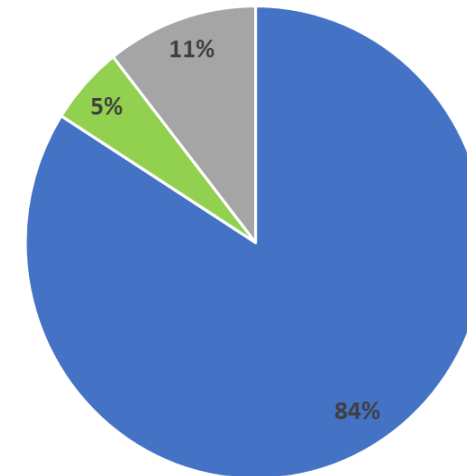
- Overtime assumed to continue at a consistent rate
- Zero Hours assumed to continue at a consistent rate

# Vacancies– Month 9

Care Group	Staff Type	Total Budgeted FTE	Total in Post	Total Vacancy	Vacancy covered by Agency
Chief Nurse	AHP	2	2	0	0
Chief Nurse	Civil Servant & Associated	45	33	12	1
Chief Nurse	Manual Workers	7	6	1	0
Chief Nurse	Medical	0	0	0	0
Chief Nurse	Nurses & Midwives	23	15	8	2
<b>Chief Nurse Total</b>		<b>78</b>	<b>56</b>	<b>21</b>	<b>3</b>
Director General's Office - HCS	Civil Servant & Associated	35	22	13	0
Director General's Office - HCS	Manual Workers	0	0	0	0
Director General's Office - HCS	Medical	3	3	0	0
Director General's Office - HCS	Nurses & Midwives	12	0	12	0
<b>Director General's Office - HCS Total</b>		<b>50</b>	<b>25</b>	<b>25</b>	<b>0</b>
Estates & Hard Facilities Management	Civil Servant & Associated	10	10	0	0
Estates & Hard Facilities Management	Manual Workers	60	53	7	0
<b>Estates &amp; Hard Facilities Management Total</b>		<b>70</b>	<b>63</b>	<b>7</b>	<b>0</b>
Improvement & Innovation	Civil Servant & Associated	33	25	8	0
Improvement & Innovation	Nurses & Midwives	1	1	0	0
<b>Improvement &amp; Innovation Total</b>		<b>34</b>	<b>26</b>	<b>8</b>	<b>0</b>
Intermediate Care	Civil Servant & Associated	22	22	0	0
Intermediate Care	Nurses & Midwives	38	37	1	1
<b>Intermediate Care Total</b>		<b>60</b>	<b>58</b>	<b>1</b>	<b>1</b>
Jersey Care Model	Civil Servant & Associated	37	36	1	0
Jersey Care Model	Medical	4	4	0	0
Jersey Care Model	Nurses & Midwives	5	4	1	0
<b>Jersey Care Model Total</b>		<b>45</b>	<b>44</b>	<b>2</b>	<b>0</b>
Medical Director	AHP	51	39	12	5
Medical Director	Civil Servant & Associated	34	27	7	0
Medical Director	Medical	61	53	8	0
Medical Director	Nurses & Midwives	2	2	0	0
<b>Medical Director Total</b>		<b>148</b>	<b>121</b>	<b>27</b>	<b>5</b>
Medical Services	AHP	75	67	9	4
Medical Services	Civil Servant & Associated	42	37	6	0
Medical Services	Medical	78	74	4	7
Medical Services	Nurses & Midwives	335	277	57	28
<b>Medical Services Total</b>		<b>530</b>	<b>455</b>	<b>76</b>	<b>39</b>
Mental Health	AHP	5	5	0	0
Mental Health	Civil Servant & Associated	146	101	45	3
Mental Health	Medical	24	17	7	8
Mental Health	Nurses & Midwives	203	155	48	22
<b>Mental Health Total</b>		<b>378</b>	<b>278</b>	<b>100</b>	<b>33</b>
Non-Clinical Support Services	Civil Servant & Associated	140	129	11	0
Non-Clinical Support Services	Manual Workers	264	248	16	0
<b>Non-Clinical Support Services Total</b>		<b>404</b>	<b>378</b>	<b>27</b>	<b>0</b>
Primary Care & Prevention	AHP	99	76	23	9
Primary Care & Prevention	Civil Servant & Associated	27	24	3	1
Primary Care & Prevention	Medical	1	0	1	0
Primary Care & Prevention	Nurses & Midwives	10	9	1	0
<b>Primary Care &amp; Prevention Total</b>		<b>137</b>	<b>108</b>	<b>28</b>	<b>10</b>
Social Care	AHP	10	8	2	0
Social Care	Civil Servant & Associated	72	63	9	1
Social Care	Manual Workers	1	1	0	0
Social Care	Nurses & Midwives	139	114	25	1
<b>Social Care Total</b>		<b>222</b>	<b>186</b>	<b>36</b>	<b>2</b>
Surgical Services	AHP	88	76	12	7
Surgical Services	Civil Servant & Associated	49	42	7	0
Surgical Services	Manual Workers	17	16	1	0
Surgical Services	Medical	68	59	9	8
Surgical Services	Nurses & Midwives	314	274	40	30
<b>Surgical Services Total</b>		<b>535</b>	<b>466</b>	<b>69</b>	<b>44</b>
Women Children & Family Care	AHP	28	24	5	1
Women Children & Family Care	Civil Servant & Associated	15	12	3	0
Women Children & Family Care	Medical	37	29	8	4
Women Children & Family Care	Nurses & Midwives	127	97	29	13
<b>Women Children &amp; Family Care Total</b>		<b>207</b>	<b>162</b>	<b>45</b>	<b>18</b>
<b>Grand Total</b>		<b>2,898</b>	<b>2,426</b>	<b>463</b>	<b>155</b>



Establishment Breakdown



■ Total in Post ■ Vacancy covered by agency ■ Vacancy not covered by Agency



# Non-Pay Position – Month 9



	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Supplies and Services	5,631	10,491	50,816	67,945	(17,129)	65,948	88,215	(22,267)	(33.7%)	(33.8%)
Drugs & Vaccinations	1,541	1,592	13,866	13,937	(71)	18,488	18,014	474	(0.5%)	2.6%
Premises & Maintenance	386	278	4,795	4,893	(98)	5,954	6,345	(390)	(2.0%)	(6.6%)
Clinical supplies	139	131	1,247	1,424	(177)	1,662	1,988	(326)	(14.2%)	(19.6%)
Administrative Expenses	23	60	206	542	(336)	274	463	(189)	(163.4%)	(68.9%)
Financial Adjustments & Write-	8	5	71	27	44	95	76	19	62.4%	20.0%
Social Benefit Payment	5	1	47	10	37	63	24	39	78.9%	62.0%
<b>Grand Total</b>	<b>7,733</b>	<b>12,558</b>	<b>71,048</b>	<b>88,778</b>	<b>(17,729)</b>	<b>92,485</b>	<b>115,125</b>	<b>(22,640)</b>	<b>(25.0%)</b>	<b>(24.5%)</b>

## • Assumptions and methodology:

### Year-to-date:

- Expenditure line items reviewed individually by Finance Business Partners, accruals entered where year-to-date expenditure is deemed as being significantly behind scheduled expenditure levels e.g. electricity invoices in arrears, accommodation rentals in Chief Nurse.

### Full-year-forecasts:

- Expenditure line items reviewed individually by Finance Business Partners
- Expenditure extrapolated full year where consistent actuals are seen
- Forecasts amended where specific information is held i.e. schedules of care placements, known contract values, budget holder confirmation received

# Non-Pay Position – Month 9



Care Groups & Directorates	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Director General's Office	(566)	542	(5,812)	3,589	(9,400)	(8,662)	1,811	(10,473)	(161.8%)	(120.9%)
Mental Health	555	756	5,016	7,615	(2,599)	6,680	9,838	(3,158)	(51.8%)	(47.3%)
Surgical Services	783	900	7,135	8,068	(933)	9,485	11,226	(1,741)	(13.1%)	(18.4%)
Chief Nurse	247	1,546	2,695	3,853	(1,158)	3,437	4,999	(1,562)	(43.0%)	(45.5%)
Social Care	1,109	1,302	9,983	11,015	(1,031)	13,311	14,797	(1,486)	(10.3%)	(11.2%)
Tertiary Care	1,079	818	9,712	10,550	(838)	12,949	14,239	(1,290)	(8.6%)	(10.0%)
Non-Clinical Support Ser	399	946	3,592	4,358	(766)	4,789	5,804	(1,015)	(21.3%)	(21.2%)
Medical Services	1,692	1,836	16,235	16,537	(302)	21,310	22,217	(907)	(1.9%)	(4.3%)
Estates & Hard Facilitie	368	317	5,008	5,339	(331)	6,110	6,628	(518)	(6.6%)	(8.5%)
Improvement & Innovation	980	2,675	12,315	11,918	397	16,185	16,476	(291)	3.2%	(1.8%)
Medical Director	96	161	861	1,507	(647)	1,147	1,368	(221)	(75.1%)	(19.3%)
Intermediate Care	6	20	56	181	(124)	75	166	(91)	(220.9%)	(121.7%)
Primary Care & Preventio	105	227	941	1,047	(106)	1,255	1,298	(43)	(11.2%)	(3.4%)
Women Children & Family	140	124	1,256	1,156	99	1,674	1,711	(37)	7.9%	(2.2%)
Jersey Care Model	741	389	2,055	2,044	12	2,740	2,546	195	0.6%	7.1%
<b>Grand Total</b>	<b>7,733</b>	<b>12,558</b>	<b>71,048</b>	<b>88,778</b>	<b>(17,729)</b>	<b>92,485</b>	<b>115,125</b>	<b>(22,640)</b>	<b>(25.0%)</b>	<b>(24.5%)</b>

- **Year-to-date overspend £17.7m, made up of:**

- £9.6m impact of baseline budget pressure (negative budget) apportioned evenly across the year
- Mental Health overspend £2.6m in relation to on- and off-Island placements and drug expenditure
- Chief Nurse overspend £1.2m in relation to Accommodation Service
- Social Care overspend £1.0m in relation to domiciliary care packages
- Surgical Services overspend £0.9m in relation to consumables mainly for Theatres and Day Surgery Unit
- Tertiary Care overspend £0.8m mainly due to high value activity in February and March

- **Full year forecast overspend £22.6m, made up of:**

- £13.9m impact of baseline budget pressure (negative budget)
- Mental Health overspend £3.2m in relation to off-Island placements and drug expenditure
- Surgical Services overspend £1.7million in relation to Theatres consumables and the charter flights contract
- Chief Nurse overspent £1.6m in relation to Accommodation Service
- Social Care overspend £1.5m in relation to care packages



# Income Position – Month 9



	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Sale of Services	(1,852)	(2,262)	(15,940)	(14,894)	(1,046)	(22,265)	(21,052)	(1,213)	(6.6%)	(5.4%)
Patient Charges	(210)	(625)	(1,888)	(2,313)	424	(2,518)	(3,349)	831	22.5%	33.0%
Other Income	(105)	(51)	(945)	(963)	18	(1,261)	(1,692)	431	1.9%	34.2%
Sale of Goods	(17)	(6)	(150)	(75)	(75)	(200)	(101)	(99)	(49.8%)	(49.5%)
Other Fees	0	0	0	(42)	42	0	(70)	70	0.0%	0.0%
Fees and fines	(1)	13	(11)	(30)	19	(15)	(60)	45	167.9%	302.0%
Course Fees	38	(3)	38	(31)	69	51	(31)	82	0.0%	0.0%
Stamp Duty	0	(1,368)	0	0	0	0	0	0	0.0%	0.0%
<b>Grand Total</b>	<b>(2,146)</b>	<b>(4,301)</b>	<b>(18,897)</b>	<b>(18,347)</b>	<b>(550)</b>	<b>(26,207)</b>	<b>(26,355)</b>	<b>148</b>	<b>(2.9%)</b>	<b>0.6%</b>

- **Assumptions and methodology:**
- **Year-to-date:**
  - Accruals entered where invoice processing timing had resulted in significant year-to-date underachievement i.e. delays in processing of private patient invoicing and Long Term Care Benefit income
  - Long Term Care income budgets reprofiled to match expected profiling of invoicing (one month in arrears)
- **Full-year-forecasts:**
  - Income line items reviewed individually by Finance Business Partners
  - Income extrapolated full year where consistent actuals are seen
  - Forecasts amended where specific information is held i.e. budget holder confirmation received

# Income Position – Month 9



	Current Month		Year-to-Date			Full Year			Year-to-Date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	% Variance	% Variance
Surgical Services	(855)	(907)	(7,697)	(5,592)	(2,105)	(10,263)	(7,261)	(3,002)	(27.3%)	(29.3%)
Medical Services	(449)	(502)	(4,039)	(4,134)	96	(5,385)	(5,644)	259	2.4%	4.8%
Social Care	(312)	(432)	(2,505)	(2,251)	(254)	(3,738)	(4,119)	381	(10.1%)	10.2%
Chief Nurse	(208)	(627)	(1,876)	(2,331)	455	(2,502)	(3,339)	838	24.3%	33.5%
Intermediate Care	(100)	(174)	(800)	(1,080)	280	(1,200)	(1,673)	473	35.0%	39.4%
Non-Clinical Support Ser	(83)	(64)	(746)	(756)	10	(994)	(1,108)	114	1.3%	11.5%
Medical Director	(71)	(8)	(641)	(834)	192	(855)	(993)	138	30.0%	16.1%
Mental Health	(20)	(94)	(160)	(558)	398	(240)	(982)	742	248.7%	309.3%
Primary Care & Preventio	(14)	(10)	(127)	(115)	(12)	(622)	(617)	(5)	(9.5%)	(0.7%)
Women Children & Family	(11)	(17)	(102)	(98)	(4)	(136)	(362)	226	(4.3%)	166.2%
Tertiary Care	(13)	(27)	(113)	(109)	(4)	(150)	(168)	18	(3.5%)	11.8%
Director General's Offic	(10)	(1,439)	(89)	(478)	389	(118)	(76)	(42)	437.9%	(35.8%)
Estates & Hard Facilitie	(0)	0	(3)	(13)	10	(4)	(13)	9	331.6%	230.8%
<b>Grand Total</b>	<b>(2,146)</b>	<b>(4,301)</b>	<b>(18,897)</b>	<b>(18,347)</b>	<b>(550)</b>	<b>(26,207)</b>	<b>(26,355)</b>	<b>148</b>	<b>(2.9%)</b>	<b>0.6%</b>

- **Year-to-date £0.6m under-achieved, made up of:**

- Surgical Services- underachieved £2.1m, mainly relating to under-achievement in relation to Private Patient income across Theatres and DSU)
- Chief Nurse- overachieved £0.5m in relation to Accommodation Service income

- **Full-year £0.1m over-achieved, made up of:**

- Surgical Services- underachieved £3.0m, of which majority relates to Private Patient Accommodation and Main Theatre Charges.
- Chief Nurse- overachieved £0.8m in relation to Accommodation Service income
- Mental Health- overachieved £0.7m in relation to Long Term Care income and rebate to Alcohol & Drugs Service
- Intermediate Care overachieved £0.5m, mainly relating to Long Term Care income at Sandybrook
- Social Care- overachieved £0.4m in relation to Long Term Care income



## FRP Programme - Progress Update

18th October 2023
Obi Hasan



Health and  
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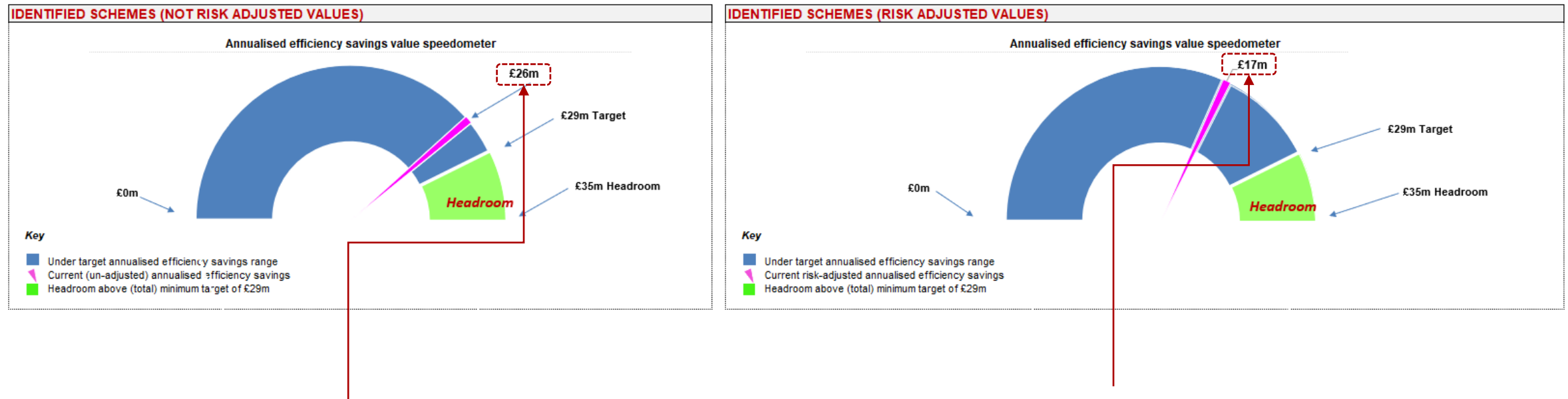
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# FRP Current Position



# FRP Dashboard overview – At a glance

Total schemes identified as at **10 October** are **£26m**. Based on risk adjustment criteria reflecting the maturity of each scheme, the overall risk adjusted schemes have a value of **£17m**. Of the gross £29m, in-year benefits identified are £1.7m.



Annualised efficiency savings equate to **c£29m** (across **59** schemes). N.b., these schemes are at various stages of development, hence the requirement to also analyse them on a risk adjusted basis – see adjacent table.

Annualised efficiency savings on a risk adjusted basis (i.e., adjusting the value for the level of confidence to delivery) equate to **c£17m** (across **59** schemes).

£'m								
FY23 Target	FY23 to date	Variance	FY24 Target	FY24 to date	Variance	FY25 Target	FY25 to date*	Variance*
3.0	1.7	(1.3)	16.0	14.6	(1.4)	16.0	5.3	(10.7)

\*phasing of FY25 schemes currently in progress

# ‘£3m in 3 months’ – Delivery Challenge



Care Group / Group	Care Group Allocation of Target Amount (% of Budget) £000's
Medical Services	733
Surgical Services	678
Mental Health	371
Non-Clinical Support Services	278
Women Children & Family	276
Social Care	168
Primary Care & Prevention	134
Director Generals Office	-
Medical Director	113
Chief Nurse	72
Estates & Hard Facilities	62
Intermediate Care	51
Jersey Care Model	35
Improvement & Innovation	26
<b>Grand Total</b>	<b>3,000</b>

Delivering £3m of savings to bring the year-end financial position down from £29m overspend to £26m overspend is essential for us all to ensure we get the £52m from Treasury in future years.

Care Groups & Finance BP's asked to review Budgets and opportunities to identify £3m in 3 months. Ideas for how this is going to be achieved will be added to the tracker for monitoring via SCM's and during monthly finance meetings.

Weekly updates will be required on progress against this from Care Groups & FBP's.



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# FRP Dashboard: Overview

# FRP Schemes At A Glance



GoJ FRP Project Plans Development Summary												
<i>All checks okay</i>			Total Saving: Remaining		Investment	Net Annualised	FY23	FY24	FY25	Total Risk	In Year Risk	RAG
Item	Workstreams	Projects	Identified FYI	Gap	Required	Amount	Identified Savings	Identified Savings	Identified Savings	Adj Amount	Adj Amount	Staus
	Clinical Productivity	Patient Flow and Discharge/LOS	1,000	-	-	1,000	-	500	500	1,000	-	<div></div>
		Theatres Efficiency	3,084	-	-	3,084	-	2,449	636	3,084	-	<div></div>
	Workforce	Clinical - Medical	2,736	-	-	2,736	223	1,668	723	2,049	223	<div></div>
		Clinical - Nursing	3,949	-	-	3,949	-	2,276	1,674	2,567	-	<div></div>
		Clinical - AHPs	1,944	-	-	1,944	-	1,329	615	1,264	-	<div></div>
		Non-Clinical/ Directorate	1,840	-	-	1,840	-	920	920	1,196	-	<div></div>
		Workforce Savings	1,190	-	-	1,190	30	160	-	374	20	<div></div>
		Service Development	-	-	163	-163	-	-	-	-	-	<div></div>
	Non-Pay and Procurement	Medicines Management	1,363	-	-	1,363	156	65	-	418	119	<div></div>
		Procurement	3,085	-	70	3,015	585	2,163	266	2,278	585	<div></div>
		Other Non-Pay	257	-	-	257	-	257	-	156	-	<div></div>
		Non-Pay Controls (NPCP)	293	-	-	293	113	180	-	280	108	<div></div>
		Theatres Efficiency	20	-	-	20	-	-	-	5	-	<div></div>
	Income	Other Income Opportunities	2,351	-	100	2,251	404	2,087	-	1,528	263	<div></div>
		Private Patients	1,940	-	-	1,940	184	371	-	457	120	<div></div>
		Service Development	200	-	-	200	50	-	-	50	13	<div></div>
		Mental Health and Social Care	600	-	-	600	-	-	-	150	-	<div></div>
	Other Care group scheme	Patient Flow and Discharge/LOS	111	-	46	64	-	-	-	72	-	<div></div>
		Clinical - Medical	200	-	-	200	-	200	-	130	-	<div></div>
	IT & Digital Health	EPR	-	-	-	-	-	-	-	-	-	
TOTAL EFFICIENCY SAVINGS			26,161	8,839	379	25,782	1,745	14,624	5,333	17,057	1,449	

The estimated value of schemes that have been quantified is ~£26m (from 59 schemes) with a risk adjusted value of FYE savings of ~£17m made up of:

- 3 in the **Idea Only** stage at an annualised efficiency saving of £1.8m (£0 on a risk adjusted basis<sup>1</sup>);
- 6 in the **scoping** phase at an annualised efficiency saving of £2.2m (£0.6m on a risk adjusted basis<sup>1</sup>);
- 26 in the **In Progress** stage (equivalent total £16.1m annualised efficiency savings, £10.5m on a risk adjusted basis); and
- 13 are **Ready** (amounting to £4.9m annualised efficiency savings)
- 3 schemes have also entered the **Delivery Phase**. The full year savings are £1.1m and the in-year delivery forecast is £0.9m.

Target	35,000	3,000	16,000	16,000
Variance	(8,839)	(1,255)	(1,376)	(10,667)

Remaining gap to £35m 3yr stretch Target

<sup>1</sup> Reflecting the current stage of development of detailed plans and confidence in delivery

FY24 and FY25 scheme phasing still being profiled hence the FY23, FY24 and FY25 figures will not yet add up to the total savings identified of ~£29m



# Development schemes and current stage gates



89% of the risk adjusted value of £16.6m are in either the scoping or in progress, stage, with only 4% ready, and 7% in delivery

Snapshot		Pipeline Stage					Total
		Idea Only	Scoping	In progress	Ready	In delivery	
Number of schemes identified	[#]	36	19	29	13	3	100
Stage percentages	[%]	36%	19%	29%	13%	3%	100%
Number of schemes quantified	[#]	3	6	26	13	3	51
Annualised efficiency savings value	[£k]	1,789	2,232	16,117	4,891	1,133	26,161
Proportional Split	[%]	7%	9%	62%	19%	4%	100%
Risk Adjusted Amount	[£k]	-	558	10,476	4,891	1,133	17,057
Proportional Split	[%]	0%	3%	61%	29%	7%	100%

64% of the risk adjusted £11m are in Scoping and In Progress.

Workstream		Annualised Efficiency Savings by Pipeline stage					Total
		Idea Only	Scoping	In progress	Ready	In delivery	
Clinical Productivity	[£k]	-	-	-	4,084	-	4,084
Workforce	[£k]	-	1,000	9,885	551	223	11,659
Non-Pay and Procurement	[£k]	789	48	3,014	256	910	5,017
Income	[£k]	1,000	1,184	2,907	-	-	5,091
Other Care group schemes	[£k]	-	-	311	-	-	311
<b>2023 TOTAL EFFICIENCY SAVINGS</b>	<b>[£k]</b>	<b>1,789</b>	<b>2,232</b>	<b>16,117</b>	<b>4,891</b>	<b>1,133</b>	<b>26,161</b>

87% of the identified £26m annualised efficiency savings value are in Scoping and In Progress.

Workforce accounts for 43% of total annualised efficiency savings and Clinical productivity accounts for 17%. See overleaf for the main contributors.



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# Programme Risks



# Programme Risks



Risks	Support required from FRG?
1. Delivery of £3m of FRP savings in-year with 3m remaining	Deliver savings
2. PMDT Recruitment – impacting ability for skills transfer and potential sustainability of programme post KPMG engagement.	Support PMDT recruitment



## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Workforce Report – September 2023 data		
<b>Report author (&amp; title):</b>	Steve Graham, Associate Director of People - HCS	<b>Accountable Executive:</b>	Chris Bown, Chief Officer

### 1. Purpose

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

### 2. Executive Summary

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

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

### 3. Finance / workforce implications

The report highlights the key workforce indicators.

### 4. Risk and issues

See main report.

### 5. Applicability to ministerial plan

See main report.

### 6. Main Report

See appended report.

### 7. Recommendation

The Board is asked to note the report.

# **Health and Community Services**

## **Advisory Board**

### **Workforce Report**

**October 2023**

**(September 2023 data)**

## Executive Summary

The figures in blue are from the finance establishment file, the figures in black all relate to the HR dashboard numbers.

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

Metric						
	Dec 22	March 23	June 23	July 23	August 23	Sept-23
Funded Establishment – FTE	2631	2675	2709	2721	2801	2863
Staff in post – FTE	2200	2239	2228	2221	2274	2405
Vacant – FTE	411	436	481	501	527	458
Vacancy Rate	16%	16%	18%	18%	18%	16%
Agency staff (headcount)	133	175	176	193	205	201
Total Turnover Rate	7.5%	6.2%	6.5%	6.6%	7.3%	7.0%
Voluntary turnover rate	5%	4%	4%	4.1%	4.4%	4.3%
Starters Headcount	23	23	15	16	11	36
Leavers Headcount	26	15	13	12	14	16
Sickness Rate	6%	4.8%	5.6%	5.6%	5.6%	5.5%
Training compliance Rate	TBA					
No objectives		0.5%	0.5%	No data	0.5%	0.5%
With Objectives		93%	80.6%		73%	70.8%
With Manager		3%	7.6%		7.5%	5.7%
Objectives approved		3%	10%		9.9%	21.5%
Mid-Year Review C0mplete			0.3%		6.8%	10.6%
Zero hours spend		£592K	£570k	£600K	£670K	
Agency Spend	TBA	TBA				

Work between the finance team and the HR Resourcelink team to reconcile the differences between systems has now completed. The new hierarchy will be loaded into the Connect system. When this has been completed an end of project report will be published which will be shared at the next Board meeting.

Due to an increase in funded establishment from Government Plan business case funded roles coming online from January 2023, this has increased the funded establishment by 232 WTE since the beginning of 2023. This has had a corresponding impact on the overall vacancy number which has

increased, as has the vacancy rate and the agency numbers. However, at the end of September, HCS is reporting 458 WTE vacancies (down from 527 WTE at the end of August) and a vacancy rate of 16% down from 18% at the end of August. This equates to 40 new nurses, 31 new doctors and 21 new Health Care Assistants.

It is worth noting that whilst we have increased funded roles by 232 WTE, the number of vacancies has only increased by 47 WTE.

Recognising this number of vacancies, several interventions into increasing support and redesigning processes have taken place to support a more effective and efficient recruitment process. Our engagement with specialist recruitment agencies is beginning to bring in experienced staff to fill roles in Nursing (both general ward and Mental Health inpatient), Midwives, Radiographers and Theatre ODPs.

The total turnover rate has dropped slightly this month to 7.0% and is down from 8% this time last year. The voluntary turnover rate (i.e. resignations) has also remained constant at 4.3%, which is equivalent to 104 staff resigning over the previous 12 months. In that period HCS has over 300 new starters.

The sickness absence rate has remained reasonably constant, with the main reason for absence continuing to be coughs, cold and flu over the last month.

The August data for the objective setting shows significant movement in the approval of objectives and the mid-year reviews with an increase from 9.9% to 21.5% of the workforce having a mid-year review and an increase from 6.8% to 10.6% of the workforce having their mid-year review completed. However, this is still low and will remain an area of focus for Executive team.

## Recruitment

A review of data back to October shows the full impact of business case approval on the funded establishment, with the table below showing the increase in all staff groups, except manual workers. It is important to note that the “Civil Servant” pay group contains all our Allied Health Professionals, so this increase in WTE also reflects increased investment in those professions.

	Funded Establishment (WTE)		
	Oct-22	Aug-23	Sept -23
<b>Medical</b>	229	250	273
<b>Nursing</b>	691	737	747
<b>Healthcare Assistants</b>	400	427	446
<b>Civil Servants</b>	917	1041	1054
<b>Manual Workers</b>	357	346	343
<b>Total</b>	2590	2801	2863

This table shows the increase in WTE staff in post across the staff groups with recruitment into the doctors, nurses, HCAs and civil servant groups.

	Staff in Post (WTE)		
	Oct-22	Aug-23	Sept-23
<b>Medical</b>	188	204	235
<b>Nursing</b>	554	561	601
<b>Healthcare Assistants</b>	346	357	378
<b>Civil Servants</b>	759	841	871
<b>Manual Workers</b>	321	311	320
<b>Total</b>	<b>2168</b>	<b>2274</b>	<b>2405</b>

The following table shows the vacancy rate for each staff group. As can be seen the increase in funded nursing and Health care assistant roles has had significant impact on the vacancy rate in both these staff groups.

	Vacancy Rate		
	Oct-22	Aug-23	Sept-23
<b>Medical</b>	19%	18%	14%
<b>Nursing</b>	20%	23%	19%
<b>Healthcare Assistants</b>	13%	20%	18%
<b>Civil Servants</b>	17%	19%	17%
<b>Manual Workers</b>	9%	10%	7%
<b>Total</b>	<b>16%</b>	<b>18%</b>	<b>16%</b>

Work continues with the Recruitment Pilot team and the Project Management Office to produce data on the recruitment pipeline going forward, which will describe the number of roles in active recruitment, length of time to recruit and projected start dates to manage any locum/agency cover for the vacancy.



Over the last 12 months HCS has recruited over 300 new starters as a mixture of movers within HCS/GoJ and new recruits into HCS.

## Recruitment Activity

It is recognised that the time to recruit is currently too long, leading to reputational risks and to a high use of agency and locum workers which is costly for the department. It has now been agreed that additional resources will support HCS recruitment activity and the redesign of the recruitment pathway and processes.

Several groups have been established within HCS to support the activity required to reduce the number of vacancies which are populated by HR and HCS colleagues. These will focus on the following areas,

- A Microsite has been created for the recruitment of all nurses in HCS which is scheduled to go live in November and contains relevant information for an interested candidate.
- A specific social media campaign has been designed for the recruitment of physiotherapists and work is underway to develop a generic campaign for the Mental Health Services.
- There are also plans to utilise specialist agencies for the recruitment of experienced colleagues such as nurses, allied health professionals and doctors.
- A redesign of the end-to-end process within HCS to ensure the “mass recruitment process” has potential and will introduce the concept of creating a bank of reserve second choice candidates.
- The department has been involved in the creation of the Priority Worker Policy to support accommodation for candidates, which will enhance our onboarding offer.

## Retention

The total turnover rate has dropped slightly this month from 7.3% to 7% with a similar drop in the voluntary turnover rate (i.e., resignations) to 4.3%; [down from 5.2% this time last year and 5% in the 12 months to the end of December 2022.](#)

This is equivalent to 104 staff resigning over the previous 12 months. In that period HCS has over 300 new starters, which is a mix of people new to HCS and people within HCS taking up alternative roles.

In addition, there were 36 retirements over the previous 12 months; the remaining 35 “involuntary” leavers consisted of 27 leavers due to end of contract (including the junior doctors), three leavers who failed their probationary period and five dismissals.

## Exit Interviews

The HCS HR team has been offering leavers face to face exit interviews since March 2023. During that time the uptake of the offer of face-to-face requests has been variable, but of those staff who have spoken with the HR team, the common themes for leaving are cost of living in Jersey, lack of communication and dissatisfaction with management. The review has also identified issues with the process and further work will be undertaken to ensure staff are given enough time to contact the HR team before they leave HCS.

## Induction

HCS currently has different induction events designed to introduce new colleagues to the Government of Jersey, HCS as a department and their local workplace.

### My Welcome

My Welcome is the online Government of Jersey induction programme all new starters to GoJ are expected to undertake. The completion rate of this programme is approximately 30% and this area needs to be closely monitored. The introduction of the HCS corporate induction will provide an opportunity to remind colleagues of the importance to complete the My Welcome induction too.

### HCS Induction

HCS has re started the face-to-face HCS corporate induction for all new starters to HCS.

The first induction day was held in May 2023 and all new starters between December 2022 and April 2023 were invited.

Whilst feedback on the event was mainly positive, the event has been revised and will be run for half a day monthly starting in November 2023.

## Learning and Development

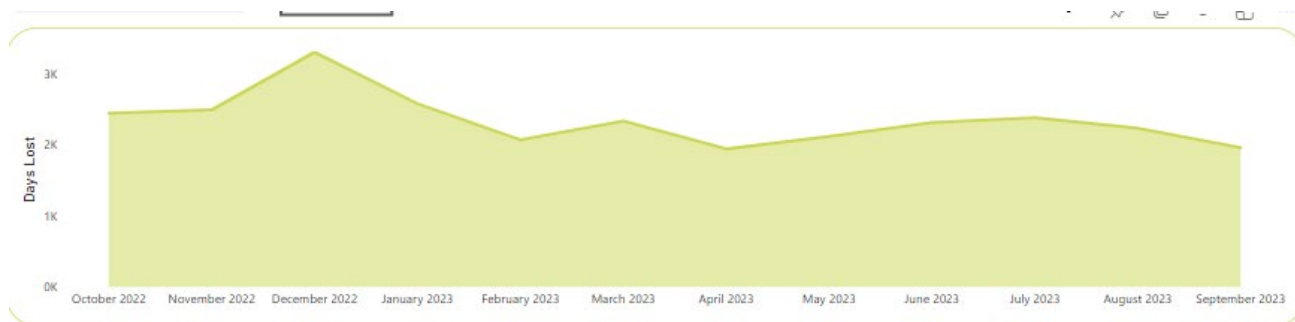
### Statutory and Mandatory Training - Placeholder

The statutory and mandatory training policy and training matrix is going through final stages of approval. Once in place, training figures will be produced and shown here.

### Health and Well Being

The sickness absence rate has remained constant at 5.5%, with the main reason for absence continuing to be coughs, cold and flu over the last month.

This is shown below in the graph showing days lost.



## Employee Relations

HCS currently has 14 live formal ER cases across disciplinary, grievance, bullying and harassment, employment tribunal and capability processes. This is a decrease from 21 cases in March 2023.

Closer working between HCS HR and Case Management has supported the earlier resolution of cases as they come to light.

In addition to those recorded as formal cases, two cases have been resolved through informal processes and a further four are in the informal process.

During 2022 HCS had a total of 36 Employee Relations cases disciplinary cases.

## Staff Appraisal and Development

The September data for the objective setting shows positive movement in the approval of objectives and the mid-year reviews with an increase from 9.9% to 21.5% of the workforce having their objectives approved and from 6.8% to 10.6% having had their mid-year review. However, this is still low and will remain an area of focus for Executive team.

System issues which prevented people from logging in and using the system, as well as problems with the hierarchy that transferred over from My View. Work has taken place in both these areas and the HR team, supported by PCS colleagues, are focussed on supporting HCS colleagues to access the system so objectives can be agreed.

Several roadshows have been held across HCS property and PCS colleagues have joined team and manager meetings to work through the process of logging into Connect and approving objectives. A bespoke package of training has been developed for managers to support them with performance conversations.

Ongoing support will continue to be provided to managers to enable them to hold meetings with staff.



## Health and Community Service Advisory Board Report

<b>Report to:</b> <i>(delete as appropriate)</i>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	23 October 2023 (initially SLT)		
<b>Title of paper:</b>	Serious Incidents		
<b>Report author (&amp; title):</b>	Andrea Bowring Head of Patient Safety	<b>Accountable Executive:</b>	Patrick Armstrong Group Medical Director

### 1. Purpose

What is the purpose of this report?  What is being asked of Board?	The Board is being made aware of the current serious incident investigation activity and challenges.	Information	x
		Decision	
		Assurance	x
		Update	x

### 2. Executive Summary

- Health and Community Services have **44** Serious Incidents (SI's) currently open.
- There are **6** SI's that have not been commenced. The longest open without an investigator is **4** months and **1** is open 1 day.
- The Quality and Safety Team struggle to assign investigators to current open SI's.
- Serious Incidents are not being completed in a timely manner or within policy timeframes.
- The Quality and Safety team are also overseeing further investigations that do not sit under the remit of HCS, for example the Ambulance Service and Child and Adolescent Mental Health Services (CAMHS).
- An interim Serious Incident Reviewer has been appointed to help carry out investigations. They will support the investigators to complete overdue reports and help investigate the cases where no investigators have been sourced.
- A draft Job Description has been written and will be submitted for Job Evaluation.

### 3. Finance / workforce implications

- The HCS Senior Leadership Team (SLT) agreed to offer investigators protected time to carry out investigations. If investigators require time from clinical duties, this request would be made to the Chief of Service for that area or Lead Nurse. This has not currently been utilized as at the point of appointing SI's clinical commitments, theatre schedules, clinics and off duty is already completed 6-10 weeks in advance and therefore being released is an additional challenge of having someone to cover.
- The Quality and Safety manager has contacted all investigators asking for a progress update and also offering support. They were asked if Quality and Safety needed to escalate to their manager about releasing them for protected time to work on the investigation.

- An email was sent to the Chiefs of Service or Executive which provided detail of who in their care group was carrying out investigations and how long the investigations had been open.
- Care Group Governance Meetings commenced in October. Open SI's and recommendations are part of this meeting.
- A UK external investigation company have been commissioned to carry out a thematic review of Massive Obstetric Hemorrhage's that have occurred within HCS (19 cases).
- An interim Serious Incident Reviewer has been appointed to help carry out investigations. They will support the investigators finalise overdue reports and help investigate the cases where no investigators have been sourced.
- Contact has been made with UK companies to deliver face to face Serious Incident training in Jersey.
- Quality and Safety have written a Job Description for an investigator which now needs to be submitted for Job Evaluation.
- SLT is also being asked to support the consideration that additional payments are offered to clinicians to carry out SI investigations. There is no budget available for this in 2023 but should this be offered in 2024 it could be partly funded by Quality and Safety depending on the number of SI's declared.

#### 4. Risk and issues

- Risk ID 1187: Inability to source specialist experts which is resulting in serious safety event investigations not occurring in a timely manner.

#### 5. Applicability to Ministerial Plan

This paper links to the Minister for Health and Social Services Delivery Plan 2023, specifically

**MHSS P1-** Advancing the quality of Government of Jersey health and care services, ensuring they are well governed, safe and person centred.

- Hold HCS to account for the delivery of safe, effective and patient centred care.
- form HCS's internal care governance structures, ensuring evidence-based standards for governing the Quality and Safety of healthcare are embedded in clinical practice and the organisational systems and processes that drive quality, safety, learning and continuous improvement.

#### 6. Main Report

Throughout the year, the Quality and Safety team have continued to strive to work in collaboration with the Care Groups to increase the focus on patient safety and to share learning from patient safety incidents. To date, there have been 31 Serious Incidents commissioned in 2023. 44 SI's are currently open and 6 have not been allocated 2 investigators.

Care Groups	Number of SI's open	Time since SI's have been declared	Number of SI's without an investigator
Medical CG	16	2 x 18 months 1 x 16 months 1 x 11 months 1 x 7 months 1 x 5 months	16 open SI's which is an increase from last month. <b>Without investigators:</b> <ul style="list-style-type: none"> <li>• 1 open 4 months (requires a 2<sup>nd</sup> investigator as the original</li> </ul>

		1 x 4 months 1 x 3 months 3 x 2 months 2 x 1 months 1 x 2 weeks 1 x 1 week 1 x 1 day	investigator can no longer complete the work)  <ul style="list-style-type: none"> <li>1 open 2 months without investigators</li> <li>1 open 1 week, have sourced one investigator requires another.</li> <li>1 open 1 day. Requires investigators to be sourced.</li> </ul>
Mental Health CG	8	2 x 14 months 1 x 11 months 3 x 7 months 1 x 6 months 1 x 3 months	<ul style="list-style-type: none"> <li>All have investigators</li> </ul>
Women's and Children's CG	9	1 x 10 months 2 x 5 months 2 x 4 months 1 x 3 months 2 x 2 months 1 x 1 month	9 open SI's is the same as last month. Without investigators: <ul style="list-style-type: none"> <li>1 open 4 months (requires a 2<sup>nd</sup> investigator as the original investigator can no longer complete the work)</li> <li>1 open 1 month. Have sourced one investigator, requires a second.</li> </ul>
Surgical CG	6	1 x 14 months 2 x 11 months 1 x 4 months 2 x < 1 months	
Intermediate CG	1	1 x 2 month	
Joint Medical and Surgical CG	2	1 x 5 months 1 x 3 months	
Joint Mental Health and Ambulance CG	1	1 x 10 months	

### Shared Learning:

- The Quality and Safety team facilitated the second Clinical Audit and Shared Learning event on October 19<sup>th</sup> with approximately 100 staff in attendance.
- The Quality and Safety team hosted a Patient Safety Week throughout HCS. Over 160 staff engaged with the event in addition to 82 patients or service users.
- The patient safety team continue to meet with the lead nurses and heads of service monthly to discuss all Datix that are graded as moderate and above and any outstanding and overdue Datix. Immediate actions are put into place and some Datix are closed at these meetings.
- In quarter 3, 103 staff received Datix training, not including bespoke Datix training that was

held for radiology and AAU.

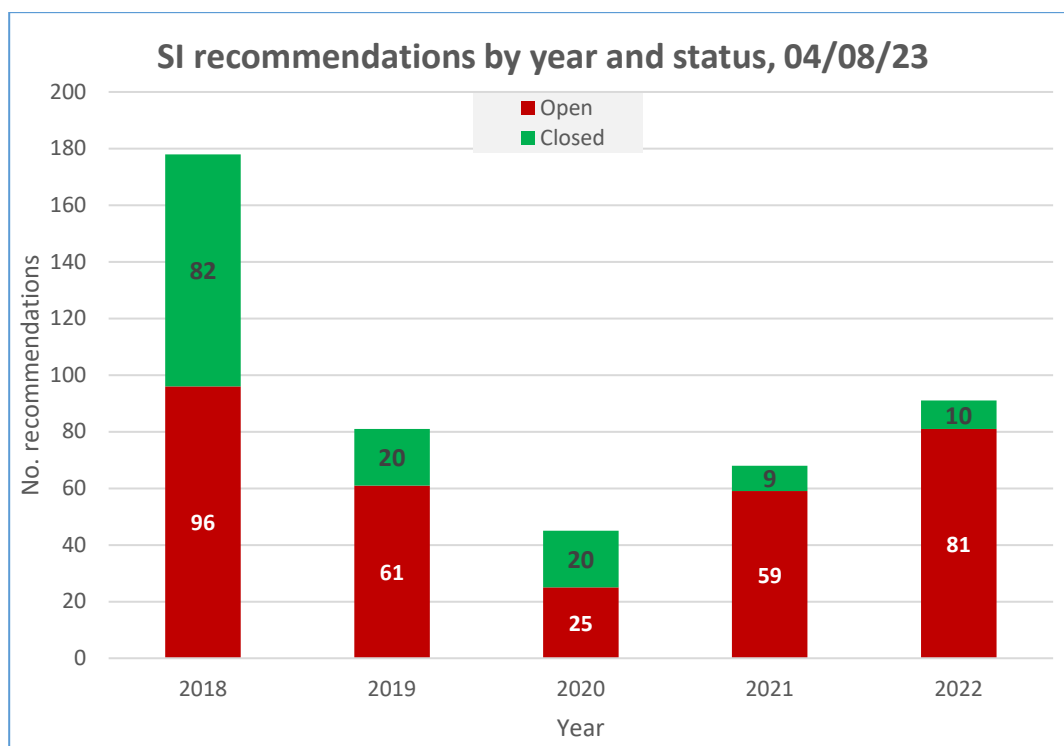
- Datix training was also held for the Surgical Inset day.
- During Quarter 3, 80 new Datix accounts were created which is almost double Quarter 2.
- Patient Safety team attended ward manager meeting to share SI and safety event data.
- Quality and Safety team attended the Medical Staffing Committee to increase awareness of Datix and Power BI dashboards.

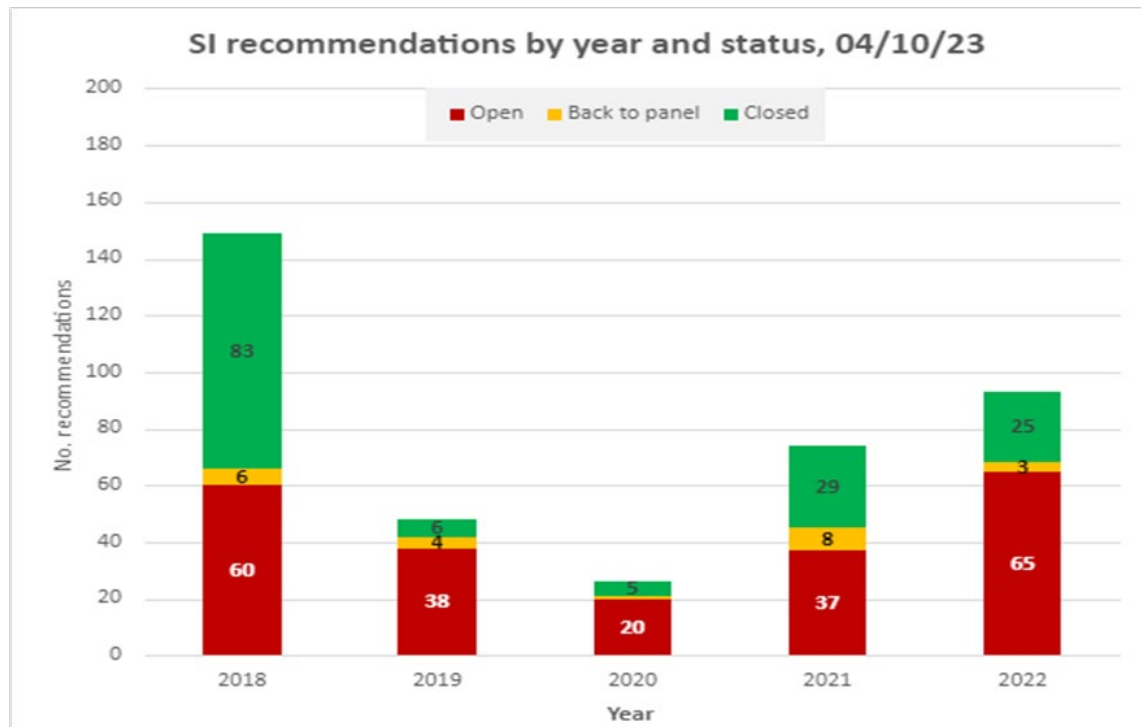
### Care Group/Lead Nurse Governance Meetings

- The Head of Quality and Safety chaired two Care Group Governance meetings, one for the Medical Care Group and another for Women and Children's Care Group.
- These Care Group Governance Meetings will be held monthly, the data being pulled by the Quality and Safety team.
- In November, the first Lead Nurse Governance meetings will occur, again the data being pulled by the Quality and Safety team, which will drill down further than the Care Group Governance Meetings to look at ward data.

### Serious incident investigation recommendations:

The Patient Safety team and Head of Quality Improvement (QI) have been collating all outstanding serious incident recommendations. Several meetings have been held with Care Group Leads in all the care groups to-date to cleanse the data and establish outstanding actions. These actions are then being allocated an owner and handler. Follow up meetings with the leads are planned over the next couple of weeks to try and gain further evidence of learning following SI's. The Quality and Safety team are working with the Mental Health (MH) Senior Leadership Team to close off the recommendations as they have been reviewed thematically. Over the next 4 weeks, this data will be further cleansed following meetings between MH and Quality and Safety team. When the Quality and Safety team supported by the Head of QI began work began on closing the SI recommendations in August, there was 322 SI recommendations open. As from the start of October this has reduced to 220 open SI recommendations.





## 7. Recommendation

The Board is asked to note the report and support the actions being taken to help the investigation of Serious Incidents in a timely manner and ensure that lessons are learnt from the resulting investigations and reports.

**END OF REPORT**





## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services (HCS) Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Complaints and Compliments position 6-month review.		
<b>Report author (and title):</b>	Patient Experience Team	<b>Accountable Executive:</b>	Interim Chief Nurse

### 1. Purpose

What is the purpose of this report?  What is being asked of the HCS Advisory Board?	The purpose of this report is to,  - Provide the Advisory Board with an overview of patient experience activity received both in the month of September 2023 and during second and third quarter of the financial year to highlight themes and trends. - Demonstrate lessons learnt in response to complaints. - The report is also able to confirm to the Advisory Board that there is no consistency of individual staff members /time or clinical area related to the complaints reported.  <i>For the purpose of this report complaint covers all aspect of patient feedback</i>	Information	√
		Decision	
		Assurance	√
		Update	√

### 2. Executive Summary

Learning from patient feedback is a crucial part of health care delivery providing information and feedback, which can be used to help drive improvement and strengthen the quality of services for patients and the public.

The Patient Experience Team within HCS is currently undergoing review and reorganisation to ensure that patients and the public receive resolution to complaints and concerns in a timely manner.

This report covers the period of April 2023 to September 2023 (April to June = Q2 July to September = Q3) with an aim to provide trend information for activity during Q2 and Q3. During this period, a total of 212 complaints have been received which represents a 31% increase for the same period last year, this is due to increase in complaints received around the pharmacy operating model. In addition, the team have been proactively seeking feedback from patients and visitors, there has been a poster campaign across the hospital sites to advise on how to contact the patient experience team.

The main category of complaints received relates to the care category. This can be further broken down into,

- administration / disposal of medication,
- coordination of medical treatment
- concerns regarding diagnosis.

Early resolution of complaints remains a key priority and the team have recently been reorganised to enable a focus on this activity and reduce the need to escalate to a formal complaint. The Patient Advisory Liaison Services (PALS) function is being relocated to the main hospital entrance and staff will visit wards and departments on a regular basis to promote early resolution of concerns through improved visibility to both patients and staff.

The patient experience team meet weekly with the care group senior leadership team to undertake a review of complaints including those complaints that remain open, to ensure that any concerns preventing early resolution can be addressed.

The organisation received 507 compliments within this period, care provided being the key subject area with 51% of all compliments relating to this. 29% of all compliments in the subject area relate to staff attitude and 20% an overall thank you.

### **3. Finance / workforce implications**

- Potential financial consequence relation to litigation following complaints.
- Senior Nurse is now in post and the Head of Patient Experience is soon to be in post. The Chief Nurse care group has redirected staff from other teams to assist in investigating complaints.

### **4. Risk and issues**

There is a continued need to improve the quality of the learning and dissemination across the organisation.

### **5. Applicability to ministerial plan**

In the Minister for Health and Social Services Ministerial Plan 2023-26, it is a key priority to enhance patient experience by introducing a service excellence standard setting out HCS's commitment to its patients and staff including standards relating to waiting times and referrals and measure of service satisfaction.

### **6. Complaints/Compliments Position**

Appended

### **7. Recommendation**

The HCS Advisory Board is asked to,

- Note the contents of the report.
- Recognise the ongoing improvement in the time to resolve complaints.

## Complaints/Compliments Position

### Total Complaints received during Q2 and Q3.

Timescale	Total Complaints received
April 1 <sup>st</sup> – September 30 <sup>th</sup> 2023	212
September 1 <sup>st</sup> –September 30 <sup>th</sup> , 2023,	28

### Current open complaints by care group: 45, (Excludes the 6 legacy cases)

Care Group	Stage 1 open	Stage 2 open	Stage 3 open
Medical Care Group	9	5	1
Surgical Care Group	10	3	1
Women, Children and Family Care Group	8	0	0
Mental Health	10	1	0
Adult Social Care	2	0	0
PPI/Therapies	0	0	0
Non-Clinical Support Services	0	0	0
Group Medical Director	1	0	0
<b>Total</b>	<b>40</b>	<b>3</b>	<b>2</b>

### Complaints comparisons year on year Q2 and Q3

Total number of complaints received April 1<sup>st</sup> – September 30<sup>th</sup>, 2023: **212**.

Total number of complaints received April 1<sup>st</sup> – September 30<sup>th</sup>, 2022: **160**.

This equates to a **31 %** Increase for the same period year in year, due to the proactive approach adopted by the patient experience team and increase in complaints regarding pharmacy services.



**Total complaints received by care group by Quarter and themes of complaints.**

<b>Care Group</b>	<b>Q2</b>	<b>Q3</b>	<b>Totals</b>
Medical Care Group	36	52	88
Surgical Care Group	31	31	62
Women, Children and Family Care Group	16	11	27
Mental Health	13	2	15
Non-Clinical Support Services	2	7	9
PPI/Therapies	2	3	5
Adult Social Care	2	3	5
Group Medical Director	1	0	1
<b>Total</b>	<b>103</b>	<b>109</b>	<b>212</b>

The significant increase in the Q's 2 and 3 within medicine are as stated earlier in the report. Q3 has also seen a significant drop in the number of complaints regarding mental health services, this is due to a focus on early resolution of complaints by the Mental Health team.

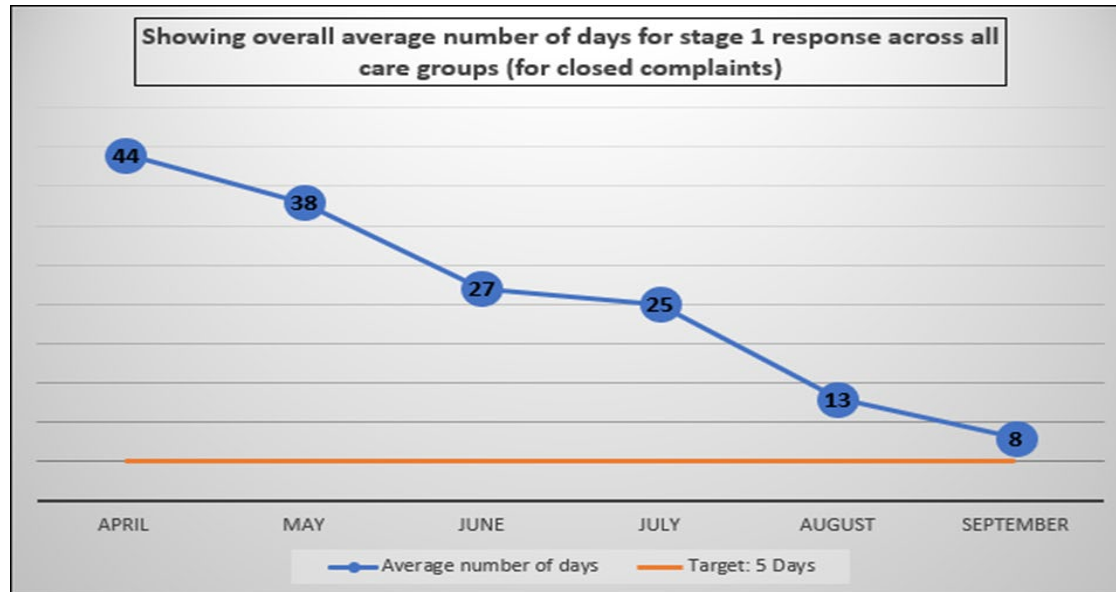
**Top 2/3 themes of complaints by care group for Q2 and Q3.**

<p><b><u>Medical Care Group</u></b></p> <ul style="list-style-type: none"> <li>• Delayed diagnosis</li> <li>• Failure to carry out care (obs, tests, examinations)</li> <li>• Staff attitude</li> </ul>	<p><b><u>Surgical Care Group</u></b></p> <ul style="list-style-type: none"> <li>• Waiting times</li> <li>• treatment didn't have the expected outcome.</li> <li>• Failure to carry out care (obs, tests, examinations)</li> </ul>
<p><b><u>Women, Children and Family Care</u></b></p> <ul style="list-style-type: none"> <li>• Waiting times</li> <li>• Delayed Diagnosis</li> <li>• Failure to carry out care (obs, tests, examinations)</li> </ul>	<p><b><u>Mental Health</u></b></p> <ul style="list-style-type: none"> <li>• Staff attitude</li> <li>• Waiting times</li> <li>• Lack of support</li> </ul>
<p><b><u>Adult Social Care</u></b></p> <ul style="list-style-type: none"> <li>• Discharge Failure</li> <li>• Poor aftercare</li> </ul>	<p><b><u>Non-Clinical Support Services</u></b></p> <ul style="list-style-type: none"> <li>• Waiting times</li> <li>• Premises</li> </ul>
<p><b><u>PPI/Therapies</u></b></p> <ul style="list-style-type: none"> <li>• No common themes</li> </ul>	

Waiting times remains an issue and work is ongoing with the appointments team to actively improve this, patients also complained regarding the length of wait to answer phone calls which has been escalated to the manager who is reviewing current process.

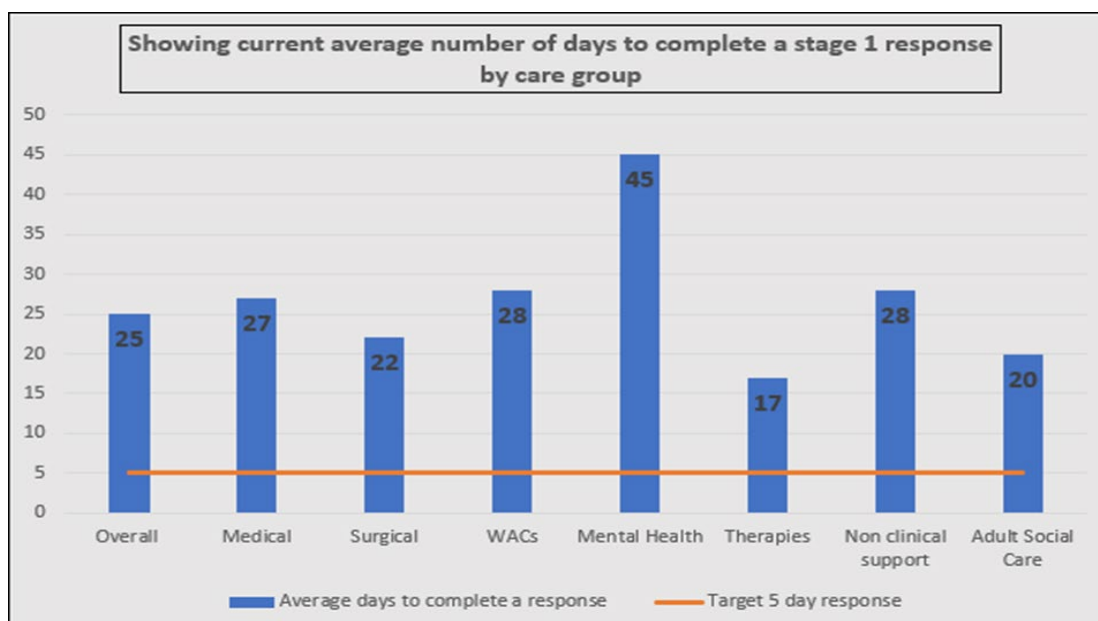
Targeted work through the Recognise Escalate Rescue (RER) program is ongoing with regards to NEWS scoring and recognition of the deteriorating patient. With regards to poor after care or complex discharges, a new transfer document has been jointly developed across HCS, Family Nursing and Home care (FNHC) and care homes and will be piloted across the inpatient wards during October.

### Response times and Targets



Average response time across all care groups for closed complaints (day's)	
Q2	Q3
36	15

Response times for closed complaints has improved by over 15 days from Quarter 2 to Quarter 3. This represents a significant achievement and recognises changes in the patient experience team working which has been highlighted in previous reports.



### **Open Legacy Complaints (6)**

Care Group	open
Surgical Care Group	1
Mental Health	1
Medical Care Group	3
Adult Social Care	1
<b>Total</b>	<b>6</b>

The rationale for the delay in closure of the legacy complaints (open greater than 6 months) relates to:

- Waiting for external investigation response (1)
- The complainant is under the management of the legal department. (3)
- Waiting internal independent review (1)
- Patient is unwell and therefore unable to support closure (1)

Whilst this is regrettable, there is ongoing communication with the families and additional face to face meetings have been established to ensure complainants are fully informed of the delay.

### **Lessons Learnt**

The sudden increase in complaints highlighted dissatisfaction with a recent change in pharmacy opening days/hours including wait times, seating etc. The issue was flagged immediately with pharmacy colleagues who responded by reviewing the procedures that were being reported to identify possible solutions. Pharmacy have now created a 24 hour turn around prescription drop off box to help reduce queues and waiting times.

Further seating has been identified within the outpatient waiting area which is now reserved for those waiting to collect a prescription, along with a new screen showing ticket numbers. There has been a significant reduction in concerns relating to pharmacy since implementation of the new procedures.

Attitude and behaviour remain a trend within two of the care groups and care groups need to consider the recommendations from complaint investigations and implement actions required. This will be monitored and should hopefully be reflected in a reduction of complaints relating to those issues.

### **Plaudits /Compliments Q2 and Q3**

Timescale	Total Compliments received
April 1 <sup>st</sup> – Sep 30 <sup>th</sup> 2023	507
September 1 <sup>st</sup> – September 31 <sup>st</sup> 2023	182

There were a larger than average number of compliments logged in September that were extracted from data received from the My Experience survey.

Compliments are categorised into three subject areas; '*staff attitude*', '*thank you*' and '*care*'. Of the 507 logged compliments within this time period, 51% referred to care provided, 29% to staff attitude and 20% an overall thank you.

The patient experience team are in final discussions with the Picker Institute to launch the independent anonymous survey of patient experience in the following areas by 20<sup>th</sup> October 2023:

- Inpatient wards
- Urgent and Emergency Care
- Maternity
- Community Mental Health
- Outpatients

A future report will be provided to the Board during 2024.

### **Workforce:**

A review of the workforce requirements within the patient experience team is underway and the Chief Nurse care group is providing resource to support this process and to ensure the management of complaints remains a priority.

### **Training and education:**

Training is available on Virtual College for Early Resolution of Customer Complaints.

Through Virtual College there are standalone sessions available which staff can undertake as part of their own continuing professional development (CPD) or request by line manager.

### **Moving Forward**

A robust tracking process with regular meetings with care groups senior leadership team has been established to focused on complaint management, including early resolution and implementation of lessons learned. To date this has had a positive impact on a reduction in the number of days it takes to respond to complainants.

Work is currently underway to establish a process to ensure lessons learned are captured through the analysis of feedback of complaints to be shared with all care groups and partner agencies to implement and monitor changes in practice.

There are plans in place to move from the My Experience feedback QR code, which requires manipulation of the data through a manual process, to the Friends and Family test which captures data in a format that is easy to analyse.

Future reports will provide rolling monthly information combined with national benchmarking. In addition, a process of triangulation of complaints, claims and incidents is being established to ensure that themes and trends are not missed when reviewing clinical events in isolation.

HCS has not previously reported or established an independent process to identify if a complaint was upheld or not. This is being explored with Customer and Local Services (CLS).

The patient experience team are working closely with CLS to support HCS in achieving compliance with the customer feedback policy.

### **Conclusion**

The previous Advisory Board report described the structural changes within the complaints department to ensure timely resolution of complaints it is reassuring to note that there has been an improvement in response and closure time. Future report will build upon themes trends and lessons learnt.

### **END OF REPORT**



## Health and Community Services Advisory Board Report

<b>Report to:</b> <i>(delete as appropriate)</i>	Health and Community Services (HCS) Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Waiting List Focused Report; five key areas (Ophthalmology, Endoscopy, Traum and Orthopaedics (T&O), Magnetic Resonance Imaging (MRI), Dermatology)		
<b>Report author (and title):</b>	Andrew Carter, Head of Access / Jemma Hammond, Planned Care Lead	<b>Accountable Executive:</b>	Claire Thompson, Director of Clinical Services

### 1. Purpose

What is the purpose of this report?  What is being asked of the HCS Advisory Board?	To advise and inform HCS Advisory Board of the current waiting list position regarding five key areas (Ophthalmology, Endoscopy, T&O, MRI, Dermatology) including information of the current restraints and issues, management actions and timelines for recovery.	Information	•
		Decision	
		Assurance	•
		Update	•

### 2. Executive Summary

The paper describes five speciality pathways of challenged waiting lists with context and background of the issues and management actions being taken to address and timeline for impact for improved access to treatment. In connection with this, HCS harm review policy is under development to provide increased assurance regarding any impact to patients. This needs to be rapidly implemented.

### 3. Finance / workforce implications

Some of the response contained in the paper is covered by substantive budget, other schemes are subject to waiting list initiative schemes. Some pathways are seeking to secure temporary workforce to stabilise services and good access to care which will affect run rate but have been included in agency forecasting in care groups and plans to reduce premium spend are observed and monitored at the workforce control panel (WCP).

### 4. Risk and issues

Services subject to rise in waiting list volume or % of patients waiting over 90 days are subject to recovery plans and were contained in the waiting list business case developed in 2024, with funding becoming available in July 2023.

### 5. Applicability to ministerial plan

Importance of access to high quality care to drive clinical effectiveness and outcomes is central to health policy and plan.



6. Main Report

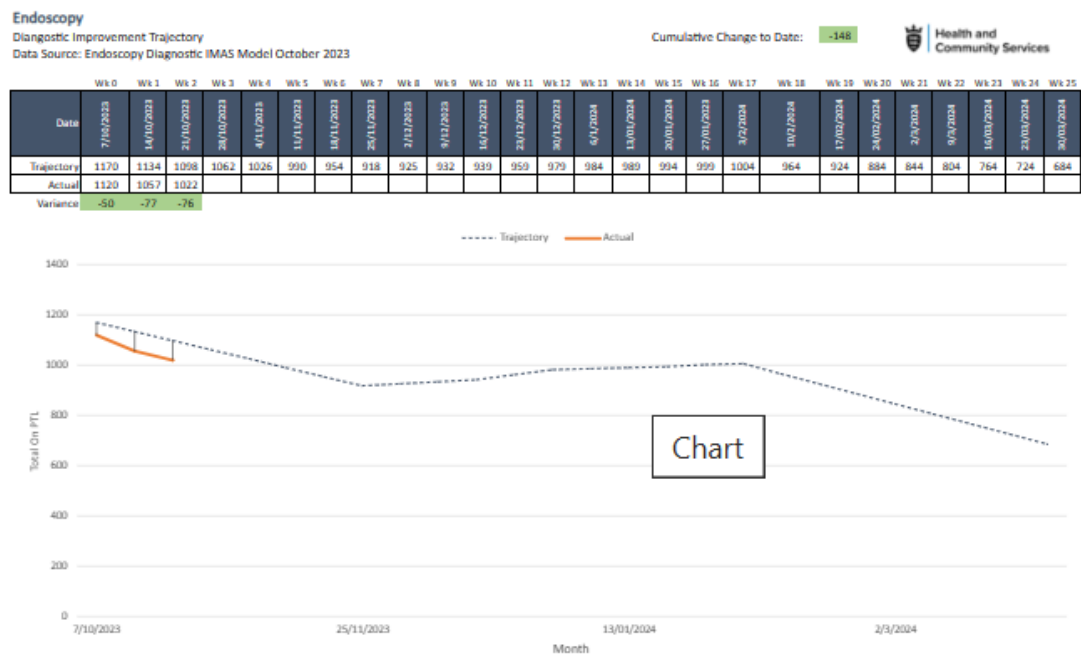
Endoscopy:

In August 2023, Health and Community Services appointed Xyla Elective Care Limited to fulfill an endoscopy insourcing requirement at Jersey General Hospital. The purpose of the insourced service is to provide additional capacity for a limited period to reduce waiting list volume and the backlog of patients, facilitated by the pandemic. The service, which runs at weekends only, includes full staffing (Consultants, Nursing and Decontamination Staff), a remote pre-assessment service, the completion of a range of endoscopic procedures and histology reporting.

The project is funded to be operational for a total period of 16 weekends, with half of the capacity being completed in Q4 2023 (07<sup>th</sup> October 2023 – 26<sup>th</sup> November 2023) and then the second half to commence from the 10/02/2024. Each weekend schedules a maximum of 96 JAG points depending upon complexity and case mix (approx. 40 patients per weekend).

The project commenced on the 7<sup>th</sup> of October with 1170 patients on the endoscopy diagnostic Patient Tracking List (PTL). Three consecutive weekends have been completed where 135 patients (253 JAG Points) have had their diagnostic procedure, a 97% completion rate. The 3% failure rate consists of patients with poor bowel prep and one patient did not attend. A diagnostic IMAS model was completed to inform the rate of backlog clearance and set the recovery trajectory as detailed in figure 1 below:

Figure 1: Endoscopy Recovery Plan Performance vs Trajectory



The project aims to reduce the total waiting list volume down from 1170 patients to 684 (-486 or 41.5%) patients by the end of March 2024.

Ophthalmology:

Health and Community Services are currently engaging with external quality assured providers to assist in supporting the identification of a suitable outsourced delivery model. The specific clinical outsourcing

service will provide additional capacity for a time limited period aiming to reduce the backlog of patients in Ophthalmology by an alternative provider at their facility for the full patient pathway of parts thereof as required. The solution is specific to the cataract pathway which currently has a 21-month routine wait for assessment.

HCS received expressions of interest (EOI) from several suppliers in response to a capability assessment which was shared via the NHS Shared Business Framework in the summer. In response to the EOIs, HCS shared a market engagement questionnaire in September 2023 which in turn informed supplier sessions which took place with key stakeholders (in October 2023) from HCS including the clinical lead for Ophthalmology.

This premarket engagement stage is not a call for competition and information being gathered is to assist HCS to better understand the services available within the marketplace and the detail needed to confirm the market and commercial approach.

As a result, HCS can describe the intended patient pathway as below:

The provider will deliver an off island surgical assessment and day case surgery solution for adults over the age of 18 years. The supplier will provide cataract procedures for Jersey patients following both national and local guidance and best practice. The supplier will be responsible for the first consultation review, pre-assessment, surgical procedure (including any complication on the day) and a post operative pressure check the day after surgery. HCS will be responsible for the post-operative follow-up 3-4 weeks post-surgery.

HCS will select patients applicable for the pathway following a consultant led review of all referrals where the presenting complaint articulated only refers to cataract and no other problems have been identified by the referrer. This process will aim to identify high risk patients with co-morbidities or any other clinical history that may impact on treatment or appropriateness to proceed to surgery.

Patients will be selected from the outpatient PTL and as such have not been seen by the department since referral. Patients already listed for surgery are out of scope for the project as they already have a management plan, diagnostics complete and To Come In (TCI) dates arranged. The referral is then passed to the supplier to complete the following:

Pathway Milestone	Brief Description
Pre-Travel Check	It is essential that there is a thorough check in place to ensure resources are not wasted. This will be in the form of a telephone pre-operative assessment conducted by clinical staff at the supplier's location that the patient will attend. The telephone pre-assessment check will assess, as far as possible, the patient's suitability for surgery and their "fit to fly" status. It will gather information about their current medications, ability to transfer, ability to lay flat and general health.
Travel to the UK	The patient travels to the UK with their chaperone and checks into their hotel. Arranged by HCS via the travel office.
Pre-Surgical Assessment (Day 1)	Shuttle transport from the hotel to the practice. Pre-operative consultation and preparation will be undertaken (including Biometry) as a 'one-stop' appointment to negate the need for multiple attendances. Diagnostic tests should be undertaken in line with Nationally and Locally agreed clinical pathways and guidance. Macular OCT (Optical Coherence Tomography) will be routinely undertaken as part of the cataract surgery pre-assessment pathway. The patient then moves directly into theatre.
Cataract Surgery (Day 1)	Patients proceeds to surgery. In addition, the provider may undertake treatment of a dropped nucleus or management of a posterior capsule tear required due to complications arising from cataract surgery. Endophthalmitis vitreous tap may be carried out by a trained consultant where necessary due to a complication of surgery.
Post-Operative Pressure Check (Day 2)	A post operative Intraocular Pressure Check is performed in addition to ensure drop compliance, removal of any dressings / shields and to deal with any problems or queries. Patient is 'Fit to Fly' back to Jersey.
Telephone Health Check (Day 3)	The supplier will call the patient once home in Jersey and complete a telephone health check to ensure the journey home has been successful and no complications have developed in transit.
Post-Operative Review (3-4 weeks post-Surgery)	The post-operative follow-up will be completed on island with HCS and include: <ul style="list-style-type: none"> <li>● Assessment of the eye including any inflammation, lens position and eye pressure</li> <li>● Visual acuity including unaided vision.</li> <li>● Auto-refraction</li> </ul>

HCS to share refraction and Visual Acuity Score with provider for NOD Submissions. Further follow-up appointments where clinically required will be undertaken by HCS in order to complete the pathway of care.
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£989,980 is allocated to the project to treat 500 patients for the full patient pathway. The pricing model has been informed by the supplier sessions in October with the preferred option to utilise the NHS tariff pricing schedule for the activity delivered.

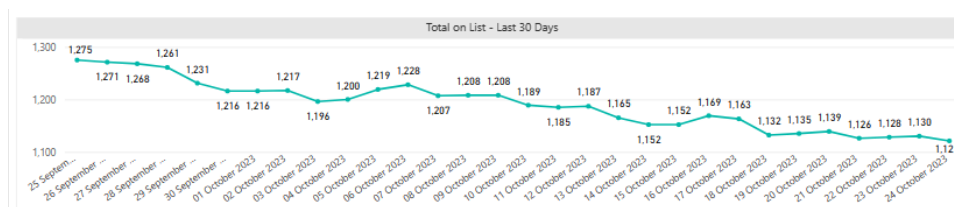
Now market analysis is complete, HCS is working with commercial services on the formation of the procurement strategy. It is anticipated that the procurement strategy will be submitted in preparation for procurement board on the 7<sup>th</sup> of November 2023.

The contract term will be 12 months. The intention is to appointment a supplier by the close of 2023, anticipating clinical activity to commence in Q1 2024. Clinical activity is expected to mobilise no longer than six weeks from the contract term commencement date. An IMAS model will be developed at the time of commencement of additional clinical capacity with a broad objective to reduce 21 month wait to less than a year.

## Trauma and Orthopaedics - Lower Limb

The Trauma and Orthopaedics outpatient PTL grew significantly post implementation of the new Electronic Patient Record (EPR) from 900 patients to 1400. A position which has since stabilised in the following months. This is primarily due to embedding in the EPR and a wider understanding of the interactions between the emergency department and the planned care pathway in the system, for example fracture clinic follow-ups versus actual referrals to T&O. The recovery has further been facilitated by the T&O outpatient waiting list initiative commencing in October 2023 and the additional clinical activity within the new Associate Medical Directors job plan (a T&O Consultant). The culmination of the above results in a minimum of 30 additional 'New' outpatient slots per week; the reduction is demonstrated below in Figure 2.

**Figure 2 – Trauma and Orthopaedics Outpatient Waiting List Volume – Last 30 days.**



The extra activity has had an impact on the Inpatient PTL which has consequently grown as patients are listed for surgery. More than 50% of this volume is listed for lower limb surgery with routine waits since listing > 1 year.

**Figure 3 – Trauma and Orthopaedics Inpatient Waiting List – Last 30 Days**



HCS now has increased staffing capacity in relation to lower limb surgery. The appointment of a dedicated spinal surgeon has released capacity from a substantive surgeon in addition to the recently appointed associate medical director's lower limb skillset. Despite this, a recovery plan is not in place, the primary constraints are due to bed pressures and kit (Hip/knee trays) creating a ceiling as to how much activity can be delivered week on week. Additional WLI sessions completed at weekends would

further compound the bed position on a Monday and put more pressure on clean kits being turned around in time and as such are ruled out until improved patient flow is realised.

HCS is, however, funded to deliver and outsourced or insourced solution to assist with the back log of patients waiting for lower limb surgery. Soft market research has been completed for both models of care. An options paper is being completed for the HCS Senior Leadership Teams consideration.

## **MRI**

A specific waiting list initiative to improve access for patients waiting for MRI scans has been in planning in September and commenced on the 9<sup>th</sup> of October following the recruitment and on boarding of staff. This has so far reduced the events (scans) waiting to be completed from 1,111 to 744 at the stage of writing this report. This means that patients were waiting 52 weeks for a scan and has improved to a wait of 31 weeks. This initiative is scheduled to complete pre-Christmas and is on trajectory for reducing waits for public patients to a wait for a routine scan by 6 weeks, soon 4 and urgent 2 and private patients can book at choice.

## **Dermatology**

Dermatology has been a difficult to recruit to specialty nationally, with an advert out for a dermatology consultant position for two years: HCS has been unsuccessful in recruitment during this time. In June 2023 a long-term locum returned to her family, and we have been unsuccessful in recruiting any suitable candidates with the skills to support the service following this. We have also had challenges with overseas applications for a middle grade post, resulting in a ten month and counting wait for a start date due to Visa and other on boarding requirements. The locum search has also been affected by the implementation of the tax changes in the UK.

This reduced the number of patients being seen as we entered Q2 2023, as there was only one consultant in post with a reduction in service further exacerbated by sickness and pre-booked annual leave.

The introduction of Maxims has further affected clinical throughput, which has now been resolved with extra resources. The nursing and support team staff also affected by maternity leave, retirement, new appointment and redeployment.

Action being taken to address:

All urgent patients have been contacted to provide assurance that we have received their referral and those patients that have been triaged as soon as possible are now in the process of being contacted after patient feedback. This is being conducted by phone or other means.

Discussions with primary care to ensure patients are reassessed/referred whilst awaiting appointment.

Specific headhunter engaged to rectify substantive Consultant post.

Over the next two weeks dermatology will see 70 'New' urgent patients shared between 2 clinicians. These patients have been clinically triaged and prioritised by the Lead Consultant. This will create a 90% conversion rate to minor ops. We have created two extra MOPS sessions to support these procedures. If the pilot is successful, then this will be repeated.

We have also now recruited a GP with special interest into post and he is seeing eight new patients a week and then spending time in his other session with patients requiring follow-ups to support their medication and to ensure correct prescribing e.g., Biologics/acne. There has been agreement that he will be able to undertake another session (as WLI) in which he can support long waiting patients requiring medication.

We are also recruiting a middle grade for a six-month contract to support outpatient work. During October a locum Consultant dermatologist who can work Saturday/Sunday/Monday has been identified and working to secure other staff to provide clinics. A Nurse prescriber due to start December has been recruited (temporary staff) and this will allow the diversion of other activity to medical staff to further impact new OP waiting list.

Overall, the impact to capacity would be to see in the region of 200 patients but further detail will be developed as the above is secured. The expected impact being good assurance on urgent referrals seen and list stabilised by the end of the calendar year. An IMAS model will be produced once we are assured of recurrent capacity and referrals stabilised.

It was hoped that capacity would be secured from NHS Trust in the UK to provide capacity in October/November which now seems uncertain, so HCS is seeking to contract WLI via main service level agreement (SLA) NHS contracts as able.

The overall model of care is being reviewed to see how tele dermatology options would impact pathway management in Jersey and is being led by our Chief of Service for Primary Care for impact in 2024. There are additional capital opportunities which will be explored to positively impact the demand as above.

## Waiting List Recovery Programme Financial Update

One-Off Costs	Business Case				Forecast				
	2023	2024	2025	TOTAL	2023	2024	2025	TOTAL	
Initiative One: Ophthalmology	494,990	494,990		989,980	0	989,980		989,980	Project Slippage, Procurement Panel 07/11/2023
Initiative Two: Clinical Genetics	45,795			45,795	0	45,795		45,795	With SLT re: wider service delivery model
Initiative Three: Respiratory Medicine	140,400			140,400	70200	70200		140,400	Slippage, Locum in post October 2023
Initiative Four: Orthodontics	0	275,000	275,000	550,000	0	275,000	275,000	550,000	On Track, Procurement Panel 07/11/2023
Initiative Five: Health Plus	10,000			10,000	10,000			10,000	Delivered
Initiative Six: Neurology	140,400			140,400	0	140,400		140,400	Slippage, unable to recruit locum
Initiative Seven: Teledermatology	100,000	152,000		252,000	0	126,000	126,000	252,000	Slippage, comms shared via Primary Care Board
Initiative Eight: Additional OPA Sessions	120,250			120,250	120,250	0		120,250	On Track activity commenced
Initiative Nine: General Surgery	122,525			122,525	24,000	98,525		122,525	Activity commenced but limited by one surgeons availability
Initiative Ten: Trauma & Orthopaedics	362,163	1,000,000		1,362,163	0	1,362,163		1,362,163	Options appraisal to SLT
Initiative Eleven: HIT Lists	280,000			280,000	100,000	180,000		280,000	Activity commenced but overall project slippage
Initiative Twelve: Endoscopy	400,000			400,000	20,000	380,000		400,000	*** 600k from Covid Recovery being used first as rolled over from 2022
Initiative Thirteen: Cardiac Investigations	350,000			350,000	50,000	300,000		350,000	Activity commenced
Travel Office Officer	45,795			45,795	0	45,795		45,795	To be deployed when Initiative One commences
MSK Physiotherapist	74,416			74,416	0	74,416		74,416	To assist Initiative Ten
Medical Secretary	45,795			45,795	0	45,795		45,795	Out to advert
Health Care Assistant (Outpatients)	45,795			45,795	45,795			45,795	Appointed
<b>Investment Total</b>	<b>2,778,325</b>	<b>1,921,990</b>	<b>275,000</b>	<b>4,975,314</b>	<b>440,245</b>	<b>4,134,069</b>	<b>401,000</b>	<b>4,975,314</b>	

## 7. Recommendation

The board is recommended to consider the contents of this report.

## END OF REPORT



## Health and Community Services Advisory Board Report

<b>Report to:</b> <i>(delete as appropriate)</i>	Health and Community Services (HCS) Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Consultant and SAS Doctors Job Planning Cycle 2023/24 Monthly Update		
<b>Report author (&amp; title):</b>	Patrick Armstrong, Group Medical Director	<b>Accountable Executive:</b>	Patrick Armstrong Group Medical Director

### 1. Purpose

What is the purpose of this report?  What is being asked of the Board?	Update to the Board on progress to date on job planning for Consultant and SAS Doctors.  To support the Group Medical Director in achieving full compliance with the contractual obligations for Consultants and SAS Doctors to have an up-to-date job plan	Information	✓
		Decision	
		Assurance	✓
		Update	✓

### 2. Executive Summary

This is an update to demonstrate progress in terms of achieving Job Planning for all Consultants and SAS Doctors working in Health and Community Services. Since last month issues have been identified in ensuring there is consistency in rewarding on-call and out of hours work. The Medical Director is working with the Chair of the Local Negotiating Committee (LNC) to ensure there is understanding of how this work is accurately reflected within the Job Plans.

### 3. Finance / workforce implications

- Value for Money not achieved, difficult to reduce costs without agreeing job plans.
- Low morale, some doctors are keen to have their job plans reviewed. There will be financial gains and losses for our staff, however the job plans will more accurately reflect their contribution to the service.
- Out of date job plans do not accurately reflect the work that our doctors are delivering for the service. Potentially inefficient utilisation of medical workforce.
- Improved healthcare outcomes for Islanders as efficient use of substantive staff will reduce reliance on temporary locum cover and will provide better continuity of care.
- Completion of job plans will result in improved morale of medical staff and assist with recruitment and retention as the job plans will more accurately reflect the medical staff contribution.

#### 4. Risk and issues

A key risk for the organisation is the lack of capacity for Clinical Leads and Chiefs of Service to complete the job planning round in a timely manner.

#### 5. Applicability to ministerial plan

Priority 1 of the [Minister for Health & Social Services Delivery Plan](#) is “Advancing the quality of Government of Jersey health and care services, ensuring they are well governed, safe and person centred.”

#### 6. Main Report \*

There are 152 job plans active at varying stages on the Allocate system. Reporting categories have been changed since last month to make it clearer as to the number of in date job plans there are. Previously all the signed off job plans were reflected in the signed off category however as some areas start the next round of job plans for 2024, these job plans move back to the ‘in discussion’ category even though they are still in date. This will become more common as job planning enters an annual cycle. There remains a significant amount of work to do to achieve 100% sign off ahead of consistency assurance and final lock down. Progress has been made in month on the signed off job plans, an increase of 16 since the last report. Over the next month focus and support will be provided to the Woman and Children’s Care Group and the Surgical Care Group where 15/23(65%) and 17/31(55%) job plans respectively, currently remain in the discussion phase.

##### Progress made to 23<sup>rd</sup> October 2023

##### 21 September 2023

Signed off	45% (67)
Awaiting 2 <sup>nd</sup> sign off	0% (0)
Awaiting 1 <sup>st</sup> sign off (By Doctor or Manager)	19% (29)
In Discussion	36% (54)

##### 23<sup>rd</sup> October 2023

Signed Off or in Date	55% (83)
Awaiting 2 <sup>nd</sup> Sign Off	3% (4)
Awaiting 1 <sup>st</sup> Sign off (By Doctor or Manager)	12% (18)
In Discussion	31% (47)

It is expected that, as a result of job planning, a change process will need to be undertaken for SAS doctors in Surgery, WACs and Medicine to improve patient care by better deployment of medical staff and achieving a better work/life balance for SAS Doctors.

#### 7. Recommendation

The HCS Advisory Board are requested to note this update, and to provide ongoing support for the job planning cycle for Consultants and SAS Doctors.

**END OF REPORT**





## Health and Community Services Advisory Board Report

<b>Report to:</b> <i>(delete as appropriate)</i>	Health and Community Services (HCS) Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Acute Medicine		
<b>Report author (and title):</b>	Adrian Noon Aisling Adams Phil Toal	<b>Accountable Executive:</b>	Claire Thompson

### 1. Purpose

What is the purpose of this report?  What is being asked of the Board?	To update the Board in relation to progress of external recommendations regarding acute medical care.	Information	√
		Decision	
		Assurance	√
		Update	√

### 2. Executive Summary

Medical Services at HCS have been subject to external reviews with a series of recommendations. The recommendations from these external reports which have been accepted, have been collated into a comprehensive action plan with the aim of tracking progress against the timescales defined. This will allow the Medicine Senior Leadership team to address areas identified and achieve sustained improvement in the quality of services. This report summarises the current position and the progress that has been made to date.

### 3. Finance / workforce implications

There are challenges surrounding our current medical model. We are heavily reliant on Locum Consultants providing our ward-based care and our current substantive consultants are specialty based. The medical care group have developed the future vision of the medical model to ensure resilience and evidence based high quality care in our base wards. Without this future model the embedding changes to the care delivery will be challenged. This workforce paper will be taken to SLT for decision making. Optimising substantive recruitment is being considered and acted upon where funding is available, with the overall aim of reducing locum spend as well as improving quality. It is anticipated there will be an increase in workforce required to optimise the quality of care on the base wards however the opportunity to utilise current resource differently and provide evidence of appropriate utilisation on this will need to be presented as part of this.

### 4. Risk and issues

This paper is the result of the clinical risks currently identified in the service. If the service is not improved, then clinical risk will remain. Failure to address this would leave HCS vulnerable to reputational and financial risk in the event of proven harm to a patient.



An increased revenue cost would be associated with adaptations to the workforce model.

## **5. Applicability to ministerial plan**

The proposal supports the delivery of the recommendations made in the report into clinical governance arrangements within Health and Community Services by Professor Hugo Mascie-Taylor, August 2022 which have been accepted by the Minister for Health and Social Services (MHSS).

## **6. Main Report**

Additional management oversight has been put into place in month with Medicine Improvement meetings. The Medicine Senior Leadership Team (SLT) have been reviewing the recommendations prior to this date with the development of an action plan. The actions and any evidence will be reviewed so that HCS can be confident of delivery, and it is accepted that slippage has occurred in our response due to both operational and quality improvement capacity to respond. This is being addressed through the onboarding of additional staff so that traction can be gained.

Due to various external reviews, it was evident that one comprehensive action plan was required to support the delivery. The purpose of the programme is to deliver coordinated and sustained improvements within the Medicine Care Group to address the recommendations and track the progress from external reviews which have been received. These reports include:

- Invited Service Review June 2014
- Initial Royal College of Physicians (RCP) Letter 2022
- Invited Service Review Nov 2022
- Visit Dr Rob Haigh Sept 2023

The Care Group SLT will now meet fortnightly with the Executive and Change Team to increase momentum, provide challenge and support with escalation. The first of a series of meetings took place on Monday 16th October 2023. A weekly meeting is also in place within the care group to monitor progress against the 45 recommendations (19 relating to the RCP). The project documentation that has underpinned monitoring of maternity has been adopted to support consistency of reporting via change and advisory board.

The themes identified by RCP recommendations and other reports include:

- Clinical record review,
- Protocol and Pathways,
- Staff and team working,
- Governance.

These provide the workstreams of the medical improvement plan. These have been mapped to the areas of which they relate to such as AAU, Wards, Same Day Emergency Care (SDEC), ECA (Enhanced Care Area) and other.

### Summary of actions include:

- Review the RCP report and recommendations by the executive team/subcommittee and provide oversight of an action plan.
- Review the findings from the Clinical Record review to embed learning.
- To ensure consistency of clerking of patients
- Review the structure, function and size of AAU including role of ECA.
- Interaction of AAU and the base wards and purpose there off, including size and subspecialty
- Weekend cover
- Appointment of a discharge nurse

- Clinical ownership and care planning including EDD, board and ward rounds.
- Linking with MDT in other centres
- Radiology working practices.
- Professional development of staff
- Clinical governance arrangements including M and M

Progress has not been made to the depth of evidence or in keeping with the timescales. In response, Dr R Haigh has been commissioned to provide physician input into delivery of the RCP assessment and regular input will be secured to support HCS response alongside improvement/operational capacity to improve the speed of response. Updates to the recommendations include:

- AAU and SDEC structure- 25 beds have been substantiated and recruitment is ongoing. The location of SDEC has been considered and feasibility study commissioned to inform estates planning.
- Standard Operation Protocol for SDEC is in development with leadership from new lead nurse and ED appointment.
- Same Sex bays in AAU- this has been implemented in September in 2 bays with ECA remaining mixed sex as is observed in areas of higher-level clinical care i.e., CCU. The conversion of the 4<sup>th</sup> bay is challenged once the need for greater than six females or males is required but further work is ongoing as part of estates/medical bed plan.
- The recruitment of a rota coordinator and implementation of electronic medical rota
- Electronic prescribing in Emergency Department has now been mitigated as the roll out plan.
- Recruitment of Clinical Fellows and the development of training programme, evidence to include list of supervisors and attendance to be reviewed at the Medical IG (improvement group)
- Job planning
- Establishment of escalation beds open in Corbiere and increase of medical bed base on Plemont.
- Consultant ward rounds including weekends. Impact to decision making being assessed and medical management/safety and discharge impact.
- Implementation of medical handover process at 8pm.
- Future Medical Model paper in development. To be presented to SLT.
- Meeting planned 31<sup>st</sup> October to review the role and function of ECA.

## **7. Recommendation**

The Board are asked to note the above. Regular updates will be provided by virtue of individual report updates and/or update overview of the work from HCS Change Programme Board into which MIG reports. A more detailed report with evidence can be provided at next months board as the additional capacity implements in November and a further visit from visiting physician 29<sup>th</sup> October.



## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	1st November 2023		
<b>Title of paper:</b>	Maternity Improvement Plan		
<b>Report author:</b>	Livi Methven Higgins, Senior Change Manager	<b>Accountable Executive:</b>	Patrick Armstrong, Medical Director Jessie Marshall, Chief Nurse Claire Thompson, Director of Clinical Services.

### 1. Purpose

What is the purpose of this report?  What is being asked of the Advisory Board.	To provide information and update on the Maternity Improvement Plan.	Information	X
		Decision	
		Assurance	X
		Update	X

### 2. Executive Summary

The Maternity Improvement Plan (MIP) was established on 28<sup>th</sup> June 2023. The purpose of the programme is to deliver coordinated and sustained improvements within Maternity to address the recommendations from internal and external reports which have been received and been within the organisation since 2018. The programme aims to consolidate the themes and actions within the plans, in addition ensuring that the responses become part of the embedded business-as-usual governance process of the organisation.

During October further progress has been made:

- The previously red recommendation 132, "To transfer Gynaecology outpatient to be performed in Day Surgery unit." has been made amber following completion of rotas and job planning to support this. The service is due to commence in Day Surgery from 1<sup>st</sup> November 2023.
- Quote received from Birth Rate Plus confirming cost of £9.6k, which has been agreed by the Chief Officer 2<sup>nd</sup> October 2023. Birth Rate Plus are due to attend on 19<sup>th</sup> and 20<sup>th</sup> October to review the midwifery workforce. Birthrate Plus (BRP) acuity tool is essential for understanding the midwifery workforce requirements and developing a workforce strategy.
- A further 13 recommendations have been approved by WACs SLT as complete. Topics from these recommendations cover:
  - Frenulotomy Clinic
  - Feedback from families

- MDT clinics for women with pre-existing medical co-morbidities
- Regular review of obstetric anaesthetic guidelines against Royal College of Anaesthetists (RCOA) guidelines
- Neonatal transfers
- Midwife blood transfusion e-training
- Further recommendations have been identified as green and these relate to:
  - Supporting holistic care for women in early stages of labour
  - Maternity dashboard
  - Continuous risk assessments throughout pregnancy
  - Governance regarding urinary catheters, elective caesarean

### Progress to date

Currently 70 out of 127 recommendations have been identified by WACS SLT as complete (up from 57 in September), of which 55 have been confirmed as having robust evidence/BAU process. 15 are under review to ensure robustness of evidence and sustainability of any BAU processes. The themes relating to the closed recommendations focus mainly on the outstanding actions relating to the delivery of the refurbished maternity unit, interaction with the maternity voice's partnership, appointment of a breastfeeding specialist, and the publication of key policies and guidelines.

High level progress to date can be found below:

	September	October
<b>Total Number of recommendations</b>	<b>127</b>	<b>127</b>
<b>Complete signed off</b>	42	55
<b>Complete</b>	15	15
<b>Green</b>	11	23
<b>Amber</b>	56	31
<b>Red</b>	3	3
<b>Escalate</b>	0	0
<b>Not started</b>	0	0

High level information of the red recommendations can be found below, each of these has been discussed with an agreed mitigating action at the Maternity Improvement Plan Monitoring Meeting (MIPMM) on 27<sup>th</sup> October. A detailed breakdown of these can be found in the attached exception report.

Rec.ID#	Topic/subject matter	Exception	MIG Outcome
004	Maternity Culture Strategy	<ul style="list-style-type: none"> <li>- Drop-in listening sessions held with Consultants on 29 Sep did not progress.</li> <li>- Drafted Maternity Culture Plan presented to MIPMM, requested for an associated programme of activity.</li> <li>- A review into a benchmarking questionnaire is underway to evidence progress.</li> <li>- Scope to roll out a Civility Saves Lives programme from Nov/Dec 2023, with a cost of circa £5k per day.</li> <li>- Identified as red due to the progress to be made with</li> </ul>	Recommendation to remain red, and for further listening sessions to be held with all Maternity Staff over October with findings to be discussed at each MIPMM.

		listening sessions with staff, to lead into a programme of activity.	
137	CGPR standardised template and Maternity CGPR to include a maternity risk report	This is an organisation wide recommendation. The standardised template has been completed and is currently under review with Execs. Maternity have agreed metrics to be included within the CGPR.	Agreed at MIPMM 11/10/23 to remain red. The recommendation is to be Executive owned as it relates to standardising CGPRs across all Care Groups.
161	Regular multi professional development and training.	Red due to the resistance to effort made to establish a session of multi-disciplinary learning.	Agreed at MIPMM to remain red. This recommendation has close ties with the Culture recommendation.

### Ongoing priorities

The Care group are focusing upon governance and workforce themed workstreams as priority which includes the training needs analysis. A further priority is the ongoing development of the care group governance process which will ensure that indicators when turn blue are able to provide confidence of sustainability and a timeline to support.

### 3. Finance / workforce implications

It has been identified that finance is required for the following recommendations:

- Rec.004 Culture
  - The rollout of the Civility Saves Lives programme is essential for improving culture within Maternity. This programme costs approximately £5k per day, the final potential cost is yet to be determined.
- Rec.041 Workforce
  - Quote received from Birth Rate Plus confirming cost of £9.6k, which has been agreed by the Chief Officer 2<sup>nd</sup> October 2023. Birthrate Plus (BRP) acuity tool is essential for understanding the midwifery workforce requirements and developing a workforce strategy.

It is understood that there may be recruitment requirements under the programme which may have financial implications, this is being reviewed.

### 4. Risk and issues

There is a risk that HCS does not have sufficient capacity to manage and address the recommendations as operational clinical and non-clinical resources are extremely stretched due to increasing operational demand and the increasing number of recommendations from clinical reviews and audits that need to be addressed and delivered by the same cohort of people. This is being mitigated by reviewing what further support the care group staff can provide, to enable a co-designed plan.

There is a further risk that Maternity staff are not yet fully engaged in the delivery of the MIP. This is being mitigated through weekly “Time to Chat” sessions with the Director of Midwifery, and with a monthly poster that details MIP updates, there is a recognition that more needs to be done to ensure staff are engaged.

### 5. Applicability to ministerial plan

In the Minister for Health and Social Services’ Ministerial Plan 2023-26, it was a key priority to “focus on improving the health and wellbeing of women” including “implementing the maternity improvement plan including pre- and postnatal mental health services and the substantive appointment of a breast-feeding specialist”.

## **6. Main Report**

A recommendation exception report is attached.

## **7. Recommendation**

The HCS Advisory Board are requested to note this monthly progress report and support the actions being taken to progress the Maternity Improvement Plan.

**END OF REPORT**



# Maternity Improvement Plan Exception Report

October 2023

## Purpose

The purpose of this document is to identify recommendations that are not progressing as planned and require further oversight and potential supporting or mitigating actions, for attention of the HCS SLT Change Programme Board.

## Introduction

The Maternity Improvement Programme was established on 28th June 2023, the purpose of the programme is to deliver coordinated and sustained improvements within Maternity to address the recommendations from 11 internal and external reports which have received and been within the organisation since 2018. These reports are:

1. Health and Social Security Scrutiny Panel – Review of Maternity Services S.R. 9/2021 – 6 July 2021
2. Royal College of Obstetricians & Gynaecologists Report – Review of the antenatal and peripartum care provided to a mother and baby at Jersey General Hospital – February 2019
3. Dr Roberts – Review of Obstetrics & Gynaecology Services at HCS – Interim Recommendation from first visit – May 2023
4. Dr Roberts – Report on O&G services HCS, Jersey from second visit – June 2023.
5. JMAAS/SCBU – Assessment Report 2022 – 27 June 2022
6. Dr Jain – Expert Neonatology Report on Amelia Amber Sweetpea Clyde-Smith – 10 December 2018
7. Ockenden Report – Final – Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust – 30 March 2022
8. Kirkup – Reading the signals – Maternity and neonatal services in East Kent – The Report of the Independent Investigation – October 2022
9. Ockenden Report - First – Maternity Services at the Shrewsbury and Telford Hospital NHS Trust - 10 December 2020
10. Dr Roberts – Review of Obstetrics & Gynaecology Services at Health and Community Services, Jersey General Hospital, St Helier, Jersey, JE1 3QS on 1 – 4 September 2020 - 2020
11. Dale T – Human Factors Observations from 14 to 17 January 2020 Jersey General Hospital Maternity Unit – 25 January 2020
12. Long standing Serious Incident actions

The programme aims to consolidate the themes and actions within the plans in addition ensuring that the responses become part of the embedded business-as-usual governance process of the organisation. Further duplicated recommendations have been identified and have reduced the number of reported recommendations from 131 to 127.

## Governance Arrangements

- WACS SLT and MIP Working Groups
  - Weekly review of excel maternity improvement plan
  - Purpose is to review progress of actions and their tasks, support requirements and identify risks and issues
- Maternity Improvement Plan Monitoring Meeting – led by the Medical Director
  - Fortnightly presentation progress report and theme summary
  - Purpose is to review reds, ambers, decisions required, escalation of non-delivery of items, risks and issues and receive assurance on the completion of recommendations.
- HCS SLT – Change Programme Board
  - Monthly cover page and exception report
  - Purpose is to receive assurance and review any further exceptions or escalations.
- HCS Board
  - Monthly cover page and report
  - Purpose is to provide assurance of progress against the MIP and embedding and sustainability of outcomes.



## High level progress to date

### Escalation Standards

There is a process of escalation standards within the care group. Changes are overseen at a senior leadership team meeting that has a structure of an agenda and action points. This is followed by a review and approval at the Maternity Improvement Group. The governance process within the care group ensures that indicators, once they are complete (blue), can provide ongoing confidence in sustainability and evidence and these become business as usual.

SLs are reviewed in line with hospital policy. Trends related to SI include massive Obstetric Haemorrhage (MOH) and issues relating to this (including procedures such as episiotomy). These are being considered by the care group along with further education to clinicians on the subject. An audit programme is being developed and compliance snapshots are in progress and reported to SLT and MIP.

	September	October
<b>Total Number of recommendations</b>	<b>127</b>	<b>127</b>
<b>Complete signed off</b>	42	55
<b>Complete</b>	15	15
<b>Green</b>	11	23
<b>Amber</b>	56	31
<b>Red</b>	3	3
<b>Escalate</b>	0	0
<b>Not started</b>	0	0

**Not Started** – Work to deliver against recommendation has not started

**Escalate** – To be escalated to MIPMM or WACs SLT

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

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

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

**Complete** - The recommendation is considered complete; evidence is being gathered for approval by WACs SLT

**Complete signed off** - The recommendation is considered complete by WACs SLT with robust evidence and sustainability of BAU processes

<b>Rec. ID#</b>	004
<b>Report</b>	Scrutiny Report
<b>Recommendation Description</b>	<p>The Minister for Health and Social Services must ensure that the Local Committee, developed following the initial Culture Summit, includes multi professional and across sector representation and that the Culture Strategy is published as an integrated part of the Maternity Services Strategy.</p> <p>Furthermore, the Culture Strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. [page 41]</p>
<b>Progress to date and cause of the exception and impacts</b>	<p>Drop-in listening sessions, led by the Director of Culture, Engagement and Wellbeing and Bev Edgar (Change Team) have been held with maternity staff over August. The 2018 culture plan has been provided to the Culture and Engagement Team. The findings from this were discussed at MIPMM 13/09/2023.</p> <p>Listening sessions were due to be held with Consultants on 29<sup>th</sup> September, unfortunately this did not progress.</p> <p>It has been suggested to establish a benchmarking questionnaire for maternity staff that could be used to evidence progress made in culture.</p> <p>It is noted that the ability to train together as a multi-disciplinary will support improvements in working relationships, this links into red recommendation 161.</p> <p>There is further scope to roll out a Civility Saves Lives programme in Maternity, however availability for this is from November/December 2023 with an associated cost of circa £5k per day.</p> <p>The drafted Maternity Culture Plan was presented to MIPMM on 11/10/23 where it was requested that an associated programme of activity presented to the Maternity Improvement Group in October, following further listening sessions, to lead into delivery of multi-disciplinary programme by end of October.</p> <p>This recommendation has been identified as red due to the progress to be made with listening sessions with staff, to lead into a programme of activity.</p>
<b>Raised at MIPMM</b>	09/08/2023, 23/08/2023, 13/09/2023, 20/09/2023, 27/09/2023, 11/10/2023
<b>MIPMM Outcome</b>	<p>It was agreed at MIPMM 11/10/23 for this recommendation to remain red, and for further listening sessions to be held with all Maternity Staff over October with findings to be discussed at each MIPMM.</p> <p>RAG rating to be reviewed following culture plan presentation.</p>

<b>Rec. ID#</b>	137
<b>Report</b>	Dr Roberts
<b>Recommendation Description</b>	<ul style="list-style-type: none"> <li>- The standardised CGPR reporting process and template should be completed and operationalised within the care group review meetings by July 2023.</li> <li>- The Maternity CGPR template for maternity must be accompanied by a maternity risk report (DR will provide exemplar)</li> </ul>
<b>Progress to date and cause of the</b>	It is noted that this is an organisation wide recommendation. The standardised template has been completed and is currently under review with Execs.

<b>exception and impacts</b>	<p>Maternity have established which metrics are to be included within the CGPR, based upon a scorecard from other maternity units, which are in line with SHIP (Southampton, Hampshire, Isle of Wight, Portsmouth). These have been confirmed with Informatics and with Executives and will be included in future WACs CGPR presentations. It is noted that these have been presented and agreed at the HCS Advisory Board who have requested regular updates on this dashboard.</p> <p>This recommendation has been identified as red due to the outstanding actions required; establishing a standardised template, agreement of template at SLT and embedding of template within CGPRs.</p>
<b>Raised at MIPMM</b>	23/08/2023, 13/09/2023, 20/09/2023, 27/09/2023, 11/10/2023
<b>MIPMM Outcome</b>	<p>It was agreed at MIPMM 11/10/23 for this recommendation to remain red.</p> <p>The recommendation is to be Executive owned as it relates to standardising CGPRs across all Care Groups and is to be raised by the Director of Clinical Services at the next HCS ELT meeting.</p> <p>RAG rating to be reviewed following approval of template.</p>

<b>Rec. ID#</b>	161
<b>Report</b>	JMASS
<b>Recommendation Description</b>	<p>Standard 15</p> <p>15.25 There should be regular multi professional development and training, including obstetric and neonatal resuscitation and emergencies, and CTG interpretation, by all who are involved in intrapartum care of the woman and her baby. This training and development should occur in realistic settings.</p>
<b>Progress to date and cause of the exception and impacts</b>	<p>It is noted that this recommendation links closely with the Culture recommendation due to relationships between multi professionals. Effort has been made to establish a session of multi-disciplinary learning, to be held in October/November.</p> <p>To update further following MIPMM 18/10</p> <p>This recommendation has been identified as red due to the current culture within Maternity.</p>
<b>Raised at MIPMM</b>	11/10/2023
<b>MIPMM Outcome</b>	It was agreed at MIPMM 11/10/23 for this recommendation to remain red until a series of multi-professional working can be committed to and measured improvement regarding the culture in Maternity.



## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	1st November 2023		
<b>Title of paper:</b>	Infection Prevention and Control (IPAC) Report		
<b>Report author (and title):</b>	Dr Ivan Muscat, Consultant Microbiologist and Director of Infection Prevention and Control and Janice Byrne, Lead Nurse IPAC	<b>Accountable Executive:</b>	Jessie Marshall Interim Chief Nurse

### 1. Purpose

What is the purpose of this report?  What is being asked of the HCS Advisory Board? <i>(brief statement and tick as appropriate)</i> <i>Any pre-reading</i>	To provide the Advisory Board with an overview of the current performance of HCS with regards to infection control rates and a summary of the work undertaken to improve patient safety with regards to infection control	Information	
		Decision	
		Assurance	
		Update	

### 2. Executive Summary:

Overall general bacteraemia rates are lower than the UK average except for hospital MSSA rates which are comparable. C. Difficile rates are in line with the UK average. Earlier GP appointments and use of antibiotics are likely to contribute to this picture.

Root cause analysis of the alert organisms highlight a number of responses that may prevent some cases including high bed occupancy rates which are not easily remediable, and in some cases, no evidently preventable cause is found.

Hand hygiene audits reflect positive compliance greater than 90% but small numbers of individuals may need further encouragement to adhere to hand hygiene. Environmental hygiene is in the 80-90% (amber) range this is a result of the age of the property and ongoing building works.

Ongoing intravenous line care requires greater ongoing focus.

### 3. Finance / workforce implications:

- IC net - £100,000 pa for 5-year
- Two data analysts circa £45,000 each per annum to support infection control, antimicrobial stewardship, microbiology and other laboratory data within informatics team.

### 4. Risk and issues:

- Absence of and /or less reliable data

- b. Reduced time for face-to-face interaction with staff
- c. Reduced ability to support HCS, Public Health
- d. Poor uptake of the vaccine programme

## 5. Applicability to ministerial plan

In the Minister for Health and Social Services Ministerial Plan 2023-26, it is a key priority to progress the effective management of risk and good governance including improving the quality and use of data to:

- better identify and manage risk.
- Understand service capacity and demand.
- Plan improvements and monitor effectiveness.

## 6. Main Report

### Hospital alert organisms January 2023 to date:

CATEGORY	INDICATOR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	TREND	YTD	STD
QUALITY AND SAFETY																	
Infection Control	MRSA Bacteraemia	Hosp	0	0	0	0	0	0	0	0	0	0	0	0		0	0
	MSSA Bacteraemia	Hosp	0	0	1	1	0	0	1	1	1	0	0	0		3	0
	E-Coli Bacteraemia	Hosp	0	0	1	0	0	0	1	1	0	1	0	1		4	0
	Klebsiella Bacteraemia	Hosp	0	1	0	0	0	1	1	0	0	0	0	0		2	0
	Pseudomonas Bacteraemia	Hosp	0	0	0	1	0	0	0	1	1	0	0	0		2	0
	C-Diff Cases	Hosp	1	2	0	0	1	2	1	1	2	1	1	0	1	10	1

Hospital alert organisms are collected across the UK because they reflect the burden of bacterial infection of a hospital and permit comparison between Hospitals. Above is the data for Jersey up to and including September 2022 with the cumulative data for the year to date (YTD). The cut off to determine whether there is exceedance and therefore give a red or green flag is being worked out but has been set at 0 per month and 1 per month for bacteraemia and C. Difficile respectively at the moment.

Below is the Jersey total and hospital alert organism data for 2022 (calendar 2022 and assuming 60,000 bed days) compared with the England and Wales (EandW) average (published April 2021 to end March 2022) to permit contextualisation of the Jersey figures.

## Reportable Organisms Comparison Data 2022

Per 105 popln	Per 105 popln	Per 105 popln	Hosp per 105 bed days	Hosp per 105 bed days ( absolute number in brackets)
	England	Jersey	England	Jersey
E coli	67	32	21.5	6.6 (4)
Klebsiella	20	8	11.2	5 (3)
Pseudomonas	7.7	4	4.9	3.3 (2)
MRSA	1.2	0	0.7	0 (0)
MSSA	21.7	16	11.3	11.6 (7)
C diff	25.2	26	16.3	18.3 (11)

The bacteraemia rates are lower than in EandW (except for hospital Staph aureus which are similar). The C. Difficile rates in the hospital and community are also similar.

At community level a contributory explanation may well be earlier GP appointments in Jersey. There is also a greater antibiotic use per capita in Jersey than the UK although our demographics are also slightly different. Greater antibiotic use will potentially decrease bacteraemia rates by treating localised infection earlier but will increase C. Difficile rates and antimicrobial resistance. There continues to be active promotion of appropriate antibiotic use locally and the rate of use is decreasing

but remains higher than the UK.

### **Root Cause Analysis Outcome Year to September 2023**

A post infection review is undertaken of all cases of reportable organisms. Key themes and trends have been previously mentioned within this report.

#### *Antibiotic utilisation*

There continues to be active promotion of appropriate antibiotic use locally and the rate of use is decreasing but is still higher than the UK.

#### *Intravenous line management*

Further within the report the outcome of intravenous line audits is described. Following IPAC team intervention there has been an improving trend noticed 100% compliance reported September 2023

### **Surgical site surveillance (SSI)**

Within the UK there is a mandatory requirement to undertake surgical site surveillance of an orthopaedic category for a minimum period of 3 months. This is not a mandatory requirement within Jersey and was previously collected however has not been collected for a period of time. It is proposed to recommence SSI collection for both orthopaedic cases and Caesarean section data in the new calendar year.

### **Outbreak Information**

During September no outbreaks were declared.

### **Infection Control Audit rolling programme – August/September 2023**

**IPAC audits compliance rates – Green (Compliant) 100%-90% - Orange 89-80% - Red (Fail) 79% below**

**Hand Hygiene** August /September overall 94% compliance

Whilst this reflects a positive picture there was observed fluctuations in compliance within clinical areas and clinical staff. Those areas of poor compliance are required to undertake daily audits and in such identified areas, compliance improved to consistently above 95%

**Environmental audits** August/September overall compliance 88% Amber

These related to required structural repairs required, for example floor surfaces need replacing, windows not insulated, leaking when it rains, clinically compliant sinks (to HBN 00-09), storage for equipment, vent cleaning. (over 7 departments) - Action, informed Estates team and IPAC team. A plan has been developed to address the outstanding issues within 4 weeks.

**Intravenous Cannula audit** Peripheral Cannula Insertion August 88% September 100%.

This improvement has been as a result of targeted intervention.

**Urinary Catheter Audit** Urinary catheter Insertion August 92% September 100%.

**Vaccination rates Flu/Covid** HCS staff uptake to 15/10/23 - COVID 12% Flu vaccination 13.4%.

HCS staff who have attended GP or elsewhere for these vaccinations are not captured in these figures. Further work is required to ensure an improved uptake of the vaccine programme.

## **7. Conclusion**

Overall, the report represents a positive set of results, however the IPAC team remain overtly vigilant in view of the forthcoming winter months. This will be achieved by timely RCA to ensure the appropriate use of antibiotics to manage infection.

The introduction of SSI within Orthopaedics and Maternity.

## **8. Recommendations**

The Advisory Board is asked to note the contents of the report.

Recognise the positive picture with regards to infection control

Support the ongoing work of the IPAC team.

Support the proactive uptake of the Covid and Flu vaccine programme.

**END OF REPORT**



## Health and Community Services Advisory Board Report

<b>Report to:</b>	Health and Community Services Advisory Board		
<b>Date of meeting:</b>	1 <sup>st</sup> November 2023		
<b>Title of paper:</b>	Health and Community Services Advisory Board Timetable 2024 / 2025		
<b>Report author (&amp; title):</b>	Emma O'Connor, Board Secretary	<b>Accountable Executive:</b>	Chris Bown, Chief Officer HCS

### 1. Purpose

What is the purpose of this report?  What is being asked of the HCS Advisory Board? <i>(brief statement &amp; tick as appropriate)</i> <i>Any pre-reading</i>	To present the Health and Community Services (HCS) Advisory Board Timetable 2024.	Information	√
		Decision	
		Assurance	
		Update	

### 2. Executive Summary

As per Health and Community Services Advisory Board Terms of Reference (2023),

*The Board will meet at least 6 times a year. The Board may meet at other times during the year as agreed between the members of the Board or as otherwise requested by the Minister. It is envisaged that it will meet up to 10 times in the first 12 months post appointment of members.*

Forward planning increases the likelihood of attendance and always having a quorum.

Board meetings are scheduled for the last Thursday of each month. Assurance Committees are scheduled quarterly.

### 3. Finance / workforce implications

N/A

### 4. Risk and issues

N/A

### 5. Applicability to ministerial plan

N/A



## **6. Main Report**

See appendix

## **7. Recommendation**

For noting.

**END OF REPORT**

## **Appendix 1**

### **Health and Community Services Advisory Board Timetable 2024 / 2025**

#### **2024**

<b>HCS Board Meeting Monthly</b>	<b>Reporting Period</b>	<b>Assurance Committees Quarterly</b>	<b>Reporting Period</b>	<b>Board Workshop</b>
25 <sup>th</sup> January	Month 11 and 12 2023 / Q4 2023 Month 1 2024	24 <sup>th</sup> January	Q4 2023	
29 <sup>th</sup> February	Month 1			28 <sup>th</sup> February
28 <sup>th</sup> March	Month 2			27 <sup>th</sup> March
25 <sup>th</sup> April	Month 3 / Q1 2024	24 <sup>th</sup> April	Q1 2024	
30 <sup>th</sup> May	Month 4			29 <sup>th</sup> May
27 <sup>th</sup> June	Month 5			26 <sup>th</sup> June
25 <sup>th</sup> July	Month 6 / Q2 2024	24 <sup>th</sup> July	Q2 2024	
26 <sup>th</sup> September	Month 7 and 8			25 <sup>th</sup> September
31 <sup>st</sup> October	Month 9 / Q3 2024	30 <sup>th</sup> October	Q3 2024	
28 <sup>th</sup> November	Month 10			27 <sup>th</sup> November

#### **2025**

<b>HCS Board Meeting</b>	<b>Reporting Period</b>	<b>Assurance Committees</b>	<b>Reporting Period</b>	<b>Board Workshop</b>
30 <sup>th</sup> January	Month 11 and 12 2024 / Q4 2024 Month 1 2025	29 <sup>th</sup> January	Q4 2024	
27 <sup>th</sup> February	Month 1			26 <sup>th</sup> February
27 <sup>th</sup> March	Month 2			26 <sup>th</sup> March
24 <sup>th</sup> April	Month 3 / Q1 2025	23 <sup>rd</sup> April	Q1 2025	
29 <sup>th</sup> May	Month 4			28 <sup>th</sup> May
26 <sup>th</sup> June	Month 5			25 <sup>th</sup> June